Devon Partnership NHS Trust

Wonford House Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. 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.

Summary of findings

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Overall summary

Community services

Devon Partnership NHS Trust has around 100 community teams. We visited a number of community teams including crisis teams in Exeter, North Devon, Torbay, East and mid Devon and Teignbridge. These teams provided care and support for people living in the community with mental health needs. The teams we visited were Liaison, Assessment and Outreach, Older People's care, Personality Disorder, Wellbeing and Access, Recovery and Independent Living, the Eating Disorders team and the Learning Disability team. We also visited a Clozaril medication administration community clinic, and the older people's community clinic in Teignbridge.

We found areas of good and excellent practice and many positive interventions across the wide spread of teams we inspected. The community services for older people, and for learning disabilities were outstanding. People told us they felt well-supported and described staff as hard working and committed to patient welfare. People who used the service could clearly describe a recovery approach to the care and support they received that was responsive and personalised to their needs. One person said "I could not do without my support worker; she is always there for me, even when I text her frequently. I know she is busy, but she is always calm and helpful to me".

The community and crisis teams were well-led at a local level, although some staff felt that senior staff were disengaged with the day-to-day delivery of the service. Staff morale was generally high, although there was a loss of confidence in some teams as they are currently undergoing a service redesign and are not yet sure of how they will fit into this.

There were three main areas where improvements need to be made. These all affect the responsiveness of the services which could present a risk to people needing care and support.

Out of hours support to patients – at night the only crisis team response is 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 their office (which they often are) the caller has to leave a message on an answer phone which might not be picked up until the crisis team start in the morning.

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.

Hospital services

Wonford House Hospital is in Exeter. Devon Partnership Trust have their head office at this site and also provide a number of services. We inspected the acute in-patient services which are provided on two wards Delderfield and Coombehaven. These two wards are called the Cedars Unit. This service is for people from Exeter, mid and East Devon but often patients are using the service from other parts of Devon. Also based at this hospital is The Haldon which is an inpatient eating disorder service which also accepts patients from across Devon and from other counties.

We found that The Haldon Eating Disorder Service provided an effective, evidence-based treatment programme and a high standard of care for people with eating disorders. It was a safe and secure unit, where staff cared for people in the least restrictive way. We found that there were enough members of staff to care for people safely. People who use the service told us that they felt safely cared for.

A thorough assessment process ensured that people had a good understanding about the treatment options available and they were supported to decide if it is the

Summary of findings

right place for them. The assessment process allowed the staff and individuals to form an individualised care plan. Good-quality information was given to carers and individuals throughout their stay on the unit. The staff worked well with other professionals to meet the needs of people.

We found that The Haldon Eating Disorder Service was well-led. Staff told us that they had the training and support they needed for their roles. There was a positive and open culture within the staff team. The manager was able to show that incidents were recorded and investigated appropriately.

Patients admitted to both wards on the Cedars Unit felt safe. Risks were managed effectively but we were concerned that some responses to patient safety had resulted in 'blanket rules', in particular the restrictions around smoking and access to fresh air. We also found that risks regarding patients' leave under section 17 of the Mental Health Act were not consistently recorded to show they were being managed.

On the Cedars Unit patients told us that the staff were friendly and helpful but the majority of people said that staff were often too busy to spend time with them; in particular nurses on the ward spent a lot of time in the ward office. A high number of patients did not know who their named nurse was or spend regular time speaking with them about their care which was an improvement that needed to take place from the previous inspection. The unit operated patient protected time from 10:30 to 11:30 but this was the time that most patients were off the ward at the activity centre.

People told us they got better on the unit but we found there was inadequate care planning for patients on both wards. On Coombehaven Ward we found two patients who did not have a care plan and 14 out of 17 patients across both units did not know if they had a care plan. Patients had not received a copy of their care plan and there was no record that they had been involved in its production. These were also areas for improvement from the previous inspection. Other patients did not have care plans that reflected their current physical healthcare needs and these needs were not always being met. However, patients had been involved in reviews of their care at ward rounds. Patients were able to discuss their medicines with their consultant and most patients were positive about their medical input. Our visit on 21 May 2014 found that required improvements in response to a warning notice had been made.

Patients received a good occupational therapy service. In addition to the activities centre there were therapy groups held on the ward that patients could attend. Occupational therapists also supported people to cook meals if they chose and were able to support people to go out.

We found there was good practice in medicines management. There was a good working relationship between members of the teams and also with other teams and providers.

On the Cedars there was a clear trust-wide governance system in place. Some routine quality audits to ensure the safety of patients had not been completed in line with the trust's targets. An improvement plan from our last inspection said the work would be finished before this inspection, but this had not happened. This means the governance processes are not yet fully embedded at a local level. Leadership needs to improve to ensure a consistently high-quality service is provided to all the patients across both wards in the Cedars Unit.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Community services

Generally, patients experienced safe care and treatment from the community teams, including the crisis teams. Teams were able to consistently demonstrate improved standards of care and safety by using the learning from previous incidents. There were clear systems in place to capture and report incidents and to notify the appropriate external bodies.

All staff we spoke with understood and followed their safeguarding procedures, and were clear about the extent of their professional responsibilities.

Staffing levels are very stretched in community services, especially out of hours, and this has an impact on the ability of services to respond quickly enough. This could also lead to a risk of unsafe quality of care.

Hospital Services

We found that The Haldon Eating Disorder Service was safe with many areas of good practice while Cedars Unit was mixed.

The Haldon provided an effective, evidence-based treatment programme and a high standard of care. It was a safe and secure unit, where staff cared for people in the least restrictive way. We found that there were enough members of staff to care for people safely, and people who use the service confirmed this.

While patients admitted to both wards on the Cedars Unit felt safe they did not feel able to speak at regular intervals to a named nurse about their care. Identified risks were managed effectively, however poor care planning meant that physical health risks were not always identified. We also found that risks regarding patients' leave under section 17 of the Mental Health Act were not consistently recorded to ensure they were being managed. When we returned on 21 May 2014 we found that all patients now had regular time with their named nurse and told us that they had a lot more contact with staff in general.

On the Cedars Unit, lessons had been learned from incidents. However, we were concerned that some responses to patient safety had resulted in 'blanket rules', in particular the restrictions around smoking and access to fresh air.

Bathrooms and toilets both had ligature points, but bathrooms were being kept locked and toilets left open. The Unit had risk assessments in place to address this.

Are services effective?

Community services

Patients experienced care and support based on the recovery model of care and we saw staff using appropriate national guidance, standards and best practice.Multi-disciplinary staff worked together across the services, and effective communications ensured a high degree of safe practice.

Audits were regularly used to enhance patient care, and to improve practice.

Hospital services

The Haldon Eating Disorder Service provided an effective, evidence-based treatment programme. The unit was accredited by the Royal College of Psychiatrists and the B-EAT Assured Quality Mark. The service provided a high standard of quality of care, using national guidelines and standards. There were both local and trust-wide systems in place to monitor quality of care.

Summary of findings

Care plans included advice and input from different professionals involved in people's care. Care programme approach (CPA) meetings took place every six weeks. These meetings included attendance by other healthcare providers – for example, the person's community care co-ordinator.

Staff working in The Haldon were supported and supervised to provide therapy to people. Dialectical Behaviour Therapy (DBT) was used as a core part of treatment. All staff received DBT training and practiced DBT skills in all areas of care.

The Cedars Unit had mixed effectiveness. Both wards were accredited by the Royal College of Psychiatrists. Reports from their visits contained recommendations that had not been followed through, and are reflected in our inspection findings.

There was a good standard of multi-disciplinary working. Morning meetings were held where consultants and nursing staff discussed each patient on the ward. There was good practice in relation to the management of medicines.

The majority of staff working in the Cedars had received their mandatory training; however, the numbers of staff who had received training on restraint were below the targets set by the trust. The frequency of supervision varied and had been below the trust targets since September 2013.

Are services caring?

Community services

The teams we looked at provided a caring service. We heard many positive comments from patients and their families. They told us that staff communicated in a respectful and pleasant manner, taking into consideration their opinions and wishes. We heard regular references to the helpful attitude of the team members.

Hospital services

The Haldon Eating Disorder Service carried out a thorough assessment process which ensured that people had a good understanding about the treatment options available. They were supported to decide if it was the right place for them. The assessment process allowed staff and each person to form an individualised care plan. Good quality information was given to carers and individuals throughout their stay on the unit. The staff worked well with other professionals to meet the needs of people.

On the Cedars Unit staff were friendly and helpful but the majority of people said that staff were often too busy to spend time with them and they did not know who their named nurse was. There were occasions when staff did not stop what they were doing to attend to the patients' requests. At our inspection on 21 May 2014 we saw that staff ensured they spent time with patients and patients confirmed they were able to speak with staff whenever they needed to.

Patients in the Cedars had not been involved in the preparation or received a copy of their care plan but had been involved in reviews of their care during ward rounds. At our inspection on 21 May 2014 we saw evidence that all patients had now been involved in the development of their care plans. Patients were able to discuss their medicines with their consultant and most patients were positive about their medical input. Patients received a good occupational therapy service.

Are services responsive to people's needs?

Community services

The responsiveness of services provided by the trust to meet the needs of people living in Devon varies widely. While some services are very accessible, others, including obtaining input from a care co-ordinator and specialist psychological therapies, are subject to a 'postcode lottery'. For many, this creates a very poor care experience that does not reflect current guidance. While the trust is aware of these challenges, and is in discussion with commissioners, there are no clear plans to address these service deficiencies.

People knew how to make complaints. Staff told us they ensured that people were supported to make a complaint if needed. There was a clear culture of learning from previous complaints to ensure a good level of service was maintained.

Summary of findings

Hospital services

There were concerns about timely admission or support for people in the community with eating disorders. One person needed admission to an eating disorder service outside Devon because there were no beds available. There was very limited specialised support for people in the community who came from Devon.

Information about the complaints process in The Haldon Eating Disorders Service was clearly displayed and there was a system in place to learn from complaints. There was information about how to access advocacy clearly displayed. Staff told us that learning took place in their staff meetings.

The Cedars Unit was not responsive to the needs of local people in respect of its section 136 place of safety arrangements. In Exeter over the course of a year ending November 2013, only 21 people went to the trust's own place of safety suite and 114 were held in police custody.

Some people from Exeter are having to be admitted to acute inpatient beds mainly in North Devon when there are not enough local beds, meaning people are a long way from families and carers.

Due to a lack of a commissioned psychiatric intensive care unit (PICU) for the trust, patients in need of this service have to be found a bed out of the area. People waiting for a bed to be found are sometimes spending many hours in seclusion where clinically needed. Staff are also spending long periods of time trying to find a suitable bed for the patient

Are services well-led?

Community services

The community teams were well-led at local level, and this had a positive and beneficial impact on patients care and treatment. Staff told us they felt well supported in their roles, and felt able to raise concerns and report incidents. They told us they would be listened to, and the information acted upon appropriately.

Hospital services

We found that The Haldon Eating Disorder Service was well-led. Staff told us that they had the training and support they needed for their roles. There was a positive and open culture within the staff team. The manager was able to show that incidents were recorded and investigated appropriately.

On the Cedars Unit there was a clear governance system in place but areas identified for improvement were not always followed up to ensure improvements had been embedded. An action plan developed to address previous areas for improvement on Coombehaven ward had not been properly implemented and no management monitoring had taken place to identify this had not been completed. Our visit on 21 May 2014 found that required improvements had been made. Some important routine ward quality audits such as infection control and resuscitation equipment checks were not taking place at the agreed intervals.

There was good leadership on Cedars Unit from the consultants. The nurse leadership on The Cedars was well received by patients and staff, but was not always delivering the actions and improvements that needed to take place.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

We found that patients were lawfully detained; however, there was room for improvement in the recording of procedures required under the Mental Health Act and Code of Practice. This included the recording of seclusion and risk assessments associated with section 17 leave.

Care planning and risk assessment were not always fully completed or inclusive of the patient's views.

Although some upgrade had occurred to the environment, we saw some potential ligature points in bathrooms and toilets in Cedars Unit although this had been risk assessed.

We heard about difficulties in accessing psychiatric intensive care facilities and that this could mean patients being secluded for long periods to manage this risk where clinically needed.

We also found that the health-based place of safety suite is not always being used as the preferred place of safety as required by the Mental Health Act Code of Practice.

Acute admission wards

We found that patients admitted to both wards on the Cedars Unit felt safe. Risks were managed effectively but we were concerned that some responses to patient safety had resulted in 'blanket rules' – in particular the restrictions around smoking and access to fresh air.

Patients told us that the staff were friendly and helpful but the majority of people said that staff were often too busy to spend time with them; in particular nurses on the ward were mostly in the ward office. A high number of patients did not know who their named nurse was. The ward operated patient protected time from 10:30 to 11:30 but this was the time that most patients were off the ward at the activity centre.

Patients received a good occupational therapy service. In addition to the activities centre there were therapy groups held on the ward that patients could attend. Occupational therapists also supported people to cook meals if they chose and were able to support people to go out.

People told us they got better on the unit, but we found there was inadequate care planning for patients on both wards. On Coombehaven Ward we found two patients who did not have a care plan and 14 out of 17 patients across both units did not know if they had a care plan. Other patients did not have care plans that reflected their current physical healthcare needs and these needs were not always being met.

Patients had not received a copy of their care plan and there was no record that they had been involved in its production. However, patients had been involved in reviews of their care during ward rounds. Patients were able to discuss their medicines with their consultant and most patients were positive about their medical input.

We returned on 21 May 2014 and found that the required improvements in respect of the warning notice had been made. We did not follow up other areas of non-compliance at this time as the trust is still in the process of implementing improvements. Patients told us that they met regularly with their named nurse and that staff made themselves available to spend time with them. They told us that things had really improved on the ward; there was always someone to talk to and they had been involved in developing their care plans. We saw that every patient had a care plan which was individualised and incorporated their views. Ward management regularly monitored care plans and ensured staff engaged regularly with patients.

Summary of findings

We found that visiting pharmacists were making a valuable contribution to ensuring that medication was well managed and prescribing was in line with National Institute for Health and Care Excellence guidance. There was a good working relationship between members of the teams and also with other teams and providers.

On the Cedars, there was a clear trust-wide governance system in place. Some routine quality audits to ensure the safety of patients had not been completed in line with the trust's targets. An improvement plan from our last inspection said the work would have been completed before this inspection, but this had not happened. This means the governance processes are not yet fully embedded at a local level. Leadership needs to improve to ensure a consistently high quality service is provided to all the patients across both wards in the Cedars Unit.

Adult community-based services

We found that a good level of care was given across the community team services in Devon.

Care plans and risk assessments were usually complete but were not always updated quickly enough. We found examples of excellent practice, most notably in the Learning Disability team, and in the Older Person's Mental Health teams.

Patients were positive about the care and treatment they received, and told us of warm and trusting relationships with the staff. Carers and relatives told us they felt engaged with the staff but not with the trust. This is because they were unsure of what the forthcoming service transformation would mean for them and their families.

Trust engagement with staff was variable. Staff told us they felt well-led at local level.Staff in the Recovery and Independent Living (RIL) teams were concerned about the length of time some patients who were not in a priority group were being "held" while waiting for a care co-ordinator and access to psychological therapies. This meant that, although their safety was being observed and monitored, they were not yet getting the treatment to enable fuller recovery.

We heard that the Iris Centre was a high performing service, where people with personality disorders were able to enjoy a safe and effective therapeutic environment.

Community-based crisis services

We found that crisis teams were held in high regard and generally provided a good service to the trust. However, a key issue for the crisis teams was the poor 'out of hours' cover for those people requiring urgent support. As there was only one nurse practitioner available overnight, they were not always able to answer the phone to people making a call. They had other duties to attend to and roles to perform. Sometimes this meant that calls to the answerphone were not received until the morning, therefore delaying the care needed for people requiring overnight urgent support.

We were told that the crisis house in Torbay was a new initiative, welcomed by the local community.

Specialist eating disorders services

We found that The Haldon Eating Disorder Service provided an effective, evidence-based treatment programme and a high standard of care. It was a safe and secure unit, where staff cared for people in the least restrictive way. We found that there were enough members of staff to care for people safely. People who use the service told us that they felt cared for safely.

A thorough assessment process ensured that people had a good understanding about the treatment options available and they were supported to decide if it is the right place for them. The assessment process allowed staff and each person to form an individualised care plan. Good quality information was given to carers and individuals throughout their stay on the unit. The staff worked well with other professionals to meet the needs of people.

Summary of findings

We found that The Haldon Eating Disorder Service was well-led. Staff told us that they had the training and support they needed for their roles. There was a positive and open culture within the staff team. The manager was able to show that incidents were recorded and investigated appropriately.

Summary of findings

What people who use the location say

Community services

People told us that they received a good service from the community teams. Some people told us they had to wait "a very long time" for treatment to start, but many people were happy with the service they currently received.

Families and carers told us they felt engaged and involved in the care and support offered to their relative. They said that team members went to great lengths to ensure they had the information they required, and that support staff regularly checked to ensure they felt "up to date" with ongoing plans.

People made positive comments about individual members of staff and emphasised that their recovery was largely due to the warm and trusting relationships they had with them. Several people told us they "could not do without" their support workers, and we heard of many instances of small kindnesses.

People described helpful and effective care, although they described their time in recovery as "long, too long". Some family members described the difficulties of waiting for psychological therapies for their relative, and how this could impact on family life, "sometimes for months".

We heard from some carers who told us their interactions with one consultant was "less than helpful". They described how they felt disregarded by him and how he "spoke over them " at appointments. One person said that her son had been "treated very dismissively by this person" but the family did not know how to address this. They were aware of the complaints procedure but thought that may not be a helpful method to use as they "were not sure anything would happen as he is a consultant".

Hospital services

As part of our inspection we held listening events across Devon to enable people who used the service and their friends and relatives to tell us about their experiences. With the support of 'Be Involved Devon' we held one of these events in Exeter. While there were positive comments from a person who had been detained on Cedars unit the majority of people were less positive. People told us that they did not always feel cared for on Cedars unit and that staff were mainly concerned with managing risks. Several people said there was not enough engagement from staff. People were critical of the environment, particularly a lack of private space available for visitors and shared bedrooms.

Areas for improvement

Action the provider MUST take to improve

Community services

- 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 recovery care co-ordinator are allocated one quickly enough to meet their needs for care and treatment.

Cedars Unit

- There must be systems in place – especially for adults of working age who need acute inpatient care, with effective bed management – that reduces the need for patients to be admitted long distances from their homes. This must ensure that valuable nursing time is not taken up with searching for a bed.
- Access to the hospital's own place of safety must be reviewed to ensure it is being used as the preferred place of safety.
- The use of seclusion and restraint must be correctly recorded and monitored. Acute admission wards must meet the trust's target in terms of the numbers of staff having up-to-date training in restraint.

Summary of findings

- Patients must be offered the opportunity to be involved in and have a copy of their care plan. Patients must know who their named nurse is and have time with them to review their care. This is an action that is outstanding from the previous inspection. .
- The care plans must be person-centred and reflect physical health care needs where necessary.
- Audits – particularly where they impact on people's health and safety, such as checking the resuscitation bag, hand hygiene and infection control – must be carried out regularly. Where action plans have been put into place to improve the service, progress must be monitored.
- Our inspection undertaken on 21 May found that required improvements had been made in respect of care planning.

Action the provider SHOULD take to improve

Community services

- People who use the services, carers and staff should be supported to feel more engaged with the new service redesign.
- Consideration should be given about whether staff in the Iris Centre should be trained in physical interventions.
- Staff should be supported to integrate their post-registration qualifications into their working practice.

Cedars Unit

- Patients should not routinely be asked to wait if they need assistance.
- Recording of procedures required under the Mental Health Act should be improved – especially in relation to risk plans associated with section 17 leave.
- Blanket restrictions and rules must be reviewed, particularly in relation to access to fresh air and arrangements for patients who smoke.

Good practice

Our inspection team highlighted the following areas of good practice:

Community services

- A new Crisis House set up in Torbay with a third sector provider is a viable alternative to hospital admission. This is excellent practice.
- We heard that the Learning Disability Team are highly regarded, and families using this service describe the very personal service that is delivered.
- The recovery-based model of care and, in particular, the recovery colleges, have provided a high quality solution to helping people manage their mental health.

The Haldon Eating Disorder Service

- Treatment options were varied and agreed according to people's individual needs. People were respected and cared for well. There was a strong emphasis on ensuring people who use the service were supported to make informed decisions.
- Carers were well supported and involved.
- The staff team were well-led, supported and respected in their roles. They created a supportive and safe environment.

Cedars Unit

- The morning meeting reflected good multi-disciplinary working where patients' risks and treatment was discussed. There was evidence of good team working.
- Good management of medicines with frequent input and advice from the pharmacist.

Wonford House Hospital

Detailed findings

Services we looked at:
Mental Health Act responsibilities; Acute admission wards; Adult community-based services; Community-based crisis services; Specialist eating disorder services

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

Our inspection teams at Wonford House Hospital were led by three CQC inspectors and included a variety of specialists: two consultant psychiatrists, a consultant clinical psychologist, two senior nurses, a Mental Health Act commissioner, and patient Experts by Experience.

Background to Wonford House Hospital

Devon Partnership NHS Trust is a Mental Health and Learning Disability Trust which was established in 2001 and has six hospital sites across Devon and Torbay. The trust employs approximately 2,500 staff and also has 100 staff assigned from Devon County Council and Torbay Unitary Authority, including social workers and support workers. Devon Partnership NHS Trust serves a large geographical area with a population of more than 890,000 people and has an annual budget of around £130 million. The trust services fall into three areas of care:

Mental Wellbeing and Access – for people experiencing a common mental health problem for the first time who need more help than their GP can provide.

Recovery and Independent Living – for people with longer-term and more complex needs.

Urgent and Inpatient Care – for people with severe mental health difficulties, in crisis or experiencing distress and who may require a stay in hospital.

At any one time, the trust provides care for around 19,000 people in Devon and Torbay. The vast majority of these people receive care and treatment in the community. A small number may need a short spell of hospital care to support their recovery if they become very unwell and an even smaller number will have severe and enduring needs that require long-term care. Teams include psychiatrists, psychologists, specialist nurses, social workers, physiotherapists, occupational therapists and support workers.

Community services

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 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.

Detailed findings

Hospital services

Wonford House Hospital is in Exeter, Devon. Devon Partnership NHS Trust have their head office at this site and also provide a number of services. We inspected the acute inpatient services which are provided on two wards - Delderfield and Coombehaven. These two wards are called the Cedars Unit. This service is for people from Exeter, mid and East Devon but often patients are using the service from other parts of Devon. Also based at this hospital is The Haldon Eating Disorder Service which is an inpatient eating disorder service which also accepts patients from across Devon and other counties.

The Care Quality Commission (CQC) has inspected the inpatient services at Wonford House Hospital three times since it was registered with Devon Partnership NHS Trust in 2010. The reports for these inspections were published in February 2011, December 2011 and December 2013. The reports in February and December 2011 found overall compliance but recommended some improvements. The report of December 2013 found the trust was meeting appropriate standards in respect of consent and supporting workers but action was needed in relation to aspects relating to the care and welfare of patients. Following this inspection the Trust sent us an action plan and then updates. The action plan stated that the trust had completed improvements, however our inspection found that these improvements had not been fully implemented and so we are taking enforcement action.

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.

We re-inspected on 21 May 2014 to monitor compliance with a warning notice issued as an enforcement action against Wonford House Hospital and found that the required improvements in respect of the warning notice had been made.

We did not follow-up other areas of non-compliance at this time as the trust was still in the process of implementing improvements and we will monitor these.

How we carried out this inspection

Our inspection team included three CQC inspectors, a Mental Health Act commissioner, senior nurse specialists with NHS management experience, a consultant psychologist (eating disorders), two consultant psychiatrists and two Experts by Experience.

We spent three days visiting the hospital and a number of community teams. We spoke with patients and their relatives, carers and friends and hospital staff. We observed care and inspected the hospital environment. We reviewed care or treatment records of people who use services.

We worked with Be Involved Devon and attended a meeting in Exeter and spoke with people about their experiences of using the mental health services in their area. We attended a carers event during the inspection in order to hear directly from carers about their experiences. Before the inspection we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

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 responsibilities
- Acute admission wards
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services

Mental Health Act responsibilities

Information about the service

During this inspection we looked at how the Mental Health Act was operated at the Cedars unit. The Cedars unit comprises of two acute admission wards, Coombehaven, on the ground floor and Delderfield on the first floor. Coombehaven covers the rural areas of Exeter and Delderfield covers the more urban areas including the city, with the client group having more complex needs such as dual diagnosis. At present Coombehaven has four beds for alcohol detoxification but this service is moving to another provider from April 2014.

Coombehaven had 19 beds and Delderfield had 20 beds. On the first day of our inspection all beds were occupied and eight patients were detained under the Mental Health Act. Two of the detained patients were in seclusion beds before we arrived, one returning to the ward during our visit.

Summary of findings

We found that patients were lawfully detained; however, there was room for improvement in the recording of procedures required under the Mental Health Act and Code of Practice. This included the recording of seclusion and risk assessments associated with section 17 leave.

Care planning and risk assessment were not always fully completed or inclusive of the patient's views.

Although some upgrade had occurred to the environment, we saw some potential ligature points in bathrooms and toilets in Cedars Unit although a risk assessment was in place.

We heard about difficulties in accessing psychiatric intensive care facilities and that this could mean patients being secluded for long periods to manage this risk where clinically needed.

We also found that the health-based place of safety suite is not always being used as the preferred place of safety as required by the Mental Health Act Code of Practice.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

We found that risk assessments were generally appropriate and balanced and we observed that the ward did feel safe at the time of our visit. We noted that at times when incidents occurred these were responded to promptly by staff from both wards at the unit. Patients told us that they did feel safe on the wards and staff were able to demonstrate that they understood the risks to individual patients. However we found that risk plans for the management of section 17 leave were not in place. We asked staff about patient's specific risks in relation to leave and staff were able to demonstrate that they were aware of issues. The paperwork for the authorisation and management of section 17 leave provided no evidence that risk has been considered, sparse evidence of conditions and no evidence that patients have been involved or have been given a copy.

We looked at the records of a recent incident where a patient went absent without leave (AWOL) following authorised leave. It was clearly recorded in the progress notes and the procedure followed was confirmed by one of the nurses. The policy was closely and promptly followed, for example the recording showed that the police were informed within five minutes of the leave having expired.

Broadly staff demonstrated they were aware of their safeguarding responsibilities.

While we found that physical assessments are undertaken as required the care plans examined did not always include details of people's specific healthcare needs. On occasion we noted this information to be included in the patient's electronic health record however this was not systematically recorded and this information would have been difficult for staff to find.

The unit has undertaken a programme to reduce some environmental risks. This had included replacement of taps and washing facilities in the majority of bedrooms for safer fittings. However we found that a number of risks remained in bathroom and toilet facilities arising from old fashioned taps and exposed pipework. Staff explained that the risks are being actively removed and in the interim the measures had been put in place to reduce the risk of people harming themselves.

Are Mental Health Act responsibilities effective?
(for example, treatment is effective)

We reviewed the care records and legal documentation for six patients and found that all patients appeared to be legally detained. We noted that the application for detention documents were usually of a high standard.

On Delderfield we asked about advance decisions and no patients had made these.

Are Mental Health Act responsibilities caring?

Overall we found the service to be delivered in a caring way and we observed a number of examples of staff treating patients with kindness, respect and dignity. However we did find examples of restrictive practices and 'blanket rules'. These included set times when patients could leave the ward to smoke or get fresh air and a lack of clear information for patients who are not detained under the Mental Health Act about how they are able to freely leave the ward.

While we found that care plans were in place for most patients this did not always include sufficient detail or reflect patient's participation or individual needs. The majority of the patients that we spoke with had not seen their care plan or were unaware of its contents. We found that the multidisciplinary team did discuss patients changing care needs however this was not reflected within patient's care plans which were not reviewed on a regular basis.

Community meetings occur on the ward on a regular basis providing patients with a means to express their needs and wishes.

We found that patients were generally aware of their rights under the Mental Health Act and that the independent mental health advocacy (IMHA) service visits the ward on a regular basis and can also support patients on an individual basis. We noted information about the advocacy service displayed within the wards visited.

Patients told us that there were a range of activities available on the ward. Protected time has recently been

Mental Health Act responsibilities

introduced at the hospital to allow staff to spend more time talking with the patients in their care. However we found that staff were not always able to use this time with patients and we saw occasions where staff were unable to spend time with patients where requested.

There is capacity for managing four people in seclusion on the Cedars Unit. There are also extra care or de-escalation areas, where every effort is made to manage the patient to avoid seclusion. There is no toilet within the seclusion area but we did observe that considerable effort was made to preserve dignity and maintain hygiene for a particularly disturbed patient.

We found incidents of seclusion where the paperwork had not been fully completed and therefore we were unable to establish whether all of the safeguards required by the Mental Health Act Code of Practice had been met.

Are Mental Health Act responsibilities responsive to people's needs?
(for example, to feedback?)

Staff told us of difficulties in accessing psychiatric intensive care facilities (PICU) as there are currently no commissioned beds available in Devon. We observed a long period of seclusion on the unit because a PICU bed could not be found and this effort consumed many hours of staff time over two days.

Section 136 place of safety facilities on the Wonford site were not satisfactory for several reasons. There are two units, one being a backup unit when the main unit becomes a clozaril clinic on Wednesdays. The backup unit is within the Russell Clinic rehabilitation unit but does not have its own entrance which means patients requiring a place of safety being moved through another service. The Mental Health Act manager's audit of use of the place of safety shows that the majority of admissions in the area are to police custody. The Code of Practice states "A police station should be used as a place of safety only on an exceptional basis." The Mental Health Act manager has a positive relationship with the police liaison officer and more effective ways of operating this facility are being discussed.

Are Mental Health Act responsibilities well-led?

We found that there was a programme of audits in place to consider how well the Mental Health Act is being implemented at the hospital. Audits undertaken included recording of consent to treatment, information on rights, section 17 leave arrangements, discharge arrangements and use of the place of safety. Through this process the Mental Health Act administrator had regularly found minor rectifiable errors in legal paperwork and during 2013 found two invalid Mental Health Act applications.

We spoke with the manager with lead responsibility for Mental Health Act administration at the trust. She confirmed that the trust has a governance process in place for looking at the use of the Mental Health Act. Inpatient audits undertaken at hospital level are aggregated and presented at the Hospital Managers meeting along with information about how frequently different sections of the Mental Health Act are used. Through this meeting the hospital managers also look at any findings from CQC and other external reviews about how the Mental Health Act is operated. Any areas of concern found are referred to the trust's quality and safety group and to directorate management groups for taking forward at hospital level.

There was not a record of overall episodes of seclusion available at the unit and we were told that this practice is not monitored for any trends or adherence to the Mental Health Act Code of Practice.

Governance of section 136 admissions was not effectively managed. The wards across the trust have been requested to submit returns under the serious untoward incident procedure when a request for admission from the police has been refused. There have been only a few returns across the trust since July 2013. However we are aware of a large number of cases where admission was refused.

Acute admission wards

Information about the service

The Cedars unit is based at Wonford Hospital in Devon. It provides acute inpatient services on two wards, 20 beds on Delderfield Ward and 19 beds on Combehaven Ward.

Summary of findings

We found that patients admitted to both wards on the Cedars Unit felt safe. Risks were managed effectively but we were concerned that some responses to patient safety had resulted in 'blanket rules' – in particular the restrictions around smoking and access to fresh air.

Patients told us that the staff were friendly and helpful but the majority of people said that staff were often too busy to spend time with them; in particular nurses on the ward were mostly in the ward office. A high number of patients did not know who their named nurse was. The ward operated patient protected time from 10.30am to 11.30am but this was the time that most patients were off the ward at the activity centre.

Patients received a good occupational therapy service. In addition to the activities centre there were therapy groups held on the ward that patients could attend. Occupational therapists also supported people to cook meals if they chose and were able to support people to go out.

People told us they got better on the unit, but we found there was inadequate care planning for patients on both wards. On Coombehaven Ward we found two patients who did not have a care plan and 14 out of 17 patients across both units did not know if they had a care plan. Other patients did not have care plans that reflected their current physical healthcare needs and these needs were not always being met. Patients had not received a copy of their care plan and there was no record that they had been involved in its production.

We returned on 21 May 2014 and found that the required improvements in respect of the warning notice had been made. We did not follow up other areas of non-compliance at this time as the trust is still in the process of implementing improvements. Patients told us that they met regularly with their named nurse and that staff made themselves available to spend time with them. They told us that things had really improved on the ward; there was always someone to talk to and they had been involved in developing their care plans. We saw that every patient had a care plan which was individualised and incorporated their views. Ward management regularly monitored care plans and

Acute admission wards

ensured staff engaged regularly with patients. Patients had been involved in reviews of their care during ward rounds. Patients were able to discuss their medicines with their consultant and most patients were positive about their medical input.

We found that visiting pharmacists were making a valuable contribution to ensuring that medication was well managed and prescribing was in line with National Institute for Health and Care Excellence guidance. There was a good working relationship between members of the teams and also with other teams and providers.

On the Cedars, there was a clear trust-wide governance system in place. Some routine quality audits to ensure the safety of patients had not been completed in line with the trust's targets. An improvement plan from our last inspection said the work would have been completed before this inspection, but this had not happened. This means the governance processes are not yet fully embedded at a local level. Leadership needs to improve to ensure a consistently high quality service is provided to all the patients across both wards in the Cedars Unit.

Are acute admission wards safe?

Learning from incidents

In the year previous to our inspection we found that there had been three serious untoward incidents which had resulted in harm to patients. The provider had learnt from this and had taken suitable steps to reduce the risks. For example, there had been incidents where patients had been able to go absent from the ward by climbing the fence. Staff told us that the fence had been replaced and we saw that there was now a much higher security fence which enclosed the ward garden.

The NHS Safety Thermometer highlighted falls as an area of risk for people being cared for by the trust. On Coombehaven there had been one fall in December 2013 and none in January 2014.

Safeguarding

We saw evidence of effective safeguarding practice. Staff had ensured that one person who lacked capacity had a solicitor and that the Court of Protection was involved. Staff at the ward meeting were all aware of this plan. We saw another incident where staff were concerned about another patient's vulnerability on the ward and intervened.

Training records displayed on the staff noticeboard showed that the majority of staff had completed safeguarding training. One member of staff told us about raising concerns when they felt a patient was vulnerable and said this had been acted upon. We saw evidence that when a patient complained about being pushed by a member of staff that a statement was taken.

Staff understood the importance of raising concerns when people were perceived to be threatened, at risk of exploitation or their mental health was deteriorating. Staff were able to tell us how they would report any concerns.

Safe Environment

Staff explained what measures had been put in place to reduce the risk of people harming themselves through the use of ligatures. Taps and washing facilities in the majority of bedrooms had been replaced with safer fittings to reduce this risk. We saw that mirrors had been removed in bathrooms following one patient breaking a mirror and using this to harm themselves. We noted that there were still potential ligature points in the ward toilets but were

told that remedial action was planned. Bathrooms and toilets both had ligature points but bathrooms were being kept locked and toilets left open with a risk assessment in place.

Delderfield ward was on the first floor and did not currently have access to the ward garden. Patients accessed the smoking area through Coombehaven ward. We saw that there was an external fire staircase from Delderfield ward but when the fence had been replaced it was positioned so that the staircase was outside the fence. The estates officer has submitted plans for a new staircase.

Another member of staff said, "Even in the summer people cannot just go out and sit in the garden. If we have time we can go out there with people but the garden is under used. It can get really hot upstairs (Delderfield) in the summer". The current arrangements for accessing the garden restricts patients' access to fresh air.

Risk Management

We were concerned that some processes for managing risk on the ward were not proportionate. There was use of 'blanket rules', particularly in relation to the management of smoking, access to the garden and fresh air in general.

Patients on each ward were required to hand over all cigarettes, tobacco and lighters to the ward staff. On Combehaven this was kept in a plastic box in the nursing office. Patients were allowed to smoke each hour for 15 minutes and lined up outside the office to be handed their cigarettes or tobacco by staff. On the hour the door to the garden was unlocked and patients were allowed into the garden.

During our three days on the ward we saw patients approach staff on a number of occasions to ask about smoking and heard staff say, "not yet" and tell them how long to wait. We asked staff why people could not have access to the garden to smoke, or not, as often as they liked. The ward manager on Combehaven told us, "It is horrible. This (Cedars) is one of the most smoking controlled units in the Trust. I have challenged it but I was told by the fire service that there is a risk people will smoke in their bedrooms. We are having a wall mounted lighter fitted to reduce the need for lighters." Another member of staff told us, "I have experienced a number of incidents caused by removing patients' cigarettes and lighters."

Medicines Management

The Cedars Unit had a high standard of medicines management with active involvement of the pharmacist based on site. Patients' medicines were reconciled within 24 hours of admission and were regularly checked by the pharmacist. The pharmacist was proactive in questioning prescribing that appeared inconsistent with best practice. Patients had access to the pharmacist to discuss any issues or ask any questions about their medicines.

Whistleblowing

We spoke with staff who told us they would report concerns to the ward manager and were confident they would be listened to. Members of staff asked were aware of the trust's whistleblowing policy and said they would use this if it was necessary.

Managing risk to the person

We observed that patients' risk was discussed during the morning meeting and appropriate management plans were decided. For example the staff discussed one person who was on the highest level of observations annd the reduction of the observations for other people. This also included a discussion with the patient themselves.

Patients we spoke with told us that they mostly felt safe on the ward; we were told by two patients that they had not felt safe when one patient became aggressive. Patients we spoke with told us that they knew what level of observations they were on and why.

We looked at the care plans of patients on both Delderfield and Combehaven and saw that there was no update of patients' care plans following incidents. For example, there was no information in care plans to guide staff on how to identify signs that a patient may be becoming distressed or agitated. This meant that staff who did not know the patient would potentially miss opportunities to de-escalate situations as the care plans and risk assessments did not contain this information.

The ward manager on Combehaven Ward told us that staff had become very aware of managing risk in response to previous incidents and that it was taken very seriously.

Safe staffing levels

People we spoke with told us that they generally felt safe but that staff were usually busy and did not always have time to talk with them. Staff told us that there was a rapid turnover of staff on the wards and that they always had

vacant band 5 nursing posts which was a recruitment challenge recognised by the trust. Two of the current band 5 nurses were new to the ward and two nurses were agency staff.

An interim measure was the use of regular staff from one agency which has a contract with the trust. Staff told us that there had been an improvement in staff continuity however a senior member of staff acknowledged it was not as good as having permanent nursing staff.

Are acute admission wards effective? (for example, treatment is effective)

Use of evidence-based clinical guidance and standards

We found that the wards made use of a range of guidance reflecting National Institute for Health and Care Excellence (NICE) guidance to inform their support to patients. Patients had access to some psychological therapies. For example Dialectical Behaviour Therapy (DBT) groups were available for patients. DBT is effective in helping patients to manage overwhelming emotions and to learn to manage behaviours that contribute to mental health difficulties.

Monitoring Quality of Care

Both wards had been visited as part of the accreditation process by the Royal College of Psychiatrists; Coombehaven in 2012 and Delderfield ward in May 2013. Both these reports had identified areas for improvement which reflected many of the findings from this inspection. The Cedars had not taken the opportunity to address the improvements that were needed.

There were trust-wide systems in place to manage the quality of care. Each ward had a 'dashboard' which identified specific areas of quality with target figures. The ward's performance was graded red, amber or green according to their achievement of the targets. We asked staff about the ward dashboard and found that the more senior staff were aware of the quality monitoring systems on the ward. The ward manager used the dashboard system, and they were aware of areas that were below target.

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

We saw good evidence of multi-disciplinary working. During the morning meeting which both wards held daily it was evident that medical and nursing staff worked together collaboratively to manage patient risk and welfare. The consultant psychiatrists had a thorough knowledge of their patients' progress and demonstrated a understanding of their individual needs, operating a holistic rather than medical model.

There was good joint working between staff on both wards. We saw that when there was an incident on Delderfield Ward a member of staff from Coombehaven attended to give additional support. Ward managers told us that they worked well together. Staff on each ward told us that things had improved between the two teams and there was more cooperative working.

We saw that admissions had been coordinated with other services when required.

Records showed that appropriate referrals had been made to other services.

We looked at patient records on the electronic system (RIO) on both wards. We found that there was poor use of the care planning section and that staff did not always know how to complete the care plan correctly. Old care plans from previous admissions or from community treatment episodes were not always closed which led to confusion about which care plan was current. Two patients did not have a current care plan which was confirmed by members of staff.

Far too much information was recorded in the progress notes and this made information difficult to find. For example, changes to patients' needs were often incorrectly recorded in progress notes rather than staff updating the care plan. As somebody on a high level of observations might have over ten notes made in the course of a day it was very difficult to track any changes in their care needs. This meant that staff would not always be aware that patients' needs had changed and there was a risk that their needs would not be met correctly.

Acute admission wards

Patients had a physical examination on admission however we found that some physical health screens were not completed by the nursing staff. For example one patient's eating and drinking was being monitored by ward staff but their records on RIO did not reflect this.

Suitably qualified and competent staff

One member of nursing staff was newly qualified and was undertaking their preceptorship. This member of staff was well supported by the team. We saw that they had the opportunity to develop their skills, such as leading the handover, with support from their mentor. They told us they had not been rushed and given sufficient time to develop competencies.

Staff told us that the majority of mandatory training was delivered by e-learning. The majority of the 28 staff on Coombehaven had completed most of the training; however eight members of staff needed to refresh their safeguarding training. Of the two staff required to complete personal safety training only one of them had completed this. We saw that there were 11 courses available for nurses to access to update their knowledge on medicines administration however we were told by the clinical lead nurse that the training would not be available until June 2014.

We looked at the trust's dashboard for staff supervision and appraisal on Coombehaven. We saw this was rated red, and in December 2013 only 44% of staff had participated in supervision within the last 60 days. At the time of our visit the latest figures showed that this had increased to 79% but was still rated red by the Trust. We asked the ward manager about this and they said it had been difficult to deliver supervision due to a lack of band 5 nurses. Staff we spoke with told us that supervision was helpful.

Are acute admission wards caring?

Choice in decisions and participation in reviews

We found that patients' experience was varied. In November 2013, as part of a compliance action for Coombehaven, patients were to be given a copy of their care plan. Nine out of eleven patients we spoke with on this ward did not know what a care plan was. There was no evidence that patients had been involved in the development of their care plans and that their views about their overall treatment were sought. The only section of their care plan which contained patients' views had been written by the occupational therapist.

We looked at the care plans of all 19 patients on Coombehaven Ward. All the care plans were generic and contained statements such as, "assess activities of daily living to identify support needed"; there was no evidence in any care plans that this had occurred. The eight care plans we looked at on Delderfield Ward did not always contain information about the patient's views. There was no evidence patients had agreed to these care plans or had received a copy of them.

Records showed that patients were involved in ward rounds and were able to discuss their medication with their consultant. We saw that where patients had not been happy about their medicines that this had been discussed with them. At the morning meeting we heard a discussion take place about changing the level of a person's observations and the decision was to be taken in discussion with the person.

When we re-inspected on 21 May we found the following:

Patients told us that they met regularly with their named nurse and that staff made themselves available to spend time with them. Comments included, "I was here a couple of years ago and this time I've noticed the difference. It's much more relaxed, there is always some staff to help you if you need someone to talk to, and they used to stay in the office all the time". Another patient said "I see my named nurse every time she's on shift and then anyone else if I need to. The staff are more attentive than they were before". Patients were now involved in developing their care plans, one patient said, "The nurse explained the care plan and we did it together. I didn't agree with something in it and she agreed to get it changed for me." A second patient told us, "Since you came last time the care plan thing has changed a lot. My named nurse sat down with me to do my care plan and I signed it and have a copy of it in my room. When things change, we change the care plan; observations, medication, anything, you sign it off. They've made me feel part of it."

There was a white board outside the nurses' station which showed that all patients were allocated a named nurse and an associate nurse. They were also allocated a staff member each shift. Where possible this was either their

named nurse or their associate nurse. Four staff told us that when they started their shift they introduced themselves to their allocated patient and advised them that they would provide them with one to one time during their shift if they wanted it.

There was a checklist in place which showed that all patients were offered one to one time a minimum of twice a day. Details were recorded in the patient's progress notes on the electronic system (RIO).

Nursing staff told us that all patients had a care plan which was developed and reviewed with patients. This usually took place at the time of admission or the day after if the patient was tired or too unwell. Patients were offered a copy of their care plan which they could amend before signing, although some refused. Care plans were reviewed each week by team leaders and the process monitored by the ward manager.

Care plans were person centred and it was evident that patients had contributed to them. For example, there was a section entitled, "My story" which contained information about the patient and their mental health. There was information from the patient about what helped when they were distressed and their view of their care plan and treatment. One patient's care plan had information about how they felt about the level of observations they were on and the staff assessment of their risk.

There was an evident improvement in staff morale. All the staff we spoke with agreed that there had been real improvements in patient care. Some staff felt that regular patient engagement had always taken place and was just not properly documented. Others acknowledged that previously it had not taken place as often as it should have.

Staff said they felt that the ward was better managed and there was better support and supervision. One member of staff commented that there was now a sense that the nurses were more accountable for the care delivered on the ward.

Effective communication with staff

Staff did not always communicate effectively. An action following our inspection in November 2013 was for all patients to be aware of their named nurse and to have consistent contact. We spoke with 17 patients on both wards, ten patients knew who their named nurse was but only three of these patients had met with their named nurse regularly. Patients told us that generally nurses did not have the time to spend with them.

At an engagement meeting prior to our inspection people told us about the care they had received at the Cedars. One person said there were “wonderful staff, deserve great credit”. Several other people said there was not enough engagement with patients by staff on the wards. They told us there was no one at the nurse’s desk, there was no one to talk to and all discussions were “on the hoof”. During our inspection we observed occasions when staff did not stop what they were doing to attend to the patients’ requests.

People receive the support they need

Patients on Coombehaven did not always receive the support they needed. We saw that there were three patients with physical disabilities who did not have important information about their individual needs in their care plans. One person needed a walking frame, a second person used a crutch and a third person was visually impaired. None of these three people had a care plan to guide staff on how to provide the support they needed. One of these people had told the consultant in the ward round, “this is not a hospital for disabled people.”

One person had a history of epilepsy but there was no information in their care plan about this. Their progress notes described a potential fit they had experienced however staff had not appeared to be aware that this patient had epilepsy.

Another person reported they had a physical illness on Delderfield which left them unable to get out of bed. No call bell system was in place and they were only able to call for help as they had their mobile phone and rang the ward office. A third person who was physically disabled told us that they had needed to call night staff but there was no call bell in their room for them to do this. At our inspection we observed there was no access to a call bell system.

Recovery services

Patients had choice about participating in activities and we found that there were excellent facilities for patients. There was an activities centre which patients could access each morning. Patients could undertake a range of activities including arts and crafts, computer skills, cookery, Tai Chi, Zumba and Shiatsu. One patient told us, “the activities centre is the best I’ve ever seen, it is brilliant”.

Acute admission wards

An occupational therapist told us that patients particularly enjoyed the opportunity to cook their own breakfasts. Patients could decide what they would like to cook and the ingredients would be bought in.

Occupational therapists were also able to support people on home visits and into the community and to assess what support, if any, they would need in developing daily living skills.

Privacy and dignity

People at a listening event were critical of the inpatient facilities at the Wonford site citing a lack of privacy, space to speak with visitors, some shared rooms and poor outside space. At our inspection we noted that there was only one small room by reception where people could spend time in private with visitors. One member of staff told us they felt this space was inadequate. They said that it was an unwelcoming place to take patients' when they were first admitted. The Cedars had three twin bedrooms in use at the time of the inspection. The bed numbers had reduced by four prior to the inspection meaning that two twin rooms that were previously in use have been removed.

Staff were able to describe how they preserved patients' privacy and dignity when they needed one to one supervision while bathing. Staff described sitting with the door slightly open and encouraging the patient to talk to them in order to be sure they were safe.

Use of restraint and seclusion

Some staff had not received training in physical interventions and other staff needed this training refreshed. Delderfield was rated red on their control and restraint training with 71% trained and Coombehaven was rated amber with 88% of staff trained.

The seclusion facilities were appropriate and staff were able to describe how they protected patients' privacy and dignity as much as possible while maintaining their safety.

There was a 'seclusion pack' of the necessary paperwork containing the forms and prompts to support staff in maintaining an accurate log of the seclusion. While we concluded that seclusion was used safely the documentation was not always completed correctly and did not provide an accurate overview of the use of seclusion for the trust.

Are acute admission wards responsive to people's needs?

(for example, to feedback?)

Individual needs met

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 trust's own place of safety have been collated. These showed that in Exeter only 21 people went to the trust's own place of safety suite and 114 were held in police custody. These figures indicate a wide disparity in practice across the trust and specifically in Exeter where the Street Triage service was starting in March 2014 the figures show that going to a police custody suite is five times more likely to happen than an admission to a preferred hospital based service.

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. These variations are causing distress to patients and their carers where patients are being admitted away from their home. The impact on the acute Exeter services is that they have many patients coming from other parts of Devon which makes contact with carers and community staff a challenge. It may also mean that at times people from the Exeter area cannot access a local bed when needed. For example one patient lived in Torbay and their relatives were unable to visit. This also impacted on people's care. For example, one patient had not been visited by their community psychiatric nurse (CPN) due to the long distance their CPN would have to drive in order to attend ward round.

Delderfield and Combehaven wards were not always able to meet patients' needs when they required a high support environment. The trust is not commissioned to provide a

psychiatric intensive care unit (PICU) so patients in need of this service have to be found a bed out of Devon. During our inspection one patient was in seclusion for over 24 hours due to their clinical needs while senior clinicians spent over ten hours trying to locate a PICU bed for this person. All the staff we talked with about bed availability highlighted this as a problem. Staff told us that sometimes patients spent longer times in seclusion where clinically needed due to the difficulty of locating a PICU bed.

Providers working together through a period of transition

There was evidence to demonstrate that both Combehaven and Delderfield wards worked with other providers to ensure a discharge plan was in place. We saw that for one person their admission had been coordinated with the neighbouring acute hospital.

All nursing staff we spoke with raised concerns about the pressure on beds and difficulties in accessing care co-ordinators in community teams for patients who are being discharged. Staff discussed the difficulties of referring a patient to the Recovery and Independent Living team as there were no staff available with space on their caseload during a meeting we attended.

Learning from complaints

During our inspection we were approached by one patient who was unhappy with their care. We saw that they made a written complaint and were able to talk to the ward manager about this. During our inspection we saw that patients were able to meet the ward manager privately to address issues they were unhappy about which meant that complaints could be dealt with quickly at local level.

We did not see any information about complaints on the noticeboards in the corridors. Patients were reminded they could talk to staff, the manager or an advocate if they felt intimidated or distressed but there was no information about how to complain about this.

Are acute admission wards well-led?

Governance arrangements

There was a clear governance framework in place however this was not always implemented effectively on Combehaven Ward. There were systems in place to carry out routine quality audits and equipment checks but these had not always been followed.

For example every month ten care plans were audited for quality, however the audit of these plans had not identified that plans were generic and not person-centred. The Coombehaven dashboard showed that audits on care plans and recovery plans had not been carried out since November 2013.

Systems to monitor infection control on Coombehaven Ward such as mattress audits, hand hygiene and environmental audits had been implemented but the information in the folder was out of date. We saw that the noticeboard displayed a compliance score of 60% on the first day of our visit but the following day had been removed. We asked for up to date information on infection control but this was not provided.

The resuscitation bag and equipment had not been checked since regularly to ensure the required equipment was present, in date, and that the automatic defibrillator was in good working order. Monthly checks had not been carried out consistently and the last recorded check of the resuscitation bag was on 1 December 2013.

After the last inspection by the Care Quality Commission an action plan had been prepared by the trust with dates for actions to be completed. These dates had passed and the work was not complete and this showed that progress had not been appropriately monitored.

Engagement with people who use the service

Community meetings occur on the ward on a regular basis providing patients with a means to express their needs and wishes.

Engagement with staff

Junior doctors told us that the consultant psychiatrists were very supportive and had good relationships with senior nursing staff. We saw that in the morning meeting that nursing staff and consultants worked together to ensure effective patient care.

Staff we spoke with told us about the provider's "Listening in Action" strategy. All staff were aware of this and the majority of staff we spoke with felt that the provider was genuinely trying to listen to staff.

Staff told us that they felt listened to by the consultants the majority of the time and that the ward managers were very

approachable. Staff felt that the teams on two wards cooperated with each other but nursing assistants felt that the difficulty the wards had in retaining band five nurses caused problems with consistency.

Supporting staff with changes and challenges

Staff were mixed in their views about the support they received. Some staff said supervision was helpful while another member of staff said they had supervision with a different supervisor each time. We were told that there were debriefs available after serious incidents but not always after the less serious incidents and that these were helpful. There is a staff support group that runs every week alternating between the two wards although some staff did not know about this.

Nursing assistants told us that morale was low and that they felt under a lot of pressure although many had worked at the unit for several years and said they enjoyed their work.

A consistent challenge mentioned by all staff was the electronic patient record system (RIO). All the staff we spoke with felt it took up too much of their time. We were told by the trust that it is aware of problems with RIO and they are currently looking at alternatives.

Leadership within the organisation

While there was good leadership on Cedars Unit from the consultants. The nurse leadership on the Cedars was well received by patients and staff but was not always delivering the actions and improvements that needed to take place.

We were concerned about leadership on Coombehaven Ward. We discussed the implementation of the action plan with the ward manager who acknowledged he had not taken the necessary steps to ensure that they had become embedded in ward practice.

Adult community-based services

Information about the service

There are approximately 100 community teams across Devon, provided by Devon Partnership NHS Trust. This includes adult community mental health teams, older people's community mental health teams, specialist services and learning disabilities. These include teams providing a range of care based on the needs of the people they support. The services provided by the trust use a personal recovery model which promotes good mental health, wellbeing and independence.

Summary of findings

We found that a good level of care was given across the community team services in Devon.

Care plans and risk assessments were usually complete but not always updated quickly enough. We found examples of excellent practice, most notably in the Learning Disability team, and in the Older Person's Mental Health teams.

Patients were positive about the care and treatment they received, and told us of warm and trusting relationships with the staff. Carers and relatives told us they felt engaged with the staff but not with the trust. This is because they were unsure of what the forthcoming service transformation would mean for them and their families.

Trust engagement with staff was variable. Staff told us they felt well-led at local level.

Staff in the Recovery and Independent Living (RIL) teams were concerned about the length of time some patients were being "held" while waiting for a care co-ordinator and access to psychological therapies. This meant that, although their safety was being observed and monitored, they were not yet getting the treatment to enable fuller recovery.

We heard that the Iris Centre was a high performing service, where people with personality disorders were able to enjoy a safe and effective therapeutic environment.

Adult community-based services

Are adult community-based services safe?

Safe Environment

The team environments we visited were clean and secure. The design and layout of the services varied considerably but were all accessible, sometimes by a lift. All the team bases appeared safe and calm on the days of our visit.

Learning from Incidents

Staff told us that the provider learned from incidents and improved standards of safety for people who used services. Staff understood and managed risk to the person using the service as well as other people who they lived with or who were involved in their care. This meant that people who used the service could be assured that they were kept safe by the use of effective and appropriate mechanisms.

Incidents were reported in line with the trust strategy, policy and procedure. Staff we spoke with confirmed that training was delivered to ensure this was done on a consistent basis. We heard there was a high degree of follow up information fed back to the relevant team or area. This practice ensured that lessons could be learned and fed back to other staff through staff meetings and at individual supervisions. In this way, lessons learnt were embedded into new practice, and areas of good practice were highlighted and shared.

We heard there was a good system in place for recording serious incidents and the trust is very open about incidents and applies the duty of candour in reporting their findings. All the incidents were collated and the trust identified numbers of different types of incidents and monitored trends. Where a root cause analysis took place the findings were also collated to identify broader areas for learning.

Safe staffing levels

People told us they felt well cared for and that staff took time to be compassionate. No-one told us they felt as if their appointments were rushed.

Staffing levels usually met the needs of patients, although some teams expressed their dismay with their current caseloads. They told us it did not always allow them to spend as much time as they wished to build relationships and deliver continuously good care.

The trust ensured that staffing levels and the quality of staffing were usually appropriate to meet assessed need, and this enabled safe practice. However, we were told that care co-ordinators sometimes struggled with their case load numbers. We addressed this with the relevant team managers and were assured that case load numbers fluctuated, but that this was known and staffing was adjusted to address this. The trust said that caseloads have been reviewed especially in the Exeter Recovery and Independent Living teams and this has led to some reductions in staff caseloads.

Safeguarding

The staff we spoke with demonstrated a good understanding of safeguarding issues and were able to clearly provide an account of what action they would take if they witnessed any abuse or suspected that abuse had taken place. They were able to produce copies of guidance on safeguarding issues and described the involvement of an expert in advising the team. The inter-agency policy and procedures for the safeguarding of adults were available and staff knew where they were kept and how to use them. These mechanisms helped to keep vulnerable people safe.

Staff training records were seen and together with discussions with the manager there was evidence that all staff had received training and updates in safeguarding of vulnerable adults and deprivation of liberty safeguards.

Whistleblowing

All staff we spoke with were able to describe what whistleblowing was, and how to report it. Some staff were not able to describe the full scope of the whistleblowing procedure, and these staff were not aware of the trust "Hotline" direct to the Chief Executive. Some staff spoke with us about the alleged behaviour and conduct of a senior member of staff. They had not felt able to address this through the correct channels. The trust were made aware of these concerns.

Managing risk to the person

All patients in the community had personalised risk assessments in place. These were generally comprehensive, although some lacked an evidence base. Patients told us they felt safe and were regularly monitored by their support staff. They expressed high levels of confidence in these staff.

Adult community-based services

We attended handover meetings for some community teams and noted that risk was usually, although not always, discussed. Not all community care records had been recently updated to reflect changes in recent circumstance.

Risk Management

The trust had a comprehensive governance process in place. This incorporates monthly dashboards for all locations, and the information taken from this identifies where there may be issues or risks to staff, patients or property. There was evidence that the information required for these dashboards was regularly collated by the relevant staff, and fed back at appropriate governance committees. However, we saw that for one team the dashboard on the noticeboard was out of date by several months. Staff told us the feedback from the governance processes was "very variable".

There is an inherent risk attached to out of date information, as staff may believe that is current procedure and circumstance.

Medicines management

Community clinics dealt infrequently with medications. We visited one medication administration clinic. The prescribed medication for depot injection was stored and within its' expiry date. However, there was an issue where we were told that nurses administering this medication did not always check with patients that medication had not also been administered by their local general practitioner.

Are adult community-based services effective?

(for example, treatment is effective)

Use of clinical guidance and standards

We noted that community teams were adhering to a range of nationally recognised quality standards and improvement targets. The trust had incorporated this guidance into staff procedures. However, community team staff told us they could not always deliver best practice as they had considerable difficulty in accessing psychological therapies to people who required them.

The trust demonstrated that some national and internationally-recognised clinical guidelines and standards were used to deliver best practice. Staff in the community teams said they provided an excellent collaborative multi-disciplinary approach within their own service. This was clearly of benefit to people who used the service, as a high level of local expertise was available to them. However, a senior manager of the community teams told us that the local general practitioners "just did not get the services we offer". We asked what had been done to provide further understanding, and heard that the planned reorganisation had allowed for recent dialogue with these doctors in the local communities.

Monitoring Quality of Care

The trust had a large range of data in place to measure and monitor quality of care. This incorporated agreed outcome measures. All managers were able to access this data, and this informed practice for the month and quarter ahead.

Staff told us that their documentation and care records were regularly quality audited. We discussed this with the community team leads and were able to ascertain that this check looked at whether data had been recorded. However, not all of the team leads focussed on the quality of the data, and this meant not all record keeping was consistently good across teams.

We saw evidence of some good quality assurance practice in the community teams. Each one was required to provide data on a monthly basis in order to assure the senior managers that the service was running effectively, and to highlight areas where improvements may be made. For example, the "Composite Risk Breakdown" for each team gave a monthly percentage score based on collated information such as care plan reviews up to date, persons on CPA having formal reviews within 12 months, incidents of harm, and staff sickness and absence rates. This ensured that the team managers were aware of constantly changing information, and they had the opportunity to improve the service based on this data. In this way, the service available to patients was made clear and unambiguous, and areas for improvement were highlighted for action.

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

There was considerable evidence of effective multi-disciplinary team working. Patients in the community have comprehensive assessments covering not only physical and mental health but also other areas such as family wellbeing. The teams told us that physical health information is accessed from the GP and this informs whether further physical health checks are needed.

Adult community-based services

Patients told us that they had regular contact with a variety of health and social care professionals. Care review meetings took place regularly, and this was attended by a variety of multi-agency staff.

Are staff suitably qualified and competent

All the staff we spoke with received regular supervision and annual appraisals. We asked what the supervision sessions covered. These were often in protected time, set aside to discuss caseload, issues of concern and any training updates required. Most staff told us they found this a valuable meeting.

Team leaders and senior managers told us of the benefit of these meetings. They told us it gave them insight into the realities of the staff teams working lives, and enabled them to assess levels of confidence, competence and any professional training likely to be needed in the near future.

We read electronic records which assured senior managers that most staff were up to date with statutory and mandatory training. Where this had not been attended, it was usual practice for the next available session to be allocated to staff requiring it. In this way, standards of professional competence and knowledge were maintained.

We heard that some staff had post-registration qualifications and specific therapeutic diplomas. However, due to work pressures they were not able to integrate this advanced knowledge into their current workload, and this meant that potential benefits to patients was lost.

Are adult community-based services caring?

Choice in decisions and participation in reviews

People told us that they had considerable choice in decision making. One person quoted the “No decision about me, without me”, and told us her support worker had told her this was her right. Most people we spoke with told our Experts by Experience that they felt their opinion was valued and their care was based on this.

However, some relatives told us they felt their opinion had been ignored or discounted by one member of medical staff. They had not addressed this formally, although one person told us “I told him straight, I didn’t agree with what he said.”

The care plans we read outlined people’s input into the way their care was delivered. Choice had been given where it was possible to do so.

One person told us he had not been involved in his care plan because he “was so unwell at that time”. He then told us that he was now regularly updated on the next steps to be expected.

Relatives told us they were “often but not always” involved in care plan reviews. We were also told that staff and family relationships were strong and trusting and that people felt well supported by the community staff.

Effective communication with staff

People we spoke with described at some length the regular and continuing conversations they had with their support staff. One person said “I am in constant contact with my support worker. I had a huge bill recently and panicked, but she was there for me and helped me to calm down and sort it out."

Staff told us they tried very hard to maintain excellent relationships with patients and thought they were largely successful.

One member of staff told us that he would like to have had more protected time to spend having productive planning conversations, but that sometimes the work load just did not allow this.

Relatives we spoke with confirmed that working relationships tended to be either good or excellent.

Do people get the support they need

We read many care plans, and had conversations with people, their families and their carers. We also spoke to carers at a carers forum. Most people were emphatic that people were given the care, support and treatment they needed.

One exception to this was the provision of psychological therapies, for which there was a “huge” waiting list. Two people told us they had lost hope of being treated by psychological therapies as they had been on the waiting list “for years”. We spoke with senior members of the trust who told us this would be “addressed in the new configuration of services, although it would take some time to embed.”

Adult community-based services

Recovery services

Both people using the service and carers were positive about the recovery approach. Wellness and recovery action plans were in place and well documented. Our Experts by Experience spoke with people who had attended courses at the local recovery college and found this very beneficial.

People requiring individualised support were assigned a care coordinator from one of the local Recovery and Independent Living Teams (RIL). People told us that if they had been an inpatient, their discharge had been comprehensively planned during their inpatient stay, and that a multi-disciplinary approach was used for this. People described the “very positive” attitude of the recovery team staff. One person said "they make me feel I can really do it, I might need some support, but I’ll get there."

Care coordinators were heavily involved in the day to day recovery activities of their patients, as were the support workers. Carers told us that people in the north of the county did not always have co-ordinators attend the regular multi-disciplinary meetings, as it was “too far” to travel. The team told us that this lack of meeting was mitigated by a telephone call to ensure the staff member knew what had been updated.

Privacy and dignity

People who used the service were emphatic that their privacy and dignity had been respected by staff from the multi-disciplinary teams. One person with a specific body disorder explained that they “always had their dignity respected, even under difficult circumstances.”

Are adult community-based services responsive to people’s needs?

(for example, to feedback?)

Service meeting the needs of the local community

Staff told us they were reassured that they were providing a service that tried to respond to people’s individual needs. People we spoke with largely agreed with this.

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 five days) or routine (assessed within ten 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 care 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 care 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 care co-ordinator between different teams. The average length of time people are waiting is 109 days but in reality people are prioritised based on their individual needs. While people are waiting for a care co-ordinator the RIL team does risk assess them and if they are a priority they will be allocated in 7 days. Staff working in RIL teams talked about their workload and the concerns they had about people waiting for a care co-ordinator and the potential for them to deteriorate during this time. There are no clear plans to address these disparities in accessing this input.

Prior to our inspection we heard from people who use the services around their frustrations about the waits they were experiencing to access 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 3 and 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 referred to the service from a priority group 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 two tier level of intervention has been agreed as the ongoing model of provision but this has not yet been implemented across all of the trust. Proposals have been produced to re-configure the service and increase capacity but these have not yet been implemented.

Providers working together during periods of change

We spoke with senior trust managers. They told us that the trust was currently undergoing a service re-design, with the intent of splitting services into two distinct categories. We asked them how this would improve services for people requiring care and treatment, and for their families. They

said that staff would be divided into categories which most suited their skills and expertise, and would therefore be able to deliver "an even better level of care". Further details regarding the rationale behind the design were available and the implementation work was ongoing.

The trust had arranged meetings with local GP's and other care professionals to discuss the changes and it was hoped this was starting to help them have a better understanding of the work of the community teams.

Learning from complaints

Staff told us the community teams dealt well with complaints. We discussed the complaints strategy with the service manager and were assured that all complaints are dealt with quickly, seriously and this information was fed back to the complainant. Comments, complaints and compliments were discussed at some team meetings, so that all staff there were aware of the current stage of the issue, and the action to be taken.

Are adult community-based services well-led?

Governance arrangements

Senior managers for the Community teams told us of the processes in place for effective governance. Senior staff do " Walk Abouts" on their own and other clinical areas. This is to ensure they are visible to their staff, can pick up on issues in "real-time" and can better understand the day to day processes in place in their areas of personal responsibility.

All clinical team leaders had access to the quality dashboards. These were printed out and disseminated to staff. Teams we spoke with described monthly governance meetings where dashboards were discussed. Minutes of these meetings showed action plans and appointed leads to ensure action was taken. Some community staff told us they thought the focus on performance parameters was numerical and thus quantitative, whereas the staff would have preferred it to be qualitative and concentrating on care outcomes.

Engagement with patients

The trust had arranged engagement meetings with people who use services and their carers to tell them about the service re-design. These meetings were not very well attended and some carers told us they were not sure if the changes would make any difference to their relative's treatment plan or care.

Engagement with staff

We asked staff what involvement they had with the community team changes. Some staff told us there had been "engagement meetings with no dissent allowed". Other members of staff did not voice this, but said they thought there had been "a little engagement".

We heard there was a "disconnect" between "reality and perceived reality". We asked what this meant in practice. Staff said that senior managers continued to go ahead with plans with which staff were disengaged. However, other staff told us they were looking forward to the new changes so they could use their wide skill base. Despite this perception amongst some staff, we were given examples of where formal and informal consultation did influence and change the final design and implementation process.

Staff were concerned about the waiting times for people to have a care co-ordinator. They told us that because people were assessed quickly, then in some teams put on an extensive waiting list, some of the community teams spent much time helping these people "get through" the next few years without the support and expertise they required. They were also concerned about whether the changes would improve this situation.

Effective leadership

The community teams were generally well-led at local level, although we heard of a lack of confidence in senior staff. Staff told us they felt well-supported by their team leaders and by middle managers. They found them helpful and approachable and felt able to raise concerns where necessary.

Many staff told us they thought the appointment of the new Chief Executive was "a positive move, and we look forward to that happening."

Community-based crisis services

Information about the service

The Crisis Resolution Home Treatment Teams (CRHTTs) serve the adult and older age population of Devon. The service aims to provide care and treatment for people experiencing a severe mental health difficulty in their own home. We inspected five of these teams.

Summary of findings

We found that crisis teams were held in high regard and generally provided a good service to the trust. However, a key issue for the crisis teams was the poor 'out of hours' cover for those people requiring urgent support. As there was only one nurse practitioner available overnight, they were not always able to answer the phone to people making a call. They had other duties to attend to and roles to perform. Sometimes this meant that calls to the answerphone were not received until the morning, therefore delaying the care needed for people requiring overnight urgent support.

We were told that the crisis house in Torbay was a new initiative, welcomed by the local community.

Community-based crisis services

Are community-based crisis services safe?

Incidents
There was shared learning from incidents at both trust and local level. We were told that all staff had access to the trust safety bulletins and resources on the intranet. We were told that learning from incidents more specific to their service was largely shared within the team meetings.

Safeguarding & Whistleblowing
Staff received training on safeguarding adults and children. Staff demonstrated knowledge on how and where to report safeguarding issues. Staff told us that they were confident in reporting any concerns. The manager told us that safeguarding concerns were also discussed during the multi-disciplinary team meetings. There were no current safeguarding issues at the time of inspection. Staff we spoke with were aware of the trust's whistleblowing policy, and would feel confident to report to management any concerns they had.

Risk Management
We heard that risk assessments involved as many key people as possible including family or carers if appropriate. This meant that risk management plans were as accurate and person centred as possible.

We saw that people's needs and risks were assessed and clearly documented. The risk assessments we looked at were up to date and comprehensive. They reflected current individual risks and relevant historical risk information. We observed a team handover and saw that people`s risks were discussed effectively.

Medicine management
Minimal medicines were stored on site at team bases. The medicines that were used were stored securely in a locked cabinet or fridge in a locked room. The keys were locked away in a cabinet in the office. There was an appropriate system in place to monitor the stocks and administration of medication.

Staff demonstrated good knowledge about safe handling of medication. We were told about the training updates for staff for medicines management. Not all staff had training competencies for administration of medicines. The Trust had implemented medicines management training for staff which was being rolled out to all of the teams however this had not been completed with CRHT staff. The clinical team leader told us that this was due to happen within the next couple of months.

We saw that in Exeter concerns had been identified relating to medication management, and an action plan was in place. The Medication Management Team confirmed they were working with the community teams to address issues identified and put together robust protocols.

Safe staffing
Staff and clinical team leader conveyed that during the day staffing was adequate and they were able to meet people's needs with current staffing levels. The clinical team leader told us that resources, including staffing, were managed dependent on need and the numbers of referrals. The clinical team leader told us that he ensured there were sufficient staff to meet patient's needs and where needed staff worked in pairs. Staff said they carried personal alarms and mobile phones. They told us they were aware of the lone working policy and knew how to be safe.

At night the only crisis team response is 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 base (which they often are) the caller has to leave a message on an answer phone which might not be picked up until the crisis team start work in the morning.

Staff told us that bed management takes considerable time. There was a system in place where a teleconference was held every day at 1pm. This involved checking the availability of beds. Some Community teams have responsibility for finding beds. This was a cause of concern from staff and their clinical team leader who felt that valuable clinical time was taken by trying to find these beds.

Are community-based crisis services effective?
(for example, treatment is effective)

Monitoring Quality of Care
Patients experienced care and support based on the recovery model of care. Evidence of this was supported by our observations of the use of appropriate national guidance, standards and best practice.

Community-based crisis services

Audits were regularly used to enhance patient care, and to improve practice. The clinical team leader said they were keeping within the targets set by the trust for access to service following referral.

People who use the service and their representatives were asked for their views about their care and treatment. We were told that surveys were sent out to all people that use the service when they were discharged from the team caseload. We saw some surveys that had been returned for November and December 2013. These were generally positive about the care and treatment people received, although some people commented that it was "not always easy to get hold of the CRHTT". We were told that results from surveys were collated and went to the trust Quality and Safety Committee.

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

Referrals were comprehensive and included information on alcohol, drugs, physical health, risk, carer perspective and past history. There was evidence of good liaison between the crisis teams and GP's. They assessed the person and then decided if the service was the correct service for them. If it is not, then the team signpost the person to an appropriate service and respond to the GP with a letter. Most referrals are seen within four hours but some within 24 hours depending on risk.

Staff told us they worked collaboratively with other professionals, for example, the wards and community mental health teams. We saw in care records that people had been supported to access a broad range of professional input as needed. We observed during handover that discussion took place about an individual, ensuring they had access to an urgent GP review.

There were no occupational therapists or psychologists working within the teams or available to offer the teams advice or individual assessment. The teams had sessional input from consultant psychiatrists who also worked on the acute inpatient wards. The psychiatrists undertook home visits if required. The teams and team doctors were able to access their Older Person's Mental Health colleagues for advice or further review as needed. We were told that the teams were able to access the appropriate professionals to undertake a Mental Health Act assessment if required. Staff told us that where possible they would work with the acute wards to facilitate early discharge. However, they did not have capacity within their current staffing levels to consistently do this.

Are staff suitably qualified and competent

All the staff we spoke with received regular supervision and annual appraisals. People could identify particular training needs in supervision or as part of their annual appraisal.

We read electronic records which assured senior managers that most staff were up to date with mandatory training. Where this had not been attended, it was usual practice for the next available session to be allocated to staff requiring it. In this way, standards of professional competence and knowledge were maintained.

Some teams had dual trained nurses. This meant the team had access to their skills and knowledge of physical health care and mental wellbeing.

The CRHT clinical team leader told us that they felt it would be beneficial for more staff to receive training in talking therapies so they could provide this service to patients that were not receiving psychological services.

Are community-based crisis services caring?

Choice in decisions and participation in reviews

Service user feedback forms showed that people who use the service felt they were generally involved in planning their care. Care records we looked at reflected that assessment and planning involved the individual. We saw that consent had been sought and who the person agreed to sharing information with. We saw detailed daily progress notes which reflected how people who use the service had engaged with the support and care given. We observed respectful discussion of a person`s choice not to see the CRHTT, when offered an initial appointment.

Do people get the support they need

We talked with people who received support from community crisis teams. They were mainly positive about the support they received and said that the staff were kind and caring.

There was a daily multi-disciplinary meeting to discuss the needs of people. We observed that this was a comprehensive discussion. Each shift, there was a shift

Community-based crisis services

co-ordinator, who would prioritise and delegate contacts required for people who use the service. Care records showed that assessment of individual need was reflected in their care plan. Service user feedback forms were generally positive and they received the support they needed.

There were good processes around supporting early discharge. Some teams attended daily meetings on inpatient units to determine if any patient was nearing discharge.

Effective communication with staff

People who use the service were given an information pack about the service when they were initially assessed by the team. They were advised that they may have contact from different members of the team. However, where possible the team tried to maintain continuity and where possible preferences were respected, if a person wanted to see a particular member of staff, for example, a female rather than a male. We were told that staff usually contacted people who use the service in a timely manner if agreed arrangements needed to change, for example, time of visit.

Recovery services

We heard that these teams are heavily patient focused, and work flexibly around the needs of patients. Their aim is to keep people out of hospital and we heard about how in many cases this is achieved.

Are community-based crisis services responsive to people's needs?

(for example, to feedback?)

Service meeting the needs of the local community

People using the service, and their carers, told us how hard it was to get the support they needed at night. They described leaving messages on an answer phone and not knowing when someone would call them back and how anxious this made them feel.

Staff told us of the difficulties in accessing psychological therapies for the people they were supporting. They explained that if the risk presented by the patient was felt to be too high they would not receive the primary care based psychological interventions and would need to have a Step 4 service accessed through the trust where there are the waiting list concerns.

Staff told us that their hours of work meant they could not provide input early in the morning or in the evening, for example to people who need support to take their medication at that time.

Complaints

People knew how to make complaints if they wished to. Staff told us they ensured that people requiring support to make a complaint were supported to do so. There was a clear culture of learning from previous complaints to ensure a good level of service was maintained.

Are community-based crisis services well-led?

Engagement with staff

From speaking to staff there were differences in the level of engagement across the different crisis teams. The Torbay crisis team were disconnected from the wider trust and it was not evident how they were involved in wider practice development. They were however very committed and caring.

Effective leadership

The crisis teams were well-led at local level, and this had a positive and beneficial impact on patients care and treatment. Staff told us they felt well-supported in their roles, and felt able to raise concerns and report incidents. They told us they would be listened to, and the information acted upon appropriately.

Specialist eating disorder services

Information about the service

The Haldon Eating Disorder Service is an NHS specialist providing care and treatment for male and female patients over the age of 16, experiencing severe eating disorders. It provides inpatient and day patient intensive treatment programmes. It can offer up to 20 places at any one time for people diagnosed with severe eating disorders, on a residential and non-residential basis. They currently provide 12 inpatient beds for people in the South West. Referral is from health professionals only. They also have community accommodation for up to six people, for those attending the five-day per week intensive, non-residential programme.

We spoke with staff, including doctors, nurses, managers, support workers and administrative staff. We spoke with people who use the service and their carers. We observed team meetings. We looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experience. We also reviewed performance information about the trust.

Summary of findings

We found that The Haldon Eating Disorder Service provided an effective, evidence-based treatment programme and a high standard of care. It was a safe and secure unit, where staff cared for people in the least restrictive way. We found that there were enough members of staff to care for people safely. People who use the service told us that they felt cared for safely.

A thorough assessment process ensured that people had a good understanding about the treatment options available and they were supported to decide if it is the right place for them. The assessment process allowed staff and each person to form an individualised care plan. Good quality information was given to carers and individuals throughout their stay on the unit. The staff worked well with other professionals to meet the needs of people.

We found that The Haldon was well-led. Staff told us that they had the training and support they needed for their roles. There was a positive and open culture within the staff team. The manager was able to show that incidents were recorded and investigated appropriately.

Specialist eating disorder services

Are specialist eating disorders services safe?

Safe Environment

We found that The Haldon Eating Disorder Service was a safe and secure unit. It ensured appropriate levels of security while caring for people in the least restrictive way. Potential ligature points were managed as part of both ward and individual risk assessments. We were shown that work had been undertaken on all bathrooms to ensure that they were ligature free. There were clear routes of safe entry and exit in the event of an emergency, for example, fire exits were clearly signed.

Male and female sleeping areas were not adequately separated. While they have separate sleeping accommodation in separate areas of the ward, they were too close together. Most people who use the service had single rooms, although there was one `dorm` room which had four beds in it. There were floor length curtains around each bed to separate individual spaces. The ward was about to start planned building work to address both the issue of lack of male space and the `dorm` room. When work is completed the accommodation will all be single rooms, with a dedicated male area.

The ward environment was able to allow for specific individual needs in relation to

disability. For example, corridors were wide, there was lift access and disabled bathroom facilities. There was a designated space for visitors who had children with them and rooms available for private meetings.

Learning from incidents

Incidents were recorded consistently to demonstrate action had been taken. The manager encouraged an open culture and we saw electronic records of incident reporting. Staff told us that they felt supported in reporting incidents and that lessons learnt were discussed in both individual supervision sessions and within team meetings. The information we saw in incident reports was clear and comprehensive. Serious incidents that required investigation were managed appropriately. We saw the root cause analysis and investigation report from two serious incidents. We saw meeting minutes from their local governance group which showed that these had been acted on.

Safe staffing levels

We found that there were enough members of staff to care for people safely. Some staff told us that there had been occasions when there had not been enough staff to facilitate a therapy group or session. However, they told us that this was not a regular occurrence and all staff felt that there were enough staff to care for people safely. People who use the service told us that they felt safely cared for. Two people also told us that there had been occasions that their therapy session had been cancelled due to staff shortages. Carers told us that they felt that there were usually staff available to meet or speak with them if needed.

The manager told us that the staffing levels were adapted when changes in people's needs were identified. People`s needs were discussed in every handover. Where an increased staffing requirement was identified, for example if a person required 1:1 support, additional staff would be employed on the unit. The manager told us that where possible this was regular bank staff who had a good understanding of eating disorders. There were planned cover arrangements for both therapeutic and medical needs for when ward staff were on leave.

Safeguarding

Staff demonstrated knowledge on how and where to report safeguarding issues. We saw electronic records which showed that the staff were up to date with safeguarding training. There was a documented process in place in the event a person under 18 years of age was admitted to the ward. There was a children`s safeguarding lead in place on the unit. This meant that the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Whistleblowing

All staff we spoke with were able to describe what whistleblowing was and how they could get more information about it. Staff felt confident in raising concerns and how to escalate if necessary.

Managing risk to the person

There were procedures in place to identify and manage risks to people who used the

service. Staff told us that they discussed people`s risks at every handover. There were three nursing handover meetings daily. There was also a weekly multi-disciplinary

team (MDT) risk management meeting. We observed both a nursing handover and a MDT risk management meeting. During these meetings, we heard a comprehensive discussion about people`s needs and risks.

We reviewed three sets of electronic notes, including the risk assessments. We saw that there were individual risk assessments related to their assessed care needs. There were clear risk management plans for areas such as self-harm and absconding. People who use the service told us that they felt they were able to take part in this process and staff explained clearly to them when restrictions were put in place.

We found that sometimes people who use the service were detained under the Mental Health Act. We looked at one person`s records who was detained under the Mental Health Act. These contained a care plan and risk assessment relating to the person`s detention. Legal paperwork was held securely at the trust Mental Health Act office. We were shown records that the person was provided with information about their rights. We spoke with the person`s carer and they confirmed that information was also provided to them. We saw service user information leaflets about the Mental Health Act and advocacy on the ward.

The service had systems in place to deal with foreseeable emergencies. All staff were trained in life support techniques. We saw training records which supported this and staff told us that they felt confident dealing with medical emergencies. We saw the emergency equipment, including a mobile defibrillator, was easily accessible. Records showed that it was checked regularly to ensure it was in good working order.

Risk management

The manager used the Trust Risk Register to identify and monitor risks. They gave the example of using this to support the need for the building work due to take place to address some of the accommodation issues. Audits were used to monitor risks and the quality of the service. The unit had in place a range of audits, for example clinical notes, food quality, safety and cleanliness of the environment. We saw that where concerns were identified action was taken. For example, following concerns about the quality of food, the dietitian was liaising directly with the supplier and the ward were using an alternative source for their vegetables. Minutes from the local governance group clearly identified where action needed to be taken, who would be responsible and when it would be reviewed.

Are specialist eating disorders services effective?

(for example, treatment is effective)

Use of clinical guidance and standards

The Haldon Eating Disorder Service was taking part in an international research trial, looking at using dialectical behavioural therapy (DBT) in the treatment of eating disorders. The staff team were committed to this research and worked in a positive and motivated way. We were told that there was a research partnership between The Haldon and Professor Thomas Lynch`s research at the University of Southampton as well as ongoing research collaboration with several other eating disorder services nationally.

People`s care and treatment reflected relevant research and guidance. Our specialist advisor looked at three people`s notes and found that they all contained a comprehensive physical, psychological and social assessment. Where nasogastric feeding was used, the Royal College of Psychiatrists and National Patient Safety Agency (NPSA) guidance was followed. Individuals were assessed by a qualified dietitian and there were individualised eating plans in place. Goals around weight restoration were individually planned and agreed with the person, following National Institute for Health and Care Excellence (NICE) guidelines.

Monitoring Quality of Care

The Haldon Unit was accredited by the Quality Network for Eating Disorders (Royal College of Psychiatrists) and the B-EAT Assured Quality Mark. In order to be accredited, services needed to provide a high standard of quality of care, using national guidelines and standards. There were both local and trust wide systems in place to monitor quality of care. Results of a wide range of data, such as staffing levels, records audits, collected by the Trust database were collated for each team. The manager could access this information by looking at their `dashboard` to monitor team performance.

Specialist eating disorder services

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

People`s health, safety and welfare was protected when more than one provider was involved in their care and treatment. The multi-disciplinary team discussed all referrals and agreed a treatment plan with the individual. This ensured that it was the right service for the person. People who use the service told us that there was often a long time to wait from the initial assessment to admission There was no community eating disorder service at present, however, The Haldon offered advice and support to GP`s and care co-ordinators while the person was on the waiting list.

There was evidence of effective multi-disciplinary team (MDT) working. People who use the service had timely access to nursing and medical staff as well as psychologists, occupational therapists, dietitian and family therapist. We saw that care plans included advice and input from different professionals involved in people`s care. People who use the service and carers told us that they worked with a number of professionals on the unit.

The manager told us that the unit had a good working relationship with Lowman ward at the Royal Devon and Exeter Acute Hospital. We saw that there was written criteria for transferring people into acute medical services and this complied with recommended guidelines. We spoke with medical staff who had a good understanding of this process. Care programme approach (CPA) meetings took place every six weeks. These meetings included attendance by other health care providers, for example, the person`s community care co-ordinator. If they were unable to attend, the unit made sure that all involved people were kept up to date through telephone and e-mail.

Are staff suitably qualified and competent

Staff received appropriate training and supervision. We saw electronic records that showed most staff were up to date with all core training, such as infection control and manual handling. All staff were trained in the use physical intervention. Specialist training was available, for example, nursing staff were trained in nasogastric feeding. The manager told us that all new staff have an induction programme and basic training in working with people with eating disorders. A new member of staff confirmed that this had taken place. Staff told us that they were able to access additional training if the needed to.

Staff were supported and supervised to provide therapy to people. Dialectical Behaviour Therapy (DBT) was used as a core part of treatment. All staff received DBT training and practiced DBT skills in all areas of care. Staff attended a weekly DBT supervision group. One member of staff told us that they would find more DBT supervision useful as it can be difficult to always attend due to their shift pattern.

Staff told us that they received regular supervision. We saw three staff files which all contained up to date supervision records. Staff told us that they were also able to access responsive supervision if they wanted it, for example, if they had a challenging shift and needed to reflect. Records also showed that staff had completed an annual appraisal.

People who use the service told us that staff were well trained and met their care needs. One person told us that staff "go above and beyond whenever and wherever possible". Carers told us that they had confidence that the staff cared for people well.

Are specialist eating disorders services caring?

Choice in decisions and participation in reviews

People told us that they felt respected and involved in making decisions about their care. There were also assessments around a person`s capacity to make decisions. We saw that care plans reflected the individuals person`s needs and choices as far as possible. Due to the health needs of the people who use the service, some elements of choice and care were therapeutically restricted. People told us that staff spent time explaining treatment options and why there may be restrictions. Carers told us that they were kept involved and informed. We observed that any restrictions were discussed in the nursing handover and MDT meeting. This meant that any restrictions were agreed by the MDT on an individual basis and reviewed regularly.

Effective communication with staff

People who use the service told us that they felt well informed about their treatment and communication with staff was clear. There was a keyworker system which ensured that people had weekly one to one meetings with their keyworker, in addition to their individual therapy programme. However, two people who use the service and one member of staff told us that this was sometimes

difficult due to other demands on staff time. We saw meeting minutes which showed that staff were trying to promote more consistency with individual meetings and that one of the lead nurses was monitoring this.

There was a weekly community meeting attended only by people who use the service. Staff attend by invite only. A service user representative then attended the local governance meeting on a monthly basis to feedback items discussed. People told us that they were able to voice concerns and views within these meetings and thought it was an effective way to communicate with staff. However, people who use the service felt that sometimes feedback to issues raised was slow.

Carers told us that they had enough information about the person`s care and treatment. Carers told us that they felt supported by staff and were always able to speak to staff if they needed to. Carers who did not live locally were encouraged to telephone or e-mail the service. We saw that there was a wide range of information displayed on the walls and in the waiting room, including information about local support groups and resources about treatment, such as NICE guidance. There was a monthly carer`s meeting on the unit. One carer told us that they had been offered individual support as an alternative because they did not want to attend the carer`s meeting at present.

Do people get the support they need

People`s needs were assessed and care was delivered in line with their individual care plan. Records showed that risks to physical health were identified and managed. Observation, physical monitoring levels and weight restoration goals were agreed according to individual need. Staff and people who use the service told us that care plans were regularly reviewed with individuals.

People who use the service were offered a range of treatment options on the unit. Therapeutic options included, DBT, group and individual therapy, family therapy, meal management, occupational activities and massage. Staff told us that they also supported people`s recovery by accompanying them to community activities, for example, going to a local café. We observed several of the people who use the service going out to shop as part of their meal preparation with the occupational therapist.

Recovery Services

The Haldon Eating Disorder Service used the recovery approach to work with people. Staff worked with the person collaboratively, providing care and treatment in the least restrictive way. The service also had a house in Exeter which was unstaffed and provided accommodation to six people who would attend the day programme. This was generally used for people to regain independent living skills when preparing for discharge from the unit. People who use the service told us that they felt they were 'equal' to the staff. The manager told us that they were looking at introducing a peer support worker. One person told us that they had been part of a recent interview panel, recruiting new staff for the service.

Privacy and Dignity

People`s privacy and dignity were respected. People who use the service told us that they felt staff treated them with respect, even when there were restrictions in place. We saw that all bedrooms had a curtain screening the door, which offered additional privacy in the event that staff had to remain close to the person. One person told us that staff always knocked before entering their room.

Staff told us that they took account of people`s cultural and religious needs. One person told us that staff had "gone out of their way to meet my religious needs". People had access to local community facilities, such as banking and were supported to access these. Work was about to commence on the ward to improve the accommodation for males and people under 18 years old, who may stay on the ward. We saw a number of rooms on the ward which were available for private consultations. People`s confidentiality was respected and care records were stored securely on the Trust electronic system.

Restraint

We found that restraint was sometimes required. The manager told us that all staff were trained in the use of physical intervention. We saw training records which showed that staff were up to date with their training. We saw that records showed a multi-disciplinary discussion had taken place to agree that restraint was needed in order to insert a feeding tube. This was because the person was at risk of serious harm by continuing to refuse food or fluids. A carer told us that they had been kept well informed about the treatment plan. We saw detailed records of a restraint that had taken place. This meant that people who use the service were protected against the risk of unlawful or excessive restraint because the provider had made suitable arrangements.

Specialist eating disorder services

Are specialist eating disorders services responsive to people's needs?
(for example, to feedback?)

Service meeting the needs of the local community
The Haldon is one of two inpatient eating disorders services for the South West commissioned by NHS England. This meant that they also took referrals for people from outside of the Devon area. Community Mental Health Teams (CMHT) staff, carers and people who use the service raised concern that they were not able to access timely admission or support for people in the community with eating disorders. They told us that there were long waiting times for admission for some patients. NHS England monitors the time from referral to assessment and assessment to admission and from April 2013 The Haldon met the targets. One person needed admission to an eating disorder service outside of Devon for 20 days between July 2013 and January 2014 due to lack of bed availability. There have been three patients transferred to out of area providers in 2013 for reasons of personal safety.

The community eating disorder service commissioned in Devon is limited to a Consultant Psychologist specialising in eating disorders

The Haldon offered advice and support to GPs, CMHTs and had booked some one off sessions to local schools with a service user to raise awareness. However, the lack of a community eating disorder service meant that people did not have the option of safe treatment at home. Most staff told us that it may increase the likelihood of readmission for some people due to lack of specialised support following discharge from The Haldon. Two people who use the service told us that they were concerned about being discharged without appropriate support. The Trust is currently working with commissioners regarding this issue.

Providers working together during periods of change
Arrangements for admission and discharge were discussed and planned with other care providers. Appropriate information was shared in order to agree the treatment plan. There were regular CPA meetings which included attendance from other professionals to discuss the person`s treatment, progress and discharge planning. The unit ensured that professionals who were unable to attend were kept informed through telephone and e-mail.

Learning from complaints
The service had a system in place to learn from any complaints made. Information about the complaints process was clearly displayed. People who use the service told us that they knew how to make a complaint and felt able to do so if they needed to. There was information about how to access advocacy clearly displayed. Staff knew the process for receiving complaints and told us that learning took place in their staff meetings. The manager gave us an example of a recent complaint and how this had been resolved. A carer confirmed that they had been satisfied with the outcome of a complaint that they had made.

Are specialist eating disorders services well-led?

Governance Arrangements
The Haldon Eating Disorder Service had an effective governance group that met bi-weekly. We saw minutes from two of these meetings. These showed that issues were identified, discussed and an action plan agreed. We saw that items were reviewed and updated. The manager and administrative team use the trust dashboard to enable them to monitor their quality and performance. We found that there were also local systems in place on The Haldon to check care and safety. For example, medication was checked weekly.

Engagement with patients
We found that The Haldon regularly talked to people who use the service, carers and staff about their opinions of the service provided. Service user surveys were also sent out each quarter. We saw collated outcomes from the most recent survey displayed on the wall. We were told that information gathered would be used as part of the research project and in developing the service.

There was a weekly community meeting that people who use the service attended and issues were fed back to the local governance meeting. We saw that action had been taken from issues raised. Information about individual experience of the service was gathered when people were first in contact with the service and people also had an interview at discharge

Effective leadership
We found that The Haldon Eating Disorder Service was well-led and there was evidence of clear leadership. There

was a positive and open culture within the team. Staff told us that they felt well supported by their manager and the wider multi-disciplinary team. Debrief sessions were provided following any incident on the ward. There was a regular nurses meeting, during which the manager told us they also held teaching sessions. There was also an informal weekly staff peer support meeting. Staff told us that this was a good opportunity to "take time out".

Staff told us they felt able to report incidents and raise concerns and that they would be listened to. The manager had introduced a number of measures that ensured staff felt supported and respected in their roles. The manager told us that they felt senior managers in the trust listened to concerns that they raised and acted.

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
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.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. Not everyone has a care plan that reflects their individual needs including their physical health needs. 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 wait long periods of time for this support. This was a breach of Regulation 9(1)(b), 9(2). The trust was found to be compliant in respect of Wonford House in relation to care planning on our reinspection 21 May 2014. We did not follow up other areas of non-compliance at this time as the trust is still in the process of implementing improvements.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury	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 such physical intervention being excessive as follows: The use of seclusion and restraint is not being correctly recorded so its use can be monitored.There are not enough staff who have completed or refreshed their training on restraint in line with the trust's training target. This was a breach of Regulation 11(2)(b)

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 specialist 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)

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
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:** 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 patient's did not always have a sense of ownership or control over the support they were receiving. This was a breach of Regulation 9(1)(b)(i). We returned on 21 May 2014 and found that the required improvements in respect of this warning notice had been made.