Requires improvement

Devon Partnership NHS Trust

Community-based mental health services for older people

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	Mid Devon OPMH Community Service (Mid Devon Central)	EX17 3NH
RWV62	Wonford House Hospital	South Hams and West Devon OPMH Community Service	TQ9 5GH
RWV62	Wonford House Hospital	Torbay OPMH Community Service	TQ3 2DW
RWV62	Wonford House Hospital	Teignbridge OPMH Community Service	TQ12 4PH

Summary of findings

RWV62	Wonford House Hospital	North Devon and Tawside OPMH Community Service	EX31 4JB
RWV62	Wonford House Hospital	Devon Memory Service (North Devon)	EX31 4JB
RWV62	Wonford House Hospital	Exeter OPMH Community Service	EX1 3RB
RWV62	Wonford House Hospital	Devon Memory Service (Exeter, East and Mid Devon)	EX2 5DW
RWV62	Wonford House Hospital	Bristol Dementia Service	BS2 9RU

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?	**Good** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Devon Partnership NHS Trust community-based services for older people as requires improvement because:

- The quality of people's care records varied in detail and quality in all the services we visited. Care plans were not always person-centred and they lacked detail required to demonstrate an understanding of the individual's circumstances and needs. Care plans did not always reflect changes in people's circumstances, and were not always clearly linked to assessment of needs and identified risks. This meant up to date information was not easily available or accessible to staff.
- Most care records we looked at did not contain clear, detailed crisis plans. Carers and patients we spoke with did not know how to contact someone in the event of a crisis. However, the trust undertook a review of a sample of records following inspection and stated that while the RIO electronic notes may not have contained a crisis plan, contingency plans were included in letters to the GP and the patient. The letters included contact details.
- Access to some sites was difficult. Although they were based within large general hospitals, signage in the older person's community mental health team part was poor and some of the other buildings had poor décor. Some furniture was not appropriate for older people, for example, low chairs, and some interview rooms were bare and poorly soundproofed.
- Environmental risk assessments had not been undertaken in community locations, although three of the sites we visited were based within large general hospitals. This meant there was no overview of the safety and suitability of the buildings. Most rooms did not have easily accessible alarms; staff viewed the client group as low risk of violence and aggression.
- Mental capacity assessments were not recorded in 18 out of 37 care records we reviewed, and of these at least six records reflected that people may not have capacity. 34 out of 37 care records had not clearly documented if the person had consented to information being shared, or with whom.
- We reviewed the referral quality assurance data provided by the trust. The data to monitor compliance with referral and response times did not reflect what teams were reportedly doing. The trust advised that the data they provided did not reflect team practice, due to the central referral system. From additional information requested from the trust, it was not clear how the directorate monitored performance with referrals, in order to ensure capacity within the service and that response times were being met.However, the trust advised that they provided waiting times data to their commissioners.
- Staff were concerned how the new hub and spoke model would affect their roles and the client group. For example, one hub in Torquay would involve a large geographical spread involving a large amount of travel time for some people, who may have cognitive impairment or mobility issues. Staff were not clear how people who used the service and their carers had been involved with the consultation for this model of care. The trust advised that they were planning to deliver a workshop, with the trust`s 'lived experience' advisory panel and 'be involved Devon'. The workshop would be aimed at people and carers that have used trust services, with regard to the SMART recovery programme, clinical hubs and single point of access.
- Lone working procedures were not consistent across the teams.

However:

- Staffing information provided by the trust, and observations during inspection, did not reflect any significant gaps in staffing levels. The training records showed that staff were up to date with mandatory training across the teams.
- The teams discussed clinical risks at weekly multidisciplinary meetings. Overall, risks were clearly documented and up to date in care records. Staff

Summary of findings

knew what kind of incidents to report and the procedures to report. Staff understood local safeguarding procedures, and what their responsibilities were.

- The care provided was in line with evidence based national guidelines, for example the Department of Health National Dementia Strategy. The service had developed clear care pathways. The teams had a wide range of experienced and qualified staff.
- People we spoke with were happy with the care they received from the service. People said that staff were polite, caring and respectful and felt staff were interested in their well-being. People said they were always treated with dignity and compassion. Staff had a good understanding of people's individual needs and social support systems.
- Each team had capacity to undertake routine and urgent referrals. Patients, carers and other professionals we spoke with, confirmed that calls were returned in a timely manner. Staff confirmed that they were able to respond effectively if they needed additional visits or contacts.
- Staff knew the organisation's vision and values. Overall, most staff felt that there had been more positive engagement from the executive team in the last 18 months. Staff, across all teams, spoke positively about the support they received from their colleagues. The level of support provided by team managers varied, although overall we found evidence of good local leadership.
- The teams all held weekly meetings and managers attended the monthly directorate meetings, where a range of quality and safety issues were discussed. Each team had a local risk register and information was shared with the senior team at the monthly directorate meeting. Managers had access to the trust 'Orbit' management system and 'Develop' training system, which enabled them to monitor individual team performance.
- Administration systems supported clinical staff effectively.

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:

- Most care records did not contain clear, detailed crisis plans. Carers and patients we spoke with did not know how to contact someone in the event of a crisis.
- Lone working procedures were not consistent. With the exception of Torbay, where procedures were clearly adhered to, not all staff in the other teams were aware of lone working procedures.
- Environmental risk assessments had not been undertaken in community locations, although three of the sites we visited were based within large general hospitals. This meant there was no overview of the safety and suitability of the buildings. Most rooms did not have easily accessible alarms; staff viewed the client group as low risk of violence and aggression.

However:

- Staffing information provided by the trust, and observations during inspection, did not reflect any significant gaps in staffing levels. Staff felt caseloads were manageable and that teams were safely and effectively resourced.
- Managers monitored staff caseloads and were providing regular supervision support for those with higher caseloads, with an aim to reduce them. Caseloads were weighted by complexity and working hours. Staff told us that their workload was manageable.
- The training records showed that staff were up to date with mandatory training across the teams.
- The teams discussed clinical risks at weekly multi-disciplinary meetings. We observed two meetings and reviewed a sample of meeting minutes for each team. These showed that a range of risk issues, such as safeguarding and clinical risks, were discussed within the MDT.
- Staff completed risk assessments during people's initial assessment and these were reviewed when there was a change in risk. Overall, risks were clearly documented and up to date.
- Staff knew what kind of incidents to report and the procedures to report. Staff understood the local safeguarding procedures, and what their responsibilities were.

Are services effective?

Requires improvement

We rated "effective" as **requires improvement** because:

Summary of findings

- The quality of people's care records varied in detail and quality in all the services we visited.
- Care plans were not always person centred and they lacked detail required to demonstrate an understanding of the individual`s circumstances and needs. Care plans did not always reflect changes in people`s circumstances, and were not always clearly linked to assessment of needs and identified risks. This meant the information was not easily available or accessible to staff.
- Mental capacity assessments were not recorded in 18 out of 37 care records we reviewed, and of these at least six records reflected that people may not have capacity. 34 out of 37 care records had not clearly documented if the person had consented to information being shared, or with whom.
- The quality of physical health assessments and monitoring varied across the teams.

However:

- The care provided was in line with evidence based national guidelines, for example the Department of Health National Dementia Strategy. The service had developed clear care pathways.
- The teams had a wide range of experienced and qualified staff. Staff across the teams were up to date with monthly supervision and annual appraisals.
- The teams worked effectively and collaboratively to plan and deliver appropriate care with other health, social and voluntary agencies.

Are services caring?

Good

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

- People we spoke with were happy with the care they received from the service. People said that staff were polite, caring and respectful and felt staff were interested in their wellbeing. People said they were always treated with dignity and compassion.
- Staff understood people's individual needs and social support systems.
- Daily progress notes within the care records showed that family and carers were involved in discussions regarding people's care and treatment. Carers spoke positively about the kindness, compassion and responsiveness they received from all staff

However:

Summary of findings

- Due to the cognitive ability of some people, it could be difficult to involve them in their care plan or provide information. However, we could not find evidence of how the decision not to share information with people was made, or the involvement of advocates or carers. It was not clear if any alternative ways to share information had been attempted, for example, in a different format.

Are services responsive to people's needs?

Good

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

- Each team had capacity to undertake routine and urgent referrals. Teams reported that they were meeting the 10-day target from referral to triage/assessment for routine referrals, and five days for urgent referrals, although the quality assurance information provided from the trust did not reflect this. The trust stated they provide waiting times information to commissioners.
- Patients, carers and other professionals we spoke with confirmed that calls were returned in a timely manner. Staff confirmed that they were able to respond effectively if they needed additional visits or contacts.
- Patients and their carers said they knew how to complain. There were information brochures about the complaints process in the reception areas of the services we visited. Staff described recent complaints and how they were managed.
- There was flexibility between the teams to support people. For example one person who was registered with a GP in one locality, but stayed with a family member in a different locality, could access the consultant from the family member's locality for appointments.

However:

- Access to some sites was difficult. Although they were based within large general hospitals, signage in the older person`s community mental health team part was poor and some of the other buildings had poor décor. Some furniture was not appropriate for older people and some interview rooms were bare and poorly soundproofed.
- There was limited access to crisis support outside of office hours for people with dementia, although people were able to access the on-call GP, social services or mental health practitioner based at the general hospitals outside of office hours in an emergency.

Summary of findings

Are services well-led?

Good

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

- Staff knew the organisation `s vision and values. Overall, most staff felt that there had been more positive engagement from the executive team in the last 18 months.
- The teams all held weekly meetings and managers attended the monthly directorate meetings, where a range of quality and safety issues were discussed. Each team had a local risk register and information was shared with the senior team at the monthly directorate meeting. Managers had access to the trust 'Orbit' management system and 'Develop' training system, which enabled them to monitor individual team performance. Administration systems supported clinical staff effectively.
- Staff, across all teams, spoke positively about the support they received from their colleagues. The level of support provided by team managers varied, although overall we found evidence of good local leadership.

However:

- We reviewed the referral quality assurance data provided by the trust. The data to monitor compliance with referral and response times did not reflect what teams were reportedly doing. The trust advised that the data they provided "does not reflect team practice", due to the central referral system. From additional information requested from the trust, it was not clear how the directorate monitored performance with referrals, in order to ensure capacity within the service and that response times were being met. However, the trust advised that they provided waiting times data to the commissioners.
- Staff were concerned how the new hub and spoke model would affect their roles and the client group. For example, one hub in Torquay would involve a large geographical spread involving a large amount of travel time for some people, who may have cognitive impairment or mobility issues. Staff were not clear how people who used the service and their carers had been involved with the consultation for this model of care.

Summary of findings

Information about the service

Devon Partnership NHS Trust provides specialist mental health services to meet the mental health needs of older adults, over 65 years old, with acute, serious, and enduring mental health problems, including dementia. Services provided include routine and urgent assessment, memory assessment, and on-going treatment and review. Services are divided according to clinical commissioning group (CCG) and geographical boundaries. The services work with three different CCGs: New Devon CCG, Torbay & South Devon CCG and Bristol CCG. There are three local authorities: Devon County Council, Torbay Council and Bristol City Council.

There are eight teams that provide a community mental health service for older people across Devon. Older adults requiring specialist mental health services can self-refer or be referred directly from their GP. Access to the service is determined by the needs of the individual as well as their age. Therefore, individuals of any age will be accepted where dementia is suspected.

The Devon memory services provide early assessment and diagnosis of dementia and ensure people access support following diagnosis. The services are provided through partnership arrangements between Devon Partnership NHS Trust, Royal Devon and Exeter NHS Foundation Trust, Northern Devon Healthcare NHS Trust, South Devon Healthcare NHS Foundation Trust, the Alzheimer's Society and Devon County Council.

The early assessment clinics, provided by the memory services, operate from one of three centres, and are provided to local people in the home town nearest to them.

- Royal Devon and Exeter Hospital
- Northern Devon District Hospital
- Torbay Hospital

The Bristol Dementia Partnership is run in partnership between Devon Partnership NHS Trust and the Alzheimer's Society. Devon Partnership NHS Trust is the lead provider organisation for delivery of the `dementia wellbeing` service in Bristol. The `dementia wellbeing` service is a community based service which provides care and support to the people of Bristol who have a diagnosis of dementia. The teams work in an integrated way with GP surgeries, each practice has named staff responsible for supporting people with dementia. The service contract was awarded in 2014, with an operational start date of April 2015. The service was still in the development phase when we inspected.

The older person`s community mental health service was under review and consultation. There was a proposed change in the model of care they were providing, in line with the trust adopting the SMART Recovery programme. The trust state that the emphasis of the model is designing new ways of working to reduce the amount of time that community staff spend travelling, and also to offer more options to the people who use services. This involves the teams becoming integrated with other services provided by the trust in central clinical `hubs` across Devon, where people who use the services will attend for appointments. Clinical hubs have not yet been identified.

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 was comprised of: two inspectors, a psychologist, a consultant psychiatrist, a social worker, three nurses, an activities assistant, and an expert by experience.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited six community teams and two memory services. We also visited the Bristol Dementia Partnership.
- spoke with 22 people who were using the service and/or their carers.
- spoke with six other professionals who work with the teams.
- spoke with the managers or acting managers for each of the teams.
- spoke with 49 other staff members including administration, psychiatrists, nurses, occupational therapists, social workers, and support workers.
- attended and observed two team meetings.
- observed 13 home visits and two memory service assessments.
- attended a memory café with staff.
- looked at 37 care and treatment records of people who use the service.
- had a tour of the premises at each location.
- looked at policies, procedures and other documents relating to running the service.

What people who use the provider's services say

People we spoke with were happy with the care they received from the service. We were told that staff were polite, caring and respectful and felt staff were interested in their well-being. People said they were always treated with dignity and compassion.

Carers spoke positively about the kindness, compassion and responsiveness they received from all staff at the teams we visited. Carers said they were given information about the service and were involved with the person's treatment and reviews.

Patients and their carers who we spoke with were not aware of having a care plan in place, or how to access support outside of office hours. Patients and their carers had not been involved with the consultation for the new proposed `hub` model of care. The trust advised that they were planning to deliver a workshop, with the trust`s 'lived experience advisory panel' and 'be involved Devon'. The workshop would be aimed at people and carers that have used trust services, with regard to the SMART recovery programme, clinical hubs and single point of access.

Summary of findings

Good practice

The Devon Memory Service provided one appointment where people could have a brain scan and a memory assessment. The assessment was comprehensive and included the views of family or carers. At the end of the appointment, the person was given feedback and, if applicable, a diagnosis. Providing the assessment and scan at the same time allowed the memory clinics to operate within a 32 day target from referral to diagnosis, compared with the national average of 90 days. Follow up appointments were provided after four weeks jointly with the Alzheimer's Society for people diagnosed with Alzheimer's or vascular dementia.

Devon Partnership trust worked effectively in partnership with the Alzheimer's Society in developing comprehensive and innovative services to people with dementia and their carers. For example, the Bristol dementia wellbeing service was a new model of care being developed to offer people a more individualised treatment plan, for life, integrated with their GP.

Staff regularly attended memory cafes, which have been established across the county, to offer support and advice to volunteers and people attending the cafes.

The South Devon `dementia learning community project` had won the British Medical Journal (BMJ) `dementia team 2015` award. The BMJ awards are an annual programme recognising and celebrating inspirational work done by doctors and their teams. The dementia learning community project was led by members of the Torbay team to deliver training and change management sessions in care homes, to improve care and outcomes for people.

The trust had developed an innovative and evidence based self-management programme, the THYMe project ("think health for your memory"), for patients with mild cognitive impairment which accounted for around 20% of diagnoses made in the trust's memory clinics. The programme showed that teaching self-management skills helped with their day-to-day lives and reduced the risk factors for conversion to dementia.

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that people's records are complete, accessible and up to date including changes in living circumstances, personal circumstances and changes in presentation. This includes people's care plans, risk assessments and physical health assessments and on-going monitoring.

The trust must ensure that carers and patients know how to contact someone in the event of a crisis, and provide a detailed crisis plan agreed with the patient and/or carers.

Action the provider SHOULD take to improve

The trust should ensure that all staff are aware of lone working procedures and these are followed robustly, especially when there is no mobile phone signal available during home visits.

The trust should ensure that all teams have an overall log of safeguarding referrals. This would allow them to monitor actions and potentially identify trends across the teams, for example, if the same care provider was involved in several concerns, and monitor feedback from the local authority.

The trust should ensure that medical equipment is properly maintained and calibrated, particularly sphygmomanometers used for taking people's blood pressure.

The trust should assess the safety and suitability of the environments where services are provided. The trust should ensure that the environment and furnishings where people attend appointments is appropriate, particularly for older people who have reduced mobility. The trust should ensure that premises are equipped with appropriate alarm systems.

The trust should ensure that patients and their carers are actively provided with opportunities to be involved with decisions about the service and to give feedback about the service.

Summary of findings

The trust should have an effective quality assurance system to accurately monitor and record referrals and response times, in order to ensure capacity within the service and that response times are being met.

Devon Partnership NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mid Devon OPMH Community Service (Mid Devon Central)	Wonford House Hospital
South Hams and West Devon OPMH Community Service	Wonford House Hospital
Torbay OPMH Community Service	Wonford House Hospital
Teignbridge OPMH Community Service	Wonford House Hospital
North Devon and Tawside OPMH Community Service	Wonford House Hospital
Devon Memory Service (North Devon)	Wonford House Hospital
Exeter OPMH Community Service	Wonford House Hospital
Devon Memory Service (Exeter, East and Mid Devon)	Wonford House Hospital
Bristol Dementia Service	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.

- Staff were able to access psychiatrists and approved mental health professionals to undertake Mental Health Act assessments if required.

Detailed findings

- Mental Health Act paperwork reviewed was in line with the code of practice

Mental Capacity Act and Deprivation of Liberty Safeguards

- With the exception of the Bristol service, staff were up to date with Mental Capacity Act (MCA) training. Staff were sent regular reminders when their training needed to be updated. The training records showed that the update for MCA training in Bristol was 54% to 64%.
- Staff were knowledgeable on the principles of the MCA and were able to describe how they applied these in practice. Daily progress notes reviewed in the care records also supported this. We observed that consent was obtained during home visits and the memory clinics, and staff checked people`s understanding throughout.
- However, mental capacity assessments were not recorded in 18 out of 37 care records we reviewed, and of these at least six records reflected that people may not have capacity; for example, an individual who was documented as being at risk from wandering, confusion and physical aggression towards their spouse.
- 34 out of 37 care records had not clearly documented if the person had consented to information being shared, or with whom. We saw that letters following appointments and decisions about care were not always copied to patients, with the statement on the letter "not copied to patient as may cause undue distress", although copies had been sent to their relatives. However, we could not find evidence of how this was agreed, and with whom.

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

- The facilities were clean and tidy, although the fabric and fittings at the locations were worn and general décor was, in some areas, poor. We were advised that the community buildings and facilities did not have environmental health and safety assessments, unless a specific concern was raised. This meant that potential risks to staff or patients might not be identified. We were advised that infection control and hand hygiene assessments were undertaken. Five were made available for us to review. These were for services that were in shared outpatient areas, for example, Crediton hospital. These also contained action plans where issues were identified.
- Most people were visited at home or other community locations, although some patients were seen at the team bases, particularly the memory services. The locations we visited did not have suitable clinic rooms, although there were hand washing facilities available. The teams did not use clinic rooms to review patients or store medicines. The inpatient clinic room that the team at Exeter Hospital used to store some of their equipment was untidy. The counter tops were cluttered and covered with various items and there was mould in the sink. The sphygmomanometer equipment staff used to measure people's blood pressure was not regularly maintained or calibrated. This was raised with the manager at the time of our visit.
- Interview rooms were not all fitted with accessible alarms. Totnes and Teignbridge teams did not regularly see people on site. People who attended for appointments at Totnes Hospital used the consultant psychiatrist's office or a room in a separate part of the hospital. Appointments held at Barnstaple hospital were in rooms that were separate from other staff offices, there were not accessible alarms in place and staff did not wear alarms. Alarm points at Torbay were obstructed by furniture, for example, a filing cabinet. Staff in all the teams generally held the view that their client group was a low risk of violence and aggression. However, we noted that two teams had highlighted violence and aggression and unpredictable behaviour in their local risk registers.
- The community services were introducing a hub and spoke model of care. This is where a range of services can be provided from one central point (the `hub`). Appropriate hubs had not yet been identified.

Safe staffing

- There was some sickness within the teams, the highest recorded 9.8% of whole time equivalent staff, at Mid Devon. At Crediton, Teignbridge, Tawside and Totnes, each team had a full-time band 5 vacancy. One of the managers held a caseload of 10 people due to a vacancy and long-term sickness on the team. Staff from across the Devon community teams provided staffing for the three memory clinics. Overall, staff felt that the Devon teams were safely and effectively resourced, and staff felt able to cover for sickness and absence without it causing an impact on service delivery.
- The Bristol service was still actively recruiting a full team to the service. They reported difficulties recruiting medical and band five staff. There were two whole-time equivalent (WTE) medical vacancies, two WTE practitioner vacancies and one WTE community development coordinator vacancy. Staff did not raise concerns about the impact of these vacancies on service delivery.
- Some managers stated that they did not have the budget or capacity to provide bank or agency coverage for vacancies, leave or sickness. Team members provided cover during these times. However, Tawside and Teignbridge reported being able to use additional bank support if required.
- Caseloads were lower than the recommended guidelines of 35 people. Managers had good oversight of staff's caseloads and were providing regular supervision

Requires improvement

Are services safe?

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

support for those with higher caseloads with an aim to reduce them. Caseloads were weighted by complexity and working hours. Staff told us that their workload was manageable.

- Staff advised that psychiatrists were accessible and would undertake home visits if required. We accompanied a psychiatrist on a home visit. Patients said that they could contact a psychiatrist when needed. This would usually be arranged through their care coordinator.
- Training records showed that most staff were up to date with mandatory training across the teams. The Bristol service was new and staff had not yet all completed mandatory training, although all had received an induction.

Assessing and managing risk to patients and staff

- We reviewed a sample of 37 risk assessments across the service. Staff completed risk assessments during people's initial assessment and these were reviewed regularly or when risks changed. Overall, risks were clearly documented and up to date.
- 28 out of 37 records reviewed did not contain a crisis plan. The crisis plans we reviewed were not always up to date and there was limited documentation to show whether copies had been given to people. One crisis plan at Totnes Hospital had not been updated since 2012. Other crisis plans we looked at did not include concise warning signs or contingency plans specific to the individual. Carers and patients we spoke with did not know how to contact someone in the event of a crisis. The trust advised that they include details about who to contact out of hours if needed on the initial assessment letter. The trust stated that there were patients on team caseloads who were for annual medication reviews only and not active caseload management. These patients were the principle responsibility of primary care and not receiving a community mental health team service.
- The teams discussed clinical risks at weekly multi-disciplinary meetings (MDT). We observed two meetings and reviewed a sample of meeting minutes for each team. These showed a range of risk issues, such as safeguarding and clinical risks were discussed within the MDT.
- The teams held clinical risk registers for patients who had been identified as having increased risks. These were discussed weekly at the MDT meetings, which ensured that the whole team were aware of the risks and had the opportunity to discuss recommendations. We reviewed the team clinical risk registers at Teignbridge, Tawside and Torbay, which showed that patients identified at increased risk were closely monitored, and actions taken were recorded.
- Staff understood the local safeguarding procedures, and what their responsibilities were. Most staff knew who the trust's safeguarding lead was. Some staff had undertaken additional safeguarding training to take part in large local authority investigations. Safeguarding information was recorded in people's electronic progress notes. However, there was no central monitoring log of safeguarding referrals across the teams. This would allow teams to monitor actions and identify trends. Some staff said that safeguarding referrals were also reported as an incident, however this was not consistent across the teams. Several staff across the teams said they did not always get feedback from the local authority on actions and outcomes after raising a safeguarding alert, apart from the case being closed.
- Lone working procedures were not consistent. With the exception of Torbay, where we observed that procedures were adhered to, not all staff in the other teams were aware of lone working procedures. Lone working was on the risk register for most of the teams we visited. Staff reportedly told team members of their whereabouts during the day, however, there were not clear systems in place. Paper diary sheets and RIO diaries on the electronic records system were not always up to date, or consistently completed with details of visits. High-risk patients were reportedly visited by two members of staff. However, teams also regularly undertook initial assessments on their own, where risks may not be clearly identified, or known, by the referrer. Staff used a code word to raise an alarm to team members, although different teams had different code words, and some staff weren't aware of any code word. In some areas across the county, including the offices at Crediton Hospital, staff were unable to get mobile phone signal. This meant that when they were lone

Requires improvement

Are services safe?

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

working they may not always be able to raise an alarm. Some staff were unaware of the procedures if a member of staff failed to return or report in and fail to answer their mobile.

Track record on safety

- There were five serious incidents reported in the last 12 months for all the older people's community mental health teams. There had been one serious incident reported in the Bristol wellbeing service. We reviewed the serious incident reports, which included detail of the incidents and actions taken.

Reporting incidents and learning from when things go wrong

- Staff knew what kind of incidents to report and the procedures to report. They gave us examples of recent incidents and the actions taken. Information about incidents was disseminated at team meetings. There were quality and safety bulletins available on the intranet.
- The trust reported that team managers could access a detailed directorate level report monthly that identifies themes and trends of incidents. Once the managers had completed their manager's section of the incident report, the report would leave their electronic records system. Managers could specifically request this information from the trust's data management team.
- Managers attended a monthly directorate governance meeting, where a range of quality and safety issues were discussed. For example, incidents and complaints.
- Staff confirmed that they received support and debrief following a serious incident. Staff felt that the senior team undertook fair and detailed investigations.

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

Assessment of needs and planning of care

- The quality of people's care records varied in detail and quality in all the services we visited. Three teams had put `RIO consistency` on their local risk register. RIO was the electronic notes system used by the trust. There were monthly randomised RIO care record audits in place to help managers identify areas to be addressed with specific clinicians.
- The Care Programme Approach (CPA) is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs. The records we looked at did not clearly identify if a person was part of this process or when a CPA review had taken place.
- People's daily progress notes were comprehensive. However, this information had not always been updated in people's care plans and core assessments. This meant the information was not easily available or accessible to staff. People's core assessments were not always complete and up to date. For example, at Crediton Hospital, three out of five core assessments were not complete including information about the person's mental health, personal and family history, social, forensic and substance misuse histories. One of these core assessments had not been updated since 2011.
- Care plans were not always person centred and they lacked the detail required to demonstrate an understanding of the individual`s circumstances and needs.
- Care plans did not always reflect changes in people's circumstances, and were not always clearly linked to assessment of needs and identified risks. For example, one person had moved into a nursing home and their care plan was still in place to find appropriate accommodation. Another person's accommodation was described as `squalor`, however, there was no detail or care plan about how to manage this or monitor the impact of risks to the person. Another individual was identified at risk of financial exploitation and was subject to the court of protection process, however, there was no financial management outlined in their care plan. Two care plans at Totnes Hospital had not been reviewed for over two years. Five care records did not have any care plans in place.
- The trust was due to change their patient electronic database system in August 2015. The trust was providing training updates, and some staff had received one day of training for this. Managers had identified champions to facilitate the transition. There was a webpage on the trust's forum with information about the system change and for staff to query and share information. There were two electronic systems used at the Bristol service, one for trust staff and one for the Alzheimer's Society staff. Staff stated that shared information was managed effectively.
- The Bristol dementia wellbeing service was a new model of care, which offered the person with dementia, and their family/carers, a service for life. People received an assessment, diagnosis and a range of post diagnostic support. The service contract was awarded in 2014, with an operational start date of April 2015. The service was still in the development phase at the time of inspection, this included developing care records, in the form of `wellbeing plans`. We were advised this was being done in conjunction with the Alzheimer`s Society and people who used the service. The wellbeing plans we reviewed did not reflect whether an individual, or where appropriate, carers, had agreed to the plan.

Best practice in treatment and care

- The care provided was in line with evidence based national guidelines, for example the Department of Health National Dementia Strategy. The service had developed clear care pathways. For example, in line with NICE guidance, the memory service assessed people`s needs before providing memory management treatment plans. Access to the service was determined by the needs of the individual as well as their age. Therefore, individuals of any age were accepted where dementia is suspected.
- Acetylcholinesterase inhibitors (ACI, such as galantamine, and rivastigmine) are used to treat mild to

Are services effective?

Requires improvement

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moderate Alzheimer's disease. Services used NICE guidelines when prescribing and managing these medicines. If ACI medicines were commenced by the Bristol Dementia Partnership, they undertook the first review of these medicines and the on-going management was with GPs. The memory services reviewed people after three months, then the GP continued to monitor. The memory service also provided an annual telephone review for people.

- Patients had access to psychological therapy and staff confirmed that assessments were undertaken in a timely manner. People had a choice of which therapy they accessed. For example, the occupational therapist in Tiverton was trained in cognitive behaviour therapy and worked with more people with functional dementia. The psychologist at Crediton Hospital provided cognitive behavioural therapy and psychodynamic therapy.
- If a person received a diagnosis of dementia at the memory service, they were offered a post diagnostic appointment within four weeks of being informed of the diagnosis. This took place within the patient's home town, by a member of the community mental health team with an Alzheimer's Society support worker. People were then offered a five-week `memory matters` course, which was run jointly by the trust and the Alzheimer's Society. The teams also signposted people to memory cafes, which were run by charities across Devon. The dementia advisor service was hosted by Devon Partnership Trust, although was run by the Alzheimer's Society in Torbay and supported patients and families with a diagnosis of dementia.
- The Bristol service worked in partnership with the Alzheimer`s Society and were in the process of linking in with local primary care psychology services, who could then refer people for on-going psychological therapies. Staff ran psycho-educational groups eight weekly for people with dementia, and a support group for their carers.
- The quality of physical health care monitoring varied across the teams. Physical health history had not been documented in 13 of 37 of the care records we reviewed across the teams. There was limited documentation of people's on-going physical health care. Care plans did not always contain information about pre-existing health conditions. Teams advised us that GPs and district nurses were responsible for people's health checks. Several staff were trained as non-medical prescribers. The trust's medicines management practice standards outlined minimum physical health checks and recommends that the multi-disciplinary teams should plan for carrying out physical health monitoring at the person's care review or CPA meeting. Nursing and medical staff we spoke with confirmed that they do not undertake physical examinations or monitoring, and there was no established link with a medical geriatrician.
- The psychiatrist at Crediton Hospital completed an audit on the use of antipsychotic medicines, which resulted in a change in practice with improved outcomes. The audit was due to be repeated.

Skilled staff to deliver care

- The teams had a wide range of experienced and qualified staff, from a range of disciplines, including nurses, psychiatrists, support workers and psychologists. Band 6 staff worked with the more complex cases and band 5 staff reported they felt well supported in managing their caseloads.
- The Bristol dementia partnership service operated a different model from the community mental health teams. A `dementia navigator` was allocated to every person. This staff member worked closely with the person and their GP to ensure the right support was in place, for example, by signposting to appropriate services. The `dementia practitioners` had capacity to provide more complex support, especially when there were significant behavioural and psychological symptoms, through co-ordinating additional care provision with other services and specialists.
- The team at Totnes Hospital had good links with a community pharmacist who did medicine reviews and delivered specialised training for the team. The psychologist at Totnes Hospital provided reflective practice for the team.
- Staff across the teams were up to date with monthly supervision and annual appraisals. We reviewed a sample of supervision records, and these showed staff were supported to discuss a range of caseload and work related issues. The Bristol service was a new service and

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therefore was still in the process of establishing consistent supervision systems and goal setting for appraisals. However, staff we spoke with felt well supported.

- Most staff said the trust was supportive of them accessing training. Two staff at Totnes Hospital were doing masters degrees in aging mental health and dementia. Other staff completed training on mindfulness and mentorship. Two staff at Torbay had been seconded to oversee the South Devon dementia learning project, and as part of this they had been supported to undertake additional training, for example, dementia mapping. Staff were also supported to complete the non-medical prescriber course. Support workers were supported to undertake the Band 3 development programme, including a health & social care diploma. One support worker had been supported to undertake additional training to work within the memory service.

Multi-disciplinary and inter-agency team work

- The teams consisted of nurses, support workers, administrative, psychology and medical staff. Staff were well engaged during the weekly team meetings we observed at Crediton Hospital and Teignbridge. We saw that this was consultant led; nursing and allied health team disciplines were in attendance, not all support workers attended. The psychologists attended one in every three team meetings.
- Managers spoke positively about monthly directorate meetings, which had been implemented earlier this year. Representatives from a range of disciplines attended, from the different localities, including psychology and psychiatry. These meetings provided staff with the opportunity to discuss local issues, complaints and serious incidents. This information was fed back at local team business meetings.
- The teams worked effectively and collaboratively to plan and deliver appropriate care, with other health, social and voluntary agencies. People's records evidenced good communication between the teams and people's GPs, solicitors, social services, day centres and dementia support workers. The teams had good links with various carer's organisations and memory cafés. Other professionals we spoke with reported that the teams worked effectively with other healthcare providers, for example, nursing homes and psychiatric liaison teams.

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

- Staff were able to access psychiatrists and approved mental health professionals to undertake Mental Health Act assessments if required.
- Mental Health Act paperwork reviewed was in line with the Mental Health Act Code of Practice.

Good practice in applying the Mental Capacity Act

- With the exception of the Bristol service, staff were up to date with Mental Capacity Act (MCA) training. Staff were sent regular reminders when their training needed to be updated. The training records showed that the update for MCA training in Bristol was 54% to 64%.
- Staff were knowledgeable on the principles of the MCA and were able to describe how they applied these in practice. Daily progress notes reviewed in the care records also supported this. We observed that consent was obtained during home visits and the memory clinics, and staff checked people's understanding throughout.
- However, mental capacity assessments were not recorded in 18 out of 37 care records we reviewed, and of these, at least six records reflected that people may not have capacity; for example, an individual who was documented as being at risk from wandering, confusion and physical aggression towards their spouse.
- 34 out of 37 care records had not clearly documented if the person had consented to information being shared, or with whom. We saw that letters following appointments and decisions about care were not always copied to patients, with the statement on the letter "not copied to patient as may cause undue distress", although copies had been sent to their relatives. However, we could not find evidence of how this was agreed, and with whom.

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

- Patients we spoke with were happy with the care they received from the service. We were told that staff were polite, caring and respectful and felt staff were interested in their wellbeing. People said they were always treated with dignity and compassion.
- Trust staff were responsible for 'combined' assessments. Combined assessments were where the carer and person using services requested an assessment to be undertaken together. All individual carer's assessments were referred directly to Devon Carers to undertake.

The involvement of people in the care that they receive

- Care records did not clearly identify the involvement of the individuals, or carers, in the care planning process. Most people had not received a copy of their care plan. 30 out of 37 records indicated that the care plans had not been distributed. Patients we spoke with, and their carers, were unaware of having a care plan in place. Due to the cognitive ability of some people, it could be difficult to involve them in their care plan or provide information. Individual clinicians made decisions about whether the person should receive information. Clinic letters were not always sent to the person, for example, we saw statements `not shared with the person as it may cause distress'. However, we could not find evidence of how this decision was made, or the involvement of advocates or carers. It was not clear if any alternative ways to share information had been attempted, for example, in a different format.
- However, daily progress notes within the care records reflected that family and carers were involved in discussions regarding people's care and treatment. Carers spoke positively about the kindness, compassion and responsiveness they received from all staff. Carers said they were given information about the service and were involved with the person's treatment and reviews.
- Patients who used services in Devon, who we spoke with, said they had not had the opportunity to become involved with decisions about the service. The Bristol service was still in development, but reported that they held feedback meetings, including with local black & minority ethnic community groups.
- There was a leadership group in place in Torbay for people with early dementia, Torbay dementia leadership group, which met fortnightly, with the support of the Alzheimer`s Society. It was formed with people who had a diagnosis of dementia. The group had reviewed a number of trust documents, for example, care plans.
- The south Devon and Torbay mental health redesign group had carer representatives on it, which included the older persons mental health client group and carers. However this was new and in the process of being developed.
- Teams said they regularly distributed 'friends and family' feedback cards to carers with assessment and discharge letters. Staff also had electronic tablets for people to complete the form online. The results from these were analysed centrally and results provided to managers at the monthly directorate meetings and to staff at weekly team meetings. From December 2014 – March 2015, the directorate received 25 returns. There was an NHS comment box and community suggestion book available in the reception area of Crediton Hospital.
- The trust received feedback from `be involved Devon` (BID), an organisation which held meetings where anyone can attend and share feedback about a range of services. BID produced a monthly 'logged issues' list, that it then provided to Healthwatch Devon. This included logged issues for the trust.

Are services responsive to people's needs?

Good

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

Summary of findings

Please see the summary at the beginning of this report.

Our findings

Access and discharge

- All referrals to the older people`s mental health service were via a single point of entry at Devon referral support service (DRSS). Referrals were triaged within one working day of receipt by DRSS. The allocated duty worker for each team then reviewed and allocated referrals. Routine referrals were allocated an appointment in the next available appropriate assessment slot. The target was for all referrals to be seen and have a first assessment within two working weeks.
- Teams reported that they were meeting the 10-day target from referral to triage/assessment for routine referrals, and five days for urgent referrals. However, when we analysed the quality assurance information provided from the trust, it did not reflect this. We analysed data provided by the trust and found that out of 4616 referrals across all the teams, 40% were seen within 10 days, 23% between 10 to 19 days, 17% over 20 days from referral, and 20% did not have data available. The trust advised that the data they provided `does not reflect team practice`. From additional information requested from the trust, it was not clear how the directorate monitored performance with referrals, in order to ensure capacity within the service and that response times were being met; however, the trust advised that they provided waiting times data to the commissioners.
- Patients, carers, and other professionals, we spoke with, confirmed that calls were returned in a timely manner. Staff confirmed that they had capacity to respond effectively if they needed to make additional visits or contacts.
- Older people with dementia who experienced mental health crises outside of office hours contacted the social services emergency duty team or `Devon doctors', the out of hours GP service. People with functional mental health issues, for example, depression, could contact the trust mental health crisis team. There was also a night nurse practitioner based at the general hospitals for anyone presenting with mental health crisis.
- There was flexibility between the teams to support people. For example one person who was registered with a GP in one locality, but stayed with a family member in a different locality, could access the consultant from the family member's locality for appointments. This reduced the travel time to appointments for this person and their family. All teams undertook home visits.
- The trust older adult beds were in Torbay, Exeter and Barnstaple. However, teams reported that it was unusual to need to access a bed outside of the trust. Teams worked together to provide additional support until an admission could be arranged. The trust reported monitoring out of area placements to ensure they moved people back to facilities nearer their homes as soon as possible. We saw information from January 2015 – June 2015 that showed the trust also monitored where clients had to be placed outside their usual admitting ward, for example someone living in Exeter admitted to a North Devon ward rather than one of the Exeter wards. There were no patients admitted to mental health hospital beds outside of the trust at the time of inspection.
- The Torbay team reported being able to access funding for intermediate beds, if respite or assessment was required. They used beds in identified local nursing homes. Most staff found this was a helpful alternative to hospital admission. Managers could arrange transport by private ambulance if required.
- The Bristol wellbeing service operated a single point of access. The initial screening process took place within five days of referral, then contact was made to arrange an appointment. There was currently no time-frame within which first appointment would be, following referral. The service accepted referrals for people with a diagnosis of dementia or who required an assessment for a possible dementia.
- The Bristol mental health crisis service undertook out of hours assessments if required. The Bristol dementia partnership worked with Bristol Community Health which provided a rapid response service for people

Are services responsive to people's needs?

Good

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requiring admission or discharge from an acute hospital. The approach aimed to assess and treat patients within their own homes, who had a physical problem as well as behaviours associated with dementia.

The facilities promote recovery, comfort, dignity and confidentiality

- Most people were visited at home or other community locations, although some patients were seen at the team bases, particularly the memory services.
- The interview rooms at Crediton were shared with the adult services. The furnishings in the interview rooms were not appropriate for elderly people. The chairs were low and would be difficult for a person with reduced mobility to get in and out of. The walls of the rooms were bare and there were sinks in some of the interview rooms.
- The interview rooms at Torbay were small and bare and they were not soundproofed. Staff tried to avoid using them for more than one person at a time. The large meeting room smelt very damp and musty. However, there were bright, yellow signposts to help orientate people to where toilets were. The memory services and some of the community teams were based within large general hospitals. The rooms the trust used at Crediton, Barnstaple and Whipton Hospitals were not well signposted for people to orient themselves to the layout of the building and various rooms. The waiting area at Barnstaple hospital was a thoroughfare for other teams, and therefore people were passing through and doors were frequently opening and shutting. People attending the memory clinic could be there for several hours, while all the aspects of their assessment were undertaken.
- There was a variety of information available in the reception areas for patients and carers including stop smoking services, dementia support services, carers groups and medicines.

Meeting the needs of all people who use the service

- Facilities were accessible for people requiring disabled access and had disabled toilet facilities. However, people with mobility difficulties could find it difficult having to walk quite a distance from the car parks to where the services were based in the main general hospitals.
- Devon memory service provided adaptations to people's assessments based on literacy, eyesight, or hearing loss. One carer said they were provided information in easy to read format and found this helpful.
- Staff could access interpreters where required. The Bristol dementia partnership service had copies of the Addenbrooke's cognitive examination-III (ACE-III), a screening test used to assess cognitive performance, in Urdu and Hindi, as well as having a copy in English that was adapted to reflect social and cultural circumstances that may be familiar to people of Somali heritage.

Listening to and learning from concerns and complaints

- There were 17 complaints for the older person`s community services between April 2014 and March 2015. Three of these were upheld and none were referred to the parliamentary health ombudsman.
- Patients and carers told us that they knew how to complain. There were information brochures about the complaints process in the reception areas of the services we visited.
- Staff described recent complaints and how they were managed. Managers only recorded formal complaints raised through PALS. Informal complaints resolved locally were not recorded centrally.

Are services well-led?

Good

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

Summary of findings

Please see the summary at the beginning of this report.

Our findings

Vision and values

- Staff knew the organisation's vision and values. Overall, most staff felt that there had been more positive engagement from the executive team in the last 18 months.
- The service was under review as part of the wider trust plan for services to adopt the SMART recovery programme. The trust stated that the emphasis of the SMART recovery programme was designing new ways of working to reduce the amount of time that community staff spent travelling and also to offer more options to the people who use services. The community services were moving towards a hub and spoke model of care. This is where a range of services can be provided from one central point (the `hub`).
- Staff told us some aspects of the new model of care had not been decided, for example where the clinical hubs would be. Staff were concerned that the change towards centralised hubs and prescribing clinics would affect their ability to effectively assess a person, for example, how they were coping in their home situation. They were concerned that the new model, for example one hub in Torquay, would involve a large geographical spread involving a large amount of travel time for some people, who may have cognitive impairment or mobility issues. The trust provided consultation opportunities for staff but not all staff felt that their feedback was taken on board to influence change. However, some staff felt that there had been effective consultation and communication about the changes, and that their concerns had been listened to.
- It was not clear how patients and their carers had been involved with the consultation for the new proposed SMART recovery programme and hub model of care. None of the staff, patients, or carers we spoke with could describe how people had been involved. The trust advised that they were planning to deliver a workshop with the trust`s 'lived experience advisory panel' and 'be involved Devon'. The workshop would be aimed at people and carers that had used trust services, with regard to the SMART recovery programme, clinical hubs and single point of access.

Good governance

- The teams all held weekly meetings and managers attended the monthly directorate meetings, where a range of quality and safety issues were discussed. Managers could add to the trust risk register by escalating issues through the monthly directorate meetings. Managers had access to the trust `orbit` electronic management system, which enabled them to monitor individual team performance. The `develop` electronic training record, allowed managers to review individual and team training records. Prompts were sent to staff when their training was due. Administration systems supported clinical staff effectively. Administration teams reported meeting targets and managing workload effectively. Teams confirmed that they had adequate administrative support.
- When we reviewed the quality assurance data provided by the trust, we found that the data to monitor compliance with referral and response times did not reflect what teams were reportedly doing. For example, overall data reflected that teams assessed 40% of referrals within their 10 day target, 23% between 10 -19 days, 17% over 20 days from referral, and 20% of referrals did not have any response time recorded. The trust advised that the data they provided `does not reflect team practice`. From additional information requested from the trust, it was not clear how the directorate monitored performance with referrals, in order to ensure capacity within the service and that response times were being met. However, the trust advised that they provided waiting times data to the commissioners.

Leadership, morale and staff engagement

- Most staff, across all teams, spoke positively about the support they received from their colleagues. The level of support provided by team managers varied, although overall we found evidence of good local leadership. Staff felt able to raise concerns, and that they would be

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listened to. For example, staff had raised concern about the quality and ability of their locum medical provision and action was taken. Staff received regular supervision and appraisals.

- A peer support group was available for band 7 staff. There were annual `our journey` events for each staff group, which staff told us they valued. The trust also held annual professional conferences. For example, we were told that the nurses' conference was held at an external venue and nurses were supported to attend.
- There were clear lines of responsibility for staff at the Bristol dementia partnership. The trust had line management responsibility for all groups of staff working in the service including administration staff employed by the trust. The Alzheimer's Society managed staff working within the service employed by the Alzheimer's Society. Staff felt positive and motivated about being part of a new and developing service.
- Most staff expressed concern that the SMART working model could affect individual team identity and valuable peer support, through `hot desking` and not necessarily being based together.

Commitment to quality improvement and innovation

- The Devon memory service provided one appointment where people could have a brain scan and a memory assessment. The assessment was comprehensive and included the views of family/carers. At the end of the appointment, the person was given feedback and, if applicable, a diagnosis. Providing the assessment and scan at the same time allowed the memory clinics to operate within a 32-day target from referral to diagnosis, compared with the national average of 90 days. Follow up appointments were provided after four weeks jointly with the Alzheimer's Society for people diagnosed with Alzheimer's or vascular dementia. The memory clinics were involved in on-going research with Exeter University.
- The Bristol dementia partnership was a new model of dementia care, being developed and run in partnership with the Alzheimer`s Society. From 1 April 2015, each GP practice and person living with dementia has access to a `dementia practitioner` and `dementia navigator`. The service was still under development at the point of inspection.
- Staff in all teams told us they were supported to contribute to service development. The service was involved in a number of research projects and worked in conjunction with Exeter University to evaluate projects. The trust had been approved for some larger commercial research projects, for example, the IDEAL project, a large longitudinal study to find out what makes it easier or more difficult for people to live well with dementia, and what can be done to help more people to live well with dementia.
- The trust had developed an innovative and evidence based self-management programme THYMe project ("think health for your memory"), for patients with `mild cognitive impairment', which accounted for around 20% of diagnoses made in the trust memory clinics. The programme showed that teaching self-management skills helped with their day-to-day lives and reduced the risk factors for conversion to dementia.
- The South Devon dementia learning community project had won the British Medical Journal (BMJ) `dementia team 2015` award. The BMJ awards are an annual programme recognising and celebrating inspirational work done by doctors and their teams. The dementia learning community project was being led by members of the Torbay team, to deliver training and change management sessions in care homes, to improve care and outcomes for people.
- Community staff across the trust were increasing their use of mobile devices, in order to enable staff to work more effectively from different parts of the community. This was part of the SMART recovery programme being implemented.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The records were not always accurate, complete and contemporaneous in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Care records were not always complete, with accessible and up to date information, including changes in living circumstances, personal circumstances and changes in presentation. This includes people's care plans, capacity assessments, risk assessments and physical health assessments and on-going monitoring. It was not clear if the individual had consented to information being shared and with whom. It was not clear why decisions not to share information with individuals had been made. This was a breach of regulation 17(2)(c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Most care records did not contain clear, detailed crisis plans. Carers and patients we spoke with did not know how to contact someone in the event of a crisis. This was a breach of regulation 12(1)(2)(a)(b).