Devon Partnership NHS Trust

Quality Report

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Date of inspection visit: 5 - 9 December 2016
Date of publication: 15/03/2017

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICUs)	Wonford House Hospital Torbay Hospital North Devon District Hospital	RWV62 RWV55 RWV12
Wards for people with learning disabilities or autism	Whipton Hospital	RWVEE
Wards for older people with mental health problems	Torbay Hospital Franklyn Hospital North Devon District Hospital	RWV55 RWV98 RWV12
Community-based mental health services for older people	Wonford House Hospital	RWV62
Mental health crisis services and health-based places of safety	Wonford House Hospital Torbay Hospital North Devon District Hospital	RWV62 RWV55 RWV12

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

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

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

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

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

Summary of findings

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

After the most recent inspection in December 2016, we have changed the overall rating for the trust from requires improvement to good because:

- In July 2015, we rated four of the nine core services as good. The intelligence we received, before the December 2016 inspection, suggested they had maintained their quality.
- In response to the December 2016 inspection findings, we have changed the ratings of five core services from requires improvement to good. These core services are:

- Acute wards for adults of working age

- Community-based mental health services for older people

- Mental health crisis services and health-based places of safety

- Wards for older people with mental health problems

- Wards for people with learning disabilities or autism.

- The trust acted to meet the requirement notices we issued after our inspection in July 2015.
- Incidents across the trust had a detailed investigation and action plan developed. The trust had a quality improvement academy that worked with individuals and teams across the trust. They had a central 'learning from experience' group which included representatives from all service areas and corporate teams; this considered all areas of learning including incidents.
- The percentage of staff who were trained in safeguarding across the trust was over 90%. Staff knew how to make safeguarding alerts. Safeguarding alerts were recorded as incidents on the risk management system. There were opportunities to discuss safeguarding concerns in ward rounds and other staff meetings although it was not a standing agenda item.
- The trust had launched the four steps programme as a project in partnership with another trust. This aimed to reduce the prevalence of violence and aggression on wards. It supported staff and patients working together to deliver evidence based interventions that reduce levels of violence.
- The trust had prescribing guidelines and psychiatrists referred to these and to National Institute for Health and Care Excellence guidance. For example, we found that this guidance in prescribing medicines for psychosis, depression, schizophrenia and bipolar affective disorder was being followed.
- In addition to mandatory training, the trust offered further training in cognitive behavioural therapy, mindfulness, motivational interviewing, mentorship, counselling skills and solution focused brief therapy. Healthcare assistants took the care certificate training to ensure they acquired the knowledge and skills required for their work.
- We observed staff interacting with patients in a gentle and respectful manner across the trust. Staff prioritised listening to patients, even when they were busy. Staff were genuinely interested in patients and to have a good rapport with them. There was a caring and calm atmosphere on in-patient wards.
- Trust board members interviewed were clear about the trust's vision and strategy. Senior clinicians were clear about their role and the trusts direction. The vision and values were on display in the trust and were available on the intranet. The majority of staff knew and understood the values of the trust.
- The executive team carried out regular walkabouts and each year were assigned a directorate which meant that they visited all locations and most services and sent reports and any actions of their visits back to teams and reported this activity to the board.
- The trust's mortality diagnostic and mortality group provided a forum for senior clinicians to review case studies and improve clinical practice within the trust.
- All of the trust's acute wards for adults of working age and psychiatric intensive care units were in the Royal College of psychiatrists - accreditation for inpatient mental health Service (AIMS) schemes.

However:

Summary of findings

- We have again rated acute wards for adults of working age and psychiatric intensive care units as requires improvement for the safe domain. We were concerned about the environmental risks on these wards. Some ligature risks which had been rated as high risk by the trust had not yet been addressed although there were clear plans to do so.
- Staff vacancies continued to be a pressure on older people's inpatient services, particularly at Meadow View in North Devon and Belvedere the dementia unit. Nursing posts remained difficult to fill. Meadow View still had a vacant consultant post, covered by a locum.
- In some areas of the service, there were waiting lists for patients to access psychological therapies.
- In the older person community servcies almost all staff told us that, regardless of complexity of need, they did not support older people under the Care Programme Approach (CPA). The trust told us they were reviewing the CPA policy to include older people's services.
- Refurbishment of the seclusion room facilities on the inpatient ward for people with learning disabilities and autism had not yet commenced, although the trust had not needed to use this facility for over 15 months. Funding and building work plans were in place and we were informed that this would start in February 2017.
- The trust had not ensured that the actions from their delivery plan developed in response to the Green Light self-assessment audit were fully embedded and followed up.

The full report of the inspection carried out in July/August 2015 can be found here at:

- http://www.cqc.org.uk/sites/default/files/new_reports/AAAD7774.pdf

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Good

We rated safe as **good** overall for Devon Partnership NHS Trust.

In July 2015, we rated five of the nine core services as requires improvement for safe. This led us to rate the trust as requires improvement overall for this key question. Following the December 2016 inspection, we have changed the rating of the provider for safe from requires improvement to good because:

- The trust had a statutory duty of candour/being open policy. Implementation of the duty of candour was included in the bi-monthly experience, safety and risk report, each report contained details of the numbers of incidents reported that met the duty of candour threshold and the level of compliance with the requirements.
- There was evidence of acute wards for adults of working age making positive changes in response to serious incidents. These had a detailed investigation and action plan developed. The trust had a quality improvement academy that worked with individuals and teams across the trust.
- Crisis teams supported people to make plans to manage their own crisis and recognise when they may be at risk of becoming unwell in the future.
- The trust had a central 'learning from experience' group which included representatives from all service areas and corporate teams; this considered all areas of learning including incidents. This group met every two months.
- The percentage of staff who were trained in safeguarding across the trust was over 90%. Staff knew how to make safeguarding alerts. Safeguarding alerts were recorded as incidents on the risk management system. There were opportunities to discuss safeguarding concerns in ward rounds and other staff meetings although it was not a standing agenda item.
- The trust had a total of 2377.2 substantive staff with 267.9 staff employed in central and corporate functions. The trust had a 12% turnover rate, 11% vacancies and 5% sickness (as at 30 September 2016). There was at least one experienced nurse on duty on each in-patient ward at all times.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations.
- The trust reported that of the people in the organisation, whose work required them to have training in restrictive interventions, 454 members of staff were trained in non-prone restraint.

Summary of findings

- The trust had emergency contingency plans in place for dealing with foreseeable emergencies. For example, within community services for adults, staff were clear about appropriate procedures to follow if people did not attend their appointments. These included telephone contact, making home visits and sending letters.

However:

- There was an observation blind spot on Haytor ward which had not been resolved and no mitigation was in place.
- The trust had not addressed and mitigated some potential ligature points on the acute admission wards that they could reasonably have made safe. The trust had rated some ligature risks as high risk but they had not addressed them although they had set target dates for completion.
- Staff vacancies continued to be a pressure on older people's inpatient services, particularly at Meadow View in North Devon and Belvedere the dementia unit. Nursing posts remained difficult to fill. Meadow View still had a vacant consultant post, covered by a locum.
- Refurbishment of the seclusion room facilities on the inpatient ward for people with learning disabilities and autism had not yet commenced, although the trust had not needed to use this facility for over 15 months. Funding and building work plans were in place and we were informed that this would start in February 2017.

Are services effective?

Good

We rated effective as **good** overall for Devon Partnership NHS Trust.

In July 2015, we rated four of the nine core services as requires improvement for effective. This led us to rate the trust as requires improvement overall for this key question. Following the December 2016 inspection, we have changed the rating of the provider for effective from requires improvement to good because:

- Patients had physical examinations on admission and there was ongoing monitoring of physical health problems. The trust had a physical health monitoring policy. Staff were trained to use the modified early warning signs tool to observe changes in patient's presentation.
- The trust had prescribing guidelines and psychiatrists referred to these and to National Institute for Health and Care Excellence guidance. For example, we found that this guidance in prescribing medicines for psychosis, depression, schizophrenia and bipolar affective disorder was being followed.

Summary of findings

- All staff including bank and agency staff completed a comprehensive standard local induction. Front line staff used a variety of assessment and outcome measures to assess and review patients.
- The trust employed a street triage worker who was able to support police they encountered people in distress in the community. They offered mental health advice and information on people's current support and contact from mental health services.
- There was good adherence to consent to treatment and capacity requirements overall. Staff were well informed in terms of gaining patients' consent to treatment. Staff understood the importance of gaining the informed consent of patients. Where staff had concerns about a patient's capacity they conducted assessments. These were clearly documented.
- Each trust directorate had a monthly meeting and the MHA team provided details of compliance with the MHA for each. This was then fed to the trust Board. An annual report on the trust's compliance with the MHA was provided to the Board the last being in September 2016.
- The trust were following clear protocol, within their bed management policy, for managing and recording Section 140 of The Mental Health Act.

However:

- The trust had not ensured that the actions from their delivery plan developed in response to the Green Light self-assessment audit were fully embedded and followed up.
- In some areas of the older people community service, there were waiting lists for patients to be seen by a psychologist accessed via the trust's older people directorate.

Are services caring?

Good

We rated caring as **good** overall for Devon Partnership NHS Trust because:

- In July 2015, we rated all nine core services as good. This led us to rate the trust as good overall for this key question. Following the December 2016 inspection, we have kept the rating of the provider for caring as good.
- We observed staff interacting with patients in a gentle and respectful manner across the trust. Staff prioritised listening to patients, even when they were busy. Staff were genuinely interested in patients and to have a good rapport with them. There was a caring and calm atmosphere on in-patient wards.

Summary of findings

- In-patient wards had admission processes which supported patients to become familiar with the ward. All wards had welcome packs for patients.
- In-patient areas enabled patients to be active in their care. They were involved in ward rounds. Most patients said staff had involved them in producing their care plan and offered them a copy.
- The trust aimed to support and enable carers to continue in their role and to help carers access support for their own health and wellbeing. The Cedars were piloting the 'creating capable teams' approach which meant sharing information with carers and families and encouraging them to share information with the team.

Are services responsive to people's needs?

Good

We rated responsive as **good** overall for Devon Partnership NHS Trust because:

- In July 2015, we rated six of the nine core services as good for responsive and one as outstanding. This led us to rate the trust as good overall for this key question. Following the December 2016 inspection, we have kept the rating of the provider for responsive as good..
- The trust has been consistently above the target of 95% of patients on CPA who were followed up within seven days after discharge for all quarters between October 2015 and September 2016.
- Wards displayed information for patients including how to complain, details of local advocacy services and helplines. The trust provided comprehensive information on specific medicines prescribed for patients.
- The majority of crisis teams were able to respond to urgent referrals within four hours. Staff made appropriate decisions based on risk to ensure people were seen in a timely manner..
- The trust had recently introduced an out of hours phone line so people could access crisis support during the night. Staff who took the calls were able to update people's electronic care records and record any advice that was given to them. Daily feedback was given to teams so they could offer people appropriate follow up the next day.
- Staff received feedback on the outcome of investigation of complaints. Ward managers attended monthly countywide learning from experience meetings to enable learning from complaints and compliments. They then fed back to ward staff through business meetings. There were also briefings about complaint outcomes on the trust's intranet system.

Summary of findings

- The trust received 304 compliments in the same 12 month period. Acute wards and psychiatric intensive care units had the most with 95 (31%) followed by community-based mental health services for older people with 85 (28%).

However:

- Four of the five core services had average bed occupancy over 85% with acute wards highest with 100%. There were 64 out of area placements in the last six months, 33 of which were for long stay/rehab wards.
- The trust did not have a psychiatric intensive care unit (PICU) in Devon but they had eight beds out of county. Staff told us there were challenges with arranging beds at the psychiatric intensive care unit and that it could take 24-48 hours to arrange. Plans are in place to build a trust PICU within the next 18 months.
- The Exeter crisis team did not have a flexible approach to assessing urgent referrals. We found incidents where they had redirected people to psychiatric liaison services in accident and emergency as they felt they did not have available staff. They did not look at their current workload to see if any appointments could be rearranged.
- The North Devon health-based place of safety was only commissioned to operate between 9am and 5pm, due to it being used, on average, less than once a day. This meant people in the area often had to be transported by the police to Exeter or Torbay whilst in a state of distress.

Are services well-led?

Good

We rated well-led as **good** overall for Devon Partnership NHS Trust because:

- In July 2015, we rated seven of the nine core services as good for responsive. This led us to rate the trust as good overall for this key question. During the December 2016 inspection we completed a 'well led' review and we found that the trust had continued to strengthen its senior leadership team and refine the trust governance processes. The rating remained good.
- We found effective governance committees with good access to ward to board information and positive board leadership to promote clear trust leadership.
- Trust board members interviewed were clear about the trust's vision and strategy. Senior clinicians were clear about their role and the trusts direction. The vision and values were on display in the trust and were available on the intranet. The majority of staff knew and understood the values of the trust.

Summary of findings

- Staff knew who senior managers in the trust were and said they were visible. The executive team carried out regular walkabouts and each year were assigned a directorate which meant that they visited all locations and most services and sent reports and any actions of their visits back to teams and reported this activity to the board.
- Frontline staff took part in some of the clinical audits. This gave staff the opportunity to be involved in the development of the service.
- All of the trust's acute wards for adults of working age and psychiatric intensive care units were in the Royal College of Psychiatrists - accreditation for inpatient mental health Service (AIMS) schemes.
- The trust's mortality diagnostic and mortality group provided a forum for senior clinicians to review case studies and improve clinical practice within the trust.
- Learning disability in patient wards had almost met the quality network for inpatient learning disability services (QNLD) standards apart from that for the seclusion facility.
- Community-based mental health services for older people were affiliated to the memory services national accreditation programme (MSNAP).

However:

- Crisis teams did not have clear guidance from the trust to ensure they were providing a consistent clinical approach. This meant that all teams had a different approach to areas such as, assessing for early discharge; managing people who were not engaging with the service; rating levels of risk; and monitoring key performance indicators on their caseload white boards.
- In the older person community mental health service almost all staff told us that, regardless of complexity of need, they did not support older people under the Care Programme Approach (CPA). The trust told us they were reviewing the CPA policy to include older people's services.

Summary of findings

Our inspection team

Our inspection team was led by:

Head of Inspection: Pauline Carpenter, Care Quality Commission

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

The team included seven inspectors, one assistant inspector, two mental health act reviewers, two analysts (shadowing) and one inspection planner.

There were 16 specialist advisors from a variety of mental health service backgrounds. These included executive directors, psychiatrists, social workers and registered mental health nurses operating in a range of roles and at various grades. Each specialist advisor had recent experience of working in services similar to those being inspected.

In addition, the team included two experts by experience that had personal experience of using mental health services or caring for someone who had used these services.

Why we carried out this inspection

We undertook this inspection to find out whether Devon Partnership NHS Trust had made improvements to their acute admission wards for adults of working age, community based mental health services for older people; mental health crisis services and health-based places of safety; wards for people with learning disabilities or autism and wards for older people with mental health problems since our last comprehensive inspection of the trust that we undertook in July 2015 where we rated the trust as requires improvement overall.

When we inspected the trust in July 2015, we rated wards for people with learning disabilities or autism as 'requires improvement' overall. We rated this service as 'requires improvement' for effective, responsive and well-led and as 'good' for safe and caring.

Following that inspection we told the trust that it must take the following actions to improve wards for people with learning disabilities or autism:

- The trust must ensure that people detained under the Mental Health Act are being read their rights under Section 132.
- The trust must make patients aware of their rights to access an independent mental health advocate by providing this information in an accessible format.
- The trust must ensure all staff are following NICE guidelines for 'challenging behaviour and learning disabilities: prevention and interventions for patients with learning disabilities whose behaviour challenges'; published: 28 May 2015. This includes guidelines on positive behaviour support.
- The trust must deliver good quality food that meets the nutritional needs and preferences of the patients.
- The trust must enable local managers to deliver a service in line with current practices specific to enabling patients with learning disabilities to become more independent.

We issued the trust with three requirement notices in relation to wards for people with learning disabilities or autism. These related to:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs.

When we last inspected the trust in July 2015, we rated mental health crisis services and health-based places of safety as 'requires improvement' overall. We rated this service as good for caring and as requires improvement for safe, effective, responsive and well-led.

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

Summary of findings

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

We issued the trust with two requirement notices in relation to mental health crisis services and health-based places of safety. These related to:

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

When we last inspected the trust in July 2015, we rated wards for older people with mental health problems as 'requires improvement ' overall. We rated this service as good for caring, responsive and well-led and as requires improvement for safe and effective.

Following that inspection we told the trust that it must take the following actions to improve wards for older people with mental health problems:

- The trust must ensure that secluded or segregated patient are monitored in line with the trust seclusion policy and MHA code of practice guidelines.
- The trust must ensure that all seclusion and segregation facilities meet the MHA code of practice guidelines and include Franklyn house within the seclusion and segregation policy as an area with a room for segregation and seclusion.
- The trust must ensure that ligature cutters and emergency equipment are always accessible.
- The trust must ensure that monitoring and checks of medical equipment follow a systematic plan.
- The trust must ensure that alarm and nurse call systems are regularly checked to ensure they are charged and fit for purpose.
- The trust must ensure all Treatment Escalation Plans (TEPs) are completed in full.

We issued the trust with four requirement notices to improve wards for older people with mental health problems. These related to:

- Regulation 11 HSCA (RA) Regulations 2014 Need for consent
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

When we last inspected the trust in July 2015, we rated acute wards for adults of working age and psychiatric intensive care units as good for caring, responsive and well led and as requires improvement for safe and effective.

Following that inspection we told the trust that it must make the following actions to improve acute wards for adults of working age:

- The trust must ensure that work identified as high priority on the ligature risk assessments is completed in a timely manner.
- The trust must ensure that action is taken to mitigate the potential risk caused by a blind spot on Haytor ward and ensure that all areas of wards are included in ligature risk assessments and management plans, including cables in communal areas.

We issued the trust with a requirement notice in relation to the following regulation under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

How we carried out this inspection

To get to the heart of people who use services' experience 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?

Before the visit, the inspection team:

- Reviewed information that we hold on the trust.
- Requested information from the trust and reviewed that information.
- Asked a range of other organisations that the trust worked in partnership with for feedback. These

included NHS England, local clinical commissioning groups, NHS Improvement, Health watch, local authority overview and scrutiny committees, Health Education England, and other professional bodies.
- Met with a number of user and carer groups, both internal and external, to hear their views on the trust.
- Reviewed information from patients, carers and other groups received through our website.

During the announced inspection visit from 5 to 9 December 2016, the inspection team:

- visited five registered locations and 27 teams across the trust,
- observed how staff were caring for patients in wards and clinics,
- accompanied community teams on visits to people's homes, seeing 17 episodes of care in the community,
- spoke with 58 people who used the services,
- met with 40 carers or their family members who used the services and reviewed 41 comment cards that we had left in patient areas before the inspection,
- spoke with 142 front line staff who worked within the trust, such as nurses, doctors, therapists and support staff,
- interviewed the chair of the board, the chief executive officer and executive directors
- held three location based staff focus groups with a total of 20 staff in attendance,
- interviewed the senior managers within the trust, including 29 managers of services, such as ward managers and team leaders,
- reviewed 144 care and treatment records of people who use services,
- reviewed 35 staff supervision and appraisal records,
- carried out a specific check of the medication management for all teams,
- observed care of eight people using the short observational framework for inspection (SOFI) tool on the dementia unit,
- looked at a range of policies, procedures and other documents relating to the running of the trust.

Following the announced inspection:

- No unannounced inspections took place as the inspection team had enough information to reach their judgements.
- A number of data requests were also met by the trust.

Information about the provider

Devon has a population of approximately 894,000 residents covering an area of 2600 square miles. The area covered by the trust is predominantly rural with areas of urban development along its north and south coastlines.

Life expectancy for both men and women was higher than the England average. There was a significantly higher rate of people aged 65 and over in Devon compared to the England average

Devon Partnership NHS Trust is the main provider of mental health services in Devon and was formed in 2001. The trust employs more than 2500 staff and has an annual income of about £140 million.

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

Devon Partnership NHS Trust has six registered locations serving people with mental health and learning disability needs from community and hospital based settings. There were 291 inpatient beds in operation across 21 wards.The trust operates from over sixty sites.

The trust provides the following core services that were inspected based on previous non-compliance:

- mental health crisis services and health based place of safety,
- community based services for older people,
- acute wards adults of working age,
- wards for older people with mental health problems,
- wards for people with learning disability or autism.

In addition the trust provides the following core and specialist services which we did not inspect:

- community based services for adults of working age,
- community based services for adults with a learning disability or autism,

Summary of findings

- forensic inpatient and secure wards,
- long stay / rehabilitation wards for adults of working age,
- perinatal mental health service,
- eating disorder service,
- specialist gender identity clinic,
- sexual medicine clinic,
- personality disorder service,
- addiction services (Torbay only).

There have been 22 inspections of Devon Partnership NHS Trust since their registration with the Care Quality Commission.

At the time of our visit, there were twelve outstanding compliance actions across five core services at five locations that were non-compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An updated Care Quality Commission action plan dated 31 July 2016 was received from the trust and this demonstrated progress by the trust in addressing all the areas of non-compliance.

There were ten Mental Health Act Reviewer visits between 1 October 2015 to 31 October 2016; all were unannounced. Over the five visits there were 38 issues found at eight locations across the trust. The categories with the most issues reported were purpose, respect and least restriction; protecting patients' rights; care, support and treatment; leaving hospital; leave of absence; consent to treatment; and general healthcare with four issues each.

What people who use the provider's services say

The majority of patients were positive about the staff, and their experience of care on the wards or in community settings. Patients and their families or carers had the opportunity to be involved in discussions about their care.

Many felt their mental health had improved as a result of the service they received from the trust.

People receiving care from community services told us that their appointments generally ran on time and they were informed if there were any unavoidable changes. Some told us they saw different members of staff which meant they had to repeat information.

Patients knew how to raise concerns and make a complaint. They felt they could raise a concern if they had one and believed that staff would listen to them.

Good practice

- The trust's active participation in the 'The zero suicide collaborative programme' in the South West of England demonstrated trust leadership across the region to promote better mental health.
- The trust was working with another trust on the innovative four step programme. This aimed to reduce the frequency of violent incidents on psychiatric wards by at least 25% within two years.
- The trust had produced an essential practice brief guide and this was available to staff across the wards. The guide included information on a variety of topics relevant to inpatient care including seclusion, de-escalation and long-term segregation. The guide was succinct and contained algorithms and checklists. We found the guide in use across the wards.
- The trust were following clear protocol, within their bed management policy, for managing and recording Section 140 of The Mental Health Act. This places a duty on Clinical Commissioning Groups (CCG) to identify beds in cases of special urgency. The trust were monitoring when they used their health-based places of safety as this alternative bed and reporting back to the CCG. This meant the CCG were aware of when the trust's bed capacity did not meet safe requirements.

Summary of findings

- The trust's mortality diagnostic and mortality group provided a forum for senior clinicians to review case studies and improve clinical practice within the trust.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should address the ligature risks which had been been previously rated as high risk.
- The trust should continue to recruit staff to areas of greatest vacancy.
- The trust should review with commissioners the provision of in patient beds to ensure that these meet the assessed needs of the local population.
- The trust should discuss with commissioners future support for patients with a diagnosis of dementia outside of normal office hours.
- The trust should review access to psychological therapies across each service.
- The trust should review their Care Programme Approach policy to include older people's services.
- The trust should ensure that the actions from their delivery plan developed in response to the Green Light self-assessment audit are fully embedded and followed up.
- The trust should ensure that all crisis teams receive clear guidance from the trust to ensure a consistent clinical approach.

Devon Partnership NHS Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act (MHA)1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Staff received MHA training as part of their induction training. Refresher MHA training was provided but this is not mandatory. The trust reported that 66% of staff were compliant with MHA training against the trust target of 90%. However, overall staff demonstrated a good understanding of the Mental Health Act. The Mental Health Act administration team provided face to face training as well as the online training.
- The managing partner for safeguarding oversaw the operation of the Mental Health Act (MHA). The trust had one central office with a satellite office in the Langdon Hospital and the North Devon Hospital. The trust had five MHA administrators and a manager.
- The trust's MHA team carried out the day to day work relating to the MHA 1983. The MHA team provided training to trust staff, carried out regular reviews of MHA documentation, did spot check ward reviews and co-ordinated tribunal and managers' review hearings. The team also carried out audits of compliance with the MHA and MHA Code of Practice. The trust have completed four audits in the last 12 months which demonstrate compliance with the MHA and MHA Code of Practice and looked at S117 aftercare, S58 consent to treatment, use of holding powers and seclusion and segregation .
- Each trust directorate had a monthly meeting and the MHA team provided details of compliance with the MHA for each. This infortion was provided to trust board. An annual report on the trust's compliance with the MHA was provided to the board the last being in September 2016.
- We found that detention paperwork was filled in correctly, up to date and stored appropriately.

Further details can be found in the main body of this report.

Mental Capacity Act and Deprivation of Liberty Safeguards

- In the last 12 months, the overall compliance rate for this training course across the trust was 96%, against the trust target of 90%. The renewal timeframe for this training course was every three years. The course was categorised as core training for staff. Forty-three out of a total 148 wards did not score above the trust result of 96%.
- The trust provided information around the number of Deprivation of Liberty Safeguards applications they have made between 15 April 2016 and 14 October 2016. Forty-two Deprivation of Liberty Safeguards (DoLS) applications were made, 24 (57%) of these were regarding Belvedere Ward older people mental health ward.
- The trust had a MCA policy and had produced a short and clear summary of the MCA for staff. Some staff were very knowledgeable and spoke confidently about the legislation. They knew about knew the five statutory principles and the capacity test.

- Care and treatment records demonstrated that patients were informed that they could make advanced decisions regarding their care and treatment. When appropriate, best interest meetings were held.
- There was good adherence to consent to treatment and capacity requirements overall. Staff were well informed in terms of gaining patients' consent to treatment. Staff understood the importance of gaining the informed consent of patients. Where staff had concerns about a patient's capacity they conducted assessments. These were clearly documented.

Further details can be found in the main body of this report.

Good

Are services safe?

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

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Track record on safety

- The trust reported 3,113 incidents to the National Reporting and Learning System (NRLS) between 1 October 2015 and 26 September 2016[1]. Fifty one per cent of incidents (1,591) reported resulted in no harm, 40% (1,256) of incidents were reported as resulting in low harm, 7% (213) in moderate harm, 1% (26) resulted in severe harm and 1% (27) resulted in death.
- The trust did not report any 'never events' in the last 12 months. These are defined as 'serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'.
- Of the incidents reported to NRLS, 22% (685) related to 'Self-harm', 12% (389) related to 'Medication', 11% (336) related to 'Slips, trips, falls, 8% (251) related to 'Physical' and 7% (225) related to 'Abscond/missing patient'.
- Trusts were required to report serious incidents to the strategic executive information system (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported 66 serious incidents between 1 October 2015 and 26 September 2016. 67% were 'apparent/actual/suspected self-inflicted harm meeting the serious incident criteria, and 9% were incidents relating to 'disruptive/ aggressive/ violent behaviour meeting the serious incident criteria.
- Between 1 October 2016 to 26 September 2016, the trust reported 66 serious incidents through its internal reporting system. Of these 23 (35%) related to 'other' services and 14 (21%) related to acute wards for adults of working age and psychiatric intensive care units. The most common type of serious incidents were 'apparent/ actual/suspected self-inflicted harm meeting the serious incident criteria with 44 (67%) and 'disruptive/ aggressive/violent behaviour meeting the serious incident criteria with six (9%).
- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care.
- Between August 2015 and August 2016, the trust reported 12 'pressure ulcers (old and new)'. Five of the 13 months reported two pressure ulcers each, this included August (new), November (new) and December (new) 2015, January (new) and August (old) 2016. August 2016 saw the higher prevalence rate of 3.4%.
- The trust reported six falls with harm during the time specified. The highest monthly number of falls with harm reported was in January 2016 with two (2.7%). Eight of the months reported no cases.
- The trust reported two catheter and new UTI cases in the time specified, October and November 2015 reporting one each. No cases were reported for 11 of the months.
- For the same date range, the trust also recorded 873 cases of 'harm free' care, with a mean of 67 cases per month. The trust saw their best performance in 2016 with three of the months recording 100% prevalence for harm free care – April 2016 (65), May 2016 (65) and June 2016 (63).
- Between 1 October 2015 and 26 September 2016, acute wards for adults of working age reported 14 serious incidents, which required investigation. Seven of the incidents were for apparent/actual/suspected self-inflicted harm, three were for unauthorised absence and two were for disruptive/aggressive/violent behaviour.

Learning from incidents

- There was evidence of acute wards for adults of working age making positive changes in response to serious incidents. Following a death of a patient who had absconded, the door to the ward was locked and this was reviewed on a daily basis. Delderfield and

Good

Are services safe?

Coombehaven wards avoided moving patients between wards to ensure continuity of care. On Ocean View ward, the welcome pack had been updated to include a new section to encourage patients to share concerning information about other patients with staff.

- Incidents had a detailed investigation and action plan developed. The trust had a quality improvement academy that worked with individuals and teams across the trust which:

- Supported them in delivering quality improvements and helping to remove the barriers to providing good quality care

- Provided training in quality and safety improvement methodologies, to better equip teams to design and implement local improvements and manage future risks to quality and safety

- Supported teams in understanding and implementing the learning from incidents, complaints, experience and other intelligence about their performance.

- Provided a range of leadership and development programmes

- The programme of trust innovative work included the trust's participation in the 'The Zero Suicide Collaborative in the South West of England' and working with another trust on the four step programme. This aimed to reduce the frequency of violent incidents on psychiatric wards by at least 25% within two years and the implementation of an absent without leave initiative within wards to reduce these across all inpatient areas.
- The trust produced a monthly report to all services detailing reporting at team level/themes/severity and other key data, specialist reports including segregation and seclusion activity, medicines management, violence and aggression incidents. Staff accessed these through the web based reporting system.
- The trust produced a bi-monthly experience, safety and risk report which included incidents, complaints, compliments, litigation and other key areas and allows the thematic review at trust and service level. This was reported through our governance structure to the directorate governance boards, senior management boards and the quality and safety Committee.
- The trust had an 'eliminating mixed sex accommodation' policy. On all the acute admission wards, men and women slept in separate areas and had either en-suite or single sex bathrooms.
- The trust had a central 'learning from experience' group which included representatives from all service areas and corporate teams; this considered all areas of learning including incidents. This group met every two months. The first half of each meeting was focused on one issue, the second half on additional and hot issues from the bi monthly experience, safety and risk report. The main focus rotated through violence and aggression (and restrictive interventions), self-harm and suicide, AWOL and record keeping, physical health care, user and carer involvement / patient and family centred care, medication, falls and pressure ulcers. Each meeting included case studies and the presentation of RCAs, other trust data from incidents, complaints, audits, and NICE compliance), external evidence and lessons learned and actions. Each meeting was summarised in notes, lessons learned and actions on the Trust's intranet.
- Learning and resultant actions across the trust was focused on resilience work streams. These were medication management, AWOL, falls, tissue viability, violence and aggression, record keeping/, access to services, MDT working and client and family centred care. Each work stream had an identified set of actions to implement local and national learning. Each work stream had these bundles or programmes to implement evidence based learning (for example the 4 steps programme for violence and aggression) and using quality Improvement methodology with the support of the trust's quality improvement academy.
- Additional learning from root cause analysis following serious incidents was picked up by the work stream for that area. New, completed and outstanding or delayed actions was monitored at a bi monthly actions and learning meeting with the same membership as the learning from experience group.
- Medicine incidents were reported via the trust incident reporting system. The trust had been seen as a low reporter of incidents compared to the national average. The average number of incidents reported in a three month period was steady at an average of 187 incidents over six months. However in the last six month period this had increased to an average of 230 incidents reported. Of these incidents an average of one per

month were rated as causing moderate or severe harm. The learning from medicine incidents were summarised and learning from experience bulletins were issued on a bi-monthly basis.

Safeguarding

- The percentage of staff who were trained in safeguarding across the trust was over 90%. Staff knew how to make safeguarding alerts. Safeguarding alerts were recorded as incidents on the risk management system. There were opportunities to discuss safeguarding concerns in ward rounds and other staff meetings although it was not a standing agenda item.
- Front line staff made alerts to the local authority by telephone. The trust were working collaboratively with the safeguarding boards to revise the system to ensure clear audit trails.

Assessing and monitoring safety and risk

- Staff we spoke with had a good understand of incidents that should be reported and gave examples. Staff used the electronic recording system to record incidents and there was evidence of care records being updated in response to incidents. We reviewed the recording of incidents and they were generally comprehensive. Incidents were risk rated for their severity and likelihood of them happening again.
- The trust advised that all inpatient teams have reviewed their units and have identified their ligature risks. Teams have mitigation plans to manage risk as identified in each of the ligature risk assessments. The trust has agreed a two year programme of works to minimise ligature risks within inpatient environments. Front line staff had ligature cutters attached to their keys and further access to larger ligature cutters and masks used for resuscitation on the wards.
- There was an observation blind spot on Haytor ward which had not been resolved and no mitigation was in place.
- The trust had not addressed and mitigated some potential ligature points on the acute admission wards that they could reasonably have made safe. The trust had rated some ligature risks as high risk but they had not addressed them although they had set target dates for completion.
- Crisis teams supported people to make plans to manage their own crisis and recognise when they may be at risk of becoming unwell in the future. Staff were mindful in ensuring the person was well enough to engage in this process and shared plans with people's support network.
- In older people mental health community services, staff routinely carried out risk assessments for all patients. In all but two of the 54 records we looked at, staff had regularly updated these assessments. The risk assessments which were not fully up-to-date were completed as soon as we identified them to staff.
- Clinical risk assessment was a mandatory training item and 97% of staff were up-to-date with this.
- The trust had a total of 2377.2 substantive staff with 267.9 staff employed in central and corporate functions. The trust had a 12% turnover rate, 11% vacancies and 5% sickness (as at 30 September 2016). There was at least one experienced nurse on duty on each in-patient ward at all times.
- Staff vacancies continued to be a pressure on older people's inpatient services, particularly at Meadow View in North Devon and Belvedere the dementia unit. Nursing posts remained difficult to fill. Meadow View still had a vacant consultant post, covered by a locum. The trust was recruiting creatively where they had been unable to fill vacant nursing posts. For example on Belvedere they had recruited an occupational therapist to the ward team.
- Medicine management arrangements across the trust were reviewed. The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. The Standard Operating Procedures for Controlled Drugs had been reviewed and updated in 2014. Incidents involving controlled drugs were reported via the incident reporting system and were investigated by the Accountable Officer for controlled drugs and records made of the actions taken.
- There was an in-house clinical pharmacy service which included cover for all the in-patient units and also an advice service for the community services. The community service was being developed to include a clinical service for community patients. The in-patient service included arrangements for medicines reconciliation, the review of prescribing and administration of medicines and the monitoring of medicine incidents. A medicines helpline was available for staff and patients to obtain medicines advice.

Good

Are services safe?

- Medicines were supplied under service level agreements from neighbouring NHS trusts. The prescribing of medicines against T2/T3 forms was checked by the in-house clinical pharmacists and if the dispensing pharmacy was asked to provide a new medicine they were provided copies of these forms. The trust staff could contact an out of hours medicines service and NHS prescription forms were also available in case medicines were needed outside routine working hours.
- The trust had a policy for rapid tranquillisation. This policy and clinical protocol was last reviewed in October 2015. It only included the use of injectable medicines. Rapid tranquillisation was prescribed on specific forms which were cross referenced to the main prescription chart. An audit of the prescribing and use of rapid tranquillisation had been conducted in October 2015. The audit showed that rapid tranquilisation had been administered 12 times in a four week period and that it had always followed trust policy. There were some issues with the recording of observations and other data. The audit was due to be repeated in early 2017.
- In the previous inspection, all older people in patient wards except Beech had routinely prescribed rapid tranquilisation. We followed this up on this inspection by reviewing medication records and speaking with doctors and nurses. Rapid tranquillisation was only prescribed when it was indicated and not written up in blanket way. Rapid tranquilisation included oral medication and depots of antipsychotic medicines were prescribed in accordance with national good practice guidance.
- The trust had a policy and procedure for the covert administration of medicines. This included how a decision would be made to administer medicines covertly and the associated legal implications. Advice was provided by the pharmacy service on how best to administer these medicines. The trust had a policy for the self-administration of medicines. This was being used successfully to empower people to understand their medicines and to prepare them for discharge.
- The trust had a number of Patient Group Directions in place for use by the community teams. This meant that they were able to provide medicines without a prescription being written. The trust also had qualified non-medical prescribers.
- The trust reported 236 incidents of restraint affecting 123 different service users between March and August 2016. There were 111 incidents of seclusion and 228 incidents of long-term segregation reported. Acute wards for adults of working age and psychiatric intensive care units had the highest number of restraint incidents with 112 (48%), the highest number of incidents of seclusion with 75 (68%) and the highest number of long term segregation incidents with 151 (66%). This core service also had the highest number of prone restraint incidents with 29 (76%) – 27 of these resulted in rapid tranquilisation. There were 38 incidents of prone restraint which accounted for 16% of all restraint incidents, of which 32 (84%) resulted in rapid tranquilisation.
- The trust reported that of the people in the organisation, whose work required them to have training in restrictive interventions, 454 members of staff had been trained in non-prone restraint.
- CQC received seven direct notifications from Devon Partnership NHS Trust between 1 November 2015 and 31 October 2016. Two of these related to deaths in detention both at Wonford House (August 2016 and September 2016). There were 16 safeguarding notifications recorded on our internal systems regarding Devon Partnership NHS Trust between 1 November 2015 and 31 October 2016. The trust has not had any serious case reviews (SCR's) in the last 12 months.
- The trust had revised its staff training programme to reduce the use of restraint and seclusion. This training change is still in the process of being rolled out. A train the trainers course has been completed and wards were now releasing staff in a phased and prioritised way to receive this training.
- The trust had launched The Four Steps programme as a project in partnership with another trust. This aimed to reduce the prevalence of violence and aggression on wards. It supported staff and patients working together to deliver evidence based interventions that reduce levels of violence. The four steps were:
  - proactive care to prevent incidents
  - patient engagement to promote a closer working arrangement between staff and patients
  - teamwork
  - a calm, therapeutic environment.
- They had recently reviewed and updated the trust's seclusion policy to provide relevant and current guidance on the use of seclusion, segregation and de-escalation.
- Inpatient wards were clean and infection control audits were completed regularly

Good

Are services safe?

Potential risks

- The trust had emergency contingency plans in place for dealing with foreseeable emergencies. For example, within community services for adults, staff were clear about appropriate procedures to follow if people did not attend their appointments. These included telephone contact, making home visits and sending letters.
- We saw trust wide contingency arrangements in place for adverse weather, IT failure and local systems for working collaboratively with local acute trusts for civil emergencies and major incidents.
- The trust had a lone working policy in place to support staff working alone in the community and to promote their safety. The community teams each had a local policy. Teams used a safe word to communicate they were in danger when working alone. The trust provided staff with mobile telephones to support them when they were lone working.

Duty of Candour

- In November 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong.
- The trust had a statutory duty of candour/being open policy. Implementation of the duty of candour was included in the bi-monthly experience, safety and risk report, each report contained details of the numbers of incidents reported that met the duty of candour threshold and the level of compliance with the requirements.
- There was a duty of candour section within the clinician induction package for new staff. The risk team visited community teams and inpatient wards to discuss the requirements of the duty of candour.
- The trust had produced a patient leaflet providing information about the implementation of the duty of candour.
- The risk management system has been updated to include a duty of candour section to be completed upon reporting an incident and staff were support to complete this as needed.

Good

Are services effective?

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Assessment and delivery of care and treatment

- The trust has participated in 71 clinical audits for 2016/2017. Of the 71 3% (22) were rated as 'Green', 14% (10) are with the Mental Health Act (MHA) Office, in addition another 10 (14%) have also been rated as 'Amber'.
- The following nine audits have all been classed as 'completed' by the trust; dual diagnosis audit – HASCAS – across all age adult services; compliance with Child K recommendations (drug service serious incident); potentially missed safeguarding incidents ; antenatal postnatal mental health; physical health monitoring in inpatient wards for psychotropic medicines; perinatal outcomes birth planning; antenatal and postnatal mental health; early intervention in psychosis self-assessment accreditation scheme and carer checklist audit.
- The trust had identified their quality goals for 2016/17. These were:
- Improving the Experience of People Using Services;
- Clinical Effectiveness;
- Safety.
- Within this programme the trust have a specific focus on improving physical wellbeing, reducing violence and aggression and avoidable harm.
- Patients had physical examinations on admission and there was ongoing monitoring of physical health problems. The trust had a physical health monitoring policy. Staff were trained to use the modified early warning signs tool to observe changes in patient's presentation.
- The trust employed a street triage worker who was able to support police they encountered people in distress in the community. They offered mental health advice and information on people's current support and contact from mental health services. This helped police make decisions on whether the person needed assessment at a health-based place of safety.
- Crisis teams made staff available to assess people on the inpatient wards to see if they were suitable for crisis team support and all teams were supporting people who had come via this pathway. This meant that people were returning home early with support and, in turn, freed up inpatient beds for people who required them.
- The majority of crisis teams were able to respond to urgent referrals within four hours. Staff made appropriate decisions based on risk to ensure people were seen in a timely manner. If required they would reschedule pre-arranged appointments to prioritise assessing people in crisis.
- The service had recently introduced an out of hours phone line so people could access crisis support during the night. Staff who took the calls were able to update people's electronic care records and record any advice that was given to them. Daily feedback was given to teams so they could offer people appropriate follow up the next day.
- In some areas of the older people community service, there were waiting lists for patients to be seen by a psychologist accessed via the trust's older people directorate.
- Some psychological therapies were provided by staff on the acute admission wards who had received training to deliver them.
- When we inspected the older people in patient wards in 2015 we found that patient information recorded on white boards were visible from outside the office at times and the side panels of the boards were not always used. This had improved and the trust had ensured that information on white boards in ward offices was not visible to patients or ward visitors. Belvedere had repositioned their whiteboard so that it was less visible though office windows. Staff on all three wards that had whiteboards used the side panel shutters to protect

patient information. On Beech ward's interactive white board, a special film had been fitted on the window to the ward office so that information on the interactive white board could not be seen outside the office.

Outcomes for people using services

- The trust's proportion of admissions to acute wards gate kept by the crisis resolution home treatment (CHRT) team was above the England average for 11 of the 12 quarters reported. 95% was the lowest point the trust reached at Jul-Sep 16 (Q2 1617). The trust achieved the national 95% target in all quarters.
- The trust had prescribing guidelines and psychiatrists referred to these and to National Institute for Health and Care Excellence guidance. For example, we found that this guidance in prescribing medicines for psychosis, depression, schizophrenia and bipolar affective disorder was being followed.

Staff skill

- The trust's overall appraisal rate for non-medical staff was 72% and 91% for medical staff as of 30 September 2016. The trust updated these rates to 96 and 94% respectively during the inspection. 84 doctors had been revalidated. The trust score for the number of staff appraised in the last 12 months in the NHS Staff Survey 2015 was the same as the national average for combined MH / LD and Community trusts; however, the question on the quality of these appraisals was worse than the national average.
- A full range of staff including occupational therapists, pharmacists, psychiatrists, nurses and health care assistants staffed wards.
- The trust had difficulty recruiting substantive experienced band five nurses. There was a preceptor programme for newly qualified nurses to prepare them for this role.
- All staff including bank and agency staff completed a comprehensive standard local induction.
- The frequency of supervision was tailored to the individual with all staff receiving supervision at least every six weeks. Preceptor nurses had supervision weekly to start with. Some wards held group supervision to supplement the management clinical supervision. Staff business meetings and ward rounds provided further opportunities to meet to discuss patient care.
- In addition to mandatory training, the trust offered further training in cognitive behavioural therapy, mindfulness, motivational interviewing, mentorship, counselling skills and solution focused brief therapy. Healthcare assistants took the care certificate training to ensure they acquired the knowledge and skills required for their work.

Multi-disciplinary working

- The trust score for effective team working in the NHS Staff Survey 2015 was better than the national average when compared with similar trusts.
- Staff attended weekly business meetings. Local step down units, community care co-ordinators, and crisis team staff were also invited. Ward managers attended monthly adult governance meetings.
- Wards held handover meetings between shifts. We attended handover meetings and these were robust and interactive. In each meeting, staff discussed every patient, their progress and needs.
- There were effective working relationships with external teams For example, with local housing officers, the police, and local authority safeguarding leads.
- Community psychiatric nurses, independent mental health advocates and families and carers were invited to and mostly attended in-patient ward reviews. Staff collaborated with acute hospitals in order to meet patients' physical healthcare needs.
- Community older people mental health teams' staff routinely advised GPs of the outcomes from patient assessments. They sent GPs a thorough update, including any diagnosis and required follow up action to be carried out by the GP and the team.

Information and Records Systems

- The information needed to deliver care was held on an electronic records system that all clinical staff had access to.
- Front line staff used a variety of assessment and outcome measures to assess and review patients. They were assessed for their risk of going absent without leave incident. There was an infection control risk assessment. Staff used the 'modified early warning scoring' chart, the 'dynamic appraisal of situational aggression' and 'Beck depression inventory'. Staff used admission and discharge checklists to ensure they completed all steps. All patients were clustered using the 'mental health clustering tool'.

Good

Are services effective?

Consent to care and treatment

- Staff had a good understanding of the Mental Capacity Act 2005. Staff understood the fluctuating nature of mental capacity. Most staff showed an understanding of the five statutory principles of the Act. Psychiatrists completed mental capacity assessments. Staff were aware of the principle of assisting patients to make specific decisions for themselves.
- Staff approached the trust's Mental Health Act administration team for advice regarding Mental Capacity Act and Deprivation of Liberty Safeguards. The administration team also monitored adherence to the Act. There was an algorithm for staff to refer to which helped them to assess if an informal patient had the capacity to consent to treatment and alternative options.
- The formal consent to treatment documentation was generally in good order across the inpatient services.
- The trust had no method of recording whether a patient had made an advance directive. We were told that there was an action plan in place for a 'safeguard tab' to be included in the computerised records system which could record whether a patient had an advance directive, advance decision, court of protection deputy or last power of attorney.
- The MHA team also maintained the applications for deprivation of liberty safeguard applications (DoLS). The trust employed best interest assessors to help with delayed discharges.

Assessment and treatment in line with Mental Health Act

- The managing partner for safeguarding oversaw the operation of the Mental Health Act (MHA). The trust had one central office with a satellite office in the Langdon Hospital and the North Devon Hospital. The trust had five MHA administrators and a manager.
- The trust's MHA team carried out the day to day work relating to the MHA 1983. The MHA team provided training to trust staff, carried out regular reviews of MHA documentation, did spot check ward reviews and co-ordinated tribunal and managers' review hearings. The team also carried out audits of compliance with the MHA and MHA Code of Practice.
- Each trust directorate had a monthly meeting and the MHA team provided details of compliance with the MHA for each. This was then fed to the trust Board. An annual report on the trust's compliance with the MHA was provided to the Board the last being in September 2016.
- Staff received MHA training as part of their induction training. Refresher MHA training was provided but this is not mandatory. Despite this the trust set a target and monitored compliance which showed that 66% of staff were compliant with MHA training against the trust target of 90%. However, overall staff demonstrated a good understanding of the Mental Health Act. The Mental Health Act administration team provided face to face training as well as the online training.
- Some actions had been taken to implement the new Code of Practice introduced on 1 April 2015; including updating the MHA training and providing guidance on the new Code for trust staff. Policies had been updated, for example, the seclusion policy; however, some staff were confused about the use of seclusion, segregation and de-escalation and the actions required.
- The trust were following clear protocol, within their bed management policy, for managing and recording Section 140 of The Mental Health Act. This places a duty on Clinical Commissioning Groups (CCG) to identify beds in cases of special urgency. This is used when patients' risks had been assessed as unsafe to be managed in the community. The trust were monitoring when they used their health-based places of safety as this alternative bed and reporting back to the CCG. This meant the CCG were aware of when the trust's bed capacity did not meet safe requirements.
- MHA documentation was properly completed. There were robust systems in place to scrutinise documents. Patients across all wards were informed of their rights regularly and advocacy services visited all inpatient units. The trust had a standardised system for authorising section 17 leave. Risks were assessed before patients went on leave and patients were given a copy of the leave authorisation. The involvement of patients in their care was well recorded.
- Staff told us that the trust's MHA administration team was supportive, provided prompt advice and guidance and delivered a good service to the ward teams.
- The trust hospital managers attend quarterly meetings which included training. The quality of managers meeting decisions was monitored; however, there was no formal appraisal system for hospital managers.

Good

Are services caring?

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Dignity, respect and compassion

- We observed staff interacting with patients in a gentle and respectful manner across the trust. Staff prioritised listening to patients, even when they were busy. Staff were genuinely interested in patients and to have a good rapport with them. There was a caring and calm atmosphere on in-patient wards.
- The trust scored better than the England average for recommending the trust as a place to receive care for five of the six months between March and August 2016.
- The percentage of staff who would recommend the trust as a place to receive care was slightly worse than the England average - 71% compared to the England average of 79%. The percentage staff who would not recommend the trust as a place to receive care was also worse than the England average - 14% compared to the England average of 6%.
- In relation to privacy, dignity and wellbeing, the 2016 PLACE score for Devon Partnership NHS Trust was 89%, which was better than the England average of 88%. North Devon Hospital, Langdon Hospital and Franklyn Hospital had a site score better than the England average. Torbay Hospital, Wonford House and Whipton Hospital had site scores worse than the England average.
- At the start of 2016, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 237 people at Devon Partnership NHS Trust. The trust scored 'about the same' as other mental health trusts in all of the ten questions.

Involvement of people using services

- In-patient wards had admission processes which supported patients to become familiar with the ward. All wards had welcome packs for patients.
- In-patient areas enabled patients to be active in their care. They were involved in ward rounds. Most patients said staff had involved them in producing their care plan and offered them a copy.

Emotional support for people

- The trust aimed to support and enable carers to continue in their role and to help carers access support for their own health and wellbeing. The Cedars were piloting the 'creating capable teams' approach which meant sharing information with carers and families and encouraging them to share information with the team. Staff gave examples of how they involved families and carers in patients' care. However, some carers gave mixed feedback about support they were offered. All wards had information for carers. Staff encouraged patients to give feedback on the service they received.

Good

Are services responsive to people's needs?

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Planning and delivery of services

- Four of the five core services had average bed occupancy over 85% with acute wards highest with 100%. There were 64 out of area placements in the last six months, 33 of which were for Long Stay/Rehab wards.
- There were 146 readmissions within 90 days reported by the trust between 1 April 2016 and 30 September 2016 across 11 wards. Acute wards had the most readmissions within 90 days with 121. A total of 129 delayed discharges were reported during the same period. Between 1 August 2015 and 31 July 2016, discharged patients had lengths of stay ranging from 29 days to 3483 days across all wards. For current patients, this ranged between 32 days and 1430 days as at 31 July 2016.
- The trust did not have a psychiatric intensive care unit in Devon but they had eight beds out of county. Staff told us there were challenges with arranging beds at the psychiatric intensive care unit and that it could take 24-48 hours to arrange.
- There were no services with a referral to initial assessment wait longer than 18 weeks. Russell Clinic (Team), a long stay / rehabilitation ward had the longest waiting time from initial assessment to onset of treatment with a wait of 143 days (approximately 20.5 weeks) as at 3 October 2016.
- The trust has been consistently above the target of 95% of patients on CPA who were followed up within seven days after discharge for all quarters between October 2015 and September 2016.
- When patients were moved or discharged this happened during the day to ensure their wellbeing during the discharge process.
- Over the 12 months, awaiting residential home placement or availability (79) and awaiting nursing home placement or availability (71) were the most common two reasons for delayed patients and accounted for almost half of all reasons patients were delayed during the period (48.9%). The number of patients awaiting a residential placement doubled in June 2016 and remained high for the last two months in the period (35 over last three months the highest three in the period).
- Across the older people mental health teams, patients waited an average of 14 days from referral to first contact with the team. East Devon older people mental health saw people the soonest, on average of 11 days. People waited longest, 17 days, at the Torbay and Exeter teams. Commissioners set a target time of 10 days for people to be seen by the community teams and 28 days for initial assessment by the Memory Service. On average, people waited 47 days for their appointment with the Memory Service but this included full assessment along with receipt of clinical feedback and diagnosis. People using the Torbay site of the Devon Memory Service received a full assessment in an average of 32 days and at the Exeter site, in 62 days.
- Between April-September 2016, the Memory Service saw 1002 patients. Of these, they saw 416 at Torbay, 404 at Exeter and 182 in north Devon. The community teams saw 2467 patients during the same period. The highest number of referrals (500) were at Torbay and the lowest (256) were at Mid Devon. There were 1613 patients using the older people mental health teams at the time of the inspection.
- On average, patients used the older people mental health community teams for 88 days. Patients used the Mid Devon team for the longest average of 106 days and the shortest average of 80 days at the Torbay team. Teams could arrange short notice urgent appointments for patients. This meant patients were able to see staff when they most needed to.
- Patients with a diagnosis of dementia were not routinely offered support by the trust outside of normal office hours because they were not commissioned to provide

Good

Are services responsive to people's needs?

this support. Patients' crisis plans contained guidance in case they needed support outside of these hours. Family members could also access further support if required from primary care services.

- High occupancy rates on wards for older people with mental health needs meant that there were times when new patients were given the beds of another patient who was on leave. Staff described this as regular but there was no trust wide system to monitor and record how regular this was. Discharges were delayed, particularly on Belvedere ward.
- At the last inspection, we had concerns raised with us about the quality of the food on the inpatient ward for people with learning disabilities or autism. However, during this inspection we could see that staff in this service had taken action to address these concerns. Food was regularly discussed as an agenda item in staff team meetings and patient community meetings to ensure that feedback was regularly sought and acted upon.

Diversity of needs

- In-patient wards had facilities for patients who required disabled access, including disabled bathrooms.
- Information leaflets were not readily available in foreign languages. None of the in-patient ward leaflets were available in easy read format or braille.
- Wards displayed information for patients including how to complain, details of local advocacy services and helplines. The trust provided comprehensive information on specific medicines prescribed for patients.
- There was access to interpreters using telephone lines and wards could access face-to-face interpreters and have materials translated if the need arose.
- A chaplaincy service provided spiritual support. A chaplain visited regularly and when requested. Chaplains provided multi-faith support. The chaplaincy service offered support to patients, families, carers and staff. Patients gave positive feedback about the chaplaincy service. There were no dedicated rooms for spiritual activities on any of the wards but there were quiet areas.

Right care at the right time

- In most cases, patients did not keep their acute in patient bed when they went on overnight leave. This was because of pressures on inpatient beds. Psychiatrists could request for a bed to be held for a patient if it was the first time they had gone on overnight leave in case they needed to come back to the ward. Although it was unlikely that a patient would return to the same bed when they came back to the ward, staff packed up patients' belongings and moved them out of their room while they were away rather than helping patients to pack before they went on leave.
- Patients were generally only moved between acute in patient wards if there were clinical grounds to do so and in their best interests. This was in response to a patient death, which highlighted that the ward a patient was moved to have inferior knowledge of the patient to the ward they had been staying on since their admission.

Learning from concerns and complaints

- Patients told us they knew how to complain. The trust provided a variety of ways for patients and carers to complain such as service user meetings and comments boxes. Wards displayed information on how to complain on noticeboards.
- The trust received 255 complaints with 44 (17.3%) fully upheld during the 12 months between 1 October 2015 to 31 September 2016. No complaints were referred to the ombudsmen. Community adult services received the highest number of complaints with 119 (47% of total) of which 14 (12%) were upheld.
- Staff received feedback on the outcome of investigation of complaints. Ward managers attended monthly countywide learning from experience meetings to enable learning from complaints and compliments. They then fed back to ward staff through business meetings. There were also briefings about complaint outcomes on the trust's intranet system.
- The trust received 304 compliments in the same 12 month period. Acute wards and psychiatric intensive care units had the most with 95 (31%) followed by community-based mental health services for older people with 85 (28%).

Good

Are services well-led?

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Vision, values and strategy

- The trust's vision was to be "an inclusive society where the importance of mental health and wellbeing is universally understood and valued". This was underpinned by their mission to become a recognised centre of excellence in the field of mental health and learning disability within the next five years. Their values were supported by the six I's which established the behaviours of innovation, improvement, involvement, inclusion, integration and inspiration.
- The trust held an annual staff road show 'Our Journey' to which all staff were invited. Over the last two years staff worked together to develop the trust's vision, values and strategy. The trust had initiated a values based recruitment process to ensure that they recruit to both values and competencies. Vision, mission and values were reinforced at corporate induction, which was opened by the chair or chief executive. Values and ways of working were celebrated through the annual celebrating achievement awards, which was open to staff, people using services, carers, volunteers and partners. These awards were segmented into categories based on examples of how people have adopted the six I's of innovation, improvement, involvement, inclusion, integration and inspiration.
- Trust board members interviewed were clear about the trust's vision and strategy. Senior clinicians were clear about their role and the trusts direction. The vision and values were on display in the trust and were available on the intranet. The majority of staff knew and understood the values of the trust.
- Most trust staff knew who senior managers in the trust were and said they were visible. The executive team carried out regular walkabouts and each year were assigned a directorate which meant that they visited all locations and most services and sent reports and any actions of their visits back to teams and reported this activity to the board.

Good governance

- During our previous inspection we found that the trust had robust governance processes and structures. During this inspection we found that the trust had continued to develop. We found effective governance committees with good access to ward to board information and positive board leadership to promote clear trust leadership.
- The trust's Assurance Framework and Risk Register (September 2016), contained high and moderate risks that trust governance may not be sufficiently robust.
- The trust identified four risks as 'High' in the September 2016 corporate register. These covered areas of staffing, cost improvement programme, recovery and strategic alignment.
- Frontline staff took part in some of the clinical audits. This gave staff the opportunity to be involved in the development of the service.
- The trust's mortality diagnostic and mortality group provided a forum for senior clinicians to review case studies and improve clinical practice within the trust.
- Crisis teams did not have clear guidance from the trust to ensure they were providing a consistent clinical approach. This meant that all teams had a different approach to areas such as, assessing for early discharge; managing people who were not engaging with the service; rating levels of risk; and monitoring key performance indicators on their caseload white boards.
- The trust's medicine management policy had been reviewed in April 2015 and was supported by procedures which were all in date.
- Medicine supply problems were monitored through the incident reporting system and there were regular meetings to review any issues. There were service level

Good

Are services well-led?

agreement meetings for the pharmacy supply services every six to eight weeks. These took place at an operational level so any issues could be resolved as they arose.

- A medicines management dashboard was completed weekly. This included medicines storage, allergy status, medicines reconciliation completed and prescription charts checked by pharmacist. Gaps on the administration records on prescription charts were monitored and recorded as medicine incidents. There was a weekly auditing system in place and processes had changed as a result of these weekly audits, for example all prescription charts were reviewed at the nurses' handover to ensure that there were no blank boxes.
- The medicines management risks were recorded on a risk register reviewed monthly and reported to the medicines optimisation directorate governance board.
- Ward managers received reports on the key performance indicators to help them to analyse and improve performance. There were deadlines to complete stages of the care pathway within given timeframes, for example, within 24 hours, psychiatrists should assess patients' capacity to consent to treatment and within 72 hours a care plan should be developed including a nutritional screen and care cluster. There were key performance indicators for staff training, supervision and appraisal and for sickness absence. However, managers told us that some key performance indicators were not up to date.

Leadership and culture

- The trust had an overall action plan for the workforce race equality scheme in place. This was published on the trust's website. We noted positive results for their previous surveys in 2015 and 2016. Directorate action plans were in place and these fed into the trust's overall action plan. The trust had appointed equality champions within each directorate. Directorate equality leads were being appointed. Clear board leadership for this workstream was provided by the Chief Executive.
- Most staff had high morale. They were happy with the support they received from team managers and team managers felt supported by senior management.
- The trust had 10 key findings that exceeded the average for combined MH/LD and community trusts in the 2015 NHS Staff Survey and six key findings which were below the average. The trust score worse than the national average for the percentage of staff that had suffered work related stress in the last 12 months.
- Between 1 April 2015 and 30 September 2016 there have been 14 cases where staff have been suspended.
- Managers recognised and effectively dealt with any staff performance issues. They were supported by clear policies and procedures as well as a human resource function within the trust.
- The percentage of staff who would recommend the trust as a place to work was slightly worse than the England average - 62% compared to the England average of 64%. The percentage staff who would not recommend the trust as a place to receive care was also slightly worse than the England average - 21% compared to the England average of 18%.

Fit and Proper Person Requirement

- The trust confirmed that all checks for 2016 were completed in June and were saved on individual personnel files.
- During the inspection the trust provided us with details of all the checks they had undertaken to meet this regulation. We reviewed six individual files at random and these met the required standard.

Engaging with the public and with people who use services

- The trust had a dedicated telephone line to the chief executive's office so that staff could leave comments or messages. The chair described how the non - executive ward visits and lead roles held by non-executives helped to keep senior leaders connected to the services and staff teams.
- We saw 'You said we did' boards where patients and staff could see the impact of feedback that they had given.
- All locations displayed posters and had leaflets explaining how to access Patient Advice and Liaison Service (PALS) if patients or their relatives wanted support in raising concerns. The trust website gave details on how to make a complaint and the actions that the trust had taken as a result of complaints received.

Good

Are services well-led?

- The lived experience advisory panel, managed by external partners, were seeking patient and carers' involvement that had lived experience of mental health challenges to influence trust development.

Quality improvement, innovation and sustainability

- All of the trust's acute wards for adults of working age and psychiatric intensive care units were in the Royal College of Psychiatrists - accreditation for inpatient mental health Service (AIMS) schemes.
- Learning disability in patient wards had almost met the quality network for inpatient learning disability services (QNLD) standards apart from that for the seclusion facility.
- Community-based mental health services for older people were affiliated to the memory services national accreditation programme (MSNAP).