Devon Partnership NHS Trust

Quality Report

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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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Overall summary

Devon Partnership NHS Trust is the main provider of mental health services in Devon. The trust covers Devon County Council and Torbay Unitary Authority, which have a combined population of 890,000 people. The trust employs around 2,500 staff, has an annual budget of £130 million and supports almost 18,000 people at any one time.

The trust has three acute inpatient services at Wonford House Hospital in Exeter, North Devon Hospital in Barnstaple and Torbay Hospital. In addition there are other inpatient services provided at Whipton Hospital, Franklyn Hospital and Langdon Hospital which are located around Exeter. Most of the services are provided to people who live in Devon but a few specialist services also support people from other parts of the country. These include services for people with a learning disability, eating disorder or those who need secure mental health services. Community mental health teams are situated throughout Devon. During this inspection we visited the following services:

Torbay

Haytor Ward: Acute Admission Ward – adults of working age

Beech ward: Acute Admission Ward – older people

North Devon

Ocean View: Acute Admission Ward – adults of working age

Moorland View: Acute Admission Ward – adults of working age

Meadow View: Acute Admission Ward – older people

Franklyn Hospital

Belvedere ward: Service for older people

Rougemont ward: Service for older people

Wonford House Hospital

Delderfield: Acute Admission Ward – adults of working age

Coombehaven: Acute Admission Ward – adults of working age

The Haldon: Specialist eating disorder service

Community Services

Community mental health services providing support for people in crisis in recovery, people with learning disabilities and older people

Whipton Hospital

Additional Support Unit: Service for people with learning disabilities

Langdon Hospital Dewnans Centre

Ashcombe: Forensic / secure services

Holcombe: Forensic / secure services

Warren: Forensic / secure services

Cofton: Forensic / secure services

Langdon Hospital

Avon House: Forensic / secure services

Chichester House: Forensic / secure services

Owen House: Forensic / secure services

Connelly House: Forensic / secure services

CQC has inspected all of the trust's locations in the last two years. Inspections of the acute services in Exeter in November 2013 and the secure services at Langdon Hospital in September 2013 had both resulted in compliance actions. The trust had prepared action plans in both these areas and we checked their progress as part of this inspection. We found that the Exeter acute services were not yet involving patients in the preparation of their care plans or making a copy available to them. They were also not ensuring people had regular access to their named nurse. The action plan for these services said that these improvements should have been in place before this inspection, so we have taken enforcement action.

We observed staff supporting patients with care and compassion and a high level of commitment to providing a good quality service. We also found a trust that is committed to providing safe care with a strong recovery focus. The trust is an open, honest and learning

Summary of findings

organisation that works well in collaboration with other stakeholders. There are also examples of good and outstanding services – especially in some of the specialist provision.

However, the trust had a number of significant challenges, especially in the provision of responsive services for adults of working age needing acute care:

- Places of safety – too many patients in crisis were being taken to police stations or to the local emergency department rather than to the trust's own Section 136 suites (which are the designated health-based places of safety) – especially in the Exeter and Torbay hubs.
- Access to section 12 doctors who are approved to assess patients who may need to be detained under the Mental Health Act – this was variable across the trust, resulting in some acutely unwell patients waiting a long time to be assessed – especially in Exeter.
- Out-of-hours support to patients – at night the only crisis team response was an out-of-hours nurse practitioner who has a wide range of roles. Patients and carers have no effective way of contacting this practitioner directly. When they are away from the office (which they often are), the caller has to leave a message on an answer phone that might not be picked up until the crisis team start work in the morning. Junior doctors working out of hours are very stretched, especially in the Exeter area where they cover inpatient services across a wide area.
- Bed management – there were three acute inpatient services with variable lengths of patient stay. Average bed occupancy was 92% and often no bed was available for a new admission. This results in some patients being admitted to a bed in a part of Devon that is a long way from their home. This problem was most severe in South and West Devon and in Torbay. In Torbay Hospital the older adult acute inpatient ward had 40% of beds occupied by working age adults although a significant number of these were over the age of 50.
- There is no psychiatric intensive care unit (PICU) in Devon. As well as leading to patients being admitted to a bed far from their home, senior nursing staff spend many hours of their time trying to find an available bed. Patients can also wait many hours, and in some cases days, in seclusion for appropriate care if clinically

Other significant challenges are as follows:

- Patients, including those who have previously presented to the crisis teams, were being held and risk assessed by staff in community mental health teams while waiting, in some cases for several months, to be allocated to a recovery team care co-ordinator. This means that whilst individual cases are prioritized and their safety is being monitored, they are not getting the treatment and support they need.
- Access to psychological therapies – the trust had a large waiting list for step 4 psychological therapies (over 700 people in Exeter, over 200 people in Torbay and over 100 in North Devon). This has an adverse effect on care and treatment. The Trust has implemented a new two-tier approach to the provision of psychological therapies but this has not been applied consistently across the trust.
- Engagement with staff – this remained patchy. The trust is aware of this and has started a Listening into Action programme, which staff felt would lead to some very practical solutions to improve the service. There is, however, further work to be done to support engagement as some staff teams feel very involved and others removed.
- Although there was a good programme of induction, mandatory and ongoing training in place, there were some areas where further training is needed. For example, training on the use of physical interventions was too low on a few wards. Some staff also told us that they had received training to provide them with an additional skill, but did not have the time to use this.
- Quality monitoring – some staff teams are making good use of the results of quality audits and others just see this as focusing on 'targets rather than quality of care'.
- Use of seclusion – one seclusion room in Torbay was in a potentially unsuitable location on a suspended ward and 'extra care areas' were sometimes being used for seclusion without this being recognised at Langdon. We found that some recording of the use of seclusion is poor and this makes it hard to monitor its use across the trust.
- Involving people in the development of their care plan – this was very mixed across the trust and in a few areas there was little evidence of this taking place.

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- The quality and quantity of food provided for patients at North Devon District Hospital and Langdon Hospital was poor.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Generally, services at Devon Partnership Trust were safe. Incidents were reported and there was a strong culture of learning from incidents at individual sites and across the trust. Performance targets have fed into a trust 'dashboard' to inform the progress of services and identify where there may be issues that could have an impact on the safety of patients. These dashboards are owned at a local and trust-wide level but the use of the information to drive changes was a challenge in some areas.

The trust's risk register is a working document and leads to plans across the trust to make improvements. Individual patient risk assessments were in place but their comprehensiveness and implementation can vary.

Staff working throughout the trust understood safeguarding. Plans were being developed to extend the training to staff who act as investigators so that allegations can be followed up at the right time by staff with the right skills.

Staff had a mixed awareness of the trust's whistleblowing procedure. Contact by staff to the Chief Executives 'hotline' was limited and not always recognised as whistleblowing, which means that emerging themes were not being identified. Most staff felt able to raise issues.

Staffing levels out of hours were stretched in acute inpatient and community services and this has an impact on the time it takes services to respond, but could also potentially lead to a risk of unsafe quality of care.

Are services effective?

We found that Devon Partnership NHS Trust provided effective services. They made use of clinical guidance and standards, but do not use a care pathway approach to improve patient flow, allow standards to be developed relating to the patient journey or to support quality improvement especially in the acute care pathway.

The trust participated actively in accreditation and peer-review schemes managed by the Royal College of Psychiatrists and in national clinical audits. They also had a good programme of routine local audits, although some of these were not being completed on time or shared at a local level. Nevertheless, there is a keen interest in becoming a quality improvement organisation.

The trust monitored their use of the Mental Health Act and, while there were a few areas for improvement, this was largely in line with the Code of Practice.

We found a commitment to appraise staff and provide them with the training needed to perform their role, although staff can struggle to find the time to use new skills.

Are services caring?

The majority of patients and carers we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect.

While we saw some excellent examples of people being involved in decisions about their care and contributing to their care plan, we also found occasions where staff found this hard to achieve or where this was not happening in a consistent manner.

The trust is endeavouring to ensure people's dignity is maintained and has acknowledged that in some inpatient services people can at times feel unsafe.

Summary of findings

Interventions, including restraint and seclusion, need to be reviewed to ensure they are being properly recognised and recorded to ensure this is monitored across all parts of the trust.

Are services responsive to people's needs?

The trust did not have a clear acute care pathway and the responsiveness of the services provided by the trust to meet the needs of people living in Devon varied widely. While some services are very accessible others, including adult acute services created a very poor care experience for many people that does not reflect current guidance. For example, the input from a recovery care co-ordinator, timely access to a section 12 approved doctor and specialist psychological therapies varied, and amounted to a "postcode lottery". While the trust is aware of these challenges and is in discussion with commissioners, there were no clear plans in place to address these issues.

The trust had a process for replying to complaints, but some responses were taking too long. There was a plan in place to reduce this backlog.

Are services well-led?

Stakeholders, and many of the other people we spoke with, were confident that the new Chief Executive, with the members of the Board of Directors, would provide the leadership and governance to make the improvements required.

The task of improving the responsiveness of services so that they meet the needs of people who use them, especially for adults accessing acute services, poses a significant leadership challenge. The size and complexity of the adult mental health directorate presents significant demands on the operational leadership.

While staff engagement is improving, this is an area for more work as this is integral to making the changes a success.

Summary of findings

What people who use the provider's services say

The views of people who use the service has been gathered in a number of ways, but they all include similar messages. The Community Mental health Patient Experience Survey 2012 showed that whilst the trusts overall score had improved it had decreased in six areas from the previous survey. This included people having access to their recovery care co-ordinator, having a copy of their care plan and other practical support with day-to-day living.

The use of the Patient Opinion website, while still low in numbers, said staff were friendly, helpful and supportive but that improvements were needed in access to psychological therapies, interaction with staff in creating care plans, access to a crisis service and wanting clearer information.

Our public engagement events before our inspection and the feedback from Healthwatch also reflected our inspection findings. We heard lots of positive stories, but also concerns about access to acute services near to home, psychological therapies, the need for timely responses to complaints and some individual details of poor experiences.

Areas for improvement

Action the provider MUST take to improve

- There must be systems in place, with effective bed management, to reduce the need for patients, especially for adults of working age who need acute inpatient care, to be admitted long distances from their homes. This must ensure that valuable nursing time is not taken up with searching for a bed.
- The trust must ensure the hospital-based places of safety have access to staff and are used appropriately to reduce the use of police custody.
- The arrangement for accessing section 12 doctors that are approved to assess patients who may need to be detained under the Mental Health Act must be reviewed across the trust to ensure they are available quickly enough especially in the Exeter area.
- Where patients are the responsibility of the crisis teams, they must be able to contact and obtain out-of-hours support from a person with the appropriate skills and experience within a reasonable period of time.
- The trust must agree and implement a plan to provide access to the full range of evidence based psychological therapies that are best provided through the trust, as these are an integral part of people's care and treatment.
- The trust must ensure that people who require a care co-ordinator are allocated one quickly enough to meet their needs for care and treatment.
- All people using the services must have a care plan that reflects their individual needs.
- The use of seclusion and restraint must be correctly recorded to enable accurate monitoring. Seclusion rooms that are potentially unsafe must be reviewed. The trust must ensure that it is recognising when 'extra care' rooms are used for seclusion, so the appropriate safeguards can be put into place. Acute admission wards must meet the trust's target for the numbers of staff having up-to-date training in physical interventions.
- The governance processes to improve services at Langdon Hospital must be embedded further, so that staff working in the secure services fully understand their purpose and the actions needed.
- The trust must check that at The Cedars, where an improvement plan has been developed, the work is completed in line with the recorded timescales.
- The trust must ensure that, at The Cedars, audits are completed as required, especially where they relate to matters of health and safety.
- At Langdon Hospital, the improvements to the food for people using the service must be fully implemented.
- At The Cedars, patients must be involved in the preparation of their care plans must have access to a copy. Patients must know who their named nurse is and have time with them to review their care. This is outstanding action from the previous inspection and a warning notice has been served.

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Action the provider SHOULD take to improve

- The trust should continue to work with commissioners to ensure people living in Devon have access to a Psychiatric Intensive Care Unit (PICU). Other areas for joint working and service development include female forensic beds and community-based support for people with eating disorders.
- The Listening into Action programme should progress and connect to staff teams that are less engaged with the work of the trust.
- The trust should ensure that the changes being made to the handling of complaints lead to more timely and appropriate responses.
- The trust should act to reduce the amount of time that clinical staff spend entering data onto the trust clinical information system.
- The trust should refresh staff knowledge of the whistleblowing process and monitor issues that are raised.
- The trust should continue to monitor the safety of its buildings with particular attention to making sure staff have clear lines of sight and ligature points.
- The trust should ensure more investigators are trained in safeguarding work to enable investigations to be carried out in a more timely manner.
- The trust should continue to monitor the implementation of the carers charter.
- The trust should ensure that audits are not just a tick box exercise; for example, care plan audits look at the quality of what is written as well as whether a record is available.
- The trust should ensure the recording of risk plans associated with section 17 leave are improved.
- At North Devon, there should be the correct details on all the Mental Health Act documentation, so that it is clear who is the detaining authority. Discussions with patients about the outcome of Second Opinion Appointed Doctor assessments must take place and be documented in the individual's records.

There are also a number of additional actions that the provider should take that relate to a specific service and these are in the reports for that service.

Action the provider COULD take to improve

- The trust could review the committees looking at quality and risk to avoid duplication.

Good practice

Our inspection team highlighted the following areas of good practice within the trust:

- We observed staff supporting patients with care and compassion and a high level of commitment to providing a good quality service.
- Staff within the trust and external stakeholders were positive about the skills and experience of the chair Julie Dent who has been in post since March 2013. The recently appointed Chief Executive, Melanie Walker, who will start in April 2014, is also felt to be a very positive appointment. We concluded that the interim management arrangements are solid.
- External stakeholders think that the senior team works collaboratively to meet the needs to people with mental health problems in Devon. This has resulted in some new initiatives, such as a crisis house in Torbay and some high-quality work around safeguarding and the Mental Capacity Act.
- The trust has some good and some outstanding services. These include their specialist inpatient eating disorder service and some of their inpatient and community services for older people and people with learning disabilities.
- Medication management across the trust is of a high standard and initiatives such as a medication information helpline provides support to patients and staff.
- The trust has some examples of people using their inpatient services receiving good physical healthcare input.
- Risk management is central to the work of the trust – with a comprehensive risk management framework in place.
- There is a strong culture of learning from incidents and complaints.

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- The trust has a strong recovery focus and this is reflected in the recent establishment of two 'recovery colleges' providing courses to patients to support them with their personal progress.
- The trust provides staff with a comprehensive induction, ongoing mandatory training and additional training to support them to undertake their roles.

Devon Partnership NHS Trust

Detailed findings

Registered locations we looked at:
Trust Head Quarters; Wonford House Hospital; Torbay Hospital; North Devon Hospital; Langdon Hospital; Franklyn Hospital; Whipton Hospital

Our inspection team

Our inspection team was led by:

Chair: Professor Tim Kendall, Medical Director, Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Jane Ray, Care Quality Commission

The team of 37 included CQC inspectors and analysts, doctors, nurses, social workers, Mental Health Act Commissioners, psychologists, patient "experts by experience" and senior managers.

Background to Devon Partnership NHS Trust

Devon Partnership NHS Trust is a Mental Health and Learning Disability Trust. It is the main provider of mental health services in Devon. The trust was established in 2001. The trust covers the geographical areas that include Devon County Council and Torbay Unitary Authority which has a combined population of 890,000 people. The trust employs around 2,500 staff, has an annual budget of £130 million and supports almost 18,000 people at any one time.

The trust has three acute inpatient services at Wonford House Hospital in Exeter, North Devon Hospital in Barnstaple and Torbay Hospital. In addition there are other inpatient services provided at Whipton Hospital, Franklyn Hospital and Langdon Hospital which are located around Exeter. Most of the services are provided to people who live in Devon but a few specialist services also support people from other parts of the country. These include services for people with a learning disability, eating disorder or those who need secure mental health services.

The trust works in partnership with other organisations to deliver its services. There are around 100 staff assigned from Devon County Council and Torbay Unitary Authority working at the trust. In addition the trust works with a number of third sector organisations to provide services.

The area covered by the trust is predominantly rural with areas of urban development along its north and south coastlines. Devon has an increasing population and a lower than average proportion of black, Asian and minority ethnic residents. There is a range of deprivation with Torridge in North Devon coming 130th out of 326 in the Index of Multiple Deprivation. By comparison East Devon is more affluent coming 215th in the same index. Life expectancy is 5.4 years lower for men and 2.8 years lower for women in the most deprived areas of Devon compared to the least deprived areas.

Most of the people who receive services do so through a network of around 100 community teams offering a range of different services. These include teams supporting

Detailed findings

people who may be acutely unwell as well as those who need more long term care. There are also community teams meeting the needs of people with more specific needs such as pregnant women. The services provided by the trust focus on personal recovery and promote mental health, wellbeing and independence.

We undertook site visits at all the hospital locations. We inspected all the acute inpatient services and crisis teams for adults of working age and older people. We also visited the specialist inpatient services and a sample of the community teams.

Why we carried out this inspection

We inspected this provider as part of our in-depth mental health inspection programme. One reason for choosing this provider is because they are a trust that has applied to Monitor to have Foundation Trust status. Our assessment of the quality and safety of their services will inform this process.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

The inspection team always inspects the following core services at each inspection:

- Mental Health Act Monitoring
- Acute admission wards and health-based places of safety
- Long stay/forensic/secure services
- Services for older people
- Services for people with learning disabilities or autism
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

We also attended four meetings where people who have used the services provided by the trust told us about their experiences. We carried out an announced visit on the 4 to 7 February 2014.

During our visit the team:

- Held focus groups with different staff members, board members and shadow governors
- Attended three carers meetings so carers could share their experiences
- Talked with patients, carers, family members and staff
- Looked at the personal care or treatment records of a sample of patients
- Observed how staff were caring for people
- Interviewed staff members
- Reviewed information we had asked the trust to provide
- Attended multi-disciplinary team meetings
- Collected feedback using comment cards

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

Generally services at Devon Partnership Trust are safe. Incidents are reported and there is a strong culture of learning from incidents at individual sites and across the trust. There are performance targets that feed into a trust dashboard to inform the progress of services and identify where there may be issues that could impact on the safety of patients. These dashboards are owned at a local and trust wide level but the use of the information to drive changes is a challenge in some areas.

The trust has a risk register that is a working document and leads to plans across the trust to make improvements. Individual patient risk assessments are in place but their comprehensiveness and implementation can vary.

Staff working throughout the trust understand safeguarding. Plans are being developed to extend the training to staff who act as investigators so that allegations can be followed up in a timely manner by staff with the right skills.

Staff have a mixed awareness of the trusts whistle-blowing procedure. Contact by staff to the Chief Executives "hotline" is limited and not always being recognised as whistle-blowing, which means that emerging themes are not being identified. Most staff told us they felt able to raise concerns.

Staffing levels out of hours are stretched in acute inpatient and community services and this impacts on the timeliness of the services but could also potentially lead to a risk of unsafe quality of care.

Our findings

Learning from incidents

All trusts are required to submit notifications of incidents to the National Reporting and Learning System and between December 2012 and November 2013, 375 incidents were reported. Of these 145 were serious incidents. During this time there were no "never events" which are serious largely preventable patient safety incidents. The trust had also not previously reported any never events since April 2011. An analysis of all the incidents reported showed that the numbers and types of incidents were within expected levels. Just over half the reported incidents occurred within inpatient areas and 18% were in community mental health services.

There is a strong commitment to improving practice through learning from incidents. Staff were able to confidently explain how they report incidents. When incidents occur there are investigations and learning from those incidents is shared with staff teams. Some staff were able to tell us about recent incidents and lessons that had been learnt although others were less clear. There had been a recent serious incident within the Cedars acute inpatient service in Exeter. This had resulted in a number of actions such as reducing bed numbers and closing one ward to admissions in response to the lessons learnt.

Learning also takes place on a trust wide basis. An example of this is a monthly "learning from experience" meeting that is chaired by the Director of Nursing and reviews incidents from across the trust. There is also a monthly newsletter that goes to all staff called the Improvement and Safety Briefing and this highlights learning from incidents.

All the incident reports are collated and the trust identifies numbers of incidents and trends. Where a root cause analysis takes places the findings are also collated to identify themes. This feeds back to the Board of Directors through the Quality and Safety Committee.

The NHS Safety Thermometer is designed to measure a monthly snapshot of four areas of harm which are the assessment and treatment of patients with venous thromboembolism, catheter related urinary tract infections, new pressure ulcers and falls. Of these falls are the greatest risk for the trust particularly for those over the age of 70 although the numbers had sharply decreased over recent months. We were able to see a falls action plan being used especially in services for older people.

We were told about an ongoing piece of work to reduce the absence of patients from wards without leave / permission (AWOLS) and improve patient safety. This has introduced a number of measures that are being used in all of the acute inpatient services and its progress is being evaluated.

Every six months the Ministry of Justice publishes a summary of Schedule 5 recommendations (previously rule 43) which have been made by coroners with the intention of learning lessons from the cause of death and preventing

further deaths. In the latest report there were no concerns about the trust. From January 2011 to July 2013 there were eight rule 43 reports and the responses from the trust show learning from preventable deaths.

Safeguarding

All the staff we spoke with understood the importance of safeguarding vulnerable adults and protecting children. The trust policy is up to date and clearly advises staff how to raise an alert and who to contact. The current levels of training in safeguarding vulnerable adults is 86% for level 1 and 79% for level 2. The level 3 training for staff who would be investigators stands at only 32%. The trust have plans to provide more training, but this affects the trusts capacity to handle all the safeguarding work. The levels of training for safeguarding children is at a higher level.

The trust closely monitors its safeguarding incidents and trends are monitored by the Safeguarding Committee.

External stakeholders have told us that the safeguarding processes have improved, there is a capable safeguarding lead and that the trust has dealt well with some complex cases. The trust is an active participant in the local multi-agency safeguarding board.

Safe Environment

Devon Partnership Trust provides services from a range of physical environments. Some are recently opened and purpose built such as the Dewnans Centre which is part of the secure services at Langdon Hospital and the services for older people at Franklyn Hospital. Some of the buildings are old and present a challenge in terms of meeting the needs of the patients. Some reports by the Royal College of Psychiatrists have mentioned risks of ligature points and staff not having clear lines of sight. This reflected the inspection findings in some of the inpatient wards we visited. The way in which these risks were being managed were not always consistent. The trust acknowledged this and does have management plans in place to address this while waiting for capital works to be undertaken. The trust has a system for completing environmental audits in each area to monitor safety risks. There is a capital programme for the year ahead which identifies the main areas needing improvement.

Risk Management

The trust places the management of risk and patient safety at the centre of its work. Each ward and team collects a range of performance information to produce a local dashboard. Staff throughout the trust are aware of their local dashboards. This information is collated to produce trust wide information. This is used to identify where performance needs to improve across wards and teams. Where needed improvement plans are put into place to address potential risks for the patients. This information is fed back through the quality and safety committee to the Board of Directors.

The trust also has a risk register and assurance framework. These monitor the progress the trust is making to address areas of organisational risk.

Medicines management

Generally medicines were managed well. The trust had completed a self-assessment and identified areas for improvement which were being addressed. This includes improving the timeliness of medication being reconciled on admission. The trust had taken steps to support people using the services to have enough information about their medication which had been highlighted as an area for improvement in the Care Quality Commission patient survey in 2012. This included the development of a trust medication information helpline. There were also examples of good practice and they were supporting other trusts to improve their medicines management. Medication management is regularly audited across the trust, staff complete a competency assessment and incidents are monitored and lessons learnt where needed. During 2013 there were two serious untoward incidents relating to medication, one an adverse reaction was unavoidable and the second related to control drugs was under investigation at the time of the inspection. At Langdon Hospital we did find in one unit that single use syringe plungers were being used more than once to measure medication as there were insufficient stocks. This was immediately rectified. We also found that in Torbay there was no audit of the quantities of stock medication which could potentially mean that medication could be removed without this being noticed. In Barnstaple we found some medication being pre-dispensed.

Whistle-blowing

The trust has a whistle-blowing policy and we found that staff were not consistently able to articulate the measures the trust has put into place for staff to raise concerns. The trust reported no whistle-blowing contacts last year. There is a “hotline” to the Chief Executive as part of the whistle-blowing process where staff can use this to report issues

without having to give their names if they preferred. This had been used to raise issues about line managers but these had not been recognised and reported as whistle-blowing. Whilst issues raised through the hotline had been addressed, we would recommend that the records of contact need to be monitored to see if there are emerging themes. Most staff we spoke to felt that if they had any concerns they would feel comfortable to raise them.

Managing risk to the person

All the patients' records we examined showed that an individual risk assessment had been completed. In some wards and community teams we saw risk being actively discussed as part of hand over meetings and multi-disciplinary team meetings. There were also a few examples of individual cases where risk management issues had not been recognised or where actions from risk assessments had not been implemented.

Safe staffing levels

Staffing levels were usually maintained at the levels agreed by the trust. The trust board has acknowledged the difficulty there has been to recruit staff, qualified nurses. There is an increasing number of nurses reaching retirement age. Staff vacancies are around 8.5% and there is a 14% annual turnover of staff. The trust monitors staff sickness which is at 5-6%. The trust has a number of measures in place to support the recruitment process such as offering a preceptorship scheme for newly qualified staff.

Temporary staff where used come from one agency which is used as the trust bank, where the contract enables staff to have appropriate training. Staff were usually able to get staff to cover absences of permanent staff.

Some services provided by the trust had staff teams with the right experience and qualifications to work in the clinical areas in which they were based. This was particularly evident in the specialist services we visited such as the eating disorder service and the learning disability service.

Staffing levels in some parts of the acute services were stretched and this impacted on the trusts ability to respond to the needs of people who experience a crisis in the community or who need admission to hospital. An example of this is the out of hours service for the crisis team where there is one nurse practitioner on duty who undertakes a number of roles. This means that patients in the community who need urgent assistance may not be able to reach this staff member. Junior doctors in the Exeter area also told us that they are very stretched at night as they cover four inpatient sites quite a distance apart and this affects their ability to respond in a timely manner. They also have a rota which includes a handover at 3am and are then expected to work the following day without having time for a sufficient sleep period. On the acute inpatient wards there are not always sufficient staff to operate the hospital based places of safety or supervise people in line with guidance while they are in seclusion.

Are Services Effective?

(for example, treatment is effective)

Summary of findings

We found that Devon Partnership NHS Trust provided effective services. They made use of clinical guidance and standards, but do not use a care pathway approach to improve patient flow, allow standards to be developed relating to the patient journey or to support quality improvement especially in the acute care pathway.

The trust participated actively in accreditation and peer-review schemes managed by the Royal College of Psychiatrists and in national clinical audits. They also had a good programme of routine local audits, although some of these were not being completed on time or shared at a local level. Nevertheless, there is a keen interest in becoming a quality improvement organisation.

The trust monitored their use of the Mental Health Act and, while there were a few areas for improvement, this was largely in line with the Code of Practice.

We found a commitment to appraise staff and provide them with the training needed to perform their role, although staff can struggle to find the time to use new skills.

Our findings

Use of clinical guidance and standards

Before we inspected the trust we looked at data we held about Devon Partnership NHS Trust. This included data from the Care Quality Commission Community Mental Health Survey 2013, the Department of Health Mental health Minimum Data Set and the information Centre for Health and Social Care. These did not highlight any areas of elevated risk.

We saw that the trust has a range of improvement targets that reflect NICE guidance, National Patient Safety Agency advice and national policies. Many of the clinical services managed by the trust participate in national accreditation and peer-review schemes. We found across the trust that staff were aspiring to deliver care in line with national guidance, however the lack of access to psychological threatments recommended by NICE is an important omission in service provision and impairs the trusts clinical effectiveness.

The trust has a Research Development Unit that is part of the Peninsula Mental Health research Group and benefits from learning from research projects.

Monitoring Quality of Care

Many of the trusts adult inpatient wards have achieved accreditation by the Royal College of Psychiatrists as have two ECT clinics and the liaison psychiatry team. The Haldon Centre eating disorders unit, the Russell Clinic rehabilitation ward and the ECT clinic at Torbay have been accredited as excellent. This achievement reflects the willingness of the trust to have its services reviewed so areas for improvement can be identified. The reports from these reviews are available and being used in services.

The trust also participates in national audits and accreditation schemes such as those undertaken by the Prescribing Observatory for Mental Health, the National Audit of Suicide, the National Schizophrenia Audit and the Psychiatric Liaison Accreditation Network. The trust is benchmarked by the Audit Commission and this data is being used to reflect on standards of quality and safety.

There is a rolling programme of internal routine quality audits, for example checking the completion of care plans. In some areas these audits were completed well and any areas for improvement were followed through, but this is not the case across all of the trust. We also found that some audits such as the care plan audit looked at whether a record had been completed rather than the quality of this record. Each year there is an agreed programme of clinical audits covering many of the clinical areas of work undertaken by the trust.

Collaborative multi-agency working for assessments, care planning and access to health services

The trust operates a central point of access for all new referrals. There are targets for urgent referrals to be seen and assessed in 5 working days and routine referrals to be seen and assessed in 10 working days. These targets are largely being met across Devon and reflect good multi-disciplinary and multi-agency working. However once assessed as needing ongoing treatment and care there

Are Services Effective?

(for example, treatment is effective)

may be a long delay before a patient is assigned a recovery care co-ordinator and starts a programme of treatment. This is a particular problem for those requiring psychological therapies.

We found that the trust is generally supporting patients to have good input for their physical healthcare needs. People using long term inpatient services were registered with a GP and we saw individual health action plans in place. In the acute inpatient services there are a few cases where peoples physical healthcare needs are overlooked which places people at risk of becoming physically unwell. At Franklyn Hospital the formal arrangements need to be put into place for people using the service to access some aspects of physical healthcare such as physiotherapy and tissue viability input.

Suitably qualified and competent staff

The trust has a staff development strategy setting out standards for recruitment, training and development of clinical staff. New staff joining the trust have access to a comprehensive induction. Staff are expected to complete and refresh their mandatory training and at the time of the inspection about 80% of staff had done so. Some staff told us that much of this training was delivered by e-learning and that this did not always meet their needs. There is also ongoing training to support staff to perform their roles and this is monitored through an essential training grid. Staff who need to manage change have access to an Improvement Academy where they are trained in methodology to help them make these changes. Staff we spoke with in focus groups and interviews confirmed the trust wants to have a well trained workforce. We also heard that if staff have an interest they are usually supported to undertake the training. Staff also told us that due to the pressures of their clinical demands they did not always get the time to use the training they received.

We found that most staff receive regular supervision. This is monitored by the trust and around 80% of staff are having supervision once a month. The number of staff having an annual appraisal is just below 85%. Some staff told us that supervision and support is focused on work performance rather than their clinical development and that they would like more input with this.

Student nurses told us that the trust is very supportive and promotes them to work more independently and take responsibility. They feel valued and part of the team and are offered new opportunities to develop their skills.

Adherence to the Mental Health Act Code of Practice

There is a team of staff in place to manage the adherence of the trust to the Mental Health Act (MHA). A number of audits are carried out to monitor progress. The team report to the Mental Health Act Managers Meeting which meets quarterly and is chaired by a non-executive director. The trust have made efforts to improve the assessment and recording of capacity to consent. They are also working closely with the police and criminal justice system in Exeter through a “street triage scheme” which aims to provide a rapid response to support people in their own homes to avoid taking people into custody and prevent admissions.

A few areas for improvement were noted. In North Devon the details of the detaining authority on some of the MHA documentation needed to be corrected. The recording of assessments from second opinion doctors and the recording of risk plans for section 17 leave needed further work.

Are services caring?

Summary of findings

The majority of patients and carers we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect.

While we saw some excellent examples of people being involved in decisions about their care and contributing to their care plan, we also found occasions where staff found this hard to achieve or where this was not happening in a consistent manner.

The trust is endeavouring to ensure people's dignity is maintained and has acknowledged that in some inpatient services people can at times feel unsafe.

Interventions, including restraint and seclusion, need to be reviewed to ensure they are being properly recognised and recorded to ensure this is monitored across all parts of the trust.

Our findings

Choice in decisions and participation in reviews

The feedback we received from people who use the services about their involvement in the preparation of their care plan and decisions about their care was very variable. In some services such as the learning disability service we saw examples of how people were involved in this process and had care plans in accessible formats. In other services such as the adult acute inpatient services in Exeter many patients told us that they had not seen or been involved in the preparation of their care plan which contrasted with patients on the acute ward in North Devon. Some wards and teams had different arrangements in place to provide people with a copy of their care plan but we also found some areas where the care plans could only be found on the trusts computer system.

The trust makes people aware of their right to access an advocate and how they can access this service. We saw examples of this service being used throughout the trust.

The trust has raised awareness about the use of the Mental Capacity Act. We saw examples of the appropriate use of capacity assessments and best interest meetings with a record of decisions. The trust is working with Devon County Council to further develop staff learning. The trust has made eight applications in the last eighteen months for an authorization of a Deprivation of Liberty Safeguard of which four have been approved.

Complaints and feedback from the carers' meetings told us that whilst some carers are very positive about the care provided by the trust, others feel that their involvement could be improved and they are not always consulted appropriately. The trust has a carers' charter and its implementation is being monitored by the Shadow Board of Governors.

Effective communication with staff

Most of the patients we spoke to during the inspection and at the engagement events spoke very positively about the caring and compassionate approach of staff. We also observed throughout the inspection examples of very positive interactions between staff and the people using the service. The trust has a range of meetings in the inpatient services to ensure patients have an opportunity to explore issues and make decisions about the ward. Patients also have a key-worker or named nurse but in some services people are not having regular time with them to discuss and plan their care.

The trust recognises the challenge of ensuring staff remain compassionate especially when they are working in a very stressful environment. In partnership with a local acute trust they are participating in an initiative called Schwartz Center Rounds where groups of staff come together to reflect on their practice.

People receive the support they need

In the Community Mental Health Survey in 2013 the trust performed as expected in all the survey domains. The National Inpatient Survey in 2012 also found Devon Partnership Trust had similar results to most other trusts. The trust also makes use of the Patient Opinion website where patients can have an honest and meaningful conversation about their care. Whilst there are only 20 comments these note the trust staff as being friendly, helpful and supportive. The trust also carries out its own inpatient survey. The most recent survey shows that about 80% of the patients say the service has met their needs at all times. This reflects the feedback received during the inspection that where people were receiving a service most were positive about the support they received.

Are services caring?

Recovery services

The trust has a recovery strategy. We heard from stakeholders about the multi-agency working with social services, education and the voluntary sector to promote opportunities for people who use the services provided by the trust. An example of this is the recent establishment in June 2013 of two recovery colleges, the Discovery Centre for people using secure services and the Devon Recovery Learning Community. These offer 39 different courses which more people are attending and the student evaluation is very positive with more than 80% of students saying that they would recommend the courses to others.

People who need individual support with their recovery are assigned a care co-ordinator from the Recovery and Independent Living teams (RIL). At the time of our inspection people were being supported by the RIL teams to achieve greater independence but a significant number of people had been assessed and were just being "held" by these teams while they waited to be assigned a care co-ordinator.

Privacy and dignity

In the 2013 Patient Led Assessment of the Care Environment (PLACE) the trust scored 93% on privacy, dignity and wellbeing above the national average of 85%. Many examples of staff promoting the privacy and dignity of people using the services were seen during the inspection.

All the inpatient services provide gender separation although this is used flexibly in line with individual risk assessments according to the numbers and gender of people using the services. There are incidents of violence and aggression on the inpatient wards and these can be distressing for the people involved. We were told that a review by the Trust Security Manager is taking place to look at how this can best managed.

Staff were aware of the importance of maintaining confidentiality. The trust uses a computerized patient record system (RiO) and staff had individual smart cards to give them access and had been trained about information management.

Use of restraint and seclusion

Most staff had been trained to use of physical interventions and understood the importance of this only being used after trying to diffuse the situation. At the Iris Centre which is a therapeutic community for people with a Personality Disorder, staff had not been trained in the use of physical interventions. Staff told us that this was because this intervention would not be used. To ensure the safety of all concerned the trust should review the need for this training. The trust monitors the numbers of people who have been trained in the use of physical interventions. Two acute adult wards were highlighted by the trust as not having enough trained staff. These were Delderfield in Exeter with 71% of staff trained and the Haytor unit in Torbay with 79% of staff trained.

The use of restraint is recorded through the incident recording system and in peoples individual records. We requested a record of restraints used in the previous six months. A list was provided but the information was not analysed to monitor trends in the use of restraint. This is also not identified clearly in the reporting of incidents that goes to the Quality and Safety Committee although the chair of the committee told us that they had been assured they would be informed about any face-down restraint.

The recording and monitoring of the use of seclusion is also not taking place consistently. A log book of the use of seclusion was not available at all the seclusion rooms. The use of seclusion is again recorded as an incident but the record of the use of seclusion provided by the trust appeared in some areas to be much less than we found when we visited the units. For example in the Torbay acute services there was only one recorded use of seclusion for six months last year whereas when we spoke to staff it was evident this facility had been used on several occasions. This meant the information used to monitor the use of seclusion was not always accurate. The location of the seclusion room in Torbay is potentially unsafe as it is on a suspended ward on a different floor to the acute ward. This means patients have to be restrained and moved a long distance to access the seclusion room. In the secure services we were told by staff about how they used the "extra care" rooms but were concerned that this could be de-facto seclusion without the appropriate safeguards in place. In the Exeter acute inpatient service junior doctors told us that out of hours they were covering four inpatient services quite a distance apart which affected their ability to carry out timely medical reviews for patients in seclusion which could potentially compromise their safety.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The trust did not have a clear acute care pathway and the responsiveness of the services provided by the trust to meet the needs of people living in Devon varied widely. While some services are very accessible others, including adult acute services created a very poor care experience for many people that does not reflect current guidance. For example, the input from a recovery care co-ordinator, timely access to a section 12 approved doctor and specialist psychological therapies varied, and amounted to a "postcode lottery". While the trust is aware of these challenges and is in discussion with commissioners, there were no clear plans in place to address these issues.

The trust had a process for replying to complaints, but some responses were taking too long. There was a plan in place to reduce this backlog.

Our findings

Services meeting the needs of the local community

Prior to the inspection we asked people using the services to tell us about their experiences and analysed the complaints received by the trust. This raised concerns about the responsiveness of services to meet people's needs, especially in terms of people using the acute services in certain parts of the county and those who have been referred for psychological therapies.

For patients in crisis and needing to go to a place of safety we found a wide variation in the numbers that were ending up in police custody rather than in the trust's own place of safety suite. From December 2012 to November 2013 the figures of the numbers of patients held in the police custody suite and the numbers in the trusts own place of safety have been collated. These showed that in North Devon 28 people used the trusts own place of safety suite and 35 went to police custody. In South Devon 47 people used the trusts own place of safety suite and 134 went to police custody. Whilst in Exeter only 21 went to the trusts own place of safety suite and 114 were held in police custody. This meant that almost 75% of people went to police custody rather that the preferred hospital based place of safety. These figures indicate a wide disparity in practice. Specifically in Exeter the figures show that at that time going to a police custody suite was five times more likely to happen than an admission to a hospital based service. Since our inspection the trust has introduced a Street Triage pilot service, which aims to provide support, information, advice and signposting to Devon and Cornwall Police response officers to enable them to make a better informed decision if they are considering detaining a person under section 136. A review of the impact of this service will soon be undertaken.

Patients across Devon who have accessed the Crisis Teams have told us about their problems in accessing support out of hours. We found that after 8pm these teams hand over to an out of hours nurse practitioner. From shadowing a nurse practitioner we saw that they have to undertake a range of roles which may include spending time in the emergency department at the local acute hospital, supporting staff in the trusts own inpatient wards and this means that any phone calls from people needing urgent assistance or their carers goes through to an answerphone which they respond to when they have time to go back to an office. We were told of occasions where people have not been called back till the following day which has been very distressing and can result in people going to the acute hospital emergency department.

In Devon the Approved Mental Health Professional (AMPH) service is arranged centrally and led by social services. They told us about the variations in their ability to access the support of an approved Section 12 doctor when someone needs to be assessed to see if they should be detained under the Mental Health Act. From speaking to staff in the trust there are different arrangements in each part of the county. The Clinical Lead for the Adult Services Directorate acknowledged that this was particularly problematic in Exeter where there were fewer doctors available with a number of responsibilities. This resulted in some patients needing to wait for a longer period of time to have their assessment completed.

The trust has an average bed occupancy of 92% and despite the appointment of a bed manager and the establishment of a daily conference call to discuss bed availability finding a bed for a person who needs to be admitted can be difficult taking up valuable nursing time. Often no bed is available locally and the person is admitted to a bed in another part of Devon. This is more likely to happen in some parts of Devon than in others. For the past six months 44% of adult patients in South and West Devon

needing an acute admission have had to go to Exeter and a few to North Devon. For the same timeframe 25% of adult patients in Torbay have had to go to Exeter and in a few cases to North Devon. This contrasts with North Devon where for the last six months there have been 222 acute adult admissions – the most in the trust and yet fewer than 3% have had to go to other parts of Devon. Average lengths of stay have also varied between the three adult acute admission wards with Exeter having the shortest at 18-20 days and South Devon the longest. These variations are causing distress to patients and their carers especially in South and West Devon and Torbay where the greatest numbers of patients are being admitted away from their home. From speaking to senior staff in the trust there is not a clearly defined acute care pathway resulting in local variations and impacting on patients having a variable and in some cases less satisfactory experience.

Adults of working age being referred to the trust are mostly being assessed within agreed timescales based on whether their needs are urgent (assessed within 5 days) or routine (assessed within 10 days). When someone is assessed as requiring treatment and care the commonest action is to refer the person to one of 14 Recovery and Independent Living teams (RIL) where they will be assigned a recovery co-ordinator who will oversee their ongoing care and treatment. At the time of our inspection there were large variations in the length of time people were waiting to have an allocated recovery co-ordinator ranging from 13 days in one team to 294 days in another. There were also wide variations in the numbers of people waiting for a recovery co-ordinator between different teams. The average length of time people are waiting is 109 days but in reality people are prioritized based on their individual needs. Those in crisis have access to a recovery co-ordinator within 7 days. While people are waiting for a recovery co-ordinator the RIL team does risk assess them to see if they need earlier input. Staff working in RIL teams talked about their workload and the concerns they had about people waiting for a recovery co-ordinator and the potential for them to deteriorate during this time. The trust has an improvement plan in place to address these waiting list issues but these need to be fully implemented.

Prior to our inspection we heard from people who use the services about their frustrations about the waits they were experiencing to access specialist psychological therapies. This is also fully recognised by the trust as an area that needs to be addressed. The information we saw shows wide variations in the number of people waiting for specialist level 4 psychological therapies provided by the trust. This ranges from over 700 people in Exeter and mid-Devon, over 200 people in South Devon and over 100 people in North Devon. New people in priority groups referred to the service now have to be seen within a target period of 18 weeks set by the commissioners but this does not address the people who have been waiting prior to the implementation of this target. This now means that new people referred wait less time than people who were previously on the list. Some additional input was provided which meant that 100 people who had been on the waiting list for the longest time were offered a service. The head of psychological services told us that a stepped care approach has been agreed as the ongoing model of provision but that this has not yet been implemented in Exeter. Proposals have been produced to re-configure the service and increase capacity but these have not yet started to be implemented. This again reflects disparities in the service provision that is impacting adversely on patients. This was highlighted for us when we heard that the trust only has 8.85 WTE consultant clinical psychologists and that two of these work in the Eating Disorder Service. The imbalance in the provision of a valuable resource is marked.

We were also told through engagement events and speaking to staff about services that are not provided in Devon and so people who need these services have to go outside the county. Information from the trust showed that in the last six months 70 people have been placed outside Devon of which 49 are patients who need access to psychiatric intensive care beds. These patients had often spent many hours in seclusion if clinically needed whilst a suitable provision was found. Another area of unmet need is for female patients who need secure services. The trust is engaged in joint discussions with commissioners to address improving the access to these services and this needs to continue.

Providers working together through a period of change

Throughout the inspection we found many examples of the trust working with other providers. Examples of this included the establishment of a crisis house with a third sector provider in Torbay as an alternative to hospital admission. The recovery colleges are another example of working collaboratively with other providers to provide creative solutions to enhance the lives of people with

Are services responsive to people's needs?

(for example, to feedback?)

mental health issues. Devon County Council as part of its feedback said the trust "works well with the statutory partnership arrangements in Devon and plays its full part". We were told of examples of the trust working well with GP's and a clinical audit in February 2013 of the West Devon Older Peoples team found that GP's had been sent a clear diagnosis for patients who had been referred to the service. The commissioners also monitor the production of medical and nursing discharge summaries within agreed timescales for adult patients being discharged from acute services. The trust demonstrated an understanding of the importance of multi-agency working to meet the needs of people using their services.

Learning from complaints

The trust has a complaints procedure and between April and September 2013 received 148 complaints. These complaints are analysed by the patient experience team and a report presented to the Quality and Safety Committee. In November 2013 91% of new complaints received a response in 3 working days. In September 2013, 41% of the complaints were taking over 60 days to resolve although this is mainly attributable to the need to improve the quality of the written response from the investigators before the letter is sent to the complainant. There is an action plan in place to address this through the provision of additional training to identified staff, more staff input for the complaints team and close monitoring of the progress with complaints. We looked at a selection of the complaints responses and found they were clear and responded to the issues that had been raised. In the last year one complaint has been upheld by the NHS Ombudsman.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

Stakeholders, and many of the other people we spoke with, were confident that the new Chief Executive, with the members of the Board of Directors, would provide the leadership and governance to make the improvements required.

The task of improving the responsiveness of services so that they meet the needs of people who use them, especially for adults accessing acute services, poses a significant leadership challenge. The size and complexity of the adult mental health directorate presents significant demands on the operational leadership.

While staff engagement is improving, this is an area for more work as this is integral to making the changes a success.

Our findings

Governance arrangement

The geographical area covered by the trust makes governance a challenge with services spread across a significant distance.

The trust has a clear vision to become the leading provider of specialist mental health and complex care services in the south west by 2018. They aim to provide services that are "good enough for my family" and are safe, timely, personalized, recovery-focused and sustainable.

The services are provided through four clinical directorates, the adult directorate, older peoples directorate, secure services directorate and specialist services directorate. Each directorate has a clinical director supported by managers. Improvement plans for the trust are based on directorates.

The trust has a Board of Directors who are accountable for the running of the trust. There is a clear governance structure that consists of committees that review areas of the trusts work and risks and these feed into the board. We looked particularly closely at the work of the Quality and Safety Committee that is chaired by a non-executive director and found its work was underpinned by a wide range of information. We did find that a number of committees feed into the Quality and Safety Committee and that there can be overlaps in their work which was also noted by the chair of the Quality and Safety Committee.

We met some of the non-executive directors and found that they were very knowledgeable and engaged with the work of the trust and gave significant time to follow through their lead roles and also to spend time in the services.

Engagement with people who use services

The trust has a patient and public engagement strategy. There are three network action groups operating across Devon and these provide a forum for people who use the trust's services to meet and provide feedback. In addition to the national patient survey the trust also carries out its own surveys on a monthly basis. They will be launching the use of the Family and Friends survey in April 2014. The trust subscribes to a Patient Opinion website where people can post their views – but the use of this is low at the moment. The trust has a shadow Council of Governors who meet quarterly and consists mainly of people who use services and members of the public. We spoke to members of this Council of Governors at a focus group and they told us about how they have been prepared for their roles, had opportunities to visit services and were engaged in work with the trust such as sitting on committees, participating in recruitment processes and supporting staff training. At a service level we were told about forums that take place in wards and departments so people can be engaged in decisions about the service. We heard of examples throughout the inspection where patients told us they had raised matters and they had not been addressed.

Engagement with staff

In the last national staff survey in 2012 the trust was in the lowest 20% for engagement. Some staff stated that peoples care was not the trust's top priority. The last internal staff survey took place in June 2013 and more than 500 staff responded. This showed that out of a maximum score of 5, there was a score of 4.03 for staff being satisfied with their team, 2.74 for staff being satisfied with their directorate which is a slight improvement and 2.45 for staff being satisfied with the trust which is also a slight improvement from the previous survey.

Listening into Action has been introduced at the trust and staff who had the opportunity to be involved in this initiative spoke positively of the experience and felt it would lead to some very practical solutions. So far there

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

have been 6 listening events and there are now 11 teams working on different projects. A pulse check of those staff who have been involved shows that their level of engagement has significantly improved. Other ways in which the trust is aiming to improve its engagement is through, newsletters, executive walk abouts, having senior staff working in different offices so they get to see people across the trust and a Chief Executive hotline that anyone can call.

Our inspection found that staff engagement was very mixed. Medical staff especially consultants were generally very positive about their engagement but for nursing and other professions it was a mixed picture depending on the service where people were working. This is an area of ongoing work for the trust.

Supporting staff with change and challenges

We heard about the changes and challenges faced by staff working across the trust. This included larger changes such as the re-configuration of some community teams through to very specific challenges such as after a serious incident has taken place. We were told about the use of care and welfare meetings in areas of significant change, access to counselling services and de-briefing after serious incidents. Most staff told us they felt well supported although a few felt that this could be improved in their area of work. Student nurses were very positive about their time working for the trust.

Effective leadership

Staff within the trust and external stakeholders were positive about the skills and experience of the chair Julie Dent who has been in post since March 2013. The recently appointed Chief Executive, Melanie Walker, who will start in April 2014, is also felt to be a very positive appointment. We concluded that the interim management arrangements are solid.

We saw many examples of effective leadership across the trust although with all the challenges facing the trust we did wonder if clinical directors, especially in the adult directorate had enough time to address them. There were a few areas where leadership was less effective as these have been highlighted in the specific reports.

The focus on the trust has been on improving the quality and safety of services and there have been a significant number of performance targets and initiatives. The CQC assesses that this attention to detail has meant that some of the more overarching challenges relating to the responsiveness of services especially in the acute adult services have not been progressed as far as expected. The leadership going forward needs to focus on these areas in order to provide a service that meets the needs of the people who use the services.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows: Many adults of working age who need acute inpatient care are being admitted to services long distances from their homes. People are being taken to police custody rather than the preferred hospital based place of safety. People mainly in the Exeter area who need to be assessed as they may need to be detained under the Mental Health Act 1983 are often having to wait a significant period of time to see a section 12 approved doctor. People being supported by the crisis teams are not able to reach a care professional in a timely manner to obtain care out of hours. Many people needing the input of a recovery care co-ordinator are having to long wait periods of time for this support. Not everyone has a care plan that reflects their individual needs including their physical health needs. This was a breach of Regulation 9(b)(1), 9(2)

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**

This section is primarily information for the provider

Compliance actions

How the regulation was not being met:

The planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows:

Many adults of working age who need acute inpatient care are being admitted to services long distances from their homes.

People are being taken to police custody rather than the preferred hospital based place of safety.

People mainly in the Exeter area who need to be assessed as they may need to be detained under the Mental Health Act 1983 are often having to wait a significant period of time to see a section 12 approved doctor.

People being supported by the crisis teams are not able to reach a care professional in a timely manner to obtain care out of hours.

Many people needing the input of a recovery care co-ordinator are having to long wait periods of time for this support.

Not everyone has a care plan that reflects their individual needs including their physical health needs.

This was a breach of Regulation 9(b)(1), 9(2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows: Many adults of working age who need acute inpatient care are being admitted to services long distances from their homes. People are being taken to police custody rather than the preferred hospital based place of safety.

This section is primarily information for the provider

Compliance actions

People mainly in the Exeter area who need to be assessed as they may need to be detained under the Mental Health Act 1983 are often having to wait a significant period of time to see a section 12 approved doctor.

People being supported by the crisis teams are not able to reach a care professional in a timely manner to obtain care out of hours.

Many people needing the input of a recovery care co-ordinator are having to long wait periods of time for this support.

Not everyone has a care plan that reflects their individual needs including their physical health needs.

This was a breach of Regulation 9(b)(1), 9(2)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010

Care and welfare of people who use services

How the regulation was not being met:

The planning and delivery of care does not reflect published research guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment as follows:

People do not have access to the levels of psychological services that are best provided through the trust as an integral part of their care and treatment.

This was a breach of Regulation 9(b)(iii)

Regulated activity

Diagnostic and screening procedures

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010

Care and welfare of people who use services

How the regulation was not being met:

This section is primarily information for the provider

Compliance actions

The planning and delivery of care does not reflect published research guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment as follows:

People do not have access to the levels of psychological services that are best provided through the trust as an integral part of their care and treatment.

This was a breach of Regulation 9(b)(iii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The planning and delivery of care does not reflect published research guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment as follows: People do not have access to the levels of psychological services that are best provided through the trust as an integral part of their care and treatment. This was a breach of Regulation 9(b)(iii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The planning and delivery of care does not reflect published research guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment as follows: People do not have access to the levels of psychological services that are best provided through the trust as an integral part of their care and treatment.

This section is primarily information for the provider

Compliance actions

This was a breach of Regulation 9(b)(iii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding service users from abuse** **How the regulation was not being met:** Seclusion is being used without suitable arrangements in place to protect service users against the risk of physical interventions being excessive as follows: The use of seclusion and restraint is not being correctly recorded so its use can be monitored. A seclusion room in Torbay is potentially in an unsafe location. Other “extra care” rooms are being used at Langdon Hospitals by staff for seclusion without this being recognised as such. There are not enough staff who have completed or refreshed their training on restraint in line with the trusts training target on two acute admission wards. This was a breach of Regulation 11(2)(b)

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding service users from abuse** **How the regulation was not being met:** Seclusion is being used without suitable arrangements in place to protect service users against the risk of physical interventions being excessive as follows: The use of seclusion and restraint is not being correctly recorded so its use can be monitored. A seclusion room in Torbay is potentially in an unsafe location.

This section is primarily information for the provider

Compliance actions

Other “extra care” rooms are being used at Langdon Hospitals by staff for seclusion without this being recognised as such.

There are not enough staff who have completed or refreshed their training on restraint in line with the trusts training target on two acute admission wards.

This was a breach of Regulation 11(2)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010

Safeguarding service users from abuse

How the regulation was not being met:

Seclusion is being used without suitable arrangements in place to protect service users against the risk of physical interventions being excessive as follows:

The use of seclusion and restraint is not being correctly recorded so its use can be monitored.

A seclusion room in Torbay is potentially in an unsafe location.

Other “extra care” rooms are being used at Langdon Hospitals by staff for seclusion without this being recognised as such.

There are not enough staff who have completed or refreshed their training on restraint in line with the trusts training target on two acute admission wards.

This was a breach of Regulation 11(2)(b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010

Meeting nutritional needs

How the regulation was not being met:

This section is primarily information for the provider

Compliance actions

At Langdon Hospital service users' were not protected from the risks of inadequate nutrition because a choice of suitable nutritious food was not available in sufficient quantities to meet their needs. Service users with special diets did not have a sufficient choice of meals.

This was a breach of Regulation 14(1)(a)

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs** **How the regulation was not being met:** At Langdon Hospital service users' were not protected from the risks of inadequate nutrition because a choice of suitable nutritious food was not available in sufficient quantities to meet their needs. Service users with special diets did not have a sufficient choice of meals. This was a breach of Regulation 14(1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs** **How the regulation was not being met:** At Langdon Hospital service users' were not protected from the risks of inadequate nutrition because a choice of suitable nutritious food was not available in sufficient quantities to meet their needs. Service users with special diets did not have a sufficient choice of meals. This was a breach of Regulation 14(1)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service** **How the regulation was not being met:** Service users are not protected from the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services as follows: The use of governance processes at Langdon Hospital are not yet fully embedded so staff fully understand their purpose and the actions that are needed to ensure services are operating effectively. The completion of the improvement plan following the last inspection of The Cedars had not been checked to ensure all the work was done. At The Cedars some quality audits relating to health and safety had not been completed in line with the timescales expected by the trust.

Assessing and monitoring the quality of service

How the regulation was not being met:

Service users are not protected from the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services as follows:

The use of governance processes at Langdon Hospital are not yet fully embedded so staff fully understand their purpose and the actions that are needed to ensure services are operating effectively.

The completion of the improvement plan following the last inspection of The Cedars had not been checked to ensure all the work was done.

At The Cedars some quality audits relating to health and safety had not been completed in line with the timescales expected by the trust.

This was a breach of Regulation 10(1)(a)(b)

This section is primarily information for the provider

Compliance actions

This was a breach of Regulation 10(1)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service** **How the regulation was not being met:** Service users are not protected from the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services as follows: The use of governance processes at Langdon Hospital are not yet fully embedded so staff fully understand their purpose and the actions that are needed to ensure services are operating effectively. The completion of the improvement plan following the last inspection of The Cedars had not been checked to ensure all the work was done. At The Cedars some quality audits relating to health and safety had not been completed in line with the timescales expected by the trust. This was a breach of Regulation 10(1)(a)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** At the Cedars the planning and delivery of care and treatment did not always meet the service user's individual needs because approaches to keyworking were inconsistent. This meant patients did not always have a sense of ownership or control over the support they were receiving. Regulation 9(1)(b)(i).

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** At the Cedars the planning and delivery of care and treatment did not always meet the service user's individual needs because approaches to keyworking were inconsistent. This meant patients did not always have a sense of ownership or control over the support they were receiving. Regulation 9(1)(b)(i).

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met:

At the Cedars the planning and delivery of care and treatment did not always meet the service user's individual needs because approaches to keyworking were inconsistent. This meant patients did not always have a sense of ownership or control over the support they were receiving.

Regulation 9(1)(b)(i).