Good

Devon Partnership NHS Trust

Mental health crisis services and health-based places of safety

Quality Report

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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 5SN
RWV62	Wonford House Hospital	East and mid Devon crisis resolution home treatment team	EX2 5SN
RWV62	Wonford House Hospital	Teignbridge crisis resolution home treatment team	TQ12 4PH
RWV62	Wonford House Hospital	South Hams and west Devon crisis resolution home treatment team	PL6 7PL

Summary of findings

RWV62	Wonford House Hospital	Exeter health-based place of safety	EX2 5SN
RWV55	Torbay Hospital	Torbay crisis resolution home treatment team	TQ2 7AA
RWV55	Torbay Hospital	Torbay health-based place of safety	TQ2 7AA
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

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

During the most recent inspection, we found the trust had addressed the issues that caused us to rate safe and effective as requires improvement following the July and August 2015 inspection. We have rated each domain as good.

Following the December 2016 inspection, the mental health crisis and health-based places of safety services were meeting Regulations 9 and 12 of the Health and Social Care Act (Regulated Activities) Regulations 2016.

We rated mental health crisis services and health-based places of safety as **good** overall because:

- At this inspection, we found the trust had made improvements to the quality of the service and care and treatment given to patients. We have rated each domain as good.
- Crisis teams had access to safe and clean environments where people could be seen outside of their homes. Caseloads were managed safely by sufficient numbers of staff who had high completion rates in mandatory training.
- Staff understood people's risk and assessed this regularly during face to face contact and team handovers. People's care plans were personalised and recovery focussed. Staff made plans with people to prepare them to better manage their mental health issues, and the risks they presented, after being discharged from the team.
- Staff were knowledgeable in clinical issues such as making referrals to safeguarding teams and incident reporting. Staff attended regular meetings where they openly discussed their practice, shared ideas and learned from each other.
- The service employed a street triage worker who was able to support police when they encountered people in distress in the community. They offered mental health advice and information on people's current support and contact from mental health services. This helped police make decisions on whether the person needed assessment at a health-based place of safety.
- Crisis teams offered people brief psychological and social support. The service was also improving the way they assessed and monitored people's physical health. They had made physical health training mandatory and were identifying physical health leads for all teams. The trust had a physical health steering group who were committed to increasing teams' access to physical health monitoring equipment.
- Crisis teams consisted of skilled staff who were experienced in supporting people in crisis. All staff received a comprehensive induction that prepared them for their roles. They treated people in a caring and professional manner, had a good understanding of people's needs, spoke with them appropriately and in line with the level of support they required. Carers of people who used the crisis teams told us they felt involved in their care.
- Crisis teams responded to urgent referrals and concerns from people already on their caseload. The service had recently introduced an out of hours phone line so people could access crisis support during the night. Staff who took the calls were able to update people's electronic care records and record any advice that was given to them. Daily feedback was given to teams so they could offer people appropriate follow up the next day.
- The Torbay and Teignbridge crisis teams were able to refer people to two crisis houses. These services allowed people to be discharged from acute hospital settings early or, alternatively, could be used to avoid people being admitted to hospital. All people were supported by crisis teams whilst using these services, and would receive regular visits and medical reviews by a psychiatrist.
- Staff felt supported by their managers and colleagues and enjoyed their roles. Team managers had full oversight of their team's daily operation. They attended meetings and shared relevant information with their staff. Psychiatrists and administration staff were fully integrated within the teams.
- Staff had opportunities for career development. We spoke to nurses who had been supported by the trust to complete their non-medical nurse prescribing training and health care assistants who had been supported to complete training to becoming associate

practitioners. The trust was committed to improving staff's clinical skills and provided them 'your essential practice guide', a brief guides on improving knowledge in 15 areas of clinical practice.

However:

- Two of the health-based places of safety within the trust had some environmental safety issues and police did not have easy access to them. The same two facilities were overlooked by people using the gardens of inpatient wards. These issues could compromise people's safety, privacy, dignity and confidentiality. The trust confirmed that both facilities were planned for refurbishments; these would be commenced in April 2017.
- People were not always having their physical health risks assessed and managed whilst being supported in health-based places of safety. Staff in one of the crisis teams were not accurately recording people's concordance with medicine.
- The systems and documentation used to record and monitor a person's episode of care, whilst being supported in the health-based place of safety, did not allow staff to record all the information required on the trust's electronic care record system. This system was also not fully accessible for staff working in the crisis houses. This meant they could read information but were unable to update care records in line with care provided.
- Crisis teams did not have clear guidance from the trust to ensure they were providing a consistent clinical approach. This included teams approach to areas such as, managing people who were not engaging with the service and monitoring key performance indicators. We also found inconsistent approaches to providing staff supervision which had an impact on quality.
- The Exeter crisis team did not have a flexible approach to assessing urgent referrals. We found incidents where they had redirected people to psychiatric liaison services in accident and emergency as they felt they did not have available staff. They did not look at their current workload to see if any appointments could be rearranged.
- The North Devon health-based place of safety was only commissioned to operate between 9am and 5pm, due to it being used, on average, less than once a day. This meant people in the area often had to be transported by the police to Exeter or Torbay whilst in a state of distress.

Summary of findings

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

Are services safe?

Good

We rated safe as good for mental health crisis services and health-based places of safety because:

- Crisis teams had access to safe and clean rooms where people could be seen outside of their homes. Staff had access to personal alarms to enable them to summon support if required.
- The service had sufficient levels of nursing and medical staff to allow the service to manage caseloads safely. There were minimal staff vacancies and extra staffing requirements were absorbed by regular staff doing extra shifts or bank staff who were familiar with the service.
- Staff received mandatory training in areas relevant to their roles and their completion rates on the vast majority of training courses was in line with targets set out by the trust.
- Staff had a good approach to assessing and managing people's risk whilst under their care. Risk assessments were completed when people entered the service and updated in response to any incidents. People's risk was discussed daily in staff handovers and multidisciplinary team meetings.
- Crisis teams supported people to make plans to manage their own crisis and recognise when they may be at risk of becoming unwell in the future. Staff were mindful in ensuring the person was well enough to engage in this process and shared plans with people's support network.
- Staff were knowledgeable in safeguarding issues relevant to people in their care. We saw many examples of safeguarding issues being discussed within teams and with external agencies. Staff also adhered to lone working systems to ensure their own safety whilst supporting people.
- The service had a good approach to reporting and learning from incidents. Staff attended regular meetings dedicated to discussing and learning from all areas of their practice. We observed one of these meetings and heard staff sharing ideas and supporting colleagues.

However:

- Two of the health-based places of safety within the trust had some environmental safety issues. These were currently being managed by staff observation and the trust confirmed that both facilities were planned for refurbishment.

Summary of findings

- People were not always having their physical health risks assessed and managed whilst being supported in health-based places of safety. We saw an example of a person's risk of alcohol withdrawal being inappropriately assessed and managed.
- The trust had appropriate systems in place to monitor whether people were taking medicine if this was an area of concern. However, staff did not always use these systems accurately.

Are services effective?

Good

We rated effective as good for mental health crisis services and health-based places of safety because:

- The service employed a street triage worker who was able to support police when they encountered people in distress in the community. They offered mental health advice and information on people's current support and contact from mental health services. This helped police make decisions on whether the person needed assessment at a health-based place of safety.
- People on crisis teams' caseloads had care plans that were personalised and recovery-focussed and were offered a copy for their personal reference. The service had made significant improvements in this area and had dedicated team away days to improve staffs skills in this area.
- Crisis teams made staff available to assess people on the inpatient wards to see if they were suitable for crisis team support and all teams were supporting people who had come via this pathway. This meant that more people were returning home early with support, which in turn, freed up inpatient beds for people who required them.
- Crisis teams were able to offer people psychosocial support. Staff used consistent information to improve people's awareness of issues, such as the importance of sleep hygiene and daily structure in maintaining their mental health. Staff offered people practical support to help them manage social issues, such as accompanying them on appointments and signposting them to specialised support agencies.
- The service was adopting many measures to improve the way they assess and monitor people's physical health. They had made physical health training mandatory and were identifying physical health leads for all teams. Staff were asking about people's physical health during initial assessment and

Summary of findings

encouraging them to see their GP if there were potential concerns. The trust had a physical health steering group who were committed to improving teams' access to physical health monitoring equipment.

- Crisis teams consisted of skilled staff who were experienced in supporting people in crisis. Staff had training in specialist areas such as, non-medical prescribing, general nursing, cognitive behavioural therapy, and mental health during pregnancy. All staff received a comprehensive induction that prepared them for their roles.

However:

- Completion rates in Mental Health Act training were significantly below the trust's target.
- The systems and documentation used to record and monitor a person's episode of care, whilst being supported in the health-based place of safety, did not allow staff to record all the information required. This meant it was not possible to identify whether certain timeframes specified in the Mental Health Act Code of Practice had been adhered to.
- The trust's electronic care record system was not fully accessible to staff working in crisis houses. This meant they could read information but were unable to update care records as they provided care. They relied on e-mailing information to crisis teams who, in turn, recorded the information on the system.
- The quality of staff supervision varied across the service. The trust had a system that captured information on staff's training, supervision and appraisals. However, the system did not contain a template to ensure all areas of supervision were discussed. Therefore, supervisors using this system were not offering their supervisees support in all clinical and personal areas.

Are services caring?

Good

We rated caring as good for mental health crisis services and health-based places of safety because:

- Staff treated people in a caring and professional manner. They had a good understanding of people's needs and spoke with them appropriately and in line with the level of support they required. People who were using the service gave consistently positive feedback on the care that the service provided.

Summary of findings

- Crisis teams allowed people to maintain management of their own medicine unless there was a clinical reason, such as risk of overdosing. Teams provided people with information on medicine if they requested it.
- We spoke with carers of people who used the crisis teams and they told us they felt involved in their care. Teams provided people, and their carers with useful information about the service and ways they could access further support.
- People were able to give feedback on the care they received via the acute care friends and family test.

Are services responsive to people's needs?

Good

We rated responsive as good for mental health crisis services and health-based places of safety because:

- The majority of crisis teams were able to respond to urgent referrals within four hours. Staff made appropriate decisions based on risk to ensure people were seen in a timely manner. If required they would reschedule pre-arranged appointments to prioritise assessing people in crisis.
- The service had recently introduced an out of hours phone line so people could access crisis support during the night. Staff who took the calls were able to update people's electronic care records and record any advice that was given to them. Daily feedback was given to teams so they could offer people appropriate follow up the next day.
- Crisis teams took referrals direct from GPs. This meant they would not require an additional assessment by mental health services to confirm they met the threshold for crisis services. Teams also reassessed people who contacted the service directly if they had been discharged within 14 days.
- Teams responded immediately to concerns from people on their caseloads. We saw many examples of staff, including psychiatrists, carrying out urgent home visits to monitor people's risks. Staff were flexible with appointments and saw people at times and locations that suited them.
- The Torbay and Teignbridge crisis teams were able to refer people to two crisis houses. These services allowed people to be discharged from acute hospital settings early or, alternatively, could be used to avoid people being admitted to hospital. All people were supported by crisis teams whilst using these services, and would receive regular visits and medical reviews by a psychiatrist.

Summary of findings

- All crisis teams provided people with information on how to complain and how to access advocacy services.

However:

- The Exeter crisis team did not have a flexible approach to assessing urgent referrals. We found incidents where they had redirected people to psychiatric liaison services in accident and emergency as they felt they did not have available staff. They did not look at their current workload to see if any appointments could be rearranged.
- The North Devon health-based place of safety was only commissioned to operate between 9am and 5pm, due to it being used, on average, less than once a day. This meant people in the area often had to be transported by the police to Exeter or Torbay whilst in a state of distress.
- Police did not have easy access to two of the health-based places of safety which meant people had to be escorted around the outside of the hospital to reach the facility. The same two facilities were overlooked by people using the gardens of inpatient wards. Both these issues could compromise people's privacy, dignity and confidentiality. We were told these issues would be addressed as part of refurbishment plans that would commence in April 2017.

Are services well-led?

Good

We rated well-led as good for mental health crisis services and health-based places of safety because:

- Staff were aware of the trust's vision and values. They felt supported by their immediate colleagues and managers and enjoyed their roles. They had no concerns with bullying or harassment and, if they had concerns, felt they would be listened to.
- Senior managers and team managers had oversight of their team's daily work schedule. They attended meetings and shared relevant information with their staff. Psychiatrists and administration staff were fully integrated within the teams.
- Staff had opportunities for career development. We spoke to nurses who had been supported by the trust to complete their non-medical nurse prescribing training and health care assistants who had been supported to complete training to becoming associate practitioners.

Summary of findings

- Across the service staff had access to 'your essential practice guide'. This had been produced by the trust and contained brief guides on improving knowledge in 15 areas of practice including, care plans, clinical records, incident reporting, physical health and safeguarding.

However:

- Crisis teams did not have clear guidance from the trust to ensure they were providing a consistent clinical approach. This included teams approach to areas such as, managing people who were not engaging with the service and monitoring key performance indicators. We also found inconsistent approaches to providing staff supervision which had an impact on quality.

Summary of findings

Information about the service

Devon Partnership NHS Trust had three health-based places of safety, or section 136 suites, located on three hospital sites across Devon. Places of safety are for people who are detained under section 136 of the Mental Health Act. A section 136 is an emergency power given to the police. It allows a person to be removed from a public place to a place of safety for assessment, if it appears to the police officer that the person is suffering from a mental disorder.

A health-based place of safety is also used when police have executed a warrant under section 135(1) of the Mental Health Act. It provides a safe place to carry out an assessment when required. A section 135(1) warrant is issued to police officers by the courts. It allows them to enter private premises to remove a person to a place of safety if there are concerns for their own, or others safety resulting from their mental state. An assessment under the Mental Health Act can then be arranged to assess whether they should be in hospital or be better supported at home.

There were six crisis and home treatment teams within Devon. These teams helped 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 people being admitted to hospital by providing home based support.

There was a street triage service in Exeter to provide police officers with support when they believed that people needed immediate mental health support. The aim of this team was to ensure that people received mental health professional input and diverted people from inappropriate police custody or Section 136 of the Mental Health Act assessments.

When the CQC inspected the trust in July and August 2015, we found that the trust had breached two of the regulations. We issued the trust with two requirement notices for mental health crisis and health-based places of safety services. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 HCSA (RA) Regulations 2014 Person-centred care.
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

During this inspection, we found the service had made improvements and were now meeting the regulations.

Our inspection team

Head of Inspection: Pauline Carpenter, Care Quality Commission

Team Leader: Peter Johnson, Inspection manager, Care Quality Commission

The team which undertook this core service inspection comprised three inspectors, a Mental Health Act reviewer and six specialist professional advisors with current experience of services similar to these.

Why we carried out this inspection

We undertook this inspection to find out whether Devon Partnership NHS Trust had made improvements to their mental health crisis services and health-based places of safety since our last comprehensive inspection of the trust in July and August 2015.

When we last inspected the trust in 2015, we rated mental health crisis services and health-based places of safety as **requires improvement**.

We rated the core service as requires improvement for safe, effective, responsive and well-led and as good for caring.

Summary of findings

Following the July and August 2015 inspection, we told the trust that it must make the following actions to improve mental health crisis services and health-based places of safety:

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

We issued the trust with two requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 Person-centred care.
- Regulation 12 Safe care and treatment.

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 this inspection, we reviewed information that we held about mental health crisis services and health-based places of safety. In order to undertake a ratings review we inspected the service across all five domains. We carried out a comprehensive inspection of the service. This included an assessment of those issues that had caused us to rate the service as requires improvement for safe, effective, responsive and well-led.

During the inspection, the inspection team:

- visited all six crisis resolution home treatment teams and all three health-based places of safety. We looked at the quality of the environments and observed how staff were caring for people who used the service;
- met with 16 patients who were using the service and three of their carers;
- interviewed the managers or acting managers for each of the crisis teams;
- spoke with 38 other staff members; including doctors, service managers, nurses, health care assistants, social workers, administration staff and students;
- spoke with an approved mental health professional and a street triage worker who both worked closely with the service;
- attended and observed seven hand-over meetings and three bed management conference calls, one 'learning from experience' meeting and the referral process;
- attended and observed nine visits to people who were using the service;
- examined 50 care records of people using the service;
- reviewed 23 staff supervision and appraisal records;
- carried out a specific check of the medication management for all teams;
- 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

People who used the service told us that staff treated them with dignity and respect. They felt involved in their care, listened to and that the support they were given had a positive impact on their mental health. People told us that staff were patient and compassionate and that they felt comfortable discussing sensitive issues. They also appreciated the support they were given in regards to social issues.

One person told us that staff had arranged for their boiler to be fixed when they explained they were finding it overwhelming. Others told us that staff would accompany them to appointments they were feeling anxious about.

Carers of people who used the service told us that staff included them in their relative's care when appropriate. They were also given individual support to discuss any stress they may be experiencing.

Summary of findings

Good practice

- The service worked collaboratively with the patient advice liaison service to ensure they were informed of any complaint or concerns generated by people using the service direct. Senior managers across the service formed an on call rota that allowed the patient advice liaison service to contact them directly to inform them of the nature of the complaint or concern. They were then able to review the incident and aim to resolve it in a timely manner.
- The trust funded a street triage worker who was based within the Exeter police control room. This qualified mental health nurse acted as a link between the police and mental health services. Police could contact them if they needed advice regarding people's mental health history and whether they had support from services. This helped police to make decisions on the appropriateness of bringing people into a health-based place of safety.
- The service had positive working relationships with many local external agencies. They worked closely with a local charity that provided crisis houses. They had strong links with Exeter University which made the service accessible to students. They offered newly recruited police officers opportunities to shadow staff in the health-based places of safety. The service also worked closely with the Samaritans to offer alternative support networks for people.
- The trust were following clear protocol, within their bed management policy, for managing and recording Section 140 of The Mental Health Act. This places a duty on Clinical Commissioning Groups (CCG) to identify beds in cases of special urgency. This is used when patients' risks had been assessed as unsafe to be managed in the community. The trust were monitoring when they used their health-based places of safety as this alternative bed and reporting back to the CCG. This meant the CCG were aware of when the trust's bed capacity did not meet safe requirements.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that planned refurbishment of the health-based places of safety at Exeter and North Devon maintains people's safety and privacy.
- The trust should have a system which allows people using the health-based places of safety at Exeter and Torbay to access outside areas without risk of people absconding.
- The trust should ensure that people using the health-based place of safety have their physical health monitored if clinically indicated.
- The trust should encourage all crisis teams to review the information they display on their caseload whiteboards, to ensure they are monitoring key areas of people's care.
- The trust should ensure that systems in place to monitor the administration of people's medicine are used and completed accurately.
- The trust should make improvements to the documentation used to record information regarding people being detained on Section 136 of the Mental Health Act, to ensure it captures all relevant information. They should also ensure that staff fully complete this documentation.
- The trust should improve the accessibility to people's electronic care records for staff who worked in Granvue and Cypress crisis houses.
- The trust should ensure the Exeter crisis teams use a system to allow them to reschedule their work to accommodate assessing urgent referrals.
- The trust should consider how the North Devon health-based place of safety could be more accessible to people to avoid them being transported to health-based places of safety in other areas of the trust.

Summary of findings

- The trust should consider how issues, such as improved practice and lessons learnt from incidents, could be shared with all crisis teams and health-based places of safety across the trust.

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
Teignbridge crisis resolution home treatment team	Wonford House Hospital
South Hams and west 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
North Devon crisis resolution home treatment team	North Devon District Hospital
North Devon health-based place of safety	North Devon District 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 received training in the Mental Health Act, 50% of staff in the mental health crisis and health-based place of safety had completed this. However, staff we spoke with were knowledgeable in areas of the Mental Health Act that were relevant to their work.

Crisis teams would support people in the community whilst on extended Section 17 leave from the ward as part of their discharge plan. Staff had access to the relevant Mental Health Act documentation.

The documentation made available to staff to record information on people who were detained under Section 136 on the Mental Health Act needed updating. Staff were not capturing all relevant information.

The trust were following clear protocol, within their bed management policy, for managing and recording Section 140 of The Mental Health Act. This places a duty on Clinical Commissioning Groups (CCG) to identify beds in cases of special urgency. This is used when patients' risks had been assessed as unsafe to be managed in the community. The trust were monitoring when they used their health-based places of safety as this alternative bed and reporting back to the CCG. This meant the CCG were aware of when the trust's bed capacity did not meet safe requirements.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act and data received from the trust showed that the current completion rate across the service was 97%. Staff we spoke with had some understanding of how to assess whether someone had capacity. However, most staff felt these issues would be discussed in multidisciplinary meetings with the psychiatrists making the decision.

We found that 28 out of 35 care records contained evidence that capacity had been considered at initial assessment. We also saw that capacity was discussed and considered in multidisciplinary meetings and handovers.

Staff who completed the initial assessment of people bought into the HBPOS were not always recording whether people had capacity. However, we saw that this was being fully assessed by approved mental health professionals in their assessments.

Good

Are services safe?

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

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

Our findings

Mental health crisis services

Safe and clean environment

- Crisis teams were located across five different sites, three of which were hospital sites. Staff at the North Devon, Exeter, East and Mid Devon and Torbay teams had access to interview rooms to see people who did not wish to be seen at home. The Teignbridge team and South Hams and West Devon team were located in non-clinical environments. They were able to see people in local GP surgeries or community mental health sites if people did not wish to be seen at home.
- The Torbay team had access to a well-maintained clinic room where full physical health examinations could be carried out. Teams had varied access to equipment to monitor people's physical health. However, all equipment we viewed was in working order.

Safe staffing

- All crisis teams were either fully staffed or had minimal vacancies which had been either recruited into or advertised. The North Devon team was increasing its operational hours until midnight from 1 January 2017 and the additional staff required had already been recruited.
- We reviewed current staff rotas and found the service was allocating the appropriate amount of staff to each shift. Staff across the service generally found the workload busy but not excessive. However, some staff in the Exeter team and East and Mid Devon crisis teams told us that the workload occasionally felt excessive. Team managers were able to adjust staff levels to respond to increased workloads. Extra staffing needs were absorbed by regular staff doing extra shifts or bank staff who were familiar with the service. Data received showed that between July 2016 and September 2016, 56 shifts had been filled by bank staff and 36 shifts had not been fully staffed. Staff told us that team managers would offer clinic support if shifts were not filled.
- Sickness rates between October 2015 and September 2016, across the crisis teams were; East and Mid Devon 5%, Exeter 8%, North Devon 6%, South Hams and West Devon 7% and Torbay 11%. We did not receive sickness rates for the Teignbridge team. In the same period the service had an overall staff turnover rate of 6%.
- All teams maintained good oversight and management of their caseloads. At the time of our inspection crisis teams' caseloads were; East and Mid Devon 18, Exeter 15, North Devon 13, South Hams and West Devon eight, Torbay 20 and Teignbridge nine.
- All teams had access to psychiatrists. The psychiatrist for the Torbay team was also covering the Teignbridge team due to sickness.
- Staff received training in 11 mandatory courses which included; clinical risk, conflict resolution, Mental Capacity Act / Deprivation of Liberty Safeguards and safeguarding Adults and Children. The overall completion rate was 92% which was in line with the trust's target.

Assessing and managing risk to patients and staff

- We looked at 35 care records across the six teams and found that 34 contained an up to date risk assessment. We saw evidence that risk assessments were reviewed and updated in response to incidents.
- During our last inspection in July 2015 we had told the service they must ensure that people using the service have crisis plans that were individual to their needs. We found a significant improvement in this area. People were given blank crisis/relapse prevention plans on admission. They were encouraged, along with their carers, to complete these when their mental state had stabilised, and when appropriate staff would support them to convert the information into an individualised crisis/relapse prevention plan. We viewed completed plans on the trust's electronic record system and found them to contain information individual to the person. Where a plan had not been completed we saw evidence that it had been discussed. Teams also made reference to crisis plans on their caseload white board to ensure they were not overlooked.

Good

Are services safe?

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

- Teams also offered a generic crisis plan, called a 'keep safe plan', to people who they did not take onto their caseload. This contained information, such as distraction techniques, that people could use to manage low level anxiety and depression.
- Teams were able to respond to people's needs. We saw examples of staff carrying out home visits immediately after receiving telephone calls that a person required support.
- We observed handovers of all teams and found that staff had good awareness of current risk issues of people on their caseloads. All teams, apart from Torbay and Teignbridge, used a Red, Amber, and Green (RAG) rating system to identify levels of risk for people using the service. Current RAG ratings were clearly displayed on teams' caseload boards and interaction with the person was based on assessed risk factors.
- Staff across the service had 100% completion rate of training in safeguarding adults and children. Staff we spoke with knew how to raise safeguarding alerts and we observed staff having discussions around potential safeguarding issues during handovers. Staff completed a family form when people used the service which identified whether they were caring for children.
- Staff visited people in pairs for initial assessments and discharge. At other times people were only visited by one member of staff if risk had been assessed as low. Staff were aware that risk could be presented by relatives or friends and used appropriate systems to ensure their whereabouts were known to colleagues. Staff we spoke with knew what phrase to say on the phone to alert their colleagues that they were in danger. This allowed colleagues to assess the level of danger by asking questions that could be answered yes or no.
- The team leader for the North Devon team had been concerned that staff's mobile phones did not get a good reception in some locations. They added this to the trust's risk register and the trust issued new phones with improved reception capacity.
- All teams had medicine cupboards that were appropriately secure and used to stock frequently used medicines that could be administered via a patient group directive. Other medicines were issued via prescription, which allowed people to collect them from pharmacies. Teams in remote areas had good links with local pharmacies to enable staff to collect medicines and deliver them to people.
- Teams had good systems to be able to store and manage people's own medicine if they were at risk of overdose or non-concordance. However, we found the Exeter crisis team were not keeping accurate records of when people were receiving and taking medicine. This meant that it was not clear if people were keeping to treatment plans whilst under the team.

Track record on safety

- Between October 2015 and September 2016 there were four incidents across the service, reported to the trust's Strategic Executive Information System. All four incidents were for unexpected / potentially avoidable death.
- Staff received information about serious incidents across the trust via a monthly safety bulletin. Team managers were updated on learning when incidents had been investigated and would pass this information on to staff via team meetings. We reviewed minutes of team meetings across the service and saw that this was happening.

Reporting incidents and learning from when things go wrong

- Staff were competent in using the trust's incident reporting system. We reviewed incidents that had been reported and found them to be appropriate. They included clinical issues such as insufficient follow up after discharge and operational issues such as bypassing the bed management process to access beds. All incidents had been reviewed by team managers and closed or escalated appropriately.
- The Exeter crisis team was not always able to respond to urgent referrals. In these instances they directed people to be seen at accident and emergency by psychiatric liaison. We could not find evidence that these incidents were reported on the trust's incident reporting system.
- All teams understood duty of candour and we saw reference to this being discussed in team meetings. Staff also had access to duty of candour training. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and

social care services to notify people (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The service operated an on call rota to support the patient advice liaison service. This was manned by senior staff and allowed any concerns or complaints about the service to be dealt with by someone who would be able to quickly get access to relevant information to ensure the issue was managed appropriately.

- Staff had access to monthly 'learning from experience' meetings where they could discuss and reflect on their practice. We observed this for the North Devon crisis team and heard staff discussing issues such as aggression from patients and medicine management in an open and supportive manner.
- Staff we spoke with felt supported by the trust, their managers and colleagues, after being involved in incidents, and felt they had sufficient opportunities to debrief after incidents.

Health-based places of safety

Safe and clean environment

- The three health-based places of safety (HBPOS) were clean and allowed staff to observe people at all times. They all had appropriate lighting which could be dimmed to people's comfort. However, at the time of inspection the North Devon HBPOS did not have a working lightbulb. The North Devon HBPOS had broken taps and a soap dispenser following a recent incident. We also found the edge of the bathroom mirror to be sharp and a screw, used to hang a clock, protruding from the main door frame. The HBPOS at North Devon and Exeter both had furniture which could be moved and potentially present a risk to people in distress. We saw the environmental risk assessment for the Exeter HBPOS, all potential risks had been identified and were being managed by staff observations. We were told that both these facilities were due for refurbishment, which would commence in April 2017. The Torbay HBPOS was a new facility and we found this provided a completely safe environment for people using it.
- People using the North Devon HBPOS had access to a garden which had low roofs, which presented a risk of people absconding. We mentioned this to staff who assured that people would not be in the garden area unsupervised. The HBPOS at Exeter and Torbay did not have direct access to a garden and we saw a care record which showed someone had absconded from the Exeter facility whilst being escorted outside. The person had been returned by the police and the incident had been appropriately recorded.
- Staff attending to the HBPOS, or seeing people using crisis teams in interview rooms, had appropriate personal call alarms which allowed them to summon support if necessary.

Safe staffing

- All three HBPOS were staffed by a qualified member of staff and a support worker who were present at all times whilst the facility was occupied. We saw rotas at all three sites that identified staff would be made available at all times from either the crisis teams or inpatient wards. Between September 2015 and August 2016 there had been 25 incidents in Exeter and 13 incidents in Torbay where the HBPOS had been unavailable due to staffing issues. All these had been logged as incidents on the trust's incident recording system.
- Psychiatric support for people using the HBPOS was available from duty doctors 24 hours a day.

Assessing and managing risk to patients and staff

- Police remained with people for one hour after bringing them into HBPOS to manage any initial risks. The trust's HBPOS policy contained an algorithm, based on current and previous risks, to guide staff as to whether they required police to remain longer. Staff told us that relationships with police were positive and that newly recruited police officers would spend time at HBPOS as one of their probationary placements.
- We reviewed a care record of a person who used the HBPOS in Exeter during August 2016. They had been brought in by the police whilst intoxicated and had previous known significant alcohol use issues. We were unable to find that their recent alcohol use or history of alcohol use had been assessed as per the trust's policy. People with a history of high alcohol use could be at risk of experiencing fatal withdrawal symptoms if not given appropriate treatment. We spoke to staff about this issue and they confirmed they did not routinely monitor people's alcohol use when they were within the HBPOS.
- During our inspection a person was brought into the Torbay HBPOS who was presenting with symptoms of

Good

Are services safe?

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

chronic obstructive pulmonary disease. We saw staff monitor their physical health and make a decision to transfer them to the general hospital for ongoing care. This person was admitted to a medical bed due to their poor physical health.

Track record on safety

- For information on this serious incidents reported by the trust, please refer to the mental health crisis services section of this report.

Reporting incidents and learning from when things go wrong

- Staff were competent in using the trust's incident reporting system. We reviewed incidents that had been reported and found them to be appropriate. Staff reported incidents of restraint, rapid tranquilisation and when the HBPOS was used for the purpose of Section 140.
- Staff had access to duty of candour training. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify people (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff had access to monthly 'learning from experience' meetings where they could discuss and reflect on their practice.
- Staff we spoke with felt supported by the trust, their managers and colleagues, after being involved in incidents, and felt they had sufficient opportunities to debrief after incidents.

Are services effective?

Good

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

Our findings

Mental health crisis services

Assessment of needs and planning

- We looked at 35 care records across the six crisis teams and saw that all contained a comprehensive assessment of the person's mental health on their first contact with the service.
- During our last inspection in July 2015 we told the service they must ensure that people using the service had care plans that were personalised and recovery focused. We found a marked improvement in this area with all teams showing evidence of including people's views and preferences in care plans. In 24 of the 35 care records we viewed, people were given copies of their care plans and six others were offered care plans but declined to accept them. We found that teams were realistic in what they could offer people in way of interventions and found that care plans were still largely focussed on risk and medical interventions.
- The North Devon team had recently dedicated a team away day to care plans. Staff told us this had helped them be more consistent when offering people psychosocial interventions. An example was that all staff now used the same NHS endorsed leaflets when advising people on issues such as sleep hygiene, daily structure and graded exposure.
- Teams allocated staff to assess people's suitability of being discharged early from inpatient care to being supported by crisis teams in the community. We saw that caseloads contained people who had come via this pathway. This meant that people were not spending unwarranted time away from their families and, in turn, freed up inpatient beds for people who were acutely unwell. All teams had appropriate assessment tools that allowed staff to identify people's suitability for early discharge. However, we found no uniform tool that was used across the trust.
- All care records we viewed contained meaningful progress notes which clearly summarised staff's contact with people, and other relevant agencies, and contained an ongoing plan for their colleagues to follow.
- All staff were competent in using the trust's electronic care record system. Staff were issued with individual login information to ensure the system was secure. We found that, generally, information was recorded in the correct areas and staff who showed us care records were able to navigate the system confidently. The system allowed staff to upload paper documents that were relevant to people's care. The system was also available to staff working in two crisis houses where people on teams' caseloads may be staying for extra support. However, these staff had read only access which meant they could not update people's care records as events happened and relied on emailing information to the crisis teams' offices for it to be added. This meant information could be missed or delayed.
- Teams displayed key information of people on their caseload on whiteboards in their office. We observed that these were referred to and updated during daily handovers. All teams had different information, for example, reference to completion of physical health assessments, safeguarding issues and carers' assessments. This meant that teams across the trust were not giving consistent consideration to key areas of people's care.

Best practice in treatment and care

- The service had a number of patient group directives in place for use by the crisis teams. This meant that they were able to provide medicines without waiting for a doctor to prescribe them. These were reviewed by a specialist pharmacist inspector who found they were being used appropriately.
- Teams did not employ psychologists. Therefore, if people required structured psychological input they would be referred to the trust's psychology department. However, we found that teams were offering brief interventions such as mindfulness and graded exposure, delivered by staff who had knowledge in these areas. Teams also offered psychosocial advice on areas such as sleep hygiene, daily structure and graded exposure. People under the Torbay and Teignbridge crisis teams could be referred to a service run by a local charity, the community care trust. This service offered courses and activities aimed at increasing people's knowledge about mental health and recovery and improving their skills in self-managing and improving their wellbeing.
- During our inspection in July 2015 we told the service they should ensure a range of interventions was

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available within each team to provide a consistent approach. We found that teams were delivering these interventions using consistent NHS endorsed information and leaflets. However, we did not always find a subsequent care plan was written to confirm the intervention and monitor progress.

- All teams offered people support around social issues such as employment, housing and benefits. People told us that staff offered practical support which included accompanying them to appointments regarding their social issues. All teams had links with external agencies, such as housing and debt management advice, where they could signpost people for further support. The North Devon and Exeter crisis teams were in the process of recruiting discharge facilitators whose role would be to support people with social issues, such as housing, which were delaying them being discharged from inpatient wards for the crisis team.
- During our inspection in July 2015 we told the service they should ensure that physical health assessments were completed for all patients if clinically indicated. Teams in North Devon, Exeter and East and Mid Devon continued to rely on GPs to monitor physical health as they did not have access to physical health monitoring equipment. However, on initial assessment, staff asked a series of questions such as 'when did you last see your GP' and 'have you had any physical health symptoms recently' to ascertain whether people should be advised to see their GP. The Torbay team were auditing how consistently physical health information was collected during assessment. Areas such as 'last GP review', current physical health', 'family medical history' and 'smoking status' were looked at and we saw data that showed a marked increase in staff gathering this information. Staff at the South Hams and West Devon team had all been issued with equipment to monitor physical health and we saw evidence that people on their caseload had their physical health monitored regularly. The team's consultant was part of the trust's physical health steering group and told us the trust was moving in the right direction in this area. Physical health training had recently become mandatory for all staff and physical healthcare leads identified within each crisis team who would be given further training.
- During our inspection in July 2015 we told the service they should ensure that outcome measures and clinical audits were routinely used. All teams used the Health of the Nation Outcome Scales, which measures the health and social functioning of people with mental illness. Since our last inspection the service had introduced the acute care friends and family test which is a survey that collected people's views on the care they received. Between August 2015 and July 2016 they had received 96 questionnaires.
- All team were adhering to the trust's policy of auditing care records. Team managers looked at two care records a week and audited them against three pre-determined clinical areas. Thirteen clinical areas were identified including care plans, relapse plans, carer involvement, physical health and safeguarding and these were rotated monthly. Team managers told us that this was improving the quality of people's care records.

Skilled staff to deliver care

- Crisis teams consisted of psychiatrists, nurses, social workers and health care assistants. All teams employed non-medical nurse prescribers or had nurses being trained in this discipline. Teams did not currently employ psychologists or occupational therapists. All teams had sufficient administrative support to enable staff to focus on clinical work. Pharmacists were available to teams for support.
- Staff were experienced and the majority had worked within crisis teams for many years. The service employed some staff who were dual trained (mental health and general nursing); had training in psychological therapies such as cognitive behavioural therapy; and had training in specialised areas such as mental health in pregnancy and new mothers.
- All staff received a comprehensive trust induction when they were employed. We spoke with two staff who had recently joined the North Devon team. They both received a local induction to the team and their roles, and felt this had prepared them sufficiently.
- Staff received regular supervision and data received from the trust showed that this ranged between 100% of staff to 81% of staff across all crisis teams. We looked in detail at supervision records of 23 staff across all teams. The North Devon and Torbay teams used their own supervision template as opposed to the trust's supervision system. We found their supervision records were detailed and addressed areas such as

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performance, staff welfare and training. However, the trust's supervision system had one generic field with no prompts to guide supervisors and this led to less detailed information. We also found that attendance at team meetings was often recognised as supervision by supervisors who used the trust's own system.

- Of all staff across the service, 85% had received an appraisal within the last year. These were also recorded on the trust's appraisal system and we found that the system supported managers to give staff detailed and meaningful appraisals that monitored performance and promoted career development.
- Team managers felt they had suitable processes and support from human resources to be able to manage poor performance. They did not have any current concerns that required formal capability management and told us they used supervision to monitor staff performance.

Multi-disciplinary and inter-agency team work

- All crisis teams had regular team meeting where clinical and business issues could be discussed. We reviewed minutes from meetings across all teams and found many examples of staff discussing clinical issues and being updated on what was happening within the service.
- Crisis teams discussed individual people's care and ongoing plans regularly. All teams had weekly multidisciplinary team meeting that psychiatrists attended. We also observed psychiatrists giving clinical input, such as medicine increases, during daily handovers.
- We observed handovers at each team and found that everyone on the caseload was discussed in detail. Handovers varied in length between teams.
- Crisis team managers attended a daily bed management conference call at 1pm. This was also attended by staff from the acute inpatient wards. We observed this meeting and found that it gave a good overview of bed availability across the trust. We spoke with an approved mental health professional who was responsible for arranging assessments under the Mental Health Act. They felt that the meeting would benefit from happening earlier in the day. They explained that the North Devon service operated between 9am and 5pm and that not knowing bed availability impacted their ability to make decisions on assessments.
- The service was also able to refer people to the Samaritans for support. This was generally done when people were discharged or when they did not meet the threshold for crisis team support. The Samaritans would phone people at pre-arranged times to offer support until they person felt confident to initiate the phone calls themselves.

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

- Staff received training in the Mental Health Act, and data received from the trust showed that the current completion rate across the service was 50%. However, staff we spoke with were knowledgeable in areas of the Mental Health Act that were relevant to their work.
- Teams would support people in the community whilst on extended Section 17 leave from the ward as part of their discharge plan. Mental Health Act documentation was available to staff as it was uploaded onto the trust's electronic recording system. We were told that this arrangement would normally be for a few days and if the person was suitable for crisis support the person's section would be rescinded.

Good practice in applying the Mental Capacity Act

- Staff received training in the Mental Capacity Act and data received from the trust showed that the current completion rate across the service was 97%. Staff we spoke with had some understanding of how to assess whether someone had capacity. However, most staff felt these issues would be discussed in multidisciplinary meetings with the psychiatrists making the decision.
- We found that 28 out of 35 care records contained evidence that capacity had been considered at initial assessment. We also saw that capacity was discussed and considered in multidisciplinary meetings and handovers.

Health-based places of safety

Assessment of needs and planning

- We looked at care records and Mental Health Act documentation of 15 people who had used the trust's

Are services effective?

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three health-based places of safety (HBPOS) within the last three months. We found that the Section 136 recording log did not allow staff to record information such as, if the person had been given information on their rights; capacity and consent to treatment on arrival; timescales of when the approved mental health professional and second opinion approved doctor arrived to start their assessments; and the final outcome of the assessment. We also reviewed HBPOS data collection sheets from people using the Exeter facility between 2 July 2016 and 6 December 2106. The sheets allowed staff to record initial data from the police such as, the person's name; time of telephone call from police; and the person's presentation. We found that out of 63 records, 31 had missing information.

- The trust funded a street triage worker who was based within the Exeter police control room. This individual was a qualified mental health nurse and acted as a link between the police and mental health services. The street triage worker had access to trust records and police could contact them if they needed advice regarding people's mental health history and whether they had received recent support from services or had any planned in the near future. Street triage helped police to make decisions on the appropriateness of bringing people into HBPOS and had also helped the police identify missing people with mental health issues. Street triage operated between 6pm and 2am seven days a week. Outside of these hours, police could contact the emergency duty service to get this information.

Best practice in treatment and care

- During our inspection in July 2015 we told the service they should, with its partner agencies, ensure that it was adhering to its local policy and the Mental Health Act Code of Practice in its use of police custody. We received data from the trust to show that use of police custody had significantly reduced. Between April 2014 and March 2015, HBPOS had been used 147 times with police custody being used 199 times. Between April 2015 and March 2016, HBPOS had been used 248 times with police custody being used 42 times.

Skilled staff to deliver care

- Staff who managed the HBPOS were provided by crisis mental health services and adult acute inpatient wards. For information on issues such as staffs' training, supervision and induction, please refer to the mental health crisis services section of this report.

Multi-disciplinary and inter-agency team work

- The service had regular meetings to monitor use of HBPOS, which were attended by the police and approved mental health professionals.
- All teams had good working relationships with external agencies. The service offered newly recruited police officers the opportunity to shadow staff in the HBPOS. Staff told us that this had improved working relationships with the police.

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

- We found that the documentation made available to staff to record information on people who were detained under Section 136 on the Mental Health Act needed updating. It did not record if the person had been given information on their rights; timescales of when the approved mental health professional and second opinion approved doctor arrived to start their assessments; and the final outcome of the assessment.
- Section 140 of the Mental Health Act was used appropriately. This places a duty on Clinical Commissioning Groups (CCG) to identify beds in cases of special urgency. This is used when patients' risks had been assessed as unsafe to be managed in the community. The trust had a clear policy for managing Section 140 and we saw that this was followed. All episodes of the HBPOS being used for the purpose of Section 140 were reported as incidents.

Good practice in applying the Mental Capacity Act

- Staff who completed the initial assessment of people bought into the HBPOS were not always documenting whether people had capacity. However, we saw that this was being fully assessed by approved mental health professionals in their assessments.

Good

Are services caring?

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

Our findings

Mental health crisis services

Kindness, dignity, respect and support

- We accompanied staff from all teams on visits to people's homes and observed them being respectful and caring. Staff were very knowledgeable and were able to answer people's, and their carers' concerns. We saw how staff changed their approach depending on whether people were new to the team, experiencing distress, acutely unwell or being prepared for discharge. Staff were comfortable discussing sensitive issues, such as suicidality, and this helped people feel supported and listened to.
- We spoke with 16 people who were currently supported by the crisis teams either in person or on the phone. We received consistently positive feedback about the care people received. Regular themes were that staff took a genuine interest in people's lives and this had a positive impact on their recovery; that the team were easily accessible by phone and would return calls if not initially available. Many people commented that there had been a noticeable improvement in this area over the last year; and that staff were very flexible and would support people at times that suited them.
- All staff had an understanding of the importance of maintaining people's confidentiality. The North Devon team were currently located in a temporary office and were aware of the potential risk of people overhearing telephone conversations. We saw staff take phone calls in quieter areas of the office where possible.

The involvement of people in the care that they receive

- We reviewed 35 care plans and found they all contained people's own views. Staff we spoke with felt the service had made considerable improvements in this area and had used resources, such as team away days, to achieve this. The trust had recently issued teams with laptops to support staff completing care plans with people during home visits. We found that most people we spoke with had a copy of their care plan or had been offered it.
- People took ownership of their medicine unless there were identified risk issues. If crisis teams initiated new medicines, they used NHS endorsed information to provide people with guidance on issues such as doses and side effects.
- We spoke to three carers who told us they felt involved in their relatives care. We saw care plans that discussed family relations as being important to people's recovery. All teams had carers' packs available that gave practical support to carers.
- People were able to give feedback via the acute care friends and family test. This asked questions such as, did people feel listened to; did they feel involved in their care; did they receive clear information; and were they given an ongoing plan. The service had received 96 surveys and feedback was positive. We found the Torbay team had been more proactive in collecting this data and had received 60 responses. The East and Mid Devon and Teignbridge teams had not received any responses.

Health-based places of safety

Kindness, dignity, respect and support

- Exeter's HBPOS shower room and North Devon's HBPOS overlooked gardens of inpatient wards. People were able to close windows or pull curtains to maintain their privacy.

The involvement of people in the care that they receive

- Staff told us they involved families and carers where possible. People were asked if they needed to contact people whilst in the HBPOS and were supported to do so.
- People had access to advocacy whilst in HBPOS and we saw this was clearly displayed with details on how to contact them.

Are services responsive to people's needs?

Good

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

Our findings

Mental health crisis services

Access and discharge

- Crisis teams had a target to respond to urgent referrals within four hours and less urgent referrals within 24 hours. Staff assessed current risks and issues, such as whether the person was with family or friends, to decide whether the person needed to be seen urgently. Staff at the Exeter team told us they sometimes struggled to meet the four hour target for urgent referrals. In these occurrences they signposted people to accident and emergency where they would be seen by the psychiatric liaison service. Staff told us this could happen quite often when they were busy as the team's work was already planned out for the day. The team was not using a system to prioritise urgent assessments by rescheduling appointments for people with lower risks. We could also not find evidence that these incidents were being reported on the trust's incident recording system. During our inspection we observed all other teams responding to referrals within appropriate time frames. We found an incident where this was not possible being reported appropriately by the East and Mid Devon team.
- Teams took referrals directly from GPs as currently the community adult mental health service could only offer assessments within five days. Staff told us that the service had good relationships with GPs but that it did lead to inappropriate referrals at times. The team manager for the Torbay team was encouraging their team to monitor inappropriate referrals. We also received data from the trust that showed between April 2016 and October 2016 out of 1921 crisis team episodes, 452 had required two or less contacts before they could be discharged. We saw minutes of meetings where teams were discussing ways to support GPs who often made referrals that did not meet the requirements for crisis work.
- The service did not operate between the hours of 10pm and 8am, however, the North Devon team was due to extend its working hours until midnight from January 2017 and staff had already been recruited to cover this increase in hours. We were told that teams in other areas of the trust would be mirroring this increase of hours in the following months. The extra hours would be covered by two staff who could carry out assessments in the community or respond to the need for home visits of people already on the caseload. Staff told us that a further benefit of the extended hours was that they could supervise evening medicine at a more appropriate time for people who did not like taking medicine too early.
- During our inspection in July 2015 we told the trust they must provide a dedicated telephone support line throughout the night for people using crisis teams. This single point of access was now in operation from the trust headquarters in Exeter. It was staffed between 8pm to 8am seven days a week by two unqualified staff who were supported by a senior night nurse practitioner. Staff used standard questions to enable them to offer appropriate support and guidance to people. They were able to access the trust's care record system and record people's concerns and the advice they had given them. Information on the service was given to people who used crisis services and it had received in the region of 2500 calls between 8 September 2016 and 21 November 2016. Crisis teams were given daily feedback of who had used the service during the night and were able to offer follow up support as appropriate.
- All teams had clear criteria which did not exclude people. Teams were able to visit people twice daily if necessary and we saw many examples of people being supported who would normally require hospital admission. The South Hams and West Devon team demonstrated a flexible approach to supporting a person whose condition meant they were showering excessively. They monitored the length of showers during home visits twice daily and this was helping the person manage in the community.
- Teams had a policy of taking people back on their caseload without needing referral if they represented within 14 days of being discharged. This meant they could contact the service directly to be offered assessment of their needs.
- Staff informed us that due to geographic distance patients attended the inpatient wards to receive their clozapine titration, rather than staff going out to patients in the community. Clozapine is a medicine that requires stringent physical health monitoring in the early stages of people starting it.

Are services responsive to people's needs?

Good

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

- All teams had different approaches to managing people who did not attend appointments. We observed teams discussing individual cases in handovers and making decisions according to individual risks and past history. The service did not provide staff with clear guidance on steps that should be taken before it was deemed the person was safe to be discharged.
- People were offered flexibility with appointment times and we saw crisis teams prioritise urgent home visits to manage immediate risk issues. Teams who did not work within clinical settings could use GP surgeries to see people who preferred not to be seen at home. Psychiatrists would also carry out medical reviews in people's homes if required.

The facilities promote recovery, comfort, dignity and confidentiality

- Teams who worked out of hospital sites had access to interview rooms that were soundproofed and had comfortable furniture. These could be used if people preferred not to be seen at home. The South Hams and West Devon and Teignbridge teams had access to interview rooms within local GP surgeries although we were unable to view these during the inspection.
- During our inspection in July 2015 we told the service they should ensure that the information leaflets for the crisis teams correctly reflect the hours of operation and services available. We found these had been updated and gave accurate information about the individual teams. All teams also gave people information on admission, such as local advocacy services and how to complain. We looked at a resource folder available to people using the Torbay team and found it contained useful information on local agencies to support people's health and social issues.

Meeting the needs of all people who use the service

- All sites we visited were accessible by wheelchair and provided disabled toilet facilities.
- The service was able to support people who had learning disabilities. Staff told us that they would make reasonable adjustments for people in this group to ensure the service met their needs.
- Staff across the service told us they had access to interpreter services. They told us that using these services was rare. However, information on how to book interpreters was available on the trust's intranet.
- The Torbay and Teignbridge teams were able to use two crisis houses run by a local charity, community care trust. One provided seven beds and was located in Torquay and another provided 12 beds and was located in Paignton. These services allowed people to be discharged from acute hospital settings early or, alternatively, could be used to avoid people being admitted to hospital.
- All people were supported by crisis teams whilst using these services, and would receive regular visits and medical reviews by a psychiatrist. The crisis team remained responsible for assessing risk and devising care plans, although staff told us that the local charity employed qualified staff who able to contribute to care plans. Staff in these teams had access to read only trust records but could not record information on it which impacted their ability to work seamlessly with the crisis teams.

Listening to and learning from concerns and complaints

- Between October 2015 and September 2016, the service received a total of 13 complaints. Two of these were upheld and none were referred to the ombudsman. Reasons for the complaints were varied however there were a significant number complaining about the care or treatment people received from the crisis teams.
- All teams provided people with information on how to complain. All people we spoke with confirmed they received this information and would feel confident making a complaint if required.
- Staff knew how to manage complaints appropriately. We saw from team meeting minutes that complaints were discussed, lessons were learnt and feedback was given.

Health-based places of safety

Access and discharge

- We received data from the trust which showed the health-based place of safety (HBPOS) in Torbay had used Section 140 of the Mental Health Act 37 times between June 2016 and November 2016. This had made

Are services responsive to people's needs?

Good

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

the HBPOS unavailable on two occasions in this same period. The trust had a clear policy for managing Section 140. The person would spend the day on the inpatient ward and only return to the HBPOS for the purpose of sleeping. We spoke with the senior night practitioner who confirmed they escorted the person to and from the HBPOS at the start and end of their shift. All incidents of Section 140 usage were reported on the trust's incident reporting system.

- HBPOS in Exeter and Torbay operated 24 hours seven days a week. However, the North Devon HBPOS only operated from 9am to 5pm. In the twelve months prior to our inspection this facility had only been used eight times. We were told that as a full assessment could take approximately three hours people would not be admitted after 2pm. The police would often have to use the HBPOS in Exeter and Torbay which meant an extended drive for people who were often in distress. We also received data from the trust which showed that between 1 September 2015 and 31 August 2016, 17 people had to be transferred from the North Devon HBPOS to either Exeter or Torbay HBPOS to complete their Section 136 assessments. This meant additional distress for these people.

The facilities promote recovery, comfort, dignity and confidentiality

- People using the Torbay HBPOS had access to a well-maintained clinic room where full physical health examinations could be carried out. The Exeter and North Devon HBPOS had access to clinic rooms in the adjoining wards. All equipment we viewed was in working order.
- All three HBPOS displayed information on people's rights and how to complain.

Meeting the needs of all people who use the service

- Police did not have easy access to the health-based places of safety (HBPOS) in North Devon and Exeter. This meant that people had to be escorted around the outside of the hospital which could compromise their privacy and confidentiality.
- All three HBPOS were accessible by wheelchairs. However, the facilities at Exeter and North Devon did not allow police to bring people directly to them. This meant people with reduced mobility had to walk a short distance to reach the facility.
- People had access to interpreter services. Staff told us that using these services was rare. However, information on how to book interpreters was available on the trust's intranet.

Listening to and learning from concerns and complaints

- For information on how the service listens and learns from complaints, please refer to the mental health crisis services section of this report.

Are services well-led?

Good

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

Our findings

Mental health crisis services and health-based places of safety

Vision and values

- Staff we spoke with had knowledge of the trust's vision and values and felt their work reflected these. We spoke with staff who had recently attended the trust induction and they confirmed that these had been applied throughout.
- We spoke with all team managers and found they had sufficient oversight of issues relevant to their teams. Team members such as psychiatrists and administration staff worked in the same office as the core team which ensured that everyone was aware of day to day objectives.
- Staff felt connected to the trust and felt senior management were visible and approachable. Some staff in the South Hams and West Devon team felt that, due to their location, they were often overlooked by the trust. They gave an example of not being considered for the provision of crisis houses when other areas of the trust had been.

Good governance

- All teams operated in accordance with trust policy and governance systems. However, we found teams used different local systems to inform their practice. We found different approaches were used in areas such as, risk rating the caseload; recording staff supervision; responding to urgent referrals; and supporting people who were not engaging with the teams. Team managers from the crisis teams told us they asked each other for advice around practice but this was informally over the phone or by email. We saw some evidence that other teams practice was discussed within team meeting, such as sharing ways to decrease inappropriate referrals. However, there were no formal meetings whereby issues such as good practice and lessons learnt from incidents could be shared across all crisis teams and health-based places of safety within the trust.
- All teams had systems to flag adherence to key performance indicators on their caseload boards. These included, assessing physical health needs; offering carers assessments; and identifying children in the household. However, we found these differed between teams which meant some teams were not routinely identifying these importance issues.
- Team leaders told us they felt supported by the trust and senior managers. They had sufficient administrative support to allow their staff to focus on direct care. Team leaders all had clinical backgrounds and supported the team with caseload management when necessary. However, they felt they had enough time to manage their teams effectively.
- Staff were aware of the trust and local risk registers. They were able to submit items to this and local risk registers were agenda items in team meetings.

Leadership, morale and staff engagement

- Staff generally enjoyed their roles. Some staff within the Exeter and East and Mid Devon team felt the job could be excessively demanding at times. We found staff morale was generally high and witnessed all staff engaging and contributing towards the safe management of their caseloads.
- Staff felt supported by their team managers and colleagues and, in turn, team managers had confidence in their staff to work autonomously.
- Staff told us the service respected their work life balance. All teams allowed staff to work long days or shifts. Staff were able to negotiate changing shifts with colleagues and received their work rota with plenty of time to plan out of work activities.
- We did not hear any concerns regarding bullying or harassment within the service and teams appeared cohesive and supportive.
- Staff told us they knew how to whistle-blow and would feel confident in doing so. Most said they would do this internally and were not aware they could raise concerns directly to the Care Quality Commission if they were concerned of repercussions.
- Staff had opportunities for career development. We spoke to nurses who had been supported by the trust to complete their non-medical nurse prescribing training and health care assistants who had been supported to complete training to becoming associate practitioners.

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Commitment to quality improvement and innovation

- Crisis teams had not committed to the home treatment accreditation scheme. It had been discussed and there was a feeling that the service needed to improve work streams currently in place before considering a national accreditation programme.
- Across the service staff had access to 'your essential practice guide'. This had been produced by the trust and contained brief guides on improving knowledge in 15 areas of practice including, care plans, clinical records, incident reporting, physical health and safeguarding. Staff we spoke with confirmed it was a useful tool to refer to.