Devon Partnership NHS Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Devon has a population of approximately 894,000 residents covering an area of 2600 square miles. The trust covers an area covered that is predominantly rural with areas of urban development along its north and south coastlines. Life expectancy for both men and women is higher than the England average. There is a significantly higher rate of people aged 65 and over in Devon compared to the England average.

Following our inspection in 2015 we rated the trust as requires improvement overall. The trust was rated as requires improvement in the safe and effective domains. The trust was rated as good in the caring, responsive and well-led domains.

Following our inspection in 2016 we rated the trust as good overall. All five domains were rated as good.

Following our last inspection in 2017 we rated the trust as good overall. All five domains were again rated good. During that inspection we rated the community mental health services for adults of working age as requires improvement. All other mental health and learning disability services were rated as good and the forensic inpatient or secure wards were rated as outstanding.

The trust provides the following services

- community based services for adults of working age
- long stay/ rehabilitation wards for adults of working age
- forensic inpatient and secure wards
- acute wards adults of working age and PICU
- wards for people with learning disability or autism.
- mental health crisis services and health-based place of safety
- community based services for older people
- wards for older people with mental health problems
- community based services for adults with a learning disability or autism
- child and adolescent community mental health services
- perinatal mental health service
- eating disorder service
- specialist gender identity clinic
- personality disorder service
- addiction services (Torbay only).
- mother and baby mental health unit

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

Summary of findings

What this trust does

The trust is commissioned to provide services by NHS Devon Clinical Commissioning Group (CCG) and Bristol CCG. The trust works in partnership with other organisations to deliver its services including Devon County Council and Torbay Unitary Authority, as well as a number of third sector organisations.

Devon Partnership NHS Trust delivers mental health and learning disability services from community and hospital-based settings across Devon and the south west. It was formed in 2001.

At the time of the inspection there were 285 inpatient beds in operation across 21 wards. The trust operates from over sixty sites. The trust also manages a large forensic mental health hospital, Langdon that provides a care pathway through medium secure, low secure and open inpatient units in addition to specialist community teams. The trust recently acquired the responsibility for the commissioning of all forensic service across all forensic units in the south west of England.

The trust has also expanded its services to include:

- Bristol Dementia Wellbeing Service which it delivers in partnership with the Alzheimer's Society
- mental health services to the three Devon Prisons which it delivers in partnership with Care UK
- a new mother and baby unit for Devon, Somerset and Cornwall
- Workways Employment Service has expanded for the whole of Devon.

The trust employs approximately 3500 staff and has an annual income of about £154 million.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether it appears to be getting better or worse.

At this inspection we inspected four core mental health services:

- Community-based mental health services for adults of working age
- Wards for older people with mental health problems
- Acute wards for adults of working age and psychiatric intensive care units
- Community based services for adults with a learning disability or autism

Other services provided by the trust that were previously rated as good or outstanding were not inspected as we had no information to suggest the quality of those services had changed.

Summary of findings

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated the trust as good overall for four of the five key questions, safe, effective, caring and well led. We rated the responsive key question as requires improvement. At this inspection we rated one of the four core services that we inspected as outstanding, one as good, one as requires improvement and one inadequate. In rating the trust we took into account the current outstanding rating in one core service and current good ratings in five core services not inspected this time.
- We rated wards for older people with mental health problems as outstanding because patients were active partners in their care and supported to make decisions for themselves. Consideration of patients' privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients' individual preferences and needs were always reflected in how care was delivered. Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff sat down with patients and went through their care plan with them. Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Incidents were low due to a deeply embedded caring culture within the wards. There was high levels of staff satisfaction across the service. Continuous improvement and safe innovation was encouraged and celebrated. Constructive challenge from patients and carers was welcomed and documented in the patient meetings and minutes. There was a strong focus on improving the quality of care and patients' experiences.
- All clinical areas and premises where patients received care were clean, well equipped and maintained.
- Staff minimised the use of restrictive practices and followed best practice when de-escalating and managing challenging behaviours. Beech Unit had won an award for their roll out of the 'four steps to safety' programme. Since implementation, their violent and aggressive incidents had halved.
- The trust managed incidents well and staff understood how to report them appropriately. Incidents were investigated and lessons learned were shared.
- Staff treated patients with compassion, respect and kindness. The privacy and dignity of patients was maintained at all times. Staff were familiar with patients and understood their individual needs. Patients were supported by staff to understand and manage their care and treatment. Families and carers of patients were involved in their care appropriately.
- Staff supported patients to make decisions about their care for themselves. Staff understood the Mental Capacity Act 2005. Staff worked within the trust's policy and clearly recorded and assessed capacity for patients who may have impaired mental capacity. Staff involved and worked with the patient's relatives and carers to ensure best interest decisions were made when appropriate.
- Concerns and complaints were treated seriously by the trust. Complaints were investigated and lessons learned were shared with all staff.
- The trust had a leadership team with an appropriate range of skills, knowledge and experience to deliver mental health services. The board was well established and stable.
- The trust was financially stable and had expertise among executives and non-executive directors relating to finance. The trust had a clear understanding and oversight of their financial position. This was regularly discussed at board meetings. The trust had a proven track record of achieving financial targets.

Summary of findings

- There were a range of mechanisms that provided assurance from service level to board level for most services. Directorate governance meetings were held regularly and considered service line performance.
- The trust engaged well with patients, staff, equality groups, the public and local organisations. These relationships were used to plan and manage appropriate services. The trust had further embedded the 'Together' engagement programme since the last inspection. The programme brought people with lived experience, including carers, to develop and co-design services. The philosophy of Together was evident in all areas of the trust and used for all engagement activity. The trust also had a number of equality, diversity and inclusion groups which met regularly.
- The trust used quality improvement methodology. Over 900 staff had been trained in quality improvement. Staff were committed to continually improving services and innovation was encouraged by leaders. For example, the 'four steps to safety' programme had led to a reduction in violence and aggression on inpatient wards and also a 50% reduction in seclusion.
- The leadership team and staff throughout the trust were open and transparent. The trust had a clear set of vision and values that were at the heart of staff who worked for the trust. We saw the trust's values embedded in the services we inspected.

However:

- We had serious concerns about the community-based mental health services for adults of working age. The trust did not have clear oversight of the large number of people on the waiting list. All the teams we inspected were not safely monitoring patients on the waiting list or responding to changing and increased levels of risk. Patients on the waiting list were not contacted by the teams in line with the trust's protocol. Patients were waiting long periods of time to access services. Some teams were unable to quickly respond to high-risk or urgently referred patients, who should have been allocated within a week. Some high-risk and urgent patients were waiting up to a year to be allocated and receive treatment. Concerns by staff about the level of risk in the service had not been responded to appropriately by the trust. As a result of the significant concerns identified we wrote to the trust to seek immediate assurances about the safety of the service. We did this under Section 31 of the Health and Social Care Act 2008 to notify the trust of the serious concerns that had been identified during the inspection. The Section 31 powers offer a provider the opportunity to put forward documentary evidence to provide assurance that identified risks have been removed or are to be immediately removed. We received immediate assurances from the trust and work was undertaken to review the waiting lists and assess the risk of those people on the waiting lists.
- A substantial number of staff that we spoke with in the community mental health teams did not feel listened to by the trust. Staff morale within the service was low and staff reported what they perceived to be a bullying and blame culture. The long waiting lists was causing pressure and stress on staff within the team.
- Staffing numbers on the acute wards for adults of working age and in the community-based mental health teams for adults of working age were insufficient. In the community mental health teams staff caseloads were high and the number of referrals exceeded the number of discharges. This was causing long waiting times for patients to be allocated and receive treatment. On two of the acute wards nursing vacancies meant newly qualified nurses were working shifts without an experienced registered nurse.
- The trust was unable to provide enough beds to ensure patients received treatment within trust area beds. The number of patients treated in out of area beds had increased since our previous inspection. Between March 2018 and February 2019 379 patients had been treated in out of area beds. During the previous inspection there had been 217 out of area placements. Some adults of working age were being cared for on the wards for older people with mental health problems due to bed shortages. This was impacting on both services. Beds were not always available on the

acute wards for adults of working age and patients who had been on leave did not always have a bed to return to. On the wards for older people the number of restraints had increased. This was related to adults of working age who had been admitted onto the wards. The trust had opened a new ward in January 2019 to increase bed numbers available and were also in the process of designing a new ward on the Torbay site to open in 2021.

Are services safe?

Our rating of safe stayed the same. We rated it as good because:

- All clinical areas and premises where patients received care were clean, well equipped, maintained, furnished and were fit for purpose.
- Staff minimised the use of restrictive practices. Staff followed best practice when de-escalating and managing challenging behaviour. Restraint and seclusion was only used after attempts to de-escalate had failed. Beech unit had a designated extra care area and seclusion room that had been renamed, in consultation with patients and staff, to reduce stigma relating to these terms. Ward staff were involved in the trust's restrictive interventions reduction programme. The 'four steps to safety' programme was being implemented on all wards to reduce violence and aggression. The programme was developed using quality improvement methodology. The trust had seen a significant reduction in violence and aggression on 13 of the 19 wards and a 50% reduction in restraint.
- Staff knew how to protect patients from abuse. The trust worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it. There were systems to report safeguarding which were connected directly to the trust's safeguarding team.
- Staff had easy access to clinical information.
- The trust used systems to safely prescribe, administer, record and store medicines. Staff regularly reviewed and monitored the effects of medications on patient's physical health.
- Staff understood and recognised incidents and reported them appropriately. Incidents were investigated and lessons learned were shared with the teams and the wider service. Staff were open and transparent when things went wrong. Staff apologised and gave patients honest information and suitable support.

However:

- Staff did not always develop robust risk management plans in response to identified needs and changing risks. Risk management plans were brief and were not updated in response to incidents and episodes of restraint or seclusion. This was a concern on all the acute wards for adults of working age and psychiatric intensive care units.
- Staff were not safely monitoring patients on waiting lists in the community mental health teams. Staff were unable to detect and respond to increases in level of risk. Risk assessments were not updated following their initial assessment. Patients on the waiting lists were not always contacted or prioritised in line with the trust's protocols. Some teams were unable to monitor and respond to high risk or urgently referred patients. Following the Section 31 letter of intent the trust provided assurances that all patients on the waiting list had been contacted and their risk reviewed.
- Staffing establishment figures were insufficient in the community mental health teams to enable effective caseload management.
- There were unmanageable staffing vacancies on the acute wards for adults of working age and psychiatric intensive care unit. This meant newly qualified nurses were working without a second experienced registered nurse. High vacancies had led to staff to be unable to provide the highest quality care, complete training sessions and receive supervision.

Summary of findings

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- Staff undertook comprehensive assessments of patient's needs, which included consideration of clinical needs (including pain relief), mental health, physical health and wellbeing, and nutrition and hydration needs.
- Staff generally developed individual care plans for patients, which were reviewed regularly through multidisciplinary discussion and updated when required. Care plans reflected the needs of patients, were personalised and recovery-orientated. Staff from a range of different disciplines worked together to benefit patients.
- Staff understood their role and responsibilities under the Mental Health Act 1983 and Mental Health Act Code of Practice.
- Staff in most teams provided a range of care and treatment interventions suitable for the patient group which were based on national guidance and best practice. Patients generally had good access to physical healthcare and were supported to live healthier lives. Some nurses on the wards for older people with mental health problems were dual trained and able to meet the needs for patients with complex needs.
- Staff used recognised rating scales to assess and record severity of outcomes. Staff participated in benchmarking and quality improvement initiatives.
- Staff supported patients to make decisions on their care for themselves. Staff understood the Mental Capacity Act 2005, the trust's policy and assessed and recorded capacity clearly for patients who may have impaired mental capacity. Staff worked with the patient's support network to ensure best interest decisions were made when relevant.

However:

- Some teams did not include a full range of specialists required to meet the needs of patients. The acute wards and the community mental health teams did not have sufficient numbers of allied mental health professionals, including occupational therapists and clinical psychology staff, to provide a full range of interventions for patients. Patients in the community teams were waiting for long periods of time for psychological interventions.
- Most of the community mental health teams, apart from Exeter, were not monitoring or assessing the physical healthcare needs of patients.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. Patient's privacy and dignity was respected. Staff understood the individual needs of patients and supported them to understand and manage their care, treatment or condition. Consideration of patients' privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated.
- Staff involved patients in the decisions on their care and treatment pathway and risk assessment. Managers and staff actively sought patient's feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. On the wards for older people patients were actively consulted about the way in which services were delivered. There was meaningful involvement in patient meetings, patients were consulted about ward refurbishment and patient voices were reflected in ward documentation.
- Staff informed and involved families and carers appropriately.
- Carers told us that they were kept informed about their loved one and that information was clear and easy to understand. Carers said they were involved in decision-making and invited to meetings when appropriate. We were told that staff were non-judgemental and that they were confident their loved ones received the right support.

Summary of findings

Are services responsive?

Our rating of responsive went down. We rated it as requires improvement because:

- The trust was unable to provide enough beds to ensure patients received treatment within trust area beds. The number of patients treated in out of area beds had increased since our previous inspection. Some adults of working age were being cared for on the wards for older people with mental health problems due to bed shortages.
- The community mental health teams for adults of working age were unable to provide treatment to all patients within the 18 week referral to treatment target time. Some high risk patients and urgent referrals were waiting up to a year for treatment. Some patients waited up to three years to be allocated to a care co-ordinator, this meant patients could not receive treatment until allocated.
- The acute inpatient wards for adults of working age were not always able to meet the needs of all patients who used the service. Delderfield ward was not accessible for patients in a wheelchair. Coombehaven ward had accessible rooms on the ground floor but patients in larger wheelchairs were cared for on older peoples wards as they were more accessible.
- Waiting times for the Autistic Spectrum Disorders and Attention Deficit Hyperactivity Disorder service were still very long. Patients were still waiting 22 months for the Autism service for the majority of the county and waiting times for the ADHD part of the service had got worse since the last inspection with patients without a previous diagnosis waiting on average 40 months.

However:

- The design, layout and furnishings of ward environments supported patients' treatment, privacy and dignity.
- Staff supported patients with activities outside the ward environments such as work, education and family relationships.
- The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The trust met the needs of all patients who used the service – including those with additional and specific needs relating to a protected characteristic**.** Staff helped patients with communication, advocacy and cultural and spiritual support.
- The trust had set up a community mental health team at the University of Exeter to provide students with quick access to mental health services. Since opening in January 2019, the service had reduced the attendance of students to the local emergency department presenting with mental health distress by 60%.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Managers had the skills and knowledge to perform their roles. They understood the issues, priorities and challenges their service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles. Staff told us they felt supported by their managers and could approach them regarding their development and with any concerns and felt that they would be responsive.
- Leaders ensured there were structures, processes and systems of accountability for the performance of the service and in the most part these worked well. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Summary of findings

- With exception of those working in the community mental health teams for working age adults, most staff told us that they felt respected and valued by the trust. Staff felt the trust promoted equality and diversity. Most staff that we spoke with told us that they felt able to raise concerns without fear of retribution. Managers were supporting teams to improve morale following bullying allegations on acute wards for adults of working age and psychiatric intensive care unit.
- The trust engaged well with patients, most staff, equality groups, the public and local organisations to plan and manage appropriate services. Leaders encouraged innovation and participation in research. Staff were committed to continually improving services and had a good understanding of quality improvement methods.
- The board and senior leadership team had set clear vision and values that were at the heart of the work of all staff in the organisation. The vision and values were aligned to local plans and the local health economy.

However:

- Some governance processes were not operating effectively on the acute wards for adults of working age. There was inconsistency in governance across the wards.
- A substantial number of staff that we spoke with in the community mental health teams did not feel listened to by the trust. Staff morale within the service was low and staff reported what they perceived to be a bullying and blame culture. Long waiting lists was causing pressure and stress on staff within the team. The governance system in the team was not robust and did not provide accurate oversight of waiting lists.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all the ratings into account in deciding the overall ratings. Our decision on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice trust wide and also on the wards for older people with mental health problems and community-based mental health services for adults of working age.

For more information, see the Outstanding Practice section of this report.

Areas for improvement

We found areas for improvement including 14 breaches of legal regulations that the trust must put right. These included concerns about staffing, risk assessments and management of risk, staff supervision, person-centred care planning, waiting times for treatment and governance. We found 27 things that the trust should improve to comply with minor breaches that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas of Improvement section of this report.

Action we have taken

We wrote to the trust to seek immediate assurances about the waiting list management and risk assessment of patient on the waiting lists for the community-based mental health service for adults of working age. The trust responded to our letter and provided assurance that measures had been put in place to follow-up and monitor the level of risk of those people on the waiting list.

Summary of findings

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

We will closely monitor the progress of the trusts assurance to improve community-based mental health services for adults of working age.

Outstanding practice

Wards for older people with mental health problems

On Belvedere, patients had informed staff that music helped them to de-escalate when they became distressed. Staff had sat down with these patients and created individual playlists for them to listen to and had documented all of this information in their care plans.

Beech Unit had a stable staff team; all had been working on the unit for over four years or more and were so dedicated and committed to the services they were delivering. Staff were passionate about the work they did, performed to a high level and contributed to a culture of positivity and least restrictive practise.

The team had won an award for their roll out of the 'four steps to safety' programme. Since they implemented it, their violent and aggressive incidents had halved.

Staff and patients had decorated and furnished the ward creatively to made it feel homely and personal. For example, the seclusion and extra care area were not referred to, in order to remove the stigma associated with these words. Instead, staff had positioned colourful block words on their doors and renamed them, 'the Retreat' and 'the Nest'. The word 'Recovery' was positioned over the exit to the ward. Patients had created appliques and blankets which decorated the walls, a health care assistant had created a detailed mural with decorated window lights. The 'Nest' (seclusion room) had LED lights controlled by a dimmer switch and ceiling lights that could change colour.

The ward's admission booklet contained photographs of all the staff and a description of what they did and how they would help patients admitted to the ward.

Staff advertised a weekly drop in session called 'tea with the pharmacist' so patients and their carers could informally chat with the ward's pharmacist about medication.

Community-based services for adults of working age

Devon Partnership NHS Trust, in collaboration with other statutory organisations, had funded a community mental health team for students of the University of Exeter to access. This service was a finalist to receive the Royal College Nursing mental health award. The service linked with the university's wellbeing practitioners and was located on the university campus. Since opening in January 2019, the service has reduced the attendance of students to the local emergency department presenting with mental health distress by 60%.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of findings

We told the trust that it must take action to bring services into line with four legal requirements. This action related to two services.

Action the trust MUST take to improve

Acute wards adults of working age and Psychiatric Intensive Care Units

- The trust must ensure there are enough suitable and qualified staff on the ward. There should be sufficient staff on the ward to ensure patients have access to leave and one to one sessions with their named nurse. Newly qualified nurses should be supported in the running of the shift by a second experienced nurse unless in exceptional circumstances (Regulation 12).
- The trust must ensure that staff complete comprehensive management plans in response to identified risks and review these management plans regularly and following incidents or use of restrictive interventions (Regulation 12).
- The trust must ensure that managers provide all staff with supervision and appraisal in line with the trust policy (Regulation 18).
- The trust must ensure staff on Coombehaven and Delderfield ward work collaboratively with patients to create holistic, recovery focused and person-centred care plans (Regulation 9).

Community-based mental health services for adults of working age

- The trust must ensure that staff safely monitor patients on waiting lists to detect and respond to increases in level of risk. This includes reviewing and updating risk assessments following contact with a patient on the waiting list. (Regulation 12)
- The trust must ensure that waiting times are managed effectively and all patients are seen within the required waiting times target. (Regulation 12)
- The trust must ensure that urgent, high-risk and priority patients are assessed and allocated promptly. (Regulation 12)
- The trust must ensure that patients' physical health is monitored in accordance with National Institute for Health and Care Excellence guidance. (Regulation 9)
- The trust must ensure that patients can access psychological therapy in a timely manner. (Regulation 9)
- The trust must ensure there are sufficient numbers of staff to ensure the service runs effectively and safely. (Regulation 18)
- The trust must improve the governance process to provide oversight of the waiting lists. (Regulation 17)
- The trust must take action to address the issues raised regarding the culture and ensure staff's wellbeing is supported. (Regulation 18)
- The trust must ensure that blank prescription forms are stored securely and that only authorised individuals have access to the keys. (Regulation 17)

Community based services for adults with a learning disability or autism

- The trust should continue working with local commissioning groups to ensure they can obtain the resources to meet the needs of people waiting for the Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder service. (Regulation 9)

Action the trust SHOULD take to improve

Acute wards adults of working age and Psychiatric Intensive Care Units

Summary of findings

- The trust should ensure that managers complete risk assessments of the ward environment, take action to mitigate risks and share these plans with ward staff.
- The trust should ensure that bathrooms are cleaned and maintained appropriately to prevent the occurrence of mould around wash facilities.
- The trust should ensure that bedrooms are well maintained and that broken fixtures are removed and fixed prior to patients using the bedrooms.
- The trust should ensure that physical health monitoring equipment is well maintained and calibrated.
- The trust should ensure that staff carry out physical health observations after rapid tranquilisation in line with trust policy and national guidance.
- The trust should ensure that there are enough clinical psychologists to provide access to psychological therapies for all patients who require this and offer both one to one and group sessions
- The trust should ensure that patients on the acute wards are involved in their care planning and that their views and preferences are recorded on these.
- The trust should ensure that staff on The Junipers are completing patients' 132 rights on admission and in line with the trust policy.
- The trust should ensure that there is adequate occupational therapy cover on Haytor ward to provide a range of activities and provide access to the ward gym.
- The trust should review bed usage, including admissions of working age adults to older persons wards, capacity and readmission rates. The trust should monitor the number of times a bed is not available to a patient when they return from leave.
- The trust should ensure that adjustments are made to ensure patients in wheelchairs who are referred to Delderfield and Coombehaven wards are treated in an appropriate acute environment for adults of working-age.
- The trust should ensure that it regularly reviews blanket restrictions, and make sure that when restrictions are in place they are necessary and individually risk assessed including those which restrict patient's access to hot drinks and communal areas.
- The trust should ensure managers have oversight of the quality of risk management plans and care plans and audit this regularly**.**

Community-based mental health services for adults of working age

- The trust should ensure that staff clearly document on medication charts when a patient has been offered medication but refused.
- The trust should ensure that medication charts are completed in full and do not contain gaps in recording.
- The trust should ensure that all teams meet the trust target for annual CPA reviews.
- The trust should ensure the service audits adherence to the Mental Capacity Act.
- The trust should ensure the letter sent to patients whilst on the waiting list contains consistent contact details across the county.

Wards for older people with mental health problems

- The trust should address the issue of corroded pipes at Beech Unit.

Summary of findings

- The trust should complete annual PAT tests on electrical equipment at Franklyn Hospital.
- The trust should mitigate against the risk of the long call bell strings in the bathrooms at Belvedere and Meadow View.
- The trust should store the oxygen cylinder safely in the clinic room on Belvedere.
- The trust should complete care plans which demonstrates outcomes for patients receiving 'as and when required' medication.
- The trust should check that supervisions are being recorded regularly at Meadow View.
- The trust should carry out impact assessments about the admission of adults of working age onto older people's mental health wards.
- The trust should aim to reduce the use of leave beds for new admissions.

Community based services for adults with a learning disability or autism

- The trust should continue to embed its processes to ensure care records contain all relevant information for patients. Including appropriate assessment and mitigation of any risks, and assessments of and plans to meet a patient's clinical needs.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust stayed the same. We rated well-led as good because:

- The trust had a leadership team with an appropriate range of skills, knowledge and experience to deliver mental health services. The board was well established and stable. The trust had strong and experienced non-executive directors (NEDs). NEDs were from a range of professional backgrounds and all were confident to escalate and challenge clinical issues with the executive team.
- Staff were proud to work for the trust and in the majority of services reported that morale was good. There was a strong sense of staff at all levels putting patients at the heart of everything they do.
- The leadership team and staff throughout the trust were open and transparent. The trust had a clear set of vision and values which staff understood. Staff had been consulted and involved in their development. We saw the trust's values embedded in the services we inspected.
- The trust was financially stable and had the relevant expertise among executives and NEDs relating to finance. The trust had a clear understanding and oversight of their financial position. This was regularly discussed at board meetings. The trust had a proven track record of achieving financial targets.
- The trust's senior leadership team were considered visible and approachable by most staff. Executives and NEDs visited services regularly to review services and meet with frontline staff.
- The trust had continued to develop and instil the 'Together' engagement programme. The approach had continued to be successful since our last inspection. The programme brought people with lived experience, including carers, to develop and co-design services. We saw that the philosophy of Together was evident in all areas of the trust.

Summary of findings

- There were leadership and development opportunities available to staff. The trust was focused on leadership development and this was a key part of the workforce and organisational development delivery plan. The trust had established a leadership framework.
- The trust promoted equality, diversity and inclusion in day to day business and there was an active and ongoing focus. There were a number of staff networks in place, including Respect network, Disability, impairment and long term health conditions staff network, LGBTI+ staff network, BME staff network and a Menopause Matters staff network. The equality, diversity and inclusion staff networks had been involved in a number of local events, including local Pride events. The trust had over 50 staff Equality Champions. Staff felt equality and diversity was promoted by the trust.
- The trust had an independent Freedom to Speak Up Guardian. The guardian provided examples of support and guidance provided to staff to raise concerns. The guardian regularly met with the executive team.
- The trust was committed to improving services and learning from when things went well and when they went wrong. There was a positive culture of quality improvement within the trust. The culture was demonstrated by the response to our letter seeking assurances about the concerns in the community-based services for adults of working age. The trust accepted our findings in relation to waiting list and risk management and provided assurances about immediate action that had been taken.
- The trust investigated and learned from incidents comprehensively.
- The trust took complaints seriously and investigated them appropriately. Responses to complaints were respectful and detailed following investigation.
- There were a range of mechanisms that provided assurance from service level to board level for most services. Directorate governance meetings were held monthly and considered service line performance by operational activity, quality governance metrics (including incidents, complaints and compliments), workforce and financial KPIs and risks faced by each individual directorate. The board reviewed performance reports that included data about services. The papers for board meetings and the other committees that fed into the board were of good quality. There was rigour at board and NEDs were able to provided challenge to the board.
- The trust was a key part of the local strategy and had strong relationships with partners. The trust was taking a lead role on the development of the Mental Health strategy for the whole of the wider Devon.
- The trust actively participated in national improvement and innovation projects. Quality Improvement was embraced and embedded across the trust and integral to day to day working. The trust had trained over 900 staff in quality improvement methodology. Staff were able to, and encouraged, to make suggestions for improvements and gave examples of ideas that had been embedded.

However:

- Staff in the community-based mental health services felt the trust had not responded appropriately to concerns about the service and long waiting lists. At the time of the inspection the governance system in place in the community mental health teams was not robust and had not provided accurate oversight of the waiting lists. There were discrepancies in the data about the numbers of people on the waiting lists. Following the inspection the trust provided an action plan detailing the steps they had taken and planned to implement a centralised team to monitor waiting lists. Following the inspection the trust made contact with all high risk and urgent patients and made appointments to meet them.

Summary of findings

- Staffing numbers on the acute wards for adults of working age and in the community-based mental health teams for adults of working age were insufficient. In the community mental health teams staff had high caseload numbers and could not manage the waiting list which was leading to delays in patients accessing treatment. Nursing vacancies on two of the acute wards meant newly qualified nurses were working without an experienced registered nurse.
- The trust was unable to provide enough beds to ensure patients received treatment within trust area beds. The number of patients treated in out of area beds had increased since our previous inspection. Between March 2018 and February 2019 379 patients had been treated in out of area beds. During the previous inspection there had been 217 out of area placements. Some adults of working age were being cared for on the wards for older people with mental health problems due to bed shortages. This was impacting on both services with increased numbers of restraint on the wards for older people due to the admission of adults of working age to the wards. The trust had put significant investment into a new ward, the Junipers, which opened in January 2019 to increase available beds and reduce out of area placements. An independent review of the trust's bed stock had been completed and agreement had been reached with the NHS Devon CCG that the trust does not have the appropriate number of beds per head of population. As a result of this work, a new acute ward is currently being designed at the Torbay site. The ward is anticipated to open in 2021.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement ↓ Oct 2019	Good →← Oct 2019	Good →← Oct 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Oct 2019	Requires improvement ↓ Oct 2019	Good →← Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↓ Oct 2019
Long-stay or rehabilitation mental health wards for working age adults	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Forensic inpatient or secure wards	Good Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Good Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017
Wards for older people with mental health problems	Good →← Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019
Wards for people with a learning disability or autism	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Community-based mental health services for adults of working age	Inadequate ↓ Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019
Mental health crisis services and health-based places of safety	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community-based mental health services for older people	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community mental health services for people with a learning disability or autism	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement ↓ Oct 2019	Good →← Oct 2019	Good →← Oct 2019
Overall	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement ↓ Oct 2019	Good →← Oct 2019	Good →← Oct 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement 

Key facts and figures

The acute wards for adults of working age and psychiatric intensive care unit provided by Devon Partnership NHS Trust are part of the trust's adult services directorate. The wards provide care for working age adults, aged between 18 to 65, who need to be in hospital for their mental health problems.

There are four acute wards and all of them provide services for men and women. The Cedars at Wonford House Hospital has two 16-bedded wards: Coombehaven ward and Delderfield ward. Haytor ward at Torbay Hospital is also a 16-bedded ward. The trust has recently reduced the beds on Ocean View ward at North Devon District Hospital and opened up the environment on Moorland and Ocean View to create one ward area with 24 beds. The ward has two ward managers and patients are allocated to Moorland View or Ocean View despite the ward operating as one, referred to as Moorland View ward. All the wards are locked wards.

There is one Psychiatric Intensive Care Unit in Exeter, The Junipers, which opened in January 2019. The Junipers is a 10-bedded mixed gender ward. Three of the beds are allocated for patients referred by Livewell South West trust.

The previous comprehensive inspection of this core service took place in December 2017. Following that inspection, we rated this service as good overall, with a rating of good in all domains except safe which we rated as requires improvement. During that inspection we told the provider they must ensure that environments are safe for patients. This included addressing the lack of secure fencing and easy access to the roof on Ocean View and ensuring appropriate maintenance of environments.

This inspection was undertaken as part of our comprehensive programme of inspections. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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 staff at focus groups.

During the inspection, the inspection team:

- visited all six wards at the three hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 26 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- interviewed 38 staff including consultants, staff nurses, healthcare assistants, psychologists, occupational therapists, assistant occupational therapists, and discharge facilitators

Acute wards for adults of working age and psychiatric intensive care units

- interviewed an independent mental health advocate who provided advocacy to patients on the ward
- reviewed 26 care records of patients
- reviewed 43 patient medication charts
- reviewed seven seclusion records
- attended various ward activities including handovers, clinical review meetings and patient activity groups
- carried out a specific check of medication management on all the wards
- looked at policies, procedures and other documents relating to the running of the service

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Managers on Moorland View had not risk assessed the ward environment to ensure all areas of the ward could be observed. Staff on Moorland View, Haytor ward and Delderfield ward were unaware of environment risks on the wards, such as blind spots, and were not acting to mitigate these risks. Moorland View bedrooms were not well maintained and there was broken equipment in the accessible bedroom. There was mould in the communal bathrooms on Coombehaven, Haytor and Moorland View wards.
- Staff on all the acute wards did not always develop robust risk management plans in response to identified needs and changing risks. Risk management plans were brief and did not address individual risks with interventions. Staff did not consistently review risk assessments and management plans in response to incidents and episodes of restraint or seclusion. Staff on Coombehaven ward did not ensure a doctor reviewed seclusion after one hour in line with the trust policy and were not documenting reasons for this not taking place.
- On the acute wards, staff did not ensure that care plans reflected patients' preferences and these were not always person-centred. Care plans on Coombehaven and Delderfield ward did not consistently meet patients' assessed needs and were not person-centred.
- Moorland View and Coombehaven ward teams had high vacancy rates for registered nurses. Managers on Haytor ward and The Junipers had not ensured that newly qualified nurses always worked with a second nurse and an experienced nurse. Clinical psychologists were unable to provide a full range of psychological interventions due to having to work on more than one ward. Managers had not ensured that staff received regular supervision and timely appraisals.
- The trust was unable to provide enough beds to ensure patients received treatment within trust area beds. Between March 2018 and February 2019, 379 patients were placed in out of area beds. Some patients were admitted to the older adults ward to ensure they remained in their local area. Patients did not always have a bed available when they returned from leave and staff were not supporting patients to pack their belongings before leave. If patients returned from leave and their bed had been taken, a bed would be sought on another ward or out of area.
- Managers on the acute wards had not ensured that patients' risk and ward environmental risks were adequately assessed and managed. The trust did not have oversight of the impact of high vacancies and bed occupancy on the number of patients whose leave had been cancelled due to staffing and patients whose beds were no longer available to them when they returned from leave. Managers were aware that supervision and appraisal compliance was below 62% for all the wards and the action plans to address this had not yet improved compliance. Clinical audits of care records were insufficient to ensure patients were receiving comprehensive and person-centred care.

However:

- The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. The service had reduced its number of delayed discharges and employed discharge facilitators on all the wards to support patients with accommodation needs.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff on the acute wards did not always develop robust risk management plans in response to identified needs and changing risks. Risk management plans were brief and did not address individual risks with interventions. Staff did not consistently review risk assessments and management plans in response to incidents and episodes of restraint or seclusion.
- Managers on Moorland View had not risk assessed the ward environment to ensure all areas of the ward could be observed. Staff on Moorland View, Haytor ward and Delderfield ward were unaware of environment risks on the wards, such as blind spots, and were not acting to mitigate these risks.
- Managers on Coombehaven ward and The Junipers had not ensured that seclusion processes were completed in line with policy. On Coombehaven ward staff did not always ensure that a second nurse or doctor completed a review in person and these were often completed over the telephone. The trust policy stated that a doctor should review seclusion after one hour. However, this review did not always take place. Staff did not review risk assessment and management plans following seclusion of patients. This had led to repeated episodes of seclusion for individual patients.
- The service had unmanageable vacancies for registered nurses and newly qualified nurses on The Junipers and Haytor ward were working shifts without a second experienced registered nurse. Managers on Ocean View ward had been unable to meet safer staffing levels and had closed 6 beds and merged the ward with Moorland View. Staff told us that the high number of vacancies had led to them being unable to provide high quality care, complete some of their training refreshers and receive clinical supervision.
- The communal bathrooms on Coombehaven, Haytor and Moorland View wards had mould around wash facilities, and bedrooms on the acute wards were not well maintained and required repainting. The service had not completed necessary maintenance works to stained walls and damaged handles in the en-suite toilet in the accessible bedroom on Moorland View, prior to using the bedroom for a new admission.
- Patients on Haytor ward told us they could not access hot drinks at night as the room was locked. Managers on the acute wards had applied a blanket restriction that kitchens should be locked from midnight until 6am to aid sleep hygiene. This had not been individually risk assessed. Staff assured us that patients could access a hot drink and snack from the kitchen if they spoke with staff who could unlock the door at their discretion.

However:

Acute wards for adults of working age and psychiatric intensive care units

- Staff followed best practice in de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Staff on the acute wards did not ensure that care plans reflected patients' preferences, and these were not always person-centred. Care plans on Coombehaven and Delderfield ward did not consistently meet patients assessed needs and were not person-centred.
- Managers on all the wards had not supported all staff with supervision in line with the trust policy and many staff had not received an appraisal on time.
- Staff were not consistently explaining patients' rights on admission, in line with the trust policy on The Junipers.
- Staff on all wards were not completing weekly monitoring of physical health for patients who didn't have specific physical health concerns, such as diabetes, or those receiving certain medications. The trust policy identified that all patients' physical health should be monitored at least weekly using the National Early Warning Score 2 (NEWS2) tool to support identification of any deterioration in their physical health.
- Patients did not have easy access to the full range of interventions for high quality care. There was limited input to the wards from a clinical psychologist.

However:

- Staff on the psychiatric intensive care unit assessed the physical and mental health of all patients on admission and developed individual care plans. These reflected the assessed needs, were personalised, holistic and recovery-oriented. Staff monitored the physical health of patients with specific physical health needs well and developed comprehensive and personalised care plans that met the patients assessed needs.
- Staff provided treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in benchmarking and quality improvement initiatives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Acute wards for adults of working age and psychiatric intensive care units

- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.
- Managers supported staff with opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in the decisions on their care and treatment pathway and risk assessment. Managers and staff actively sought patient's feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However

- Although patients told us they had received copies of their care plan, on Coombehaven and Delderfield ward there was often a delay in them receiving the care plan and staff on all wards did not always document that patients had received them. Patients on Coombehaven and Delderfield ward told us that the needs and interventions on their care plans were out of date when they received them.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- The trust was unable to provide enough beds to ensure patients received treatment within trust area beds and average bed occupancy for all the wards was 100% between March 2018 and February 2019. The number of patients treated in out of area beds over this period was 379, which had increased since our previous inspection and patients were being cared for on older adult wards due to beds being unavailable.
- A bed was not always available when needed and patients returning from leave did not always have a bed on the ward they had leave from. The number of readmissions within 28 days of discharge had increased from 52 to 60 since our previous inspection. Managers from the community mental health teams told us that they were often unable to identify a bed on the acute wards and therefore were managing more complex cases in the community.
- Patients on all the acute wards were reliant on staff to allow access to the kitchens for hot drinks and some lounges between the hours of midnight and 6am. Patients on Haytor ward were not aware that they could access hot drinks and snacks by requesting a staff member to unlock the doors.

However:

Acute wards for adults of working age and psychiatric intensive care units

- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. Moorland View and The Junipers had ensuite facilities in the bedrooms. There were enough shared bathrooms and toilets for patient use on Haytor, Delderfield and Coombehaven wards. There were quiet areas for privacy.
- Staff supported patients with activities outside the service, such as work, education and family relationships.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- There was inconsistency in governance across the wards. The governance systems and procedures did not ensure that staff worked within policies, there were enough suitably qualified staff on shifts and that those staff were supervised and supported to provide high quality care. Audit processes on the acute wards had not ensured that ward environment and patient's risk were adequately managed.
- Staff on Moorland View told us that they had not been consulted in a timely manner prior to the two wards merging together. Staff and patients told us they had been given 24 hours notice of the merge and this caused anxiety amongst staff and patients.
- Managers on the acute wards had not ensured that staff were able to perform their role to a high standard due to staff shortages preventing them from completing fundamental tasks.

However:

- Ward managers had the skills and knowledge to perform their roles. Staff told us they felt supported by their managers and could approach them regarding their development and with any concerns and felt that they would be responsive.
- Most staff told us that they felt respected and valued. They felt able to raise concerns without fear of retribution. Managers were supporting teams to improve morale following bullying allegations on Haytor ward and The Junipers.
- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. Leaders encouraged innovation and participation in research.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community-based mental health services of adults of working age

Inadequate 

Key facts and figures

Devon Partnership NHS Trust provides adult community mental health services across Devon.

The trust's adult community mental health service provides mental health support to individuals aged 18 - 65. The teams predominately support individuals in the community, but also support individuals who are inpatients and those in residential care homes. Referrals to this service are predominately from local GPs. The service has five assessment teams who are responsible for the referrals and initial assessments. The teams triage and pass to the appropriate community mental health team, dependant on which part of the county the individual lives.

The service was previously inspected in December 2017 and was rated requires improvement overall. Following the December 2017 inspection, we told the trust it must make the following improvements to the service:

- The trust must ensure that medicines are managed effectively and stored correctly.
- The trust must ensure that patients physical health is monitored in accordance with National Institute for Health and Care Excellence guidance.
- The trust must ensure that waiting times are managed effectively and all patients are seen within the required waiting times target (95% of all patients receive treatment within 18 weeks of referral).

During the 2019 inspection we visited 11 of the 17 adult community mental health teams as part of our comprehensive inspection programme of Devon Partnership NHS Trust. Our inspection of the adult community mental health teams was announced (staff knew we were coming) to ensure that everyone we needed to speak to was available, as well as allowing us access to home visits where appropriate.

Following this inspection, we served a letter of intent to the trust. The letter of intent detailed that we would take enforcement action if the trust did not take immediate action to address concerns raised. The trust sent the commission an action plan which detailed what steps they had and will continue to take to ensure it delivered safe services. We therefore took no further action and will continue to monitor and engage with the trust closely to ensure on-going improvements are made.

We inspected:

- North Devon Sector A team based at the Ilfracombe centre.
- North Devon Sector B team based at Riverside in Barnstaple.
- North Devon Sector C team based at Abbotsvale in Bideford Hospital.
- Torbay North, South and Central teams based at Chadwell Health & Wellbeing Centre.
- Newton Abbot & Teignbridge teams based at Estuary House.
- Exe, Clyst, Culm teams based at Wonford House.

Before the inspection, we reviewed information we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

Community-based mental health services of adults of working age

- visited the premises where teams were based or were seeing patients and looked at the quality of the service environment
- spoke to ten team managers, one team leader, two deputy managers and three service managers covering the county. We also spoke to one manager of an early intervention for psychosis service, one referrals manager and one administrative manager.
- spoke with nine patients and two carers
- received comment cards from three patients
- spoke to 45 staff including 21 nurses, two student nurses, one occupational therapist, one lead for psychology and psychological therapies, two social workers, three support workers, seven consultant psychiatrists, one junior doctor, three administrative staff, one mental health practitioner, two senior mental health practitioners, and one senior research officer
- reviewed 51 care records of patients
- completed a specific review of 36 care records of patients currently on the waiting list for the service
- reviewed 97 medication records of patients
- attended one visit to a patient's home and observed two patient appointments
- observed one multi-disciplinary meeting with an assessment team and one learning from experience meeting and
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Following this inspection, we served a letter of intent to the trust. We did this under Section 31 of the Health and Social Care Act 2008 to notify the trust of the serious concerns that had been identified during the inspection. The letter of intent detailed that we would take enforcement action if the trust did not take immediate action to address concerns raised. The Section 31 powers offer a provider the opportunity to put forward documentary evidence to provide assurance that identified risks have been removed or are to be immediately removed. We received immediate assurances from the trust and work was undertaken to review the waiting lists and assess the risk of those people on the waiting lists.The trust sent the commission an action plan which detailed what steps they had and will continue to take to ensure it delivered safe services. We therefore took no further action and will continue to monitor and engage with the trust closely to ensure on-going improvements are made.

Our rating of this service went down. We rated it as inadequate because:

- None of the teams we inspected were safely monitoring patients on waiting lists to detect and respond to increases in level of risk. Staff were not always contacting patients on waiting lists in line with the trust's protocol. Staff did not update risk assessments of patients on waiting lists following their initial assessment. Patients were not always prioritised in line with trust policy. For example, patients who disclosed they had become pregnant while on the waiting list did not become urgent referrals and move up the waiting list. Some teams were unable to monitor and quickly respond to high-risk or urgently referred patients, who should be allocated within a week. Some high-risk and urgent patients were waiting between 28 days and a year to be allocated and receive treatment.

Community-based mental health services of adults of working age

- The service was unable to provide treatment to all patients within the 18-week referral to treatment target time. Patients who were referred as urgent were not always being assessed and allocated within one week. This was raised as a concern at the previous inspection and during this inspection we found that patients were waiting significantly longer to access the service.
- Patients were not able to access psychological therapies in a timely manner. Patients would only be referred to the psychology team if they had been allocated a care co-ordinator. Some teams had identified that approximately 50% of patients on the waiting list would benefit from psychological intervention.
- Except for the Exeter community mental health teams, staff were not always assessing and monitoring the physical health of patients in line with best practice recommended by the National Institute for Health and Care Excellence. This was raised as a concern at the previous inspection and despite progress being made, the majority of teams were not monitoring and assessing patients' physical health appropriately.
- Staff establishment figures were insufficient to allow adequate caseload management. Managers could not recruit above established levels and had previously been asked to reduce staffing numbers due to a change in budget. Staff were working at full capacity, and many were stressed and at the point of burn-out. Staff described a 'flow and capacity issue' as the number of referrals received by the service out-weighed the number of clients being discharged. Some teams were being impacted by staff absences such as those on long-term sick or on maternity leave. One team did not have a consultant psychiatrist and this role was being covered by other consultant psychiatrists in the locality, putting additional pressure on the staff to ensure patients had their medical needs met. In one of the Exeter teams there had not been a substantive consultant psychiatrist for over two years and there had not been a consistent locum in place.
- Staff at all levels described an unsupportive, blame culture from the trust board. Of the staff we spoke to, eight described a negative culture within the trust. Staff were afraid to make mistake during the inspection as they feared being reprimanded by the trust. Some staff felt valued by the trust. However, most felt that their service had been neglected, and that funding and focus was on more specialist services. Staff felt this pulled resources from the community mental health teams. There were areas of good morale in the teams, but this was variable. Of the staff we spoke to, 18 described being stressed, under pressure and close to burn out. This was particularly apparent in the teams in South and Central Torbay, who had low levels of morale.

However:

- Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Staff in the Torbay North team had received 'Open Dialogue' training and were identifying patients who would benefit from this specific intervention.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- A community mental health team had been set up at the University of Exeter to provide students with quick access to mental health services. Since opening in January 2019, the service had reduced the attendance of students to the local emergency department presenting with mental health distress by 60%.
- Carers told us that they were kept informed about their loved one and that information was clear and easy to understand. Carers said they were involved in decision-making and invited to meetings when appropriate. We were told that staff were non-judgemental and that they were confident their loved ones received the right support.

Community-based mental health services of adults of working age

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- Staff in all teams inspected were not safely monitoring patients on waiting lists to detect and respond to increases in level of risk. Staff were not contacting patients on waiting lists in line with the trust's protocol. Staff did not update risk assessments of patients on waiting lists following their initial assessment. Patients were not always prioritised in line with trust policy, for example patients who disclosed they had become pregnant while on the waiting list did not become urgent referrals and move up the waiting list. Some teams were unable to monitor and quickly respond to high-risk or urgently referred patients, who should be allocated within a week.
- Staff establishment figures were insufficient to allow adequate caseload management. Managers could not recruit above established levels and had previously been asked to reduce staffing numbers due to a change in budget. Staff were working at full capacity, stressed and at the point of burn-out. Staff described a 'flow and capacity issue' as the number of referrals received by the service out-weighed the number of clients being discharged. Some teams were being impacted by staff absences such as those on long-term sick or on maternity leave. One team did not have a consultant psychiatrist and this role was being covered by other consultant psychiatrists in the locality, putting additional pressure on the staff to ensure patients had their medical needs met.
- In Bideford the clinic responsible for seeing all patients in North Devon who were on clozapine, an anti-psychotic medication that requires monitoring, did not have a dedicated staff team. Staff from the community mental health team were running the clinic but with 'skeleton' staffing. This was having a significant impact on the team resources and ability to run the clinic.
- In Barnstaple, blank prescription forms were stored in the clinician's desk and a spare key was held at reception. This meant unauthorised staff had access to blank prescriptions.

However:

- Clinical premises where patients received care were safe, clean, well equipped, furnished and maintained and were fit for purpose. Patients were not seen on premises deemed not to be suitable and some teams were in the process of finding new premises that were fit for purpose.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had completed all mandatory training.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Except for the Exeter community mental health teams, staff were not assessing and monitoring the physical health of patients in line with best practice recommended by the National Institute for Health and Care Excellence (NICE). This was raised as a concern at the previous inspection and despite progress being made, the majority of teams were not monitoring and assessing patient's physical health appropriately.

Community-based mental health services of adults of working age

- Patients were not able to access psychological therapies in a timely manner. Patients would only be referred to the psychology team if they had been allocated a care co-ordinator. However, 269 out of 650 patients of the teams we inspected were waiting longer than 18 weeks to access treatment before being assessed for psychology. Some teams had identified that approximately 50% of patients on the waiting list would benefit from psychological intervention.
- Some teams did not include or have access to a full range of specialists required to meet the needs of patients under their care. For example, the teams in North Devon consisted of nurses and did not have other disciplines within the team such as an occupational therapists or community support workers. The psychology teams were separate to the community mental health teams and long wait times meant patients could not directly access the psychology teams. One team did not have a permanently employed registered mental health nurse and was relying on an agency staff member to cover this role.
- Not all teams were meeting trust and national targets to ensure patients had their annual review as required as part of the care programme approach (CPA). The Culm team had 14 patients out of 46 and the Exe team had 13 patients out of 46 who had not had their annual review. Out of 17 teams only three were meeting the target of 95% of patients under CPA to receive an annual review.

However:

- Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Staff in the Torbay North team had received 'Open Dialogue' training and were identifying patients who would benefit from this specific intervention.
- In Exeter, the trust had employed a qualified personal trainer. They had been contracted for a pilot project for five months, which started at the end of March 2019. The role of the personal trainer was to provide exercise classes to patients who could not access them in the community due to their mental health. There was a timetable of groups patients could join and attendance to these groups was high.
- The Trust commissioned Crisis Cafes which were an evening service for people to meet and get support. There were three crisis cafes across Devon.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Most patients who were accessing the service told us that they felt respected, listened to and that staff were caring. Staff gave patients help, emotional support and advice when they needed it.
- Staff supported patients to understand and manage their own care treatment or condition. Staff understood and respected the individual needs of each patient.
- Staff directed patients to other services and supported them to access those services if they needed help.
- Carers told us that they were kept informed about their loved one and that information was clear and easy to understand. Carers said they were involved in decision-making and invited to meetings when appropriate. We were told that staff were non-judgemental and that they were confident their loved ones received the right support.

However:

- Some patient feedback we received described that their treatment had not been caring. One patient told us that some staff did not appear to care and that they were left without support for 10 weeks. One patient said when they were in a hospital out of area and their discharge was delayed until they were allocated a care co-ordinator.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- The service was unable to provide treatment to all patients within the 18-week referral to treatment target time. Of the 11 teams we inspected, 10 had patients waiting longer than 18 weeks to receive treatment. Some high-risk and urgent patients were waiting between 28 days and a year to be allocated and receive treatment. The trust target was within a week. The longest wait was in North Devon Sector C, where there was 108 patients waiting longer than 18 weeks and the longest wait was 114 weeks. Patients could not receive treatment from other services, such as psychology, until they were allocated a care co-ordinator. This was raised as a concern at the previous inspection, where we found 29% of patients were waiting longer than 18 weeks to receive treatment. During this inspection we found that this had increased to 42% of patients.

However:

- A community mental health team had been set up at the University of Exeter to provide students with quick access to mental health services. Since opening in January 2019, the service had reduced the attendance of students to the local emergency department presenting with mental health distress by 60%.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- Some staff across all teams inspected felt that there was a top-down approach whereby staff were not included in decision making. Some staff we spoke with felt that they were not being listened to about the capacity of the community teams and the extra workloads that had resulted from changes in staffing numbers. This feedback from staff was similar to that of the inspection in December 2017.
- Staff at all levels described an unsupportive, blame culture from the trust board. Of the staff we spoke to, eight described a negative culture within the trust. Staff were afraid to make mistake during the inspection as they feared being reprimanded by the trust. Some staff felt valued by the trust. However, most felt that their service had been neglected, and that funding and focus was on more specialist services. Staff felt this pulled resources from the community mental health teams. There were areas of good morale in the teams, but this was variable. Of the staff we spoke to, 18 described being stressed, under pressure and close to burn out. This was particularly apparent in the teams in South and Central Torbay, who had low levels of morale.
- Of the staff we spoke to, 18 described high levels of pressure and stress that they were experiencing working in the service. Staff did not feel that the trust leadership team were aware of the pressures and some felt the trust did not care. Staff told us that the trust were focussed on funding new, specialist services and that the community mental health service was neglected.

Community-based mental health services of adults of working age

- Despite the long waiting lists being on the corporate risk register, the trust had yet to take appropriate, definitive action to reduce the length of time people are waiting. At the time of the inspection, the trust had not implemented a robust system for ensuring all patients on the waiting list were monitored in line with policy.
- The trust did not have a robust governance system in place to provide accurate oversight of the waiting lists in the community mental health teams. There was a significant discrepancy between the number of patients on the waiting lists we saw on site and those sent by the trust after the inspection. The figures sent following the inspection were significantly lower for some teams, sometimes by as much as 100 patients. The discrepancy in the data provided by the trust and the figures we were told on-site represent potentially 400 patients that have been overlooked on the waiting lists.

However:

- Following the inspection, the trust provided an action plan which detailed what steps they had and will continue to take to ensure it delivered safe services. This included a plan to implement a centralised team to monitor and contact those on the waiting list for the service, which had not started at the time of the inspection. Immediately following the inspection the trust contacted all high-risk and urgent patients on the waiting lists, allocated them to a care co-ordinator and made appointments to meet them. This action was completed by 4 July 2019.
- All but two teams we inspected felt valued, respected and listened to by local team managers and described a local culture of supporting one another.

Outstanding practice

Devon Partnership NHS Trust, in collaboration with other statutory organisations, had funded a community mental health team for students of the University of Exeter to access. This service was a finalist to receive the Royal College Nursing mental health award. The service linked with the university's wellbeing practitioners and was located on the university campus. Since opening in January 2019, the service has reduced the attendance of students to the local emergency department presenting with mental health distress by 60%.

The team in North Torbay had completed 'Open Dialogue' training. Open dialogue is a model of mental health care which involves a consistent family and social network approach where all treatment is carried out via network meetings, always involving the patient. The aim of the training was to reduce admissions to hospital and reliance on medication. The team were in the process of identifying patients who would be suitable for this intervention. Managers and staff were very positive about this training and passionate about the potential outcomes for patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Wards for older people with mental health problems

Outstanding ☆ ↑

Key facts and figures

Devon Partnership NHS Trust has four wards for older people with mental health problems.

Beech Unit in Torquay is situated within Torbay Hospital and is a 14 bed mixed sex ward for the assessment and treatment of older people with severe mental health needs, such as depression, anxiety and psychosis.

Meadow View in Barnstaple is situated in North Devon District Hospital and is a 14 bedded mixed sex ward for assessment and treatment of older people with severe mental health needs, such as depression, anxiety and psychosis.

Rougemont is one of two wards in Franklyn Hospital, Exeter. Rougemont is a 16 bedded mixed sex ward for assessment and treatment for older people with severe mental health needs, such as depression, anxiety and psychosis.

Belvedere ward is a 14 bedded complex care and dementia mixed sex ward for older people across Devon and Torbay. It shares the building and some facilities with Rougemont ward, such as the extra care area and the family room.

We inspected older people's mental health wards because we had not inspected them since December 2016. Our intelligence summary report also recommended we reviewed staffing levels, staff turnover, use of agency staff and frequency of the use of restraint.

In December 2016, we rated the service Good in overall and in all key questions: is care safe, effective, caring, responsive and well led

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team visited all four wards and:

- spoke with nine patients who were using the service and four carers
- spoke with the managers for each of the wards
- spoke with 23 other staff members; including matrons, doctors and nurses
- observed five handover meetings or multidisciplinary meetings
- reviewed 27 patient records
- reviewed 11 staff supervision records
- reviewed 37 prescription charts
- reviewed policies and procedures related to the operational running of the service

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

Wards for older people with mental health problems

- All staff demonstrated a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that was kind, compassionate and promoted patients' dignity. This was reflected in the way staff interacted with patients, in patients care records, during patient meetings and multidisciplinary meetings.
- Patients were active partners in their care. Staff were fully committed to working in partnership with patients and supported patients to make decisions about their care and their environment for themselves. Feedback from all patients and carers was overwhelmingly positive and all felt staff went the extra mile.
- Patients' individual preferences and needs were always reflected in how care was delivered. Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- There were high levels of staff satisfaction across all wards. Staff were proud of the wards as a place to work and spoke highly of the culture. Leaders had an inspiring shared purpose and strived to deliver and motivate staff. There was strong collaboration between staff, patients and leaders.
- Leaders strived for continuous improvement and safe innovation was celebrated. There were clear proactive approaches to seeking out and embedding new and more sustainable models of care.
- The service provided safe care. The ward environments were well equipped, well furnished, fit for purpose and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

However:

- Some wards had environmental safety issues, such as out of date PAT testing, a corroded pipe, long call bell strings and an unfixed oxygen cylinder. The corroded pipe was on the ward's risk register, being dealt with by estates and managers put plans into place during our inspection to address the other issues.
- Staff had not created care plans for 'as and when required' medication, such as Lorazepam
- Staff supervision at Meadow View was not recorded as taking place within the trust's targets, although staff received weekly peer reflection and monthly staff meetings and staff we spoke with felt they received adequate support and supervision.
- Beds were not always available for older people with mental health needs, which led to some out of area placements. There were 41 out of area placements between 1 March 2018 and 28 February 2019. Adults of working age were occupying beds on three of the wards. On all wards, patients experienced delayed discharges because of a lack of social care beds or beds in a step down facility.

Is the service safe?

Good 

Our rating of this service stayed the same. We rated it as good because:

Wards for older people with mental health problems

- All wards were clean, well equipped, well-furnished and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received training to ensure they kept patients safe from avoidable harm. Staffing levels had recently improved and at the time of our inspection there was only one nurse vacancy and one consultant psychiatrist vacancy on Belvedere and one occupational therapist vacancy on Meadow View. Wards supported each other to fill any vacant shifts rather than use agency staff.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. We noted that there had been a recent increase in restraint but this had occurred as adults of working age had been admitted onto the ward for older people with functional illness and therefore not an accurate reflection of the wards' general use of restraint, which was low.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. Systems to report safeguarding issues were simple to use and connected directly to the trust's safeguarding team.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Beech Unit had corroded water pipes which led to water discolouring sinks on the ward and PAT tests on some appliances at Franklyn Hospital were out of date.
- There were long call bell strings in the bathrooms at Meadow View and Belvedere which could be used as a ligature.
- There was an unsecured oxygen cylinder in the clinic room at Belvedere which could be easily knocked over.
- Staff had not created care plans for 'as and when required' medication, such as Lorazepam. This meant that it could have been more difficult to assess the effectiveness of the treatment.

Is the service effective?

Good 

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission, although there had been a slight delay with two patients who had been transferred over from an adult acute ward. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Some nurses were both general nurses and mental health nurses and so able to meet the needs of patients with more complex needs.

Wards for older people with mental health problems

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Although staff on Meadow View were receiving regular supervision, the managers had not kept proper records.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Outstanding ☆ ↑

Our rating of this service improved. We rated it as outstanding because:

- Feedback from patients, families and stakeholders was continually positive about the way staff treated people. Patients and carers told us that staff could not do any better and the care they received was outstanding. Staff treated patients with compassion and kindness. Patients were always treated with dignity by staff involved in their care, treatment and support. Consideration of patients' privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- During our inspection, we observed a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between patients, carers and staff were strong, caring and supportive. Those relationships were highly valued by staff and promoted by leaders. Patients we spoke with felt really cared for and that they mattered. Patients valued their relationships with the staff team and felt that they often went 'the extra mile' for them when providing care and support.
- Staff demonstrated determination and creativity to overcome obstacles in delivering care. Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff sat down with patients and went through their care plan with them. Doctors and pharmacists spent time with patients explaining their medication and side effects. Staff recognised that patients needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. Staff ensured that patients had easy access to independent advocates who visited the wards weekly.
- Patients' individual preferences and needs were always reflected in how their care was delivered. Patients were actively consulted about the way in which services were delivered. We saw evidence of meaningful patient involvement via patient meetings, patient choice in refurbishments, patient's art and craft works decorating the walls and patient voices reflected in service documents such as the admissions booklet.
- Patient's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Wards for older people with mental health problems

Is the service responsive?

Good ➔➔

Our rating of this service stayed the same. We rated it as good because:

- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Most patients had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with additional and specific needs relating to a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- There was one shared bedroom on Meadow View and three on Beech Unit.
- Beds were not always available locally for older people with mental health needs, which led to some admissions to wards managed by the trust that were not the closest to the patient's home. There were 41 such admissions between 1 March 2018 and 28 February 2019. Adults of working age were occupying beds on three of the wards. On all wards, patients experienced delayed discharges because of a lack of social care beds or beds in a step-down facility.

Is the service well-led?

Outstanding ☆ ➔

Our rating of this service improved. We rated it as outstanding because:

- Leaders were inspirational and had a clear vision and shared purpose; they acted as role models and motivated staff. All strived to deliver excellent standards of care. There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development and succession planning. For example, staff had been mentored and trained to a senior level and were given managerial roles within the wards. Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Incidents were low due to a deeply embedded caring culture within the wards. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and patients' experiences.
- There were high levels of staff satisfaction across all wards. Staff were proud of the wards as a place to work and spoke highly of the culture. Newer managers had addressed areas of previous concern and staff reflected how much

these wards had improved in both safety and culture. There were consistently high levels of constructive engagement with staff and staff at all levels were encouraged to raise concerns. Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

- Governance and performance management arrangements were proactively reviewed in several leadership groups and reflected best practise. A systematic approach was taken to working with other wards to improve care outcomes, such as the input from staff on Beech Ward with the development of a seclusion room on a neighbouring acute ward. Wards completed several audits per month to check and assess the quality and safety of care in their wards. Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Constructive challenge from patients and carers was welcomed and documented in the patient meetings and minutes. There was a strong focus on improving the quality of care and patients' experiences. Staff and patients on Beech Unit thought outside of the box when it came to decorating and furnishing the ward, so it resembled more of a home than a hospital ward. Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. There was a fully embedded and systematic approach to improvement and Improvement was seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change.
- Leaders sought to continually improve and made staff accountable for delivering change. Safe innovation was celebrated, such as the implementation of an interactive whiteboard, the division of a new electronic database, electronic prescribing, the trialling of wrist mounted call bells and supporting more physically unwell patients in a mental health ward. There were clear proactive approaches to seeking out and embedding new and more sustainable models of care. Staff engaged actively in local and national quality improvement activities. For example, the trust had a medical student budget which allowed staff to learn about quality improvement. The trust worked in conjunction with the health foundation around a project named 'Generation Q'. Quality improvement and leadership were built in to continuous professional development. For example, teaching people about quality improvement at the royal college of psychiatrists and old age directorate.

Outstanding practice

On Belvedere, patients had informed staff that music helped them to de-escalate when they became distressed. Staff had sat down with these patients and created individual playlists for them to listen to and had documented all of this information in their care plans.

Beech Unit had a stable staff team; all had been working on the unit for four years or more as they were so dedicated and committed to the services they were delivering. Staff were passionate about the work they did, performed to a high level and contributed to a culture of positivity and least restrictive practise.

The team had won an award for their roll out of the 'four steps to safety' programme. Since they implemented it, their violent and aggressive incidents had halved.

Staff and patients had decorated and furnished the ward creatively to made it feel homely and personal. For example, the seclusion and extra care area were not referred to, in order to remove the stigma associated with these words. Instead, staff had positioned colourful block words on their doors and renamed them, 'the Retreat' and 'the Nest'. The word 'Recovery' was positioned over the exit to the ward. Patients had created appliques and blankets which decorated the walls, a health care assistant had created a detailed mural with decorated window lights. The 'Nest' (seclusion room) had LED lights controlled by a dimmer switch and ceiling lights that could change colour.

Wards for older people with mental health problems

The ward's admission booklet contained photographs of all the staff and a description of what they did and how they would help patients admitted to the ward.

Staff advertised a weekly drop in session called 'tea with the pharmacist' so patients and their carers could informally chat with the ward's pharmacist about medication.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community mental health services for people with a learning disability or autism

Good 

Key facts and figures

Devon Partnership NHS Trust provide community learning disability services in 16 teams across 12 sites. These include seven primary care learning disability teams (to help patients with learning disabilities access primary care services), three learning disability general hospital teams (to help patients with learning disabilities access general hospitals), two autistic spectrum condition services (to diagnose and offer professional advice for people with autistic spectrum conditions and diagnosis and treatment for people with attention deficit hyperactivity disorder) and four intensive assessment and treatment teams (IATTS). The IATTs provide multidisciplinary support for patients with a learning disability who may be in other clinical placements who are severely distressed. This support includes specialist assessment of needs, as well as training for staff and providing specialist treatments for patients.

The teams operate across the county of Devon and provide care during working hours (9am to 5pm, Monday to Friday). Outside of these hours, patients can access the mental health crisis teams provided by the trust.

The trust is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

There has only been one inspection of this core service, in 2015 and at that time the service was rated as good overall, and good in each domain.

Prior to this inspection, and since the last inspection we had received no information about any risks at the service. We inspected four teams, these were:

- Devon Autism and ADHD service (which the trust now refers to as the Autistic Spectrum Condition Service).
- North and Mid IATT
- Exeter and East IATT
- South and Torbay IATT

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

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

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

Community mental health services for people with a learning disability or autism

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

During the inspection visit, the inspection team:

- visited three IATTs and one Autistic Spectrum Condition Service, and looked at the quality of the environment
- observed four episodes of care and spoke with either the patient or their carers as part of this
- spoke with three patients and five carers separately
- interviewed the managers (or stand in manager) of each of the teams we inspected
- spoke with 30 other staff in focus groups, and seven staff individually.
- reviewed 26 care records
- attended five meetings including two multidisciplinary discussions, a consultation meeting, a governance meeting and a referrals meeting.
- reviewed four staff appraisals and six supervision records.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The community mental health services for people with learning disabilities and autism provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of most of the teams, and of most individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff mostly managed waiting lists well to ensure that patients who required urgent care were seen promptly (apart from in the Autism Spectrum Condition service). Staff mostly assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed mostly holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent and managed and recorded decisions relating to these well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Community mental health services for people with a learning disability or autism

- The service was easy to access and staff and managers of the Intensive Assessment and Treatment Teams managed waiting lists and caseloads well. The criteria for referral to the service did not exclude patients who would have benefitted from care. Staff assessed and initiated care for patients who required urgent care promptly and those who did not require urgent care did not wait too long to receive help.
- The service was well led and the governance processes mostly ensured that procedures relating to the work of the service ran smoothly.

However:

- The processes in place to ensure high quality care records did not always ensure that patient records had all of the information to ensure high quality care. We reviewed 26 care records across the teams and found that eight were missing elements of care plans or risk management. These were found in six records reviewed in the North and Mid Intensive Assessment and Treatment Team (IATT) and in two records in the Exeter and East IATT.
- Despite trust staff liaising with and working with local commissioning groups, the trust had been unsuccessful in securing the resources to meet the waiting list issues that we identified at the last inspection. Waiting times for the Autistic Spectrum Condition Service were either the same or worse on average since the last inspection and the waiting list had increased.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good because:

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the patients and received training to ensure they kept patients safe from avoidable harm. The number of patients on the caseload of most of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

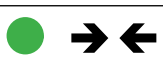
Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

Community mental health services for people with a learning disability or autism

- Staff took a function-based approach to assessing the needs of all patients. They worked with patients and with families and carers to develop individual care plans and updated them as needed. In most of the care plans we reviewed we found that care plans reflected the assessed needs, were personalised, holistic, function-based and recovery-oriented.
- Staff provided a range of treatment and care interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff understood and applied National Institute for Care Excellence guidelines in relation to behaviour that challenges. This included support for families, early identification and assessment, psychological and environmental interventions, medications and interventions for co-existing health and sleep problems.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff worked with the patient's support network to ensure best interest decisions were made when relevant.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions.

Community mental health services for people with a learning disability or autism

Is the service responsive?

Requires improvement  

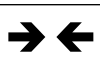
Our rating of responsive went down. We rated it as requires improvement because:

- Waiting times for the Autistic Spectrum Disorders and Attention Deficit Hyperactivity Disorder service were still very long. Patients were still waiting 22 months for the Autism service for the majority of the county and waiting times for the ADHD part of the service had got worse since the last inspection with patients without a previous diagnosis waiting on average 40 months.

However:

- Most parts of the service were easy to access. Referral criteria did not exclude patients who would have benefitted from care. Staff in the Intensive Assessment and Treatment Teams assessed and initiated care for patients who required urgent care promptly and most patients who did not require urgent care did not wait too long to start receiving care. Staff followed up patients who missed appointments.
- The teams met the needs of all patients including those with additional and specific needs relating to a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.
- Staff felt respected, supported and valued. They felt the service promoted equality and diversity, and provided opportunities for career development. They could raise concerns without fear.
- Leaders ensured there were structures, processes and systems of accountability for the performance of the service and in the most part these worked well. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level.
- The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

Community mental health services for people with a learning disability or autism

- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

However:

- Despite the electronic performance system monitoring care records, and separate processes the trust put in place to ensure care records contained appropriate and up to date information, we saw these did not always ensure records were of enough detail or complete enough. In eight out of twenty six care records we saw that some information was missing, and staff could not show us it. This included a less detailed risk assessments or care plans that did not address a patient's full needs.
- Despite liaising with local commissioners, and staff developing service models and demonstrating the clinical need of patients in Devon for an Autistic Spectrum condition service and ADHD service, the trust had been unable to secure funding to reduce their waiting lists and ensure patients were seen in a timely manner.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

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 9 HSCA (RA) Regulations 2014 Person-centred care

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

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

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 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Karen Bennett-Wilson, Head of Hospital Inspection for South West Mental Health chaired this inspection and Evan Humphries, Inspection Manager, led it. Executive reviewers supported our inspection of well-led for the trust overall.

The team included inspectors, executive reviewers, specialist advisers and experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.