Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
8-12 Fore Street, Ivybridge	South and West Devon Community Mental Health Team (Base 2)	-	-
Chadwell Health and Wellbeing Clinic	Torbay Central Community Mental Health Team	-	-
Chadwell Health and Wellbeing Clinic	Torbay North Community Mental Health Team	-	-
Chadwell Health and Wellbeing Clinic	Torbay South Mental Health and Recovery Team	-	-
Crediton Hospital	Crediton Community Mental Health Team	-	-
Crediton Hospital	North and Mid Devon Mental Health Assessment Team (Base 1)	-	-
Estuary House	Newton Abbot Community Mental Health Team	-	-
Estuary House	South West and Torbay STEP	-	-
Estuary House	Teignbridge Community Mental Health Team [including STEP]	-	-

Exeter Health and Wellbeing Clinic	Clyst Community Mental Health Team	-	-
Exeter Health and Wellbeing Clinic	Culm Community Mental Health Team	-	-
Exeter Health and Wellbeing Clinic	Exe Community Mental Health Team	-	-
Exeter Health and Wellbeing Clinic	Exeter and East Devon Mental Health Assessment Team (Base 1)	-	-
Haydons Court	Honiton Community Mental Health Team	-	-
Leatside Surgery	Totnes Community Mental Health Team	-	-
Quay Centre	North Devon Psychosis & Recovery Sector C [including STEP]	-	-
Riverside	North Devon & Mid Devon Assessment Team Sector A	-	-
Riverside	North Devon Mental Health & Recovery Team Sector B	-	-
Silverlea, Tiverton Hospital	Tiverton Community Mental Health Team	-	-
St John's Court	Exmouth Community Mental Health	-	-

	Team		
The Briars	Arts Therapies Service	-	-
The Quay	South Hams and West Devon Community Mental Health Team	-	-
Torbay Health and Wellbeing Hub	South West Devon and Torbay Mental Health Assessment Team	-	-
TorHouse	North Devon & Mid Devon Assessment Team Sector A (base 2)	-	-
Whipton Hospital	Devon Liaison and Diversion Service – Ashclyst	-	-

Is the service safe?

Safe and clean environment

- The community team sites were fitted with alarms in order for staff to call for assistance. Staff were aware of where to go to find help if needed. Alarms were either individual panic alarms or permanent alarms fitted to the rooms. Staff tested the panic alarms periodically to ensure that they worked.

- We found variation in the suitability of the clinic rooms and there was variation in practice. For example, staff at Torbay acknowledged that the clinic room was not fit for purpose due to its size. This resulted in staff having to give depot injections in an interview room rather than the clinic. There was no physical monitoring equipment and there was no thermometer to monitor room temperature to ensure medicines were stored at a safe temperature. At Sherbourne Lodge there was no scales and there was a blood pressure monitor that had not been calibrated since 2011. This meant that staff could not guarantee the machine was getting the correct blood pressure reading.

- The community sites appeared clean and well maintained throughout. Cleaning schedules were in place. Wonford House appeared very clean and clinical.

- Staff demonstrated knowledge of infection control principles and there were appropriate bins to dispose of clinical waste and sharps.

- Throughout the inspection we found that physical monitoring equipment when available was not always calibrated to ensure that it was working effectively and providing the correct reading. The exception to this was the wellbeing treatment room at Wonford House that was well equipped to monitor physical healthcare. Portable appliances at the Torbay site had not been tested for their electrical safety.

Safe staffing

- Staffing levels varied across teams and we found that there were vacancies for nurses in some teams. This was having some impact on the staff's wellbeing and service delivery in some teams. However, managers informed us that there was a clear recruitment plan in place. There were vacancies that staff had been recruited into but waiting to start in the STEPS team at Estuary House. There had been one vacancy appointed into at North Torbay, also waiting to start. The South Torbay team had two vacancies and ones of these was being covered by agency.
- Managers at four of the teams we inspected had issues with long-term sickness and training that had begun to impact on the teams. The South Torbay team had not been at full establishment since the service had changed its approach to working with service users in

the community. As a result, it had the highest waiting list. Sickness had affected caseloads as service users were allocated to existing care coordinators. Staff told us that the extra pressure had caused stress within the teams. Sickness with the Torbay assessment team had affected their ability to meet the target times for assessment and met only 5% of those needed to be seen within 10 working days. This meant that service users requiring assessment in the community were not being seen in the agreed periods. The assessment team at Wonford House had used internal bank workers to cover sickness in order to meet the agreed assessment times.

- Caseloads were reassessed regularly but we heard that they had grown due to pressures with sickness and vacancies. Managers felt they tried keeping caseloads to 30 for a full times staff member. However, there were part time staff with 25 service users on their caseload and full time with up to 42 services users. Staff recognised that service users must be allocated, one member of staff with a high caseload was reassured that they were not getting more service users added due to being under pressure with their current caseload. Staff told us that despite the workload being relentless they felt supported by managers and by their team. The impact of higher caseloads and sickness meant that staff were having to support more service users through the duty function rather than their care co-ordinator due to the increase in service users phoned in.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31July2017	247	N/A
Total number of substantive staff leavers	1 August 2017-31 July 2017	36	N/A
Average WTE* leavers over 12 months (%)	1 August 2017-31 July 2017	8%	14%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31July2017	30	N/A
Total vacancies overall (%)	At 31July2017	11%	12%
Total permanent staff sickness overall (%)	Most recent month (At 31 July 2017)	6%	5%
	1 August 2017-31 July 2017	6%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31July2017	143	N/A
Establishment levels nursing assistants (WTE*)	At 31July2017	63	N/A
Number of vacancies, qualified nurses (WTE*)	At 31July2017	24	N/A
Number of vacancies nursing assistants (WTE*)	At 31July2017	2	N/A
Qualified nurse vacancy rate	At 31July2017	17%	18%
Nursing assistant vacancy rate	At 31July2017	3%	1%

Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 August 2017-31 July 2017	0 (0%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 August 2017-31 July 2017	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 August 2017-31 July 2017	0 (0%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	0 (0%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	0 (0%)	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 17% for registered nurses at 31 July 2017.

This core service reported an overall vacancy rate of 3% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 11% as of 31 July 2017.

Vacancy rates for this core service have been above trust levels for nine of the 12 months reported, with February 2017 reporting the highest vacancy of 16.9%.

Team	Registered nurses			Health care assistants			Overall staff figures		
	Vacancies	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Community Service manager Admin	-	-	-	-	-	-	2	5	44%
East and Mid Adult Community Crediton	-1	3	-28%	-1	1.4	-74%	-0.8	7.3	-11%
East and Mid Adult Community Exmouth	2	8	25%	0	2	0%	1	10	10%
East and Mid Adult Community Honiton	0	4	0%	1	1	100%	1	9	13%
East and Mid Adult Community Tiverton	1	4	26%	0	2	0%	2	8	24%
Exeter Adult Community Clyst	4	7	53%	0	3	0%	4	12	29%
Exeter Adult Community Culm	1	8	10%	0.2	2	9%	2.0	12	16%
Exeter Adult Community Exe	2	7	27%	0	3	0%	2	13	14%
Exeter and East Mental Health Assessment Team	-3	6	-50%	-1	0	0%	-2	10	-17%
Exeter and East STEP	-2	4	-45%	0	0	0%	-3	5	-56%
Exeter PAR STEP	3	3	100%	0	0	0%	3	3	100%
Health and Wellbeing Clinic (Paignton)	-1	0	0	1	4	39%	-1	0	0%
Health and Wellbeing Clinic (Barnstaple)	0	0	0%	1	1	100%	1	2	60%

Health and Wellbeing Clinic (Exeter)	0	0	0%	1	4	29%	1	5	22%
Health and Wellbeing Clinic (Torbay)	0	0	0%	1	4	39%	2	6	43%
Newton Abbot East Administration	0	0	0%	0	7	0%	1	8	8%
Newton Abbot Mental Health	0	3	0%	0	2	0%	0	8	-2%
North Adult Community Review	0	1	0%	0	1	0%	0	3	0%
North Adult Community Sector A	0	6	0%	0	2	0%	0	8	0%
North Adult Community Sector B	0	5	0%	0	0	0%	0	7	3%
North Adult Community Sector C	2	5	40%	0	2	0%	3	9	34%
North and Mid Mental Health Assessment Team	3	9	35%	0	0	0%	3	11	30%
North and Mid STEP	1	5	27%	0	2	0%	2	10	16%
Paignton administration	0	0	0	2	11	19%	2	12	17%
South and West PAR STEP	9	9	100%	2	2	100%	11	11	93%
South Hams and West Devon Mental Health	1	5	21%	0	1	0%	0	8	5%
South West and Torbay Mental Health Assessment Team	1	13	11%	-3	0	0%	-3	14	-22%
Teignbridge Community Mental Health	1	5	23%	0	1	0%	1	7	16%
Torbay Central Adult Community	2	7	31%	0	3	0%	1	10	12%
Torbay Community Practice Leads	1	1	100%	0	0	0%	1	1	100%
Torbay North Adult Community	0	7	0%	0.1	3	3%	0.1	10	1%
Torbay South Adult Community	4	6	67%	0	2	0%	4	10	42%
Torbay, South and West STEP	-8	0	0	-2	0	0	-11	0	0
Totnes Mental Health	1	5	20%	0	2	0%	1	9	11%
Self-harm service North Devon	0	0	-	0	0	-	0	2	0%
Core service total	**24**	**143**	**17%**	**2**	**63**	**3%**	**30**	**264**	**11%**
Trust total	**131**	**739**	**18%**	**3**	**597**	**1%**	**292**	**2396**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 August 2016 and 31 July 2017, there is no data for bank and agency shift cover for qualified nurses or nursing assistants, pertaining to this core service.

This core service had 36 (8%) staff leavers between 1 August 2016 and 31 July 2017.

Across six of the 12 months, the core service turnover has been above trust levels, with the highest turnover reported in September 2016 with 2.6%.

Team	Substantive staff (as of 31 July 2017)	Substantive staff Leavers (12 months)	Average % staff leavers (12 months)
Community Service Managers Administration	3	0	27%

Devon Liaison and Diversion Service	15	0	8%
East and Mid Adult Community Crediton	6	1	12%
East and Mid Adult Community Exmouth	9	2	12%
East and Mid Adult Community Honiton	8	1	13%
East and Mid Adult Community Tiverton	6	0	10%
East and Mid Community Practice Leads		0	0%
East and Mid Psychosis and Recovery	1	3	1%
East Devon Mental Health and Recovery		0	0%
Exeter Adult Community Clyst	10	1	10%
Exeter Adult Community Culm	10	1	11%
Exeter Adult Community Exe	11	0	12%
Exeter and East Mental Health Assessment Team	12	1	9%
Exeter and East STEP	8	0	12%
Exeter Community Practice Leads		0	0%
Exeter Mental Health and Recovery – Clyst		0	0%
Exeter Mental Health and Recovery – Exe		1	0%
Exeter PAR STEP		0	0%
Exeter Psychosis and Recovery		1	0%
Exeter Psychosis and Recovery Team		1	0%
Haydons Court Admin	0	1	0%
Health and Wellbeing Clinic (Barnstaple)	1	0	44%
Health and Wellbeing Clinic (Exeter)	4	2	15%
Health and Wellbeing Clinic (Paignton)		0	0%
Health and Wellbeing Clinic (Torbay)	4	0	20%

Mid Devon Mental Health and Recovery		1	0%
Newton Abbot Community Mental Health Team	9	0	7%
North Adult Community Review	3	0	15%
North Adult Community Sector A	8	0	15%
North Adult Community Sector B	7	0	15%
North Adult Community Sector C	6	1	15%
North and Mid Mental Health Assessment Team	8	3	7%
North and Mid STEP	8	0	17%
North Devon Administration	6	2	6%
North Devon Community Practice Leads	0	0	4%
North Devon Mental Health and Recovery		0	0%
North Devon Psychosis and Recovery	0	2	0%
Paignton Administration	10	0	25%
Paignton and Brixham Mental Health and Recovery		1	0%
Self harm service North Devon	2	0	0%
South and West PAR STEP	1	0	3%
South Hams and West Devon Mental Health	7	1	6%
South West and Torbay Mental Health Assessment Team	16	3	8%
Teignbridge Community Mental Health	6	0	6%
Torbay Central Adult Community	10	0	12%
Torbay Community Practice Leads		0	0%
Torbay North Adult Community	10	0	10%
Torbay Psychosis and Recovery	0	1	0%
Torbay South Adult Community	6	3	8%

Torbay, South and West STEP	11	0	13%
Torquay Mental Health and Recovery		0	0%
Totnes Community Mental Health Team	8	2	7%
Core service total	247	36	8%
Trust Total	2187	298	14%

The sickness rate for this core service was 6.4% between 1 August 2016 and 31 July 2017. The most recent month's data 31 July 2017 showed a sickness rate of 6%.

The core service sickness had been above the trust levels for 10 of the 12 months reported. Their highest sickness occurred over a three-month period between November 2016 and January 2017, where their levels were between 8.4% and 8.8%.

Team	Total % staff sickness (at 31 July 2017)	Ave % permanent staff sickness (over the past year)
Community Service Managers Administration	0%	2%
Devon Liaison and Diversion Service	9%	4%
East and Mid Adult Community Crediton	0%	14%
East and Mid Adult Community Exmouth	8%	11%
East and Mid Adult Community Honiton	9%	11%
East and Mid Adult Community Tiverton	1%	2%
East and Mid Community Practice Leads	-	2%
East and Mid Psychosis and Recovery	100%	6%
East Devon Mental Health and Recovery	-	16%
Exeter Adult Community Clyst	7%	4%
Exeter Adult Community Culm	6%	11%
Exeter Adult Community Exe	14%	9%
Exeter and East Mental Health Assessment Team	8%	10%
Exeter and East STEP	0%	2%
Exeter Community Practice Leads	-	0%
Exeter Mental Health and Recovery – Clyst	-	1%

Exeter Mental Health and Recovery – Exe	-	3%
Exeter PAR STEP	-	15%
Exeter Psychosis and Recovery	-	9%
Exeter Psychosis and Recovery Team	-	0%
Haydons Court Admin	-	7%
Health and Wellbeing Clinic (Barnstaple)	0%	0%
Health and Wellbeing Clinic (Exeter)	29%	10%
Health and Wellbeing Clinic (Paignton)	0%	5%
Health and Wellbeing Clinic (Torbay)	13%	4%
Mid Devon Mental Health and Recovery	-	4%
Newton Abbot Community Mental Health Team	0%	3%
North Adult Community Review	0%	0%
North Adult Community Sector A	13%	10%
North Adult Community Sector B	0%	0%
North Adult Community Sector C	6%	1%
North and Mid Mental Health Assessment Team	1%	3%
North and Mid STEP	5%	1%
North Devon Administration	0%	7%
North Devon Community Practice Leads	0%	0%
North Devon Mental Health and Recovery	-	6%
North Devon Psychosis and Recovery	-	10%
Paignton Administration	9%	7%
Paignton and Brixham Mental Health and Recovery	-	3%
Self harm service North Devon	0%	4%
South and West PAR STEP	0%	5%

South Hams and West Devon Mental Health	8%	18%
South West and Torbay Mental Health Assessment Team	7%	9%
Teignbridge Community Mental Health	2%	1%
Torbay Central Adult Community	4%	3%
Torbay Community Practice Leads	-	0%
Torbay North Adult Community	4%	4%
Torbay Psychosis and Recovery	-	8%
Torbay South Adult Community	0%	7%
Torbay, South and West STEP	1%	4%
Torquay Mental Health and Recovery	-	2%
Totnes Mental Health	7%	3%
Core service total	6%	6%
Trust Total	5%	5%

Medical staff

- Staff were able to access a psychiatrist at short notice. Consultants were attached to an assessment clinic each week for one whole day. While this meant that the assessment function was able to refer service users into medical appointments, doctors we spoke to felt it added pressure to their responsibilities in their community teams.

Mandatory training

- The overall compliance for mandatory training courses at 31 July 2017 was 81%. However, of the training courses listed 18 failed to achieve the trust target and of those, nine failed to score above 75%.
- Fire safety and information governance both scored under the required 90% compliance rate for mandatory training within the trust.

Key:

Below CQC 75% | Between 75% & trust target | **Trust target and above**

Training course	This core service	Trust target %	Trustwide mandatory training total %

Business Continuity Planning	96%	tbc	89%
Clinical Risk	97%	90%	97%
Clinical Risk (Level 2)	83%	Tbc	80%
Clinical Risk Basic Awareness - Non Clinical	94%	tbc	88%
Conflict Resolution	90%	90%	90%
Equality and Diversity	97%	90%	98%
Fire Safety 2 years	81%	90%	83%
Health and Safety (Slips, Trips and Falls)	95%	tbc	95%
Infection Prevention (Level 1)	97%	90%	95%
Information Governance	88%	90%	94%
Manual Handling – Object	96%	90%	90%
MAPPA (Level 1)	93%	tbc	94%
Medicines Optimisation - Administration of Injectables	60%	tbc	71%
Medicines Optimisation - Anaphylactic Shock	68%	tbc	74%
Medicines Optimisation - Basic Awareness (Level 1)	80%	tbc	83%
Medicines Optimisation - Controlled Drugs - Community	67%	tbc	73%
Medicines Optimisation - Introduction (Level 2)	84%	tbc	83%
Medicines Optimisation - Shared Decision Making	76%	tbc	74%
Mental Capacity Act (Level 2)	31%	tbc	32%
Mental Capacity Act Level 1	96%	90%	97%
Mental Health Act - Level 2 – Community	69%	tbc	77%
MEWS	0%	tbc	83%
Physical Health and Wellbeing	77%	tbc	88%
PREVENT (Level 2)	54%	tbc	62%
Safeguarding	98%	90%	98%
Safeguarding Adults (Level 2)	83%	tbc	87%
Safeguarding Adults (Level 3)	16%	tbc	27%
Safeguarding Children (Level 2)	88%	tbc	90%
Safeguarding Children (Level 3)	54%	tbc	58%
Core Service Total %	**81%**	**N/A**	**82%**

Assessing and managing risk to service users and staff

Assessment of patient risk

- All records held a comprehensive risk assessment of service users at first contact with the service. We looked at 43 sets of service user records across the sites. Risk assessments were updated regularly and all were in date. Staff were risk aware and said that they updated when things changed but would also carry out a periodic reassessment of risk every six months.

Management of patient risk

Crisis plans to manage relapse of mental health problems were in place and there was clear service user involvement in creating these. Crisis plans were given to the service user. However, crisis plans varied in quality and detail and it was not always clear what steps a person should take if they were in crisis. The trust had migrated to a new care record system approximately 12 months prior to the inspection and archived risk information was not always pulled across effectively into the new risk assessment or clearly accessible.

Waiting lists into the team varied across the trust and there was a clear waiting list protocol in place to ensure that the risk of service users waiting for treatment was assessed. Despite waiting lists being managed differently from team to team there was evidence of regular contact with service users documented in the electronic care records.

Safeguarding

Staff were aware of how to respond to a safeguarding alert. There were allocated nurses within the trust who were identified as leads for safeguarding. Local panels had been set up to keep track of open cases related to safeguarding.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Lone working practices were in place across the trust and staff showed that they understood the need to be safe while out in the community. Staff details were kept updated in reception to ensure that they had the right information to contact staff while off site.

Staff access to essential information

Staff used an electronic record system to record information essential to care such as care plans and risk assessments.

Medicines management

In the community teams there was a lack of governance arrangements in place to ensure that medicine cards were completed thoroughly with essential personal and clinical information included and to ensure that medicines were stored safely and for staff to be assured that all medicines were in date. At the last inspection fridge temperatures were not consistently monitored so the trust was advised that they should ensure that this was addressed. At this inspection, Fridge temperatures were not being monitored at Estuary House or Sherbourne Lodge. At Sherbourne Lodge there was no ongoing recording of room temperature. On the day of the

inspection, the room temperature was just over 25 degrees Celsius on a cold day. There was medication that could not be stored above this temperature; there was therefore no assurance that staff were keeping the medication at a safe temperature to ensure it worked effectively. The trust had provided medicines optimisation briefing on ensuring that medicines were stored safely in the event of the temperature exceeding 25 degrees celsius. There was no evidence that this briefing was being followed. For example staff were supposed to be monitoring the temperature and responding by reducing medication stock if it went above 25. An incident form for medication stored above 25 degrees celcius for more than 14 days should be completed but staff would not have known if this had occurred. A drug cupboard at Estuary House had a number of service user specific injections that had no service user identifiable label on them. It was not clear whether doses were missed or if medication was over ordered. There were a number of injections in the fridge which was not being monitored for its temperature. There was long acting injection demonstration kits for students mixed in with prescribed and stock medication. There were out of date medicines in one of the cupboards, one of these expired over four years ago. There was no evidence that medication was being audited in line with trust policy. Although medication was stored safely it was accessible to all staff including unqualified members of the team and admin staff.

There was no audit system in place to ensure that staff completed medication cards effectively in order to have all the information needed in the safe administration of depot medication. We reviewed 15 medicine cards for the administration of depot medication. Nine were from the Newton Abbot team, two of the cards had missing batch numbers and one of them had a missing expiry date. The remaining six were with the Teignbridge team. Two were fully completed, four of them had missing allergy information, two were signed as being given but there was no date and one of them had a missing medication batch number. There were five cards amongst that were no longer being used, that were out of date and had not been filed with service user records.

Track record on safety

Staff gave examples of how the trust responded to serious incidents. One incident that involved a fatality had a route cause analysis conducted which showed that the staff had clearly worked to their policy about conducting reviews of the service user. The route cause analysis was conducted in order to see if there was any learning that needed to take place. Staff felt the approach to investigating serious incidents was fair and supportive.

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 August 2016 and 31 July 2017 there were 16 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was apparent/actual/suspected self-inflicted harm meeting SI criteria with 14. Two of the unexpected deaths were instances of apparent/actual/suspected self-inflicted harm meeting SI criteria.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

Exeter adult community – Culm and North adult community sector B both reported the highest number of incidents out of the other areas with two incidents each.

Type of incident reported on STEIS	Number of incidents reported			
	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Unauthorised absence meeting SI criteria	Grand Total
East & Mid Adult Community Team – Crediton	1			1
East and Mid Adult Community – Exmouth	1			1
Exeter & East Mental Health Assessment Team (Exeter)		1		1
Exeter Adult Community – Culm	2			2
Exeter Adult Community - Exe (Exeter)			1	1
Exeter Adult Community Clyst	1			1
Exeter Mental Health & Recovery – Exeter	1			1
Newton Abbot Mental Health Team	1			1
North Adult Community Sector B	2			2
North Devon Mental Health & Recovery-Barnstaple	1			1
North Devon Psychosis & Recovery STEP team (Bideford)	1			1
South & West Mental Health Assessment Team	1			1
Teignbridge Community Mental Health Team	1			1
Torbay Central Community Mental Health Team	1			1
Total	14	1	1	16

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the previous inspection staff were not always clear on the threshold for reporting incidents and needed more guidance. Staff we spoke with on this inspection appeared to be clear on what to report and how to report it. Staff gave examples of incidents that they had reported and the learning that had been cascaded as a result.

Staff were aware of the duty of candour and the importance of being open with service users when something had gone wrong with their care.

Incidents were reported using the electronic recording system. Feedback was given to staff following an incident in order to gain some learning and to close the incident down. Incidents were discussed in a learning experience meeting and shared across the community teams. Managers fed back learning through their local business meetings. Safety bulletins were updated on the intranet page.

Is the service effective?

Assessment of needs and planning of care

Assessments were conducted by dedicated assessment teams. The assessment was aimed at identifying the problems that a service user was experiencing and then identifying the correct treatment pathway for them. The service had changed the way it provided the service by creating two care pathways for service users to access. The first intervention pathway was there for staff to provide treatment and structure to service users experiencing mental illness such as depression or schizophrenia. The second pathway was the personality disorder change pathway for those service users with a diagnosis or working diagnosis of personality disorder.

Assessments conducted were comprehensive and focussed on areas such as lifestyle, smoking, alcohol, substances, diet, exercise and experience. Consent to treatment was sought. Following the assessment staff created a formulation and working diagnosis in order to identify if the treatment pathways were appropriate. Following a referral into the community mental health teams, service users were placed on a waiting list until there was capacity to start treatment. If a service user required urgent treatment then the community teams accepted them for treatment immediately or they were referred to the crisis team.

Information gained from the assessment was communicated to the service user and GP through a letter. While the letters were written in different styles we found that essential information was included with a plan for treatment, if accepted. However, we did not always find that the letter was in the electronic care record due to the pressure on the admin team responsible for writing them.

Of the 43 sets of notes we looked at, there was only one set of notes with no care plan included. Care plans were generally personalised and recovery orientated but included service users views, however there was variation in the detail of information in the care plans. All care plans were kept in an electronic records system.

Best practice in treatment and care

There was clear evidence that staff followed National Institute for Health and Care Excellence (NICE) when prescribing medication. The care records showed how decision for medication had met the guidance, for example, for prescribing antipsychotic medication. The intervention and personality disorder care pathways had been set up based on NICE guidance.

However, we found there was a lack of appropriate physical health monitoring recommended by NICE for service users prescribed antipsychotic medication. NICE guidance advises that service users receiving antipsychotic treatment should have a physical health assessment each year and that the results should be shared with the GP. The NHS Five Year Forward View emphasises the need for service users to have their physical health assessed and having physical health needs met. Of the 43 sets of notes we reviewed we found only seven physical health assessments were carried out. There was no evidence of use of best practice resources such as the Lester cardio-metabolic tool. There were no physical health care plans, as a result of the gap in physical health assessment. We spoke to staff working within the community teams, we spoke to the team managers, all felt that physical health assessment and care was a gap in their practice. They felt they were not provided the equipment to do the job properly in this area so could not practice effectively. Staff at the Torbay hub stated that they wanted to set up a physical health clinic to

improve physical health monitoring. However, the staff member at the Clozapine clinic at Wonford House undertook comprehensive physical reviews of service users. There was access three half days per week to a cardiologist who reviewed service users.

Staff expressed concern about the gap in a specialist eating disorders service for the mental health teams. The GP was the lead for physical healthcare but there was no formal one to one support from an eating disorder service.

The trust had introduced care bundles for staff to use with service users on the care pathways. The care bundles were set up to work with service users around areas such as managing with distress, anxiety and emotional regulation. Following on from the work using the care bundle staff assessed whether a service user needed to be referred through to psychological therapies. A decision was also made as to whether a care coordinator was still needed. Despite the care bundle being introduced, we heard from many staff who said that they had not had the time to use it and that it had not been embedded into their practice. Managers acknowledged that more work was needed to embed the bundles into practice.

Staff used the Health of the Nation Outcome Scale (HONOS) to assess the outcomes of service users treatment. The clustering attached to HONOS allowed staff to identify the appropriate treatment pathway. Staff showed evidence of using recognised tools such as the Becks Depression Inventory and the Generalised Anxiety Disorder Assessment.

This core service participated in four clinical audits as part of their clinical audit programme 2016 – 2017.

Audit name / title	Audit scope	Core service(s) that participated in the audit	Type of audit	Date completed
Antimicrobial prescribing	Adult, Older Adult, Specialist and Secure	Cross Directorate	This audit was to identify the level of compliance with Trust antimicrobial prescribing standards (Trust Policy P05) and local prescribing formulary recommendations. This audit is a requirement of the Trust's Infection Prevention and Control annual work programme and action plan which ensures Trust adherence to national best practice guidance issued by the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI), Department of Health: Antimicrobial Stewardship: "Start smart - then focus" Guidance for antimicrobial stewardship in hospitals (England).	June 2017 to be presented at IPCC in October
Physical Health Monitoring - Schizophrenia CQUIN	Acute Inpatient Ward, Medium or High Secure Unit, Low Secure Unit, Older Adults Ward, High Dependency/Rehabilitation Ward, Community Teams	Inpatient and Community	This audit was undertaken to meet the requirements of a nationally set CQUIN target. To ensure physical health monitoring checks are taking place within the inpatient and community settings.	April 2017

Physical Health Monitoring - Schizophrenia CQUIN	East and Mid PAR STEP, East and Mid Adult Community – Crediton, East and Mid Adult Community – Exmouth, East and Mid Adult Community - Honiton, East and Mid Adult Community – Tiverton, Exeter Adult Community – Clyst, Exeter Adult Community – Culm, Exeter Adult Community – Exe, Exeter and East Devon STEP, Exeter OPMH, LD Intensive Assessment Team -North & Mid, North Adult Community Ilfracombe, North & Mid Devon STEP, North Devon Mental Health and Recovery North Devon PAR, Russell Clinic, South Hams and West Devon OPMH Community, Teignbridge Community Mental Health, Torbay Central Adult Community, Torbay North Adult Community, Torbay PAR STEP, Torbay South Adult Community Torbay, South and West Devon STEP, Totnes Mental Health	Cross Directorate	This audit was undertaken to meet the requirements of a nationally set CQUIN target. To ensure essential information needed for safe and effective care of service users who are also seen by secondary care mental health services is communicated to primary care professionals.	April 2017

The uptake and utilisation of clozapine assays in Exeter, east and mid Devon	Community Exeter, East & Mid Devon	Community services	The purpose of this audit was to identify whether there was a disparity in service offered to service users depending on whether or not they attend the Wellbeing Clinic for their Clozapine monitoring. Specifically, whether more service users have a Clozapine assay taken if their monitoring is undertaken at the Wellbeing Clinic, than those where it is done by the GP or acute hospital blood room.	18 October 2016

Skilled staff to deliver care

Staff were experienced and qualified to undertake the role that they were working in. There was a variety of professionals such as nurses, occupational therapists, social workers, doctors, psychologists and support workers. Staff felt that they had received an appropriate induction when they started within the service.

Managers supervised and appraised members of staff in their teams. Staff said that they felt that they had sufficient support on both an informal basis and formally through the supervision process. Managers said that they had attempted to stay on top of appraisals and supervision but they were often missed due to sickness or absence such as annual leave rather than not being done due to lack of time or priority. For example Torbay North team had members of staff on long term sick and as a result had an appraisal completion of 60% and supervision completion of 70%. The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for non-medical staff within this core service was 79%.

Staff were able to access specialist training appropriate to their role. For example we found examples of staff accessing non-medical prescribing courses. Staff booked training through their intranet site. Managers were generally supportive of staff when they wanted to access training.

There was one issue raised regarding staff performance. This had affected members of the team involved due to the seriousness of allegations. The issue had been dealt with swiftly and effectively by the provider.

Nineteen teams were failing to achieve the trust's appraisal target, the lowest being North Devon Community Practice Team, Paignton & Brixham Mental Health Recovery, Self-harm North Devon and Torquay Mental Health & Recovery all with 0% (albeit the teams only having one individual each which required an appraisal). North Adult Community Sector A and East & Mid Adult Community Exmouth both followed with 44%.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals

East Devon Mental Health and Recovery	1	1	100%
Exeter Adult Community Culm	10	10	100%
Exeter and East STEP	7	7	100%
Exeter PAR STEP	1	1	100%
Health and Wellbeing Clinic (Exeter)	1	1	100%
Health and Wellbeing Clinic (Torbay)	1	1	100%
Mid Devon Mental Health and Recovery	2	2	100%
North Adult Community Review Team	3	3	100%
North and Mid Mental Health Assessment Team	9	9	100%
North Devon Administration	7	7	100%
Teignbridge Community Mental Health	10	10	100%
Torbay Central Adult Community	9	9	100%
Torbay Psychosis and Recovery	1	1	100%
Torbay, South and West STEP	10	10	100%
Torbay North Adult Community	12	11	92%
Totnes Mental Health	10	9	90%
South Hams and West Devon Mental Health	9	8	89%
Exeter Adult Community Clyst	14	12	86%
Newton Abbot Mental Health	12	10	83%
Torbay South Adult Community	6	5	83%
East and Mid Adult Community Crediton	9	7	78%
Exeter Adult Community Exe	11	8	73%
Exeter and East Mental Health Assessment Team	11	8	73%
East and Mid Adult Community Honiton	6	4	67%
East and Mid Adult Community Tiverton	9	6	67%
North Adult Community Sector B	6	4	67%
South West and Torbay Mental Health Assessment Team	19	11	58%
North Adult Community Sector C	7	4	57%
North and Mid STEP	2	1	50%
East and Mid Adult Community Exmouth	9	4	44%
North Adult Community Sector A	9	4	44%
North Devon Community Practice Leads	1	0	0%
Paignton and Brixham Mental Health and Recovery	1	0	0%
Self-Harm Service North Devon	1	0	0%
Torquay Mental Health and Recovery	1	0	0%
Community Service Managers Administration	0	0	-
Health and Wellbeing Clinic (Barnstaple)	0	0	-
Health and Wellbeing Clinic (Paignton)	0	0	-
Newton Abbot East Administration	0	0	-

Newton Abbot West Administration	0	0	-
North Adult Community Review	0	0	-
Paignton Administration	0	0	-
South and West PAR STEP	0	0	-
Totnes Administration	0	0	-
Core service total	237	188	79%
Trust wide	2095	1763	84%

The trust's target rate for clinical supervision is 90%. As at 31 July 2017, the overall clinical supervision compliance for non-medical staff ranged between 55.6% and 100%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it is important to understand the data they provide.

The trust have not provided the actual number of sessions identified and undertaken, they have provided the percentage by month of staff (medical and qualified nursing staff, Band 5 and above) in date under trust clinical supervision polices. The ranges are outlined in the table below:

Name of hospital site or location	Ward/Team	Clinical supervision 9%) as of 31 July 2017
Crediton Hospital	East and Mid Adult Community Crediton	100.0%
St John's Court	East and Mid Adult Community Exmouth	83.3%
Haydon's Court	East and Mid Adult Community Honiton	50.0%
Silverlea, Tiverton	East and Mid Adult Community Tiverton	100.0%
Wonford House	East and Mid PAR STEP	-
Wonford House	East and Mid Psychosis and Recovery	-
Wonford House	East Devon Mental Health and Recovery	-
Wonford House	Exeter Adult Community Clyst	75.0%
Wonford House	Exeter Adult Community Culm	33.3%
Wonford House	Exeter Adult Community Exe	100.0%
Wonford House	Exeter and East Mental Health Assessment Team	77.8%
Wonford House	Exeter and East STEP	50.0%
Wonford House	Exeter Community Practice Leads	-
Wonford House	Exeter Mental Health and Recovery - Clyst	-
Wonford House	Exeter Mental Health and Recovery - Exe	-
Wonford House	Exeter PAR STEP	-
Wonford House	Exeter Psychosis and Recovery	-
Chadwell Health and Wellbeing Clinic	Health and Wellbeing Clinic (Paignton)	-
Silverlea, Tiverton	Mid Devon Mental Health and Recovery	-
Estuary House	Newton Abbot Mental Health	100.0%
Riverside	North Adult Community Review	100.0%
Riverside	North Adult Community Review Team	-
TorHouse	North Adult Community Sector A	85.7%
TorHouse	North Adult Community Sector B	100.0%
Quay Centre	North Adult Community Sector C	33.3%
Crediton Hospital	North and Mid Mental Health Assessment Team	100.0%
Quay Centre	North and Mid STEP	100.0%

Tor House	North Devon Community Practice Leads	-
Riverside	North Devon Mental Health and Recovery	-
Quay Centre	North Devon PAR STEP	-
Quay Centre	North Devon Psychosis and Recovery	-
Chadwell Health and Wellbeing Clinic	Paignton and Brixham Mental Health and Recovery	-
Estuary House	South and West PAR STEP	-
The Quay	South Hams and West Devon Mental Health	83.3%
Torbay Health and Wellbeing Hub	South West and Torbay Mental Health Assessment Team	100.0%
Estuary House	Teignbridge Community Mental Health	80.0%
Chadwell Health and Wellbeing Clinic	Torbay Central Adult Community	100.0%
Chadwell Health and Wellbeing Clinic	Torbay Community Practice Leads	-
Torbay Hospital	Torbay North Adult Community	100.0%
Chadwell Health and Wellbeing Clinic	Torbay PAR STEP	-
Chadwell Health and Wellbeing Clinic	Torbay Psychosis and Recovery	-
Chadwell Health and Wellbeing Clinic	Torbay South Adult Community	0.0%
Chadwell Health and Wellbeing Clinic	Torbay, South and West STEP	100.0%
Chadwell Health and Wellbeing Clinic	Torquay Mental Health and Recovery	-
Leatside Surgery	Totnes Mental Health	75.0%

Multidisciplinary and interagency team work

The teams had regular effective multidisciplinary team meetings to review referrals and to discuss current service users who were receiving treatment within the service. These were attended by a variety of professionals. Staff were engaged in the meetings and there was a clear agenda to follow.

Staff felt handover within the teams worked well for example when they were referring someone on to the crisis team.

We found good examples of staff working closely with local teams such as the police and the local housing services. Staff had worked with them and attended meetings in order to share risks and to build relationships for the benefit of services users. For example to improve access to the local substance misuse service. Staff felt there were good links with social services and safeguarding leads within them. There was a monthly meeting with child and adolescent mental health services (CAMHS) to smooth transition for those needing to access adult services.

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

A S117 register was in place and there had been a recent push on completing reviews for those requiring after care. Staff were working with social care colleagues to ensure that appropriate funding was in place. A social care panel reviewed the resource allocation requests from care coordinators when additional social care needs were identified.

The AMHP team held the register for service users on a community treatment order. We reviewed a sample of community treatment order records (CTO) and all were in order.

Staff said that there were no delays in accessing a Mental Health Act assessment when required. The local crisis services and the approved mental health practitioner team were responsive.

As of 31 July 2017, 69% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Good practice in applying the Mental Capacity Act

In the previous inspection, there was varied knowledge of the Mental Capacity Act (MCA) amongst staff. On this inspection, staff were knowledgeable of the Mental Capacity Act (MCA) and when they might assess a service users capacity.

We found examples where best interest decisions were made when service users capacity was an issue. We reviewed notes for adherence to the MCA and found that the assessment teams assessed capacity using the principles and when there was evidence of impaired capacity.

As of 31 July 2017, 96% of the workforce had received training in the Mental Capacity Act (Level 1) and only 31% of the workforce received training in Level 2. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff spoke about service users in a compassionate and caring way. They were knowledgeable of service user's needs and we found good evidence that they included them in their care planning. Service users that we spoke with were happy with the care that they were receiving and spoke positively about the staff and felt that they understood their needs and were supportive. We heard that staff were approachable and were good listeners, service users felt staff cared for them.

We observed staff interaction with service users and found them to be kind and caring. They were able to respond to risk effectively and they showed awareness of how to protect service users at risk in the community. However, we also heard that some service users felt there were too few staff and that the ones there were very busy.

The involvement of people in the care they receive

Involvement of service users

Care plans demonstrated service user involvement. Of the 42 records that we reviewed there were three that did not demonstrate that a service user had been involved with and been given a copy of the care plan. Care plans showed that service user's independence was encouraged, for example supporting them to attend appointments away from their home in order to work through anxiety. Service user's consistently fed back that they were included in the care planning process and felt that their views were taken on board. Records showed letters were written in the first person and shared with the GP, this showed that the service user was listened to and communication was directed at them rather than to the GP.

Service users provided feedback on the performance of the team through questions based on the friends and family test. The friends and family test was given out at the time of assessment, staff also sought views of service users at points through their treatment.

Involvement of families and carers

Carers allocated workers were attached to each team. Staff provided carer forums in order to ensure that carers were involved. Carers' views were sought when necessary and these were reflected in care plans that we reviewed. Carers were invited to be involved in more senior interview panels.

Is the service responsive?

Access and waiting times

The new pathways for care gave clear criteria for who was accepted into the community mental health teams. At the time of the inspection there were 675 service users on the waiting lists across the county, 197 of these were waiting over 18 weeks. Referrals were triaged by the teams when they were received. Managers managed the risk of service users on the waiting lists effectively. Service users were rated according to risk when accepted into the community team in order to safely triage the referral. Those that were rated red were immediately allocated a care coordinator; amber risks were contacted monthly to reassess their risk and to provide verbal support; green risks were contacted two monthly. Staff felt that this was good approach and an opportunity to offer genuine support while people waited.

The trust had put a plan in place to reduce the waiting lists into the community team. The manager at Torbay South showed the trajectory for reducing the waiting list. Since March 2017 the waiting list had reduced from over 80 to below 50 by October, however, October was the month that there should have been zero on the waiting list. We were told that the team simply did not have the resources to fulfil the plan. Statistics showed that rather than zero there were 82 waiting for treatment. Over the previous year from November 2016 to October 2017 the service had gone from having 11 referrals and 21 discharges per month to 15 referrals and eight discharges per month. However over the year the team had discharged 199 service users while only accepting 176 referrals.

Waiting times for assessment were given clear performance indicators of 10 days wait for a routine assessment and five days wait for an urgent assessment. There was a clear difference between teams in meeting this target. At the time of the inspection the Torbay assessment team was seeing only 15% of service users within 10 days and 46% seen within five days, this was due to staffing levels. Staff at Wonford House were able to see service users much quicker with the 10 day target being met.

Each team continued to have a duty worker to respond to service users who called in or needed support over the phone or turning up in person. This service was given to those on the waiting list to ensure that they can access the service despite not having a named practitioner.

Staff were aware of the policy for if service users did not attend appointments. There were proactive measures in place to maximise engagement with the service such as meeting service users in their preferred location as well as on site. Staff proactively followed up service users that did not attend assessments and communicated with the GP if they were not able to assess them.

When appointments were cancelled, for example if a staff member was off sick, then staff communicated with the service users to rearrange. If the appointment was urgent then the duty worker was expected to cover.

The provider had set up SMART recovery that meant staff were able to see service users in satellite hubs in smaller market towns in order for service users to attend appointments and be seen closer to home. The emphasis was for service users to attend clinics rather than be seen at home. However, home visits were still being conducted when needed.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The core service met the referral to assessment target in one of the targets listed. Torbay health and wellbeing hub service users are waiting an extra six days (20 vs 14 days), before receiving their initial assessment from the day that they were referred. Exeter health and wellbeing clinic are also taking an extra five days before service users are receiving their initial assessment.

The core service met the assessment to treatment target in one of the targets listed. Service users under North and Mid Devon Mental Health Assessment Team are receiving treatment 23.5 weeks after their initial assessment, more than the 13-week target. South West and Torbay mental health assessment team are taking slightly longer from assessment to treatment with 14 weeks.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
			National target	Actual (mean)	National target	Actual (mean)
Exeter Health and Wellbeing Clinic	Exeter and East Devon Mental Health Assessment Team	Adult Community Mental Health	14 Days (10 working days) Local Internal	19	13 Weeks (Local)	0
Crediton Hospital	North and Mid Devon Mental Health Assessment Team	Adult Community Mental Health	14 Days (10 working days) National	11	13 Weeks (Local)	23.5
Torbay Health and Wellbeing Hub	South West and Torbay Mental Health Assessment Team	Adult Community Mental Health	14 Days (10 working days) National	20	13 Weeks (Local)	14

Lost to Follow Up

There is no data pertaining to the number of 'out service users' who have been lost to follow up for this core service.

However, the trust has advised of the average waiting times for a follow up appointment for this core service. Between August 2016 and July 2017 community based mental health services for adults of working age have an average wait time for a follow up appointment of 0.29 weeks (0.29 of a week = almost three days). The trust target is one week (7 days).

The facilities promote comfort, dignity and privacy

Staff had appropriate rooms in order to meet for individual sessions and group sessions with service users. While there were ample rooms in the Torbay site we were told that rooms were of a premium at Wonford House. Staff felt that it was often difficult to book rooms and guarantee that they had a place to meet with service users. Staff also felt the environment was too clinical. However, the environments were comfortable, clean and soundproofed.

There was evidence of a number of different leaflets in the waiting rooms and throughout the buildings, which included mental health problems, local services, service user's rights, help-lines, how to complain and advocacy services.

Service users' engagement with the wider community

Prior to the redesign of the service into care pathways the trust had engaged with the local community in order to communicate their plans. They sought experience of people in the community and talked about a range of issues in order to help their strategy for providing services.

Meeting the needs of all people who use the service

Leaflets and information in different languages were not on display in team buildings but they could be printed from the trust's intranet system. Translation services were available via their intranet.

There was evidence of attempts to engage service users whose first language was not English by accessing interpreters for the assessments. Staff were aware of how to access an interpreter.

Listening to and learning from concerns and complaints

The trust had appointed formal complaints investigators, this had taken the work load off of managers which was welcomed by them. Managers said that all formal complaints went through the Patient Advice and Liaison Service (PALS). However not all managers formally recorded informal complaints in order to record trends within the service. Managers in the assessment service said that complaints themes were generally around waiting times and recommendations that had not been followed through, for example, referrals into psychology. However the biggest issue was complaints by people who were not given a service following assessment.

Service users we spoke with knew how to complain and there was complaints information displayed on the sites. We spoke with one person that was currently going through a complaint at the time of the inspection; this was not about the quality of the care being provided but a separate issue.

Staff received feedback and learning from complaints through their local business meetings

This core service received 113 complaints between 1 August 2016 and 31 July 2017.

Top five complaints received for this core service included: Patient Care with 27% (30), Values & Behaviours (Staff) with 18% (20), Access to treatment with 14% (16), Communications with 14% (16) and Clinical treatment with 10% (11).

Exeter adult community – Exe received the most complaints with 14, five were in relation to patient care and three regarding communications. Exeter & East mental health assessment team followed with 12 complaints, five relating to values & behaviours (staff) and three regarding clinical treatment.

Ward	Access To Treatment Or Drugs	Admissions & Discharges (Exc Delayed Discharge)	Appointments	Clinical Treatment	Communications	Consent	Other	Patient Care	Trust Admin/Policies/Procedures Inc Patient Record	Values And Behaviours (Staff)	Waiting Times	Grand Total
Exeter Adult Community – Exe	2		1	1	3		1	5			1	14
Exeter And East Mental Health Assessment Team			1	3	2		1			5		12
South And West Mental Health Assessment Team	2	1			3					1	2	9
Torbay North Community Mental Health Team	2	1			1		1	1		2		8
South Hams And West Devon Mental Health	1				1				2	2		6
Exeter Mental Health And Recovery - Exe			1	2	1			1				5
Teignbridge Community Mental Health							1	3	1			5
Torbay South Community Mental Health	2							1		2		5
Totnes Mental Health	1							2		2		5
East And Mid Psychosis And Recovery STEP					1		1	3				5
Exeter Adult Community – Culm				1		1		1		1		4
Newton Abbot Community Mental Health Team	1				2					1		4
Torquay Mental Health And Recovery	1			1				1		1		4
East And Mid Adult Community - Exmouth	1				1			1				3
East Devon Mental Health And Recovery	2							1				3
Exeter Adult Community – Clyst	1	1						1				3
North Devon Mental Health And Recovery					1			1		1		3
East And Mid Adult Community – Honiton				1						1		2
Exeter Mental Health And Recovery - Clyst								2				2
North Adult Community Sector A								1		1		2
North Adult Community Sector B								1			1	2
North And Mid Mental Health Assessment Team				1				1				2
East And Mid Adult Community - Crediton								1				1
East And Mid Adult Community - Tiverton								1				1
North Adult Community Review Team							1					1
North Adult Community Sector C								1				1
Torbay, South And West STEP				1								1
Grand Total	16	3	3	11	16	1	6	30	3	20	4	113

This core service received 28 compliments during the last 12 months from 1 August 2016 to 31 July 2017, which accounted for 4% of all compliments received by the trust as a whole (627).

Is the service well led?

Leadership

Staff we spoke with were aware of the senior leadership team within the trust. There were mixed reports from staff who felt that they were supportive but others felt that there was a dictatorial top down approach to the trust where staff were not included in decision making. Some staff we spoke with felt that they were not being listened to about the capacity of the community teams and the extra workloads that had resulted from changes.

All managers felt supported by the relevant service managers who were visible, responsive and able to escalate effectively. The individual community teams were well led and managers were knowledgeable and worked with their team to provide good treatment. The recent change in the service to care pathways had been implemented but staff acknowledged that there was still work to be done. For example, to reduce waiting times and to embed use of the intervention bundle.

Vision and strategy

Generally staff were aware of the visions and values set by the trust and agreed with them. We did not however find any local objectives based on trust values.

Culture

Most staff felt valued by the organisation and there were areas of good morale in the teams but this was variable. Staff were supportive of one another although they were very busy and felt stretched at times. Staff were supervised formally and provided informal supervision and support to each other on a daily basis. Relationships between staff were generally very good.

There was a bullying issue at one site that we inspected. This issue was discussed with the service manager and it was clear that when the issue had come to light, the trust had taken swift action to deal with it but it had impacted staff.

Staff were aware of the whistleblowing process. The culture within the trust was one that staff felt they could speak up, they were not aware of a speak up guardian that they could approach if needed. There was a small number of staff that were unhappy with changes made to the assessment function and felt that the commitment to the assessment team had impacted on their ability to work effectively in the community teams. One member of staff said that they feared of raising concerns within the trust through fear of victimisation.

During the reporting period (14 August 2016 to 14 August 2017), there were two cases where staff have been suspended. Of the two cases, one involved a Band 6 individual and the other a Band 7, both suspended.

Team name	Timeframe	Suspended	Grade	Comments
Wonford House	11/7/17 to present	Yes	7	Investigation on going. Initially redeployed for a previous investigation.

Wonford House	26/9/16 – 15/12/16	Yes	6	Individual dismissed then re-instated during appeal. Working for a new employer then. HCPC involved.

Governance

The teams used key performance indicators to ensure that they were operating effectively and identify areas for improvement. The performance indicators were held within and electronic system that was updated regularly to show areas such as adherence to waiting times for assessment and treatment, supervision and appraisal compliance and electronic record completion.

Managers took a sample of service user notes each month to audit in order to check for completion and quality.

There were local delivery unit meetings and learning from experience meetings to discuss trends of complaints across the trust and to share learning from incidents. We reviewed meeting minutes and discussed learning from incidents with managers. The service managers then fed into a senior team meeting which in turn fed into a board report in order to escalate issues and areas of good practice.

The trust have provided their board assurance framework, which details any risk scoring 16 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The two strategic ambitions outlined by the trust relating to this core service are as follows:

1 – To deliver consistently high quality care and treatment/To build a reputation as a recognised centre of excellence.
2 – To be an efficient, thriving and successful organisation with a sustainable future.

The trust has provided a document detailing their 11 highest profile risks. Five have a current risk score of 15 or higher. The following three of the five relate to this core service.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
20 February 2017	1833	If there is no Team Manager in the culm Team and two locum consultants THEN there will not be a comprehensive service in place to support clinicians and service users	16	6	1	Not yet reviewed
No date	1407	If the Adult Directorate does not achieve sustainable financial balance for 2017/18 and beyond THEN this will impact on the financial uncertainty of the Adult Directorate and services	16	6	2	18 August 2017

		offered. Financial unbalance will also cause a negative effect on the trust ability to invest in services and make further capital investment.					
1 September 2015	806	If the Adult Directorate is unable to recruit staff members from a larger external pool THEN we will continue to have issues of vacancies across the teams, areas and services that will not be reliant on drawing from an internal pool of possible applicants. This will not solve the issue of services capacity and delivery but will shift to a different service area.	16	8	2	18 August 2017	

Management of risk, issues and performance

Managers reported good access to training for their staff, including external training and events where it was demonstrated that it was required or part of their appraisal. Managers were able to request locum staff, although they were not always able to find suitable staff.

Staff were able to submit items to the risk register easily. Managers demonstrated how this could be done using the electronic incident record.

Some staff felt that financial pressures had affected their ability to provide care effectively. They felt that the teams did not have as many resources as they did in the past, for example, fewer staff. This was particularly evident at the Torbay site where lower staffing numbers through sickness and vacancies had impacted on certain staff caseloads. The Exeter site had difficulty with 12 staff leaving over the previous two years and this had impacted on the capacity of the team.

Information management

Staff were provided with IT equipment on site in order to effectively record service user contact and to store confidential information. There were however issues with remote working as not all staff had been given equipment in order for them to work off of the site. Staff thought that care would be enhanced if they could work on notes and care plans in a service users own home.

There were issues within the admin team at Wonford House who were responsible for uploading consent and in writing the formulation letters to the GPs and service users. The admin team were often short staffed and under pressure. There was a target of two weeks for uploading consent and in getting the formulation letter out but this target was not always being met.

Engagement

Some staff that we spoke with felt that they were not consulted about the change in the service towards using the personality disorder change pathway and the intervention pathway. Staff had reportedly left because of the changes and how they had been implemented.

Staff used their business meetings to discuss issues within the team and to feedback on what was working.

Learning, continuous improvement and innovation

The service had employed care coordinators and support workers into a veterans team in order to identify army veterans in the community who experienced mental health problems. Rates of referral had increased into this team due to their engagement with local charitable services such as combat stress. The team had worked on an assessment of service users mental health condition and provided extended support in order for them to access local services aimed at improving the mental health of army veterans. The service was tailored towards meeting the needs of veterans and included army veterans on the team.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

There is no data to insert under this heading at this present time for this core service.

Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Wonford House	Russell Clinic	16	Mixed

Is the service safe?

Safe and clean care environments

Safety of the ward layout

The building had many problems with line of sight. Staff had tried to mitigate this lack of sight by installing mirrors and CCTV. However, the design of the ward prevented clear lines of sight for staff. This, coupled with the ease of absconsion had meant that the ward was not suitable for someone who was at risk of absconding, or for someone who was at high risk of harming themselves. This had led to the trust implementing strict admission criteria.

Over the 12 month period from 1 Augusts 2016 to 31 July 2017 there were no mixed sex accommodation breaches within this core service or trust.

The wards main clinic room was in the female bedroom corridor. Staff also would use the female lounge as an extra care area when a patient required a low stimulus environment to calm down. Staff said that the last time they had used the extra care area was in July 2017, and that if patients were unhappy with males being present on the female corridor, then male patients could receive their medicines from a separate clinic room in a different part of the ward. Although there was a patient who needed a female only space on the ward at the time of this inspection, we saw that male patients were receiving medicines from the clinic on the female corridor.

The ward had a large number of environmental risk factors. To help manage these, staff completed audits of points that patients could fix a cord or rope to for the purpose of strangulation (known as a ligature point). These audits identified risks and included methods of managing them. The management plans included CCTV to cover the garden of the unit, increased staffing to manage nights and clinical observations. Some risks, such as mould had led to staff closing rooms. We saw that these actions were reflected in the incident log. There had been no ligatures in the six months before inspection.

There was a ligature risk at Russell Clinic over the last 12 months. The risk identified was considered ‘low’ risk by the trust.

The trust had taken actions in order to mitigate the ligature risk.

Maintenance, cleanliness and infection control

For the most recent Patient-led assessments of the care environment (PLACE) assessment (2017) one location contained a long stay rehab ward. Wonford House scored similar to other trusts for cleanliness however fell short of the England and trust averages for condition, appearance and maintenance of facilities and disability.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
WONFORD HOUSE HOSPITAL	Long stay/rehab Community adults	98.4%	91.6%	-	74.4%

Trust overall	98.2%	96.1%	89.3%	86.4%
England average (Mental health and learning disabilities)	98.0%	95.2%	84.8%	86.3%

At our visit, the ward was clean. However, we saw damage to furnishings and room closures due to the presence of mould. Staff said that works were delayed until senior management made a decision whether to renovate or relocate the ward.

Staff held audits on their adherence to infection control policies, there was access to hand washing facilities and alcohol gel. However, we saw that not all taps used for hand washing could be operated without using hands, which could present an infection control risk.

Seclusion room

The seclusion room on the ward was not fit for purpose and was not in use. Refurbishment work was under way to ensure the seclusion room met the requirements of the Mental Health Act Code of Practice. The seclusion room was located on the female corridor. Staff had identified and raised with the trust the risk of transporting a patient requiring seclusion to a suitable room, either on a neighbouring ward or by transporting them to another hospital.

Clinic room and equipment

The clinic room was clean, and well stocked with equipment and emergency medicines. Staff checked the emergency response kit once a week and a trust pharmacist visited weekly to assist with auditing the clinic room and disposing of medicines appropriately.

Safe staffing

Nursing staff

At the time of inspection, staff had successfully recruited to all vacant posts. The senior management board were reviewing staffing levels for the ward as part of the service re-design. Patients told us that leave was rarely cancelled due to staffing numbers.

The table below presents information that was made available by the trust in advance of this inspection. This inspection took place on the 21 December 2017, over four months since this data was submitted as accurate.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31July2017	21.5	N/A
Total number of substantive staff leavers	1 August 2017-31 July 2017	1	N/A
Average WTE* leavers over 12 months (%)	1 August 2017-31 July 2017	4.5%	14%

Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31July2017	3	N/A
Total vacancies overall (%)	At 31July2017	11%	12%
Total permanent staff sickness overall (%)	Most recent month (At 31 July 2017)	0%	5%
	1 August 2017-31 July 2017	5%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31July2017	10	N/A
Establishment levels nursing assistants (WTE*)	At 31July2017	11	N/A
Number of vacancies, qualified nurses (WTE*)	At 31July2017	1.5	N/A
Number of vacancies nursing assistants (WTE*)	At 31July2017	1	N/A
Qualified nurse vacancy rate	At 31July2017	15%	18%
Nursing assistant vacancy rate	At 31July2017	9%	1%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 August 2017-31 July 2017	771 (24.5%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 August 2017-31 July 2017	86 (2.7%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 August 2017-31 July 2017	30 (1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	N/A	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	N/A	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	N/A	N/A

*Whole Time Equivalent

This core service had reported a vacancy rate of 15% for registered nurses at 31 July 2017. The vacancy rate for registered nurses was lower than the 18% reported trust wide. This core service reported there is a 9% vacancy of nursing assistants. The trust vacancy rate is 1%. This core service has reported an overall vacancy rate for all staff of 11% as at 31 July 2017. This was similar to the trust rate.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Russell Clinic	1.5	10	15%	1	11	9%	2.5	24	11%
Core service	**1.5**	**10**	**15%**	**1**	**11**	**9%**	**2.5**	**24**	**11%**

total									
Trust total	**131**	**739**	**18%**	**3**	**597**	**1%**	**292**	**2396**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 August 2016 and 31 July 2017, bank staff filled 12% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 8% of shifts for qualified nurses. 3% of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Russell Clinic	3145	771	86	30
Core service total	3145	771 (12%)	86 (8%)	30 (3%)
Trust Total	**88812**	**10747**	**7181**	**2936**

*****Percentage of total shifts

This core service had one (4.7%) staff leavers between 1 August 2016 and 31 July 2017. This was lower than the 14% trust average.

There was no obvious trend over the period.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Russell Clinic	21.5	1	4.7%
Core service total	21.5	1	4.7%
Trust Total	2187	298	14%

The sickness rate for this core service was 2% between 1 August 2016 and 31 July 2017. The most recent month's data 31 July 2017 showed a sickness rate of 0%.

The core service average of 5% was the same as the trust average over the 12 month period.

Sickness rates have remained relatively stable over the period.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Russell Clinic	0%	5%
Core service total	0%	5%
Trust Total	5%	5%

The below table covers staff fill rates for registered nurses and care staff during June, July and August.

Russel Clinic has an under establishment of registered nurses on day shifts in July and August 2017.

Night shifts have had an over establishment of care staff in each of the three months in the period from June to August 2017.

The unit used regular bank and agency staff in order to meet the clinical needs of patients on the ward and to manage risks. Where there were gaps in staffing numbers, these were covered by staff who were originally supernumerary. For example, the manager was a nurse and could assist.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	June				July				August			
Russel Clinic	90.9%	107.5%	100.2%	166.4 %	80.8%	104.7%	96.8%	197.7 %	87.9%	95.8%	99.8%	188.2 %

Medical staff

Staff had access to a consultant psychiatrist with experience in rehabilitative care and a junior doctor. They could also access the trusts on call psychiatry service after hours.

Mandatory training

The core service reported a mandatory training compliance of 90% (12 courses) against a trust target of 90%.
Four courses failed to meet the trust target of 90% and three fell below CQC's 75% compliance benchmark during the period from 1 April 2017 to 31 July 2017.
Those falling below CQC's compliance benchmark include: Fire safety, manual handling (both 69%) and personal safety breakaway – level 1 (70%).
On the day of our inspection, staff had booked onto or completed mandatory training to ensure they were up to date.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trust wide mandatory training total %
Clinical Risk	100%	90%	92%
Conflict Resolution	88%	90%	79%
Equality and Diversity	100%	90%	94%
Fire Safety 2 years	69%	90%	87%

Health and Safety (Slips, Trips and Falls)	100%	90%	91%
Infection Prevention (Level 1)	96%	90%	94%
Information Governance	96%	90%	92%
Manual Handling – Object	69%	90%	94%
Mental Capacity Act Level 1	100%	90%	94%
Personal Safety Breakaway – Level 1	70%	90%	
Restraint	95%	90%	
Safeguarding	96%	90%	95%
Core Service Total %	90%	**90%**	**92%**

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed six care records and saw staff had completed risk assessments for patients and updated them regularly. They used a standardised form in the electronic care records system to do this.

Management of patient risk

Staff demonstrated good knowledge of patient risks and management plans.

There were no unnecessary blanket restrictions. Blanket restrictions that were in place were for the benefit of patients.

Staff followed the trusts search policy. Staff conducted searches when risks were identified or situations warranted it under the policy.

Patients who voluntarily stayed in hospital were informed by staff about their right to leave. This information was also visible on noticeboards around the ward. The ward was unlocked except for at protected meal times.

Patients had access to an outdoor area in which they could smoke. The trust was due to implement a smoke free policy in 2018. Staff offered patients nicotine replacement on admission. The trust had organised smoking awareness and cessation roadshows for patients and staff. However, one patient said there was no ongoing support to stop smoking.

Use of restrictive interventions

This core service had reported no incidents of restraint or cases of seclusion between 1 September 2016 and 31 August 2017. However, staff told us there had been a restraint a couple of months before the visit. There had been one episode of rapid tranquilisation between 1 September 2016 and 31 August 2017. This took place in the female lounge, which doubled up as the extra care area. The ward did not have access to a seclusion room and patients' bedrooms were too small for staff to use restrictive interventions. Staff relied upon de-escalation as the first and preferred method of managing aggression.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Russell	0	0	0	0 (0%)	1

Clinic

Safeguarding

Safeguarding referrals[1] (Internal use only - Remove before publication)

Staff made safeguarding referrals and sought advice from their team and the trusts safeguarding team. There were posters in communal areas of the ward that contained information on how to make a safeguarding referral.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Although there were 40 adult and 18 child safeguarding referrals made, it was not possible to relate these to a core service.

Devon Partnership NHS Trust indicated that there are serious case reviews ongoing in relation adult mental health services. The trust stated:

'There are no actions from SAR's or SCR's which DPT has yet to implement. There are a number of SAR's which are on-going in Devon, but final reports have yet to be published and recommendations finalised.'

Staff were aware of the Equalities Act.

A private meeting room was available for use by patients when children visited the ward.

Staff access to essential information

Staff had timely and secure access to information they needed via the electronic records system.

Medicines management

The ward pharmacist visited weekly and helped to ensure that staff managed medicines appropriately.

Medical staff followed guidance from the National Institute for Health and Care Excellence in checking patients physical health.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 August 2016 and 31 July 2017 there were one STEIS incident reported by this core service which was a*n 'Apparent/actual/suspected self-inflicted harm meeting SI criteria.'*

The ward had made changes to procedures following this incident. The learning had been shared with the staff team. Learning included a change to referral criteria for the ward and revisiting the lone working policy.

[1] 20170614 RPIR Universal VFinal - Safeguarding Refs

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

Reporting incidents and learning from when things go wrong

Staff reported incidents and were able to explain how the trust shared learning from incidents. Local managers, as well as a team from the wider trust reviewed incidents. They were aware of the duty of candour (the need to be open and honest) when things went wrong.

Staff had access to a visiting psychologist to debrief following any incidents.

We reviewed the most recent incidents and saw that learning had been shared, and that action plans had been implemented. For example, increasing clinical observations and using bank or agency staff to do this.

Is the service effective?

Assessment of needs and planning of care

We reviewed six care records and saw that staff had completed a full assessment of the patient when they were admitted to the ward. This included physical health checks, and ensuring patients were registered with the local dentist, as well as linking in with podiatry and dietician services as required.

Staff used these assessments to develop care plans so that patients' needs were met while they were on the ward. Plans included views of the patient and their goals for treatment.

Best practice in treatment and care

Due to difficulties in recruiting staff, patients only had access to part time art therapy. A new psychologist was due to start work in January 2018 improving patient access to psychological therapy, including art therapy. The ward was not operating as a rehabilitation ward but as a step down ward. This meant that, despite referral criteria around risk, patients were at very different stages of their rehabilitation. We saw that there were some activities to help patients develop skills to live independently, and staff told us that they had to tailor care based on individual patient needs.

We saw that there was a co-located clozapine clinic (clozapine is an antipsychotic drug that requires many physical health checks to monitor side effects) that was utilised by patients on the ward. This meant that they were familiar with the clinic when they were discharged into the community. Accessing the clinic ensured that skilled staff monitored physical health needs specific to Clozapine while they were an inpatient.

Staff followed the smoking cessation policy. The smoking cessation work was led by an occupational therapist on the ward, and there had been visits from a smoking cessation 'road show' to help patients stop smoking.

Staff used the Health of the Nation Outcome Scales to measure the clinical outcome for patient treatment. This scale is nationally recognised and used throughout the health service.

The trust did not inform us of the audits that were carried out in this core service during the period between 1 August 2016 and 31 July. On inspection we saw that staff audited different aspects of the service. The results of completed audits were displayed on the ward. For example, infection control audit results were available for patients and staff to see in the communal areas of the ward.

Skilled staff to deliver care

At the time of inspection, the multidisciplinary team included nurses, occupational therapists, an art therapist and psychiatrist. A pharmacist visited at least weekly. However, there was a gap in psychology provision, as the clinical psychologist was not yet in post. They were due to start in January 2018. The senior management team had conducted a service review, which may lead to further changes to the multidisciplinary team. The staff were experienced in rehabilitation care, and were knowledgeable about the needs of patients on the ward. We saw that there appropriate induction procedures in place for new staff. This was also the process for volunteers. An ex patient was able to work as a sessional worker to help with the therapeutic art groups.

Staff had supervision every two months. This was held with more senior nurses on the ward. Staff also had access to two weekly meetings with a visiting psychologist for clinical supervision.

Staff were able to request specialist training and staff said access to this was good. However, they said there could be a waiting list for mandatory training due to the trust not providing enough sessions.

The senior manager responsible for the ward was able to explain how they managed poor performance effectively and promptly.

The data in the table below was not correct at the time of inspection. When we inspected in December 2017, we saw that all non-medical staff had received an appraisal.

The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for non-medical staff within this core service was 88%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Russell Clinic	25	22	88%
Core service total	25	22	88%
Trust wide	2095	1763	84%

The trust did not provide data for medical staff within this core service.

The trust reported no data for clinical supervision.

Multi-disciplinary and interagency team work

Staff held a number of weekly multidisciplinary team meetings. These focused on new referrals and patient progress.

There were effective handovers between shifts to ensure that staff passed the relevant information along to staff on the next shift.

Ward staff said that relationships with other teams in the trust were constructive and helpful for ensuring patients had continuity of care. They gave examples of where the crisis team in the trust had liaised with them to ensure a patient was cared for appropriately after discharge.

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

As of 31 July 2017, 76% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is non-mandatory for the core service and should be renewed every three years.

Staff knew how to get advice from the trusts' Mental Health Act office. All legal documentation for patients went through this central office to be uploaded to the patient care record. This office reminded medical secretaries in advance of a lapse of detention under the act, and the visiting pharmacist audited patient consent to treatment documentation.

The Mental Health Act office audited the legal paperwork to ensure the ward complied with the Act.

Ward staff knew the trust's policies for the Mental Health Act. They ensured patients received the authorised leave they were entitled too. Staff took a photograph of each patient on admission as stated in the absent without leave policy.

Around the ward, staff had displayed information about advocacy groups in the area, as well as the advocate for the ward. There was clear information about patient's rights to leave the ward. The ward only had a locked door during meal times.

We saw that staff included information about section 117 aftercare services (where necessary) in patient care plans. Staff had also documented when they had informed patients of their rights and when this was next due.

Good practice in applying the Mental Capacity Act

As of 31 July 2017, 100% of the workforce in this core service had received training in the Mental Capacity Act level 1. The trust stated that this training is mandatory for all core services staff and should be renewed every three years.

Staff documented capacity decisions in line with the Mental Capacity Act, and were aware of the principles of the Act.

No Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2016 and 31 March 2017.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff were caring and respectful when speaking with patients. The patients we spoke with felt staff genuinely cared for their wellbeing and tried to help them recover. They said staff knocked before entering their rooms.

Patients said staff treated them well and the ward felt safe and therapeutic for them.

The trust scored 91.8% in the 2017 PLACE score for privacy, dignity and wellbeing. This score is better than other similar organisations.

Wonford house hospital scored worse than similar trusts.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
WONFORD HOUSE HOSPITAL	Long stay/rehab Community adults	87.5%
Trust overall		91.8%
England average (mental health and learning disabilities)		90.6%

The involvement of people in the care they receive

Involvement of patients

Patients were complimentary of the induction process to the ward. They said it helped to orientate them and that staff were very friendly and welcoming.

We saw that patients' views were written in their care plans. Patients felt very involved in their care on the ward.

Patients had information about advocacy and contact information for the advocate assigned to the ward. They could use the ward computer or phone to contact them.

Involvement of families and carers

Staff tried to include families and carers and they collected feedback through surveys, a suggestions box, and a 'you said, we did' board.

Is the service responsive?

Service Planning

Moves at Night

Between 1 August 2016 and 31 July 2017, there was one move at night reported within this core service. This was in August 2016, over 15 months before this inspection.

The service was in a re-design process. However, staff told us they had regular meetings on how to manage beds in the trust, particularly as the ward was used as a step down unit from the acute mental health wards rather than for rehabilitation. This mean the needs of patients admitted to the ward differed to those expected on a rehabilitation ward.

Staff had developed referral criteria in order to ensure that patients were only admitted onto the ward if they had a diagnosis of psychosis, and they were not at risk of absconding or self-harm (due to the limitations of the building).

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for one ward in this core service between 1 August 2016 and 31 July.

The provider did not provide a benchmark however, Russell Clinic had bed occupancy rates ranging from 65% to 91% over the period.

Ward name	Average bed occupancy range (1 August 2016 and 31 July) (current inspection)
Russell Clinic, Wonford House	65- 91%

Staff did not re-allocate a patients' bed when they were on leave so that it would be available on their return.

We saw that there had only been one patient move to an acute inpatient unit within the 12 months before our inspection.

The trust provided information for average length of stay for the period 1 August 2016 and 31 July. Data was not provided for each month in the period.

Ward name	Average length of stay range (1 August 2016 and 31 July) (current inspection)
Russell Clinic, Wonford House	54-693

This length of stay is expected for traditional rehabilitation units.

This core service reported no out area placements between 1 August 2016 and 31 July 2017.

Staff told us that previously, the ward had taken patients that the trust had placed out of area. The trust had now repatriated all out of area patients who were suitable for rehabilitation.

This core service reported no readmissions within 28 days between 1 August 2016 and 31 July 2017.

Discharge and transfers of care

Between 1 August 2016 and 31 July 2017 there were 39 discharges within this core service. This amounts to 2% of the total discharges from the trust overall.

Of the 39 discharges, 18 (46%) were delayed at Russell Clinic.

Staff explained that this was a historic issue, and was due to the lack of suitable packages of care, or services in the community. At the time of this inspection, only one patient was considered a delayed discharge.

Staff met weekly to discuss discharges and to monitor the care pathway to ensure that patients were receiving appropriate care. We saw that staff were planning for a patients discharge when they were admitted, to ensure that their care was recovery oriented.

There was no data for this core service relating to the metric.

Facilities that promote comfort, dignity and privacy

The 2017 PLACE score for ward food at the one location within this core service scored better than similar trusts.

Site name	Core service(s) provided	Ward food
WONFORD HOUSE HOSPITAL	Long stay/rehab Community adults	92.5%
Trust overall		92.5%
England average (mental health and learning disabilities)		89.7%

Patients had their own bedroom with secure storage. They had the opportunity to personalise the room.

There were rooms for group activities, communal areas for patients to gather, private visiting rooms and a patient kitchen. There were quiet areas on the ward and separate lounges for female patients. Patients had access to a private room for meeting visitors.

Patients had access to a pay phone they were able to borrow the ward telephone. There was a computer for patient use. The ward had a garden that was unlocked during the day. Patients could request access to the garden at night or fresh air and to smoke.

Patients had access to hot and cold drinks at all hours and staff could make them snacks as needed.

Patients' engagement with the wider community

Staff encouraged patients to maintain links with the community and based these on the patients' specific goals and interests. The engagement with the community formed a large part of the proposed clinical model for the ward, which was under review.

Meeting the needs of all people who use the service

The ward did not have appropriate facilities for patients or staff requiring disabled access. There were no adapted bathrooms, or toilets. However, there were walk in showers. Access to the ward required going up steps, or via the patient garden.

Staff had access to translators and information in a range or languages and easy read format.

There was a range of information available to patients, both throughout the ward, and in reception. This included information on treatments, how to complain, what to do if they suspected abuse and patients' rights under the Mental Health Act.

Food was available to meet the dietary requirements of patients and was made on site.

The trust's chaplaincy team visited the ward regularly to help meet patients' spiritual needs.

Listening to and learning from concerns and complaints

There were no complaints received for wards within this service.

This service received 65 compliments during the last 12 months from 1 August 2016 to 31 July 2017. This accounted for 10.4% of all compliments received by the trust as a whole.

Patients knew how to complain, and that staff would manage their complaints appropriately.

Although there were no complaints in the year before this inspection, staff knew the process to manage them appropriately. Learning was fed back through team meetings.

Is the service well led?

Leadership

The ward did not have a dedicated ward manager; rather a senior manager that also had responsibility for other teams was managing it. However, we saw that there was good local leadership and that the senior manager in charge was experienced in working in rehabilitation units and was knowledgeable about the needs of staff and patients on the ward. They worked the majority of their week at the ward and staff found them approachable. The senior manager was also working with the senior nursing staff to help develop their management skills.

The ward benefited from the leadership provided by the senior psychiatrist. Everyone we spoke with (staff and patients) felt that the doctor had been a positive addition to the ward, helping to engage patients and staff during a time of uncertainty. They said that the psychiatrist and the senior manager worked together to ensure good care on the ward.

Vision and strategy

The service was under review. The senior manager, nursing staff and psychiatrist had helped to develop a proposal for a new service model, which was under for review.

At the time of this inspection, the new model for the service had not been decided.

Culture

Staff told us that there had been a period of uncertainty over whether the ward would be closed or relocated. This had caused some turnover in the year and a half before this inspection. However, there had been recruitment, as well as team away days that had helped staff to feel respected and supported.

While it was a time of relative uncertainty, staff were positive about the work they did and felt they worked well together.

Staff were aware of how to raise concerns including the whistle-blowing process and felt they could do so without fear of it affecting them negatively.

The trust had an employee assistance program to help staff with their emotional and physical health needs.

There were no staff suspended or placed under supervised practice within this core service during the 12 month period.

Governance

The trust have provided their board assurance framework, which details any risk scoring 16 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The two strategic ambitions outlined by the trust relating to this core service are as follows:

1 – To deliver consistently high quality care and treatment/to build a reputation as a recognised centre of excellence.
2 – To be an efficient, thriving and successful organisation with a sustainable future.

The trust has provided a document detailing their 11 highest profile risks. Five have a current risk score of 16 or higher. The following three of the five relate to this core service.

Key:

High (16-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
8 February 2017	1672	IF Russell Clinic does not have a seclusion room when there are aggressive/violent incidents THEN it is possible that patients will need to be kept in holds and restraint for longer than is safe.	16	16	Moderate		16/08/2017

The identified risk above was due to the old seclusion room being closed, as it was not fit for purpose. The trust were in the process of renovating it.

There was a robust system of audits and controls to ensure that important information was discussed and we saw that when issues were identified by audits, they were addressed.

The change between the information submitted some time before the inspection visit and our visit in December 2017 highlights the effective governance procedures in place. Changes were made to quickly address the issues identified. This was in part due to the leadership of the senior staff on the ward.

Management of risk, issues and performance

The senior manager responsible for the ward had access to the trust's risk register and could add information that staff brought to them. We saw that issues of concern to staff were on the risk register.

Information management

Staff nominated themselves to champion different aspects of care and to collect data for it to help the ward manage their performance.

The electronic care records system was accessible to staff and helped to protect patients confidentiality.

Staff had access to equipment to help them provide care to patients. There were a number of structural issues with the building but these were due to be addressed once the new service model had been approved

The manager in charge of the ward received regular performance updates from the trust's reporting team. This allowed them to monitor and manage the team's performance.

Engagement

Staff displayed ward performance updates in communal areas of the ward. They also displayed anonymous feedback and their response on a 'you said, we did' board.

The service was in the process of a re-design at this inspection. Staff had been included in the process and were kept informed of progress by their manager.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain

standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services in this core service which have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
AIMS - Rehab (Rehabilitation wards)	N/A	N/A

The manager had recruited newly qualified nurses and was making sure that they finished their preceptorship in order to help them develop professionally.

Staff were involved in a research project in partnership with a local university to look at the best way for widening social networks for people with psychosis.

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

Facts and data about this service

The trust had five inpatient wards:

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
North Devon District Hospital	Moorland View	16	Mixed
North Devon District Hospital	Ocean View	16	Mixed

The Cedars	Coombehaven Ward, The Cedars Unit	16	Mixed
The Cedars	Delderfield Ward, The Cedars Unit	16	Mixed
Torbay Hospital	Haytor Ward	16	Mixed

Is the service safe?

Safe and clean care environment

Safety of the ward layout

Staff took measures to ensure a safe environment. Fire risk assessments and fire evacuation plans were being carried out on all the wards. There were health and safety audits supported by the Health and Safety Manager, annual infection control audits and regular audits were carried out by the cleaning contractors.

Ward layouts did not provide a good view of all areas. Mirrors were installed to help staff to see around corners and staff walked around the ward to complete 'intentional rounding' which was checks on patients at regular intervals throughout the day to ask how they are and respond to their needs. These checks were recorded in care records.

The wards identified risks in the environment of patients using potential ligature anchor points to self-strangulate. These risks were recorded on ligature risk assessments.

There were ligature risks on all five wards within this core service over the last 12 months. None of the risks identified were considered 'high' risk by the trust. The need to complete ligature works was on the risk registers for Delderfield and Coombehaven wards.

Improvements in ligature safety had been made since our last inspection. At our previous inspection in December 2016, we said the trust must identify and mitigate the potential risk caused by blind spots and ligature points. The blind spot on Haytor ward was partially mitigated by mirrors and the three potential ligature points had been replaced with anti-ligature fittings following our previous inspection. The trust had fitted four new convex mirrors since our last inspection. This allowed staff to observe patients in parts of the ward known as blind spots.

During the current inspection, we found an unidentified ligature point above a fire door that had not been identified by the provider in an unidentified blind spot on Haytor ward. A mirror was in place to give a view around a corner but it did not provide a good view of the blind spot as you could not see far and could only see lower legs of people standing there. We informed the provider about the risk this posed. They informed staff of the risk and began making checks of the area every 15 minutes. Senior management and estates reviewed the potential risk. All patients in the area were placed on enhanced observations and no high risk patients were placed in the area. The risk was placed on the ward risk register while arrangements were made for the potential ligature point to be removed. Staff arranged for a new magnetic lock to be fitted above the door so the door closer with the ligature point could be removed.

Wards took steps to reduce risks of patients harming themselves. Fixtures that posed a ligature risk such as doors in en-suite bathrooms on Ocean View and Moorland View wards were being managed by locking doors if there was a clinical risk and by observation. The patient environment and safety action group were discussing removing en-suite doors following an incident.

Staff completed ligature assessments and audits on all the wards. The trust had made changes to mitigate some of the risks from potential ligature ligatures, for example, new bathrooms were fitted with anti-ligature fixtures on Coombehaven and Delderfield wards and some door handles and wardrobe doors had been removed. The need to complete further ligature works was on the risk registers for Delderfield and Coombehaven wards and risks were being mitigated in the meantime.

Over the 12 month period from 1 August 2016 to 31 July 2017 there were no mixed sex accommodation breaches within this core service. This meant men and women were not placed in bedrooms or asked to use bathrooms assigned to the opposite gender. All the wards were mixed but the wards separated men and women's sleeping and bathroom facilities. The Mental Health Act code of practice requires that sleeping and bathroom areas should be segregated by gender and patients should not have to walk through an area occupied by another sex to reach toilets and bathrooms. Haytor, Coombehaven and Delderfield wards did not have en-suite bathrooms but they had clearly designated female or male corridors, this applied to patients and visitors. Ocean View and Moorland View wards bedrooms had en-suite facilities.

The idea of changing all the wards to single gender wards was being discussed in an acute pathway meeting and senior nurse forum. We talked to managers and psychiatrists about mixed gender wards and some were in favour of gender segregation to reduce the risk of sexual incidents.

Staff carried emergency personal alarms. There was no nurse call system in place for patients to summon assistance.

Informal patients could leave the ward by asking a member of staff. All five wards were locked; staff completed a pre-leave check before patients went out.

Maintenance, cleanliness and infection control

Most ward areas were clean, had good furnishings and were well maintained. However, we found mould on the grout and shower curtains in several bathrooms on Ocean View and Moorland View wards. There were signs of water damage behind the toilets in bathroom 19 on Ocean View ward. Coombehaven and Delderfield wards' gardens were muddy and untidy at the time of our visit. After our visit the trust told us they were increasing the frequency of the garden maintenance schedule The cleaning contractor did not clean the garden areas and it was not on the daily cleaning rotas for the wards. Ocean View's bedrooms were in need of redecoration, for example paint was chipping and there were marks on the walls. The ward matron was aware and told us this had previously been raised with management. Haytor ward was clean and tidy. Soft furnishings were well-maintained. There were posters on all bedroom doors, which told staff and patients when the rooms were due to be cleaned. However, on Haytor ward there were problems with drainage. The staff bathroom had been known to have sewage regurgitated. The toilets on Haytor ward were stained and there had been a longstanding bad smell reported in the male patient bathroom.

For the most recent Patient-led assessments of the care environment (PLACE) assessment (2017) two locations with Acute/PICU wards/units scored better than, or similar to other MH/LD trusts in all four care aspects overall.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
North Devon District Hospital	Acute/PICU MH Older people wards Crisis services	98.7%	98.1%	89.7%	95.7%
Torbay Hospital	Acute/PICU Crisis services MH Older people wards Community adults of a working age	97.8%	95.4%	87.7%	90.0%
Trust overall		98.2%	96.1%	89.3%	86.4%
England average (Mental health and learning disabilities)		98.0%	95.2%	84.8%	86.3%

Some processes were in place to maintain cleanliness and infection control across the wards. Staff supported patients to clean and tidy their rooms and had allocated room cleaning days. Cleaning schedules including mattresses were in place.

There were annual infection control audits and regular audits were carried out by the cleaning contractors. Staff carried personal hand gels. There were handwashing signs above basins. Wards carried out annual health and safety audits with the support of the Health and Safety Manager and created action plans in response.

Seclusion rooms

Seclusion rooms mostly had appropriate facilities including observation windows, two-way communication, toilets, washing facilities and clocks. Seclusion areas were used to remove patients to a safe area whilst experiencing heightened emotions or feeling distressed and seclusion rooms were sometimes used for de-escalation.

However, on Haytor Ward, staff had not changed the clock to reflect daytime saving hours. There were no windows apart from one in the ceiling and no access to outside space. Patients in the seclusion room had to use the toilet and shower in the extra care area or a disposable pan.

Delderfield and Coombehaven wards' seclusion suite was in need of repair in some areas. In the seclusion suite a repair to a radiator cover was overdue and this was a ligature risk. The seclusion facilities for both wards did not have integrated toilet and washing facilities. The toilet was position next to the seclusion room. When patient were well enough they were taken out of seclusion to use the toilet, if not, they were given suitable receptacles. The bathrooms in the extra care area were not ligature free. The observation window to the bathroom was broken and staff could only

see inside when the door was open and they looked in a mirror opposite the bath. The clock on the wall was not protected and could be removed. Staff were aware of plans to refurbish the seclusion suite but managers were not updating them as to why the works were delayed.

The seclusion suite at Moorland View and Ocean View was closed for refurbishment. Patients that needed seclusion were not admitted to the wards or they were moved to other wards if the need arose.

Clinic room and equipment

Clinic rooms were appropriately equipped to enable doctors to carry out physical health examinations. Emergency medicines and resuscitation equipment were available. Clinic rooms were kept at an appropriate temperature to ensure medicines were stored as directed by the manufacturer.

Equipment was maintained on each ward but items that were out of date were not being removed and replaced. There were out of date items on all the wards such as anti-embolism stockings and saline (Delderfield Ward), saliva testing kits, glucose and sodium chloride (Coombehaven Ward) and various items including resuscitation pads (Ocean View Ward). We brought this to the attention of the ward managers and they arranged for the out of date items to be removed.

Safe staffing

Nursing staff

The service was short of registered nurses and compensated for this by recruiting more than their target number of nursing assistant staff to ensure there were enough staff to care for patients. The table below shows staffing data for the 12 months ending 31 July 2017.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31July2017	149	N/A
Total number of substantive staff leavers	1 August 2017-31 July 2017	26	N/A
Average WTE* leavers over 12 months (%)	1 August 2017-31 July 2017	16%	14%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31July2017	18	N/A
Total vacancies overall (%)	At 31July2017	11%	12%
Total permanent staff sickness overall (%)	Most recent month (At 31 July 2017)	6%	5%
	1 August 2017-31 July 2017	6%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31July2017	64	N/A
Establishment levels nursing assistants (WTE*)	At 31July2017	81	N/A

Number of vacancies, qualified nurses (WTE*)	At 31July2017	19	N/A
Number of vacancies nursing assistants (WTE*)	At 31July2017	8 over establishment	N/A
Qualified nurse vacancy rate	At 31July2017	30%	18%
Nursing assistant vacancy rate	At 31July2017	10% over establishment	1%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 August 2017-31 July 2017	1915 (8%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 August 2017-31 July 2017	2420 (10%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 August 2017-31 July 2017	786 (3%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	N/A	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	N/A	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 August 2017-31 July 2017	N/A	N/A

*Whole-time Equivalent

Staffing establishments were reviewed by the director of nursing. The recent review resulted in the creation of development posts. Wards encouraged healthcare staff to train as nurses by, for example, giving them flexible working arrangements. The managers sometimes had to work on the wards in order to ensure there were enough staff. There were incentive schemes in use by the centralised recruitment team.

Staff vacancies were on the risk registers for Coombehaven, Delderfield and Haytor wards.

The service reported an overall vacancy rate of 30% for registered nurses at 31 July 2017.

The vacancy rate for registered nurses was higher than the 18% reported trust wide.

This core service reported there was a 10% over establishment of health care assistants. The trust vacancy rate is 1%.

This core service reported a vacancy rate for all staff of 11% as at 31 July 2017. This was below the trust rate of 12%

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Cedars Admin				2	7	31%	2	7	31%
Coombehaven	5	13	43%	-7	14	-47%	-1	32	-2%

Delderfield	2	13	19%	-1	14	-6%	4	31	12%
Haytor	6	13	46%	-2	14	-15%	6	32	19%
Haytor Admin				2	4	60%	2	4	60%
Moorland View	5	13	40%	-2	14	-17%	3	29	11%
Ocean View	1	13	8%	-1	15	-5%	2	31	5%
Core service total	**19**	**64**	**30%**	**-8**	**81**	**-10%**	**18**	**165**	**11%**
Trust total	**131**	**739**	**18%**	**3**	**597**	**1%**	**292**	**2396**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 August 2016 and 31 July 2017, bank staff filled 8% of shifts to cover sickness, absence or vacancy for qualified nurses.

At the time of our inspection staff vacancy rates had improved. Haytor ward had revised their staffing structure and no longer had any staff vacancies. Delderfield ward had two band five nurse vacancies and Coombehaven had five band five nurse vacancies at the time of our inspection. Moorland View had a band six nurse vacancy. Ocean View had a 0.6 whole time equivalent vacancy for a nurse.

Staff covered the place of safety adjoining their ward when it was in use. Coombehaven and Delderfield had two band three crisis team members that covered the place of safety and worked as additional staff on the wards.

In the same period, agency staff covered 10% of shifts for qualified nurses. 3% of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Coombehaven	4981	512	305	160
Delderfield	5183	509	725	242
Haytor	4804	465	658	278
Moorland View	4800	374	495	63
Ocean View	5315	55	237	43
Core service total	**25083**	**1915 (8%)**	**2420 (10%)**	**786 (3%)**
Trust Total	**88812**	**10747**	**7181**	**2936**
		(12%)	**(8%)**	**(3%)**

*****Percentage of total shifts

Staff told us that, although infrequent, when agency or bank staff are used they are generally regular and therefore familiar with the ward. Temporary staffing was organized by a 'safer staffing and bed capacity' team. Ward managers could request staff, for example, to take account of case mix.

This core service had 26 (18%) staff leavers between 1 August 2016 and 31 July 2017. This was slightly higher than the 14% trust average.

Haytor (24%). Delderfield (22%) and Coombehaven (22%) wards had the highest turnover rates in the core service.

There was no obvious trends over the period.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Cedars Admin	5	0	0%
Central Admin W.Hse	1	0	0%
Coombehaven	32	7	22%
Delderfield	27	6	22%
Haytor	27	6	24%
Haytor Admin	2	0	0%
Moorland View	26	5	18%
Ocean View	30	2	7%
Core service total	149	26	17%
Trust Total	2187	298	14%

Haytor Ward had the highest number of staff leave in the time period. The manager explained some staff had left when they introduced some changes to the culture. For example, managers expected staff to be out on the ward engaging patients in meaningful activities and conversations rather than working in closed offices. Another change was that staff who previously only worked at night now worked a mixture of night and day shifts to ensure they could attend team meetings and training.

The sickness rate for this core service was 6% between 1 August 2016 and 31 July 2017. The most recent month's data 31 July 2017 showed a sickness rate of 6%. This was similar to the trust average of 5% currently and over the 12 month period.

Sickness rates have remained relatively stable over the period.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Cedars Admin	0%	1.5%

Central Admin W.Hse	0%	15.8%
Coombehaven	10%	6.9%
Delderfield	2%	6.7%
Haytor	2%	7.0%
Haytor Admin	10%	1.7%
Moorland View	9%	7.6%
Ocean View	6%	4.4%
Core service total	6%	6%
Trust Total	5%	5%

We talked to managers about sickness and they told us most sickness was not work-related stress. Managers said the work sometimes caused stress but staff were resilient and supportive of each other. On all the wards, managers worked actively on the wards and covered shifts to assist the staff team.

The below table below covers staff fill rates for registered nurses and care staff during June, July and August 2017.

Coombehaven, Delderfield and Moorland View wards were below minimum staffing levels for nurses on day shifts for all three months in the period. Haytor ward had nursing staffing levels for two of the three months (June and July), below the minimum expected level.

Shortfalls in nursing levels at night were noticeable on all wards in August and in four of the five in July 2017.

Care staff have noticeably increased particularly in night shifts in August and July, potentially to cover the shortfall in registered nurses. Low registered nursing levels coincide with an over establishment of care staff.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	June				July				August			
Coombehaven Ward	77.1%	119.5%	97.3%	124.4%	75.5%	117.3%	79.8%	127.5%	71.5%	126.6%	73.5%	131.8%
Delderfield Ward	81.1%	89.0%	99.6%	138.6%	80.6%	91.6%	85.9%	156.9%	85.2%	121.6	80.2%	225.5%
Haytor	86.0%	107.0%	90.0%	112.6%	85.3%	107.8%	75.8%	129.6%	94.4%	99.5%	87.1%	117.7%

Ward												
Moorland View	87.0%	85.3%	75.6%	112.1%	84.0%	83.9%	68.8%	109.7%	78.6%	80.0%	66.7%	121.3%
Ocean View	104.4%	88.8%	91.1%	102.7%	98.3%	90.9%	94.6%	103.2%	106.7%	77.9%	83.9%	111.0%

Ward managers told us there was always one or two qualified member of staff on duty during the day and one at night and two or three unqualified staff during the day and two unqualified staff at night.

Managers had to complete a form to request additional staff and they found this time consuming at a time when the ward was short staffed and they needed to work on the ward.

Patients did not always have a named nurse. Patients on Coombehaven ward did not have a named nurse because of staffing shortages. Patients had three named staff instead, (a band five nurse, a band six nurse and a support worker). Haytor ward allocated a patient to a named nurse and two health care assistants. Staff on Moorland View and Ocean View wards were not always able to provide patients with one to one time with their named nurse. They could provide time with the allocated nurse for the day.

Activities were rarely cancelled due to short staffing. When activities were cancelled, Coombehaven and Delderfield managers told us this was reported as an incident. One staff nurse felt that there was not enough one-to-one time with patients.

Wards tried to prioritise taking patients out of escorted leave but this was not always possible because of staffing numbers. Occupational therapy staff who were trained in restraint, sometimes took patients out on leave. One psychiatrist told us they had to consider staffing levels when authorising leave. The psychiatrist did not always authorise as much escorted leave for patients as they could safely have because there were not enough staff to take patients out on leave.

The trust recognised that the fencing could easily be climbed. Two patients had left the ward over the fence during the two years previous to our inspection. This posed a risk of patients falling as well as absconding. The trust was planning to go to tender for new fences and anti-climb control measures in January 2018. Following the inspection the provider told us the works were under way and would be completed by August 2018.At the time of our inspection, patients were able to access the gardens independently throughout the day.. This risk was on the service risk register. Steps had been taken to remove benches which allowed access to the roof on one side of the garden.

Medical staff

All the wards had ward based consultant psychiatrists. There are nine consultants on the out-of-hours duty rota. Staff told us doctors were responsive in an emergency.

Mandatory training

The core service reported a mandatory training compliance of 92% (12 courses) against a trust target of 90%.

Four courses failed to meet the trust target of 90% however no courses fell below CQC's 75% compliance benchmark during the period from 1 April 2017 to 31 July 2017.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trustwide mandatory training total %
Clinical Risk	98%	90%	92%
Conflict Resolution	89%	90%	79%
Equality and Diversity	99%	90%	94%
Fire Safety 2 years	78%	90%	87%
Health and Safety (Slips, Trips and Falls)	100%	90%	91%
Infection Prevention (Level 1)	97%	90%	94%
Information Governance	95%	90%	92%
Manual Handling - Object	76%	90%	94%
Mental Capacity Act Level 1	100%	90%	94%
Personal Safety Breakaway - Level 1	80%	90%	
Restraint	97%	90%	
Safeguarding	99%	90%	95%
Core Service Total %	**92%**	**90%**	**92%**

Managers told us of plans to complete mandatory training that was out of date and about training that had taken place since 31 July 2017 including fire safety and manual handling at Coombehaven and Delderfield and fire safety training at Haytor ward.

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at 38 patient records and 17 prescription charts. Risk assessments were completed for all patients on a standard risk assessment tool. Staff also completed a weekly review with patients that determined the level of observation the patient would be under. Most risk assessments were being regularly updated but staff did not always make it clear which risks were current as the system automatically included all risks. Ward managers told us they had already escalated this concern. Two patients from Haytor ward lacked comprehensive risk plans despite risks being identified in their initial risk assessments and both patients were on high level observations because of risks.

Management of patient risk

Patient assessments included discussion of specific risks such as falls and pressure ulcers and staff completed physical examinations upon the patients' admission

Care records showed that staff generally identified and responded to changing patient risks. However, one Coombehaven patient's risk increased and actions were taken to safeguard them but their risk assessment was not updated.

The wards used the 'four steps to safety' approach to managing patient risk. The four steps were proactive care, patient engagement, teamwork and environment. This involved 'intentional

rounding' which was to talk to patients regularly throughout the day about how they are feeling and their needs. The four steps aimed to make wards safer, improve care, improve the environment and increase interactions between patients and staff. Using intentional rounding, staff aimed to be proactive and identify potential causes and triggers before they escalate.

At our previous inspection in December 2016, we said the trust should ensure risk assessments are in place for the safe management of patients on community treatment orders attending inpatient wards for depots. However, this action had not been completed. Haytor ward provided this service to patients on community treatment orders. Although the depot clinics continued, no risk assessments had been made and community treatment order patients were not searched when they came onto the ward. Managers had not determined the risk of this activity to current patients, for example the increased number of patients for staff to care for or the possibility of items that are unsafe for patients being brought onto the ward.

At our previous inspection we said the trust should clarify for staff that they should complete patient observations at staggered intervals. At this inspection Ocean View and Moorland View ward managers told us they used their clinical judgement during ward rounds to decide whether or not observations should be random for each patient. Haytor ward manager told us observations were random but they were sometimes delayed by a minute or two due to staffing pressures. Missed patient observations were a factor in several of the serious incidents that occurred in the year leading up to our inspection. Observation charts and rounds showed staff were carrying out observations in line with the set observation levels. Delderfield and Coombehaven wards recorded exact observation times following feedback from a coroner's inquest while other wards marked time slots with initials.

Blanket restrictions were inconsistent. Blanket restrictions are rules or policies that restrict people's liberty or other rights without carrying out individual assessments. The Mental Health Act code of practice says blanket restrictions should be avoided unless they are necessary and proportionate. On all wards patients were prevented from having items they could use to self-harm, such as phone charger cables. However, these measures were inconsistent across the service and checks were not in place that ensured items were removed. We found items on the wards that should not have been available to patients. For example, there were plastic bags in patients' bedrooms and removable cables and phone chargers in the computer room and pool room on Ocean View and Moorland View wards and this had gone unnoticed. On Delderfield ward, all the bathrooms were locked due to ligature risks but they were open on Coombehaven ward. Wards had different rules about patients having their own mobile phones. Patients on Haytor ward were allowed to have their mobile phones. Coombehaven and Delderfield patients were allowed to have their mobile phones in their bedrooms only. This was to prevent patients taking photographs. Ocean View and Moorland View patients were allowed to have their mobile phone unless they used them inappropriately.

All the wards were locked but informal patients could ask to leave and there were posters on the ward doors to tell them to ask staff if they wanted to leave. Staff completed a pre-leave checklist with patients before they left the wards to ensure they were safe to leave.

Use of restrictive interventions

This core service had 237 incidents of restraint (on 106 different service users) and 140 incidents of seclusion between 1 September 2016 and 31 August 2017.

Over the 12 months, there was an increase in the incidence of both restraint (up 17%) seclusion (up 5%) and rapid tranquilisation of patients (up 9%) when compared to the previous 12 months. The below table focuses on the last 12 months' worth of data:

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Coombehaven	23	27	14	7 (26%)	18 (67%)
Delderfield	21	73	23	30 (41%)	42 (58%)
Haytor	49	43	24	19 (44%)	17 (40%)
Moorland View	28	55	23	9 (16%)	17 (31%)
Ocean View	19	39	22	7 (18%)	13 (33%)
Core service total	**140**	**237**	**106**	**72 (30%)**	**107 (45%)**

During our visit, ward records gave different data than was shared with CQC by the trust. For example, on Haytor ward, records showed there had been 114 seclusions, 62 restraints (of which one was in a prone position as opposed to 19 as stated in the trust data) and 16 incidents of rapid tranquilisation. We invited the trust to check the data the data they supplied to us and this showed similar numbers to those they originally provided. This meant there was a discrepancy between the data held by the trust and the records held on the wards.

We asked ward managers if there were plans in the trust to try to reduce restrictive interventions but none of them were aware of a reduction programme. However the policy states 'restrictive interventions must only be used as a last resort and when all other measures (including de-escalation) have been unsuccessful and the situation is deteriorating'. There had been an increase in the number of patients secluded compared to our previous inspection.

The trust had policies on rapid tranquillisation and on seclusion, de-escalation and long term segregation. Since our previous inspection, the policy had been updated to reflect the Mental Health Act code of practice 2015 definition of seclusion. However, the definitions in the front of the policy were not updated and this meant the policy gave conflicting advice about what constitutes seclusion and de-escalation.

Rapid tranquilisation was not routinely prescribed on any of the wards and patients' behaviour was managed through communication and conflict management rather than with medicines.

Delderfield ward had seen an increase in the use of rapid tranquillisation but managers told us of a spike in self-harming behaviour on the ward that saw as many as eight cases of restraint in one day. Staff also told us that when rapid tranquilisation training changed from electronic learning to face to face training this resulted in better reporting of the use of rapid tranquilisation on Delderfield ward.

Staff monitored patients' physical health, including blood pressure, pulse and respiration, following rapid tranquillisation in addition to weekly physical health checks. Delderfield and Coombehaven ward staff were using least restriction and restraining for as short a time as possible as per The National Institute for Health and Care Excellence guidance. Rapid tranquilisation was also care

planned with patients having a choice of early rapid tranquillisation if appropriate. Oral medicines were routinely offered as a first line of treatment.

The trust reported there were 72 incidents of prone restraint which accounted for 30% of the restraint incidents.

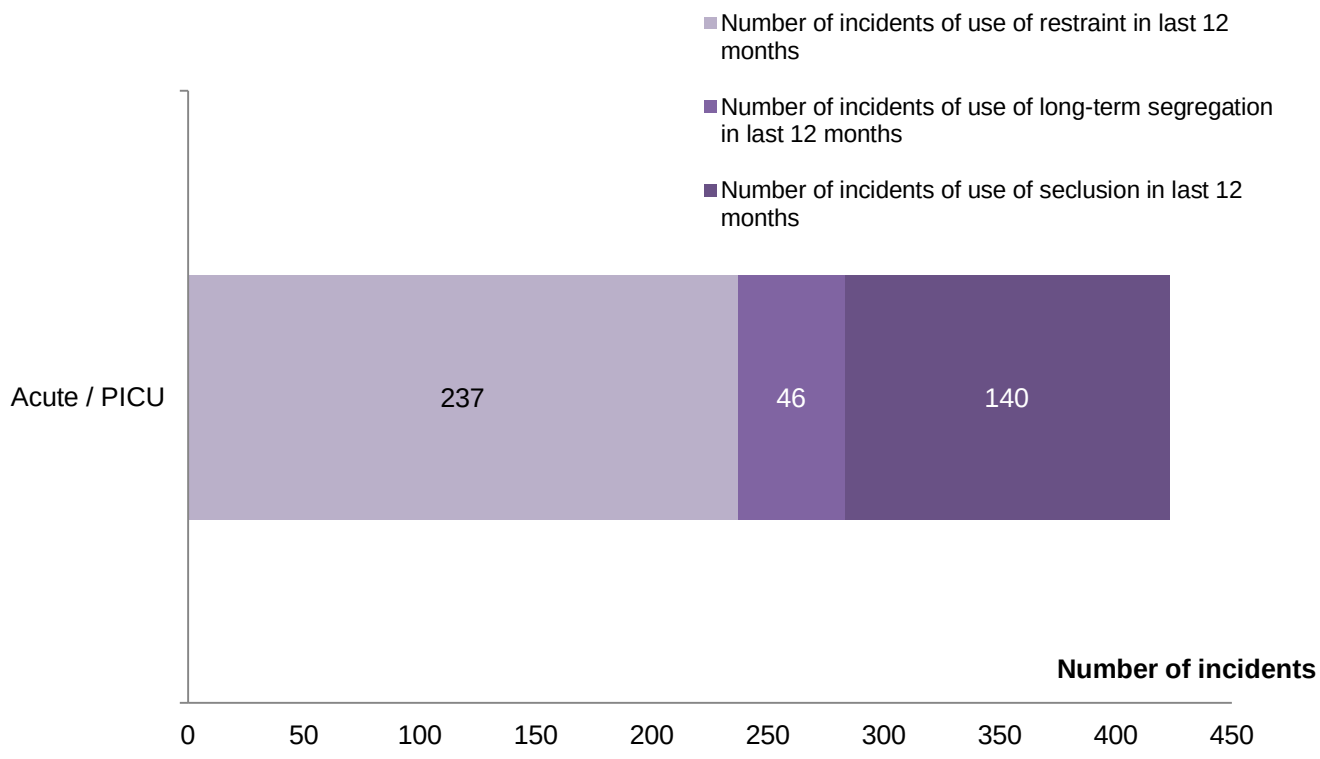
There were no obvious peaks and troughs to comment on in terms of monthly figures however Delderfield ward had the most restraints with 73, 31% of all incidents reported by the core service.

Incidents resulting in rapid tranquilisation for this core service have also increased 9% since last year with Delderfield reporting the most instances (42) accounting for 58% of cases within the core service.

There have been no instances of mechanical restraint over the reporting period.

The number of restraint incidents reported during this inspection was 17% higher than the 166 reported at the time of the last inspection.

Number of incidents of restraint, segregation and seclusion for this core service over the 12 months



Staff understood and applied the least restrictive principle when using restraint. Care records showed staff tried to deescalate situations before removing patients to a seclusion area. Restraint was most often used to prevent self-harm.

The trust policy stated that if it was necessary to use restraint, staff should do so in the supine position if possible and if the prone position were necessary they should it use for as short a time

as possible. Records showed that when using prone restraint, staff maintained the patient's airway in all cases.
During our inspection, ward managers told us they thought the data the trust had provided was incorrect. The trust confirmed the data was broadly accurate. They said that in future prone restraints would trigger an alert and a review. They looked into the reasons why prone restraint was being used and sent us the following information:

Reason for prone restraint	Number of prone restraint incidents (2017)
Prone for IM	51
Seclusion Entry/Exit	25
IM & Seclusion Exit	8
Fell into prone type position which was corrected	7
Incorrect recording of 'Position Held' field	7
Grand Total	**98**

Staff were trained in 'proactive understanding and management of aggression' (PUMA). Delderfield and Coombehaven ward managers told us the rise in the use of restraint in the prone position was due to staff receiving training that taught them to start in a prone position but roll over to the supine position within 30 seconds. Restraints that held patients in the prone position for only a few seconds were counted as prone restraint. Managers told us that further training delivered to staff in July 2017 included the option of using the supine position first but both techniques were taught. The training said prone restraint should be avoided and when it is used it should be for a maximum of three minutes. Staff told us that each ward in the trust had a trainer on the staff team who was available to give advice and updates. Staff completed annual updates of this training. The trust told us that training in the use of prone restraint had already been removed from the training programme'.

Seclusion records were kept appropriately with clear start and end dates and reasons for the use of seclusion. On Haytor ward, where they did not use segregation because they did not have the facilities, they sometimes called seclusion 'open seclusion' if the patient was locked in the extra care area but not into the seclusion room itself. If more than one patient were in extra care they could interact with one another.

However, on Haytor ward, 4 seclusion records we reviewed were incomplete. For example, one set of seclusion records had two nursing reviews missed and three other nursing reviews were completed by only one nurse instead of the two required. The reviews carried out by only one qualified nurse were as a result of only one qualified nurse being on shift during that time period. During a night shift on Haytor ward, a member of staff had signed to say they had been part of two nursing reviews during the night shift when ward records had stated that the member of staff was not on duty. There was nothing documented to state that the member of staff had returned to the ward for the reviews or if reviews had been carried out over the telephone and signed retrospectively.

Safeguarding

Staff completed safeguarding training and training updates and knew how and when to make a safeguarding alert. Decisions were made in teams and with the support of the trust safeguarding team. There was evidence of staff making appropriate safeguarding referrals. Trust safeguarding teams regularly visited the wards to offer advice and training.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each local authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person. An assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the Police should take place.

Although there were 40 adult and 18 child safeguarding referrals made, it was not possible to relate these to a core service.

Devon Partnership NHS Trust have indicated that there were serious case reviews ongoing in relation adult mental health services. The trust stated:

'There are no actions from safeguarding adults reviews or serious care reviews that the trust have yet to implement. There are a number of safeguarding adults reviews which are on-going in Devon, but final reports have yet to be published and recommendations finalised.'

Children could safely visit patients in suitable visiting rooms off the wards.

Staff access to essential information

Staff used an electronic system to record patient care. Seclusion records were kept on paper.

Staff, including agency workers, had access to care records. However, on Haytor ward, only regular staff were given access to care records and temporary staff dictated entries to the care records to another member of staff.

Staff could access information, such as policies on the trust intranet.

Medicines management

Staff followed good practice in medicines management and worked in line with national good practice guidance. We looked at seventeen prescription charts and these were completed appropriately.

Pharmacy technicians completed checks on all the wards and pharmacy teams were involved in learning from incidents. Pharmacists shared information with patients about their medicines and liaised with other services to ensure patients got the medicines they needed after they were discharged. Pharmacy staff attended the wards every day. Staff attended medicines optimisation training and considered the effects of medicines on patients during ward rounds and weekly physical health checks.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 August 2016 and 31 July 2017 there were 15 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *Apparent/actual/suspected self-inflicted harm meeting SI criteria* with five incidents, two of which resulted in an unexpected death of the patient.

A must action at the last inspection regarded blind spots and ligature risks.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

Delderfield Ward accounted for seven of the 15 serious incidents for the core service and one of the unexpected deaths. It also accounted for three of the four unauthorised absence meeting Serious incident criteria incidents.

	Number of incidents reported					
Type of incident reported on STEIS	Coombeh aven	Delderfiel d	Haytor	Moorland View	Ocean View	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	1		1	2	5
Disruptive/ aggressive/ violent behaviour meeting SI criteria		1	2			3
Unauthorised absence meeting SI criteria		3		1		4
Abuse/alleged abuse of adult patient by staff	1	1				2
Pending review (a category must be selected before incident is closed)		1				1
Total	2	7	2	2	2	15

We looked at care records for patients that had been involved in serious incidents to see how risks were being managed. There were boxes to tick in care records to indicate the presence of different kinds of risk and in two cases these boxes were not ticked when they should have been. Risks had been identified and risk management plans were in place prior to the incidents but observation levels were reduced while risks continued in one case. We talked to a senior nurse manager about the use of observations and they explained that intentional rounding was intended to reduce upcoming risks and that patients were being occupied with activities to reduce their risks.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and they reported them directly on to the electronic incident management system. They understood the duty of candour and managers gave examples of apologising to patients and informing them when things had gone wrong. There was an open, 'no

blame' culture. Staff knew the reporting procedures and what to report. There was a culture on all the wards of reporting incidents routinely in order to learn from them.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been two 'prevention of future death' reports sent to Devon Partnership NHS Trust. It is not clear if these related to this core service.

Staff on all five wards reported that they receive feedback from investigations into incidents. They received emails and discussed learning from incidents in handovers and business meetings. Learning by experience meetings were shared in the adult directorate bulletin. The trust issued monthly safety briefings to staff.

Following serious incidents, arrangements were made for staff to learn from outcomes of investigations through ward business meetings or through extraordinary meetings if required.

Changes were made as a result of learning from incidents. One serious incident report we reviewed included an action plan to improve record keeping and to inform staff of what to do to prevent similar future incidents.

Haytor ward recognised they needed a better way of feeding back learning from the team following incidents and this was on their risk register.

Doors were locked on Delderfield ward following a serious incident. There were incidents of sexual safety during the 12 months previous to our inspection on Coombehaven, Delderfield and Haytor wards.

A thematic review on sexualised behaviour was underway and the trust was considering introducing gender segregation. Following incidents of sexualised behaviour, patients were separated at the earliest opportunity by moving one party to another ward. All the incidents were being investigated and measures had been taken to safeguard the patients involved. One psychiatrist we spoke with said as a result of the incidents there was a greater staff awareness of risk.

There was an incident on Coombehaven and Delderfield wards where the fire alarm was activated and two patients left the wards through the open fire exit doors. This was added to the wards risk registers as there was a risk of patients absconding from the ward. Staff were aware of the need to monitor the doors during a fire alarm and they were discussing possible solutions at a fire meeting.

Staff and patients from all wards said they were offered a debrief following an incident. However, six staff from three wards said they felt that the debriefing process could be more effective and efficient. They felt that debriefing did not always happen fast enough and was too informal. Support from a psychologist could be arranged if needed and often the psychologist would attend meetings after serious incidents. An incident on one of the wards had led to learning and improvement in the way staff were debriefed after incidents.

Is the service effective?

Assessment of needs and planning of care

We looked at 38 care records. All but two patients had an up to date care plan completed upon admission.

Most patients were given physical health assessments and examinations on arrival and regularly thereafter, including measurement of weight and discussion of nutrition. One patient on Delderfield ward had not had a physical examination. One patient on Haytor ward had a physical health examination but it had not been updated for five weeks and there was no record to explain why. Two patients told us the wards were enabling them to continue seeing hospital consultants for a physical health condition that required it.

Care records were holistic and the form on the electronic records system had a variety of sections for staff to complete to ensure all areas of health and wellbeing were covered in the assessment. Most care plans reflected the needs identified during the assessment. The degree to which care plans were personalised varied with nine containing very minimal personalisation. Some care plans lacked detail of interventions to be provided by the staff. Most of the care plans were recovery oriented although in six cases this was vague and minimal.

Care records were stored on an electronic system that was available to staff across the trust. All staff had access to care records including agency staff following their induction.

Best practice in treatment and care

Staff provided suitable care for patients that followed guidance from the National Institute for Health and Care Excellence.

Doctors prescribing medication use the trust formulary which is based on National Institute for Clinical Excellence guidelines. The trust Drugs and Therapeutic Committee provided advice to prescribers.

Staff referred to guidance published by the National Institute for Health and Care Excellence. The ward managers for Coombehaven and Delderfield told us they used the guidance for schizophrenia, personality disorders and psychosis, for example, in reviewing patients' physical health including diabetes and tissue viability. Ocean View and Moorland View ward managers said staff used guidance on violence and aggression, anti-psychotic medicines and self-harm. Haytor ward managers said staff referred to guidance on psychosis and depression. The trust was developing a personality disorders pathway to better meet the needs of this patient group based on national guidance.

There were a range of activities throughout the week on all the wards. All the wards had a weekly plan of activities that were coordinated by occupational therapists. These included healthy lifestyle options such as relaxation, walking, swimming, yoga and use of a gymnasium. Four of the wards had a visiting 'pets as therapy' dog. Activities included board games, art, cooking classes; there were examples of patients' art work being used to decorate the wards. Coombehaven and Delderfield had a horticultural project for patients and work advisors that supported patients to create CVs. The wards had lots of colourful art on the walls these were completed by patients or donated by previous patients. We saw recovery trees being produced by patients on the ward walls. Haytor ward had a beauty therapist that ran a self-nurturing group. On Ocean View and Moorland View wards there was a pizza club for patients to make their own pizzas with support from occupational therapy

Psychological therapies were being provided on some wards but psychologists were only in post on two wards. At our previous inspection ward managers said they were recruiting half time psychologists to every ward in January 2016. However, Ocean View and Moorland View wards had only recently appointed a psychologist. On Ocean View and moorland View wards an occupational therapist was providing mindfulness, solution focused and relaxation and anxiety management interventions. A charge nurse on Ocean View and Moorland View was running a group on sleep, depression and anxiety. Coombehaven and Delderfield wards had a psychologist three days per week working across both wards and they also had a nurse therapist who was trained in dialectic behavioural therapy which is a treatment recommended for people with personality disorders. The nurse therapist ran a dialectical behavioural group on distress tolerance. Another was trained in cognitive behavioural therapy. Haytor ward did not have a psychologist but they ran compassionate mind groups.

Moorland View and Ocean View wards were continuing to trial the 'self-accessed flexible treatment intervention'. This involved providing brief structured admissions to patients experiencing emotionally unstable personality disorder. This was compliant with guidance from the National Institute for Health and Care Excellence.
All of the wards were counting down to becoming smoke free in March 2018 and patients were offered stop smoking support. Staff were being trained in supporting patients. There was a trust wide steering group and local working groups that included pharmacy staff to advise on nicotine replacement therapy.

Staff used recognised rating scales to record severity and outcomes. They used the Health of the Nation Outcome Scale and patients were mental health clustered.

Staff took part in audits in environmental risks on all the wards. All wards carried out annual audits including, ligatures, fire safety, health and safety and infection control.

Deputy ward managers completed care record audits to ensure they were fully completed on a weekly basis to support the improvement in the quality.

This core service participated in one clinical audit as part of their clinical audit programme during the period between 1 August 2016 and 31 July.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Prescribing of PRN Sedatives/Hypnotics on Admission to a General Adult Inpatient Ward	Haytor Ward	Adult Services	This audit was to review the current prescribing practice to determine the frequency of PRN Prescribing on admission and to establish to what extent such medications are clinically indicated.	1 February 2017	Results to be disseminated among psychiatry SHOs in Torbay and presentation at the weekly teaching session. Departmental induction packs to be reviewed in order to include the required information. Re-audit in 3-6 months.

Skilled staff to deliver care

A range of staff worked on wards including health care assistants, nurses, occupational therapists, psychologists and pharmacists.

Wards had some experienced staff. Haytor ward had a higher turnover of staff and had employed some inexperienced staff but these staff worked alongside experienced staff.

The trust had a local induction checklist that was completed by new staff on all the wards over a two week period. Staff also completed a two week corporate induction. Staff said the induction process prepared them to work on the wards and other staff felt that it prepared new starters to work on the wards.

Appraisals and supervision were completed using standardised forms.

The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for non-medical staff within this core service was 91%.

Ocean View (80%) and Haytor admin (67%) were the only teams now to meet the trust target.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Cedars Admin	5	5	100%
Coombehaven	30	28	93%
Delderfield	26	24	92%
Haytor	29	26	90%
Haytor Admin	3	2	67%
Moorland View	28	28	100%
Ocean View	30	24	80%
Core service total	151	137	91%
Trust wide	2095	1763	84%

The trust did not provide data for medical staff within this core service.

Clinical supervision[2] (Internal use only - Remove before publication)

The trust reported no data for this metric.

The trust policy was for staff to receive supervision every four weeks. Some records showed that staff were waiting up to six months between supervisions. The manager for Haytor ward recorded attendance at meetings as supervision. Ocean View and Moorland View staff had group supervision facilitated by a psychologist every two weeks on the ward in addition to management supervision

Appraisals were not being completed on some wards and the standard of appraisals was not good. Haytor managers and nurses had stopped completing appraisals and only 36% were

[2] 20171114 Clinical supervision analysis

complete with some being five months out of date. This was due to staffing issues and there was a plan to complete appraisals over the forthcoming months. Appraisals that were completed for Haytor staff were written by the manager with little input into the form from the appraisee. Appraisals lacked identification of learning needs and plans to develop skills and knowledge. Appraisals for staff on Coombehaven ward were inconsistent. On Coombehaven and Ocean View wards appraisals were rated on a four point scale, however where gaps or room for improvement was noted there was no action plan written in the appraisal. The appraisals had a section specifically for an action plan and this was not utilised well. All but one of the appraisals for Coombehaven and Delderfield staff were complete. On Ocean View ward all appraisals were completed and up to date.

Staff had access to specialist training on a variety of subjects: cognitive behavioural therapy, mentorship, personality disorders, leadership in care training. Band three staff completed the care certificate.

There was evidence of managers addressing poor staff performance when needed and of supporting staff to improve.

Multi-disciplinary and inter-agency team work

Wards held weekly business meetings that were attended by all staff. Staff discussed each patient's current state, risk level, activities, current medication and any changes that needed to be made. If the patient was nearing discharge this was also discussed and any necessary contact with external agencies was discussed.

Handover meetings were held daily on all wards. During handovers staff discussed each patient and provided feedback on their previous 24 hours including any incident.

Teams reported good working relationships with safeguarding agencies and good support from safeguarding leads within the trust. Safeguarding leads visited the wards to provide advice and training and community staff attended the ward to visit patients and attend ward rounds when possible.

All the wards had links with general health including local hospitals. Ocean View and Moorland View wards were on the same site as the general hospital and specialist staff from the hospital visited the wards to see specific patients. A service level agreement provided Moorland View and Ocean View wards with daily phlebotomy, cardiology and respiratory services.

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

As of 31 July 2017, 76% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is non-mandatory for the core service and should be renewed every three years.

All the wards had Mental Health Act offices that held and processed Mental Health Act papers. Staff could consult with the Mental Health Act administrators for advice and support. Policies and procedures were available to staff on their intranet.

All wards had systems for ensuring detained patients there were given their rights on a regular basis and patients said they were receiving their rights regularly.

Staff told us escorted leave was rarely cancelled and they tried to accommodate patients going on leave on the same day they requested it. At our previous inspection we said the trust should review systems for patients taking section 17 escorted leave to include a record of how often leave is cancelled. The trust planned to implement this by 1 April 2018.

Mental Health Act offices on each ward audited Mental Health Act paperwork and pharmacists monitored section paperwork every week.

Good practice in applying the Mental Capacity Act

As of 31 July 2017, 100% of the workforce in this core service had received training in the Mental Capacity Act level 1. The trust stated that this training is mandatory for all core services staff and should be renewed every three years.

Managers and staff demonstrated a good understanding of the Mental Capacity Act. Although only one staff member was able to recite the five principles, they all knew where to find the information, either on the trust intranet or on a poster or leaflets in the office.

Staff could ask the Mental Health Act office for advice and support on the Mental Capacity Act.

The trust produced a quick reference pocket sized guide for staff on the Mental Capacity Act that described the principles, how to assess for capacity and acting in the patient's best interests.

There were examples of mental capacity assessments and best interests assessments being completed for specific decisions including consent to treatment. Staff did not always record patients' capacity to consent to treatment.

The trust told us that three Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2016 and 31 March 2017. Two were from Delderfield ward and the remaining one from Ocean View. All three were not approved by the local authority.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff were supportive and kind with patients. We saw staff approach patients on all the wards, for example offering them a drink and support with daily tasks. Staff completed intentional rounding checks on patients at regular intervals throughout the day and recorded in the patients' care records details of patients' mental state.

We spoke to 17 patients and they all said they felt safe. They said the wards were clean. They said staff were respectful, friendly, approachable, receptive, polite, sympathetic and empathic. One patient on Moorland View ward said the standard of care was very high. Patients said there were always staff available to talk to. There were fixed televisions in communal areas but Wi-Fi was not provided to patients and some patients wanted to use tablets and mobile phones.

Carers told us that all staff had been caring, communicative and supportive. They gave examples such as staff visiting the patient in the acute hospital after an incident, allowing pets onto the ward,

patients bringing their computer consoles to use in communal areas and staff caring for a patient's pets in their own homes. They felt staff had time to talk to carers about the patient's care if the patient consented.

Staff understood patients' individual needs. They got to know patients personally and took an interest in their preferences and needs. For example, some patient activities had a Christmas theme at the time of our inspection. Staff ensured there were groups that did not have a Christmas theme to cater for patients who do not celebrate Christmas. Coombehaven and Delderfield patients and staff told us about the 'no conversation about me without me' the concept they followed. This meant they always included patients in discussions about their care.

The trust scored 91.8% in the 2017 PLACE score for privacy, dignity and wellbeing. This score is better than other similar organisations.

Both locations were either equal to or better than the England average.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
North Devon District Hospital	Acute/PICU	93.4%
	MH Older people wards	
	Crisis services	
Torbay Hospital	Acute/PICU	90.6%
	Crisis services	
	MH Older people wards	
	Community adults of a working age	
Trust overall		91.8%
England average (mental health and learning disabilities)		90.6%

The involvement in care

Involvement of patients

All the wards had an admission process that oriented patients to the ward. Patients received welcome packs on each of the wards that included essential information about their stay in hospital. Patients are welcomed on to the ward by a band three member of staff and a nurse who conducted a search of the patients' belongings with their consent. Patients were given Mental Health Act rights, leaflets and information about who would be looking after them. Staff and patients developed a 'community code' that outlined what patients and staff on the ward should expect from each other.

The degree to which patients played an active part in their care planning and risk assessment was unclear. We saw examples of care plans written in the first person and examples of care plans that contained information about the patient's thoughts and feelings. Patients on the Coombehaven and Delderfield wards had copies of their care plans and staff encouraged patients to stick them to the insides of their bedroom doors. Sixteen patients had been offered a copy of their care plan but

in the other 18 records this part of the record was not completed. Coombehaven and Delderfield patients had all been offered a copy of their care plan.

Care records showed some patients did not agree with their admission or acknowledge their mental health difficulties but staff tried to help patients understand by talking to them about why they had been admitted.

During the ward round on Moorland View ward patients received advice about their medicines and discussed their physical health problems, a patient from Ocean View said they had been given information about medication choices before deciding what to take.

Staff involved patients in the development of services. Coombehaven and Delderfield said they always involved patients in the interview process for new staff and at the Cedars Academy that provided training to staff and patients. Patients were involved in the smoke free meetings.

There were a variety of ways for people to give feedback on the service. Patients attended weekly community meetings and they said they could make requests. All the wards displayed, 'you said, we did' boards with examples of changes made in each wards in response to feedback from patients. Patients were asked to complete the family and friends test. Some of the wards had letter boxes and leaflets about how to complain. However on Haytor wards the leaflets and boxes were outside that door to the ward. The wards, in particular at the Coombehaven and Delderfield wards unit had started patient and staff led quality improvement projects driven by the patients for example, new staff uniforms. Patients that had been discharged from the wards continued to be involved proactively with the service by leading and developing quality improvement projects for example, a trial of staff uniforms to be able to identify the different staff including allied health professionals. Pictures of the new uniforms were up on the wall to help patients understand staff roles.

All the wards were visited by the mental health advocates and staff enabled patients talk to the advocates as required. The signs were up on the wards to let people know about advocacy. Patients generally knew how to access advocacy. However, three patients on Moorland View ward did not know how to contact an advocate.

Involvement of families and carers

All the wards involved carers and families in line with patients' wishes. Carers and families could attend ward rounds. Haytor ward told us they had referred carers for carers' assessments with a carer service run by the county council.

Is the service responsive?

Access and discharge

Bed management

Staffing was organised by a 'safer staffing and bed capacity' team who oversaw the management of beds across all five wards and there were regular telephone conferences with representatives from each ward to consider the movement of patients and the availability of beds.

The trust provided information regarding average bed occupancies for five wards in this core service between 1 August 2016 and 31 July.

The provider did not provide any benchmark however, Haytor ward had the highest bed occupancy over the period with rates ranging from 113% to 134% over the period.

Ward name	Average bed occupancy range (1 August 2016 and 31 July) (current inspection)
Coombehaven	99-113%
Delderfield	104-117%
Haytor	113-134%
Moorland View	92-111%
Ocean View	93-104%

Haytor had a 17th bed they opened when needed although they were commissioned for 16 beds.

Average Length of Stay data[3] (Remove before publication)

The trust provided information for average length of stay for the period 1 August 2016 and 31 July 2017.
There is no clear trend over time however Coombehaven had the largest fluctuation in bed occupancy over the period.

Ward name	Average length of stay range (1 August 2016 and 31 July) (current inspection)
Coombehaven	14.4 - 79
Delderfield	22.4 - 56.5
Haytor	13.7 – 35.4
Moorland View	18.6 – 68.8
Ocean View	17.9 – 44.8

This core service reported 217 out of area placements between 1 August 2016 and 31 July 2017. 216 were returned to the same ward.

Readmissions[4] (Remove before publication)

This core service reported 52 readmissions within 28 days between 1 August 2016 and 31 July 2017

Twenty five readmissions (48%) were readmissions to the same ward as discharged from. Eleven of the fourteen readmissions from Haytor ward were readmitted back to the same ward.

Ward/service	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission

[3] 20170614 RPIR MH VFinal – bed occ and LOS
[4] RPIR Universal vFinal – delays

Haytor	14	11	79%	2-28	14
Ocean View	13	7	54%	1-25	11
Coombehaven	8	3	38%	2-24	13
Moorland View	8	2	25%	1-17	9
Delderfield	9	2	22%	7-25	18
Total	52	25	48%	1-28	13

Referral to assessment and treatment times[5] (Remove before publication)

There was no data for this core service relating to the metric.

The service was unable to keep beds open for patients if they went on leave for more than one night. If patients went on day leave (including one night), they usually had a bed to go back to. However, since our last inspection, staff now supported patients to pack up their belongings and either take them with them or store them safely on the ward so they were aware they would not be coming back to the same room.

Staff did not move patients between wards unless there were clinical grounds to do so.

Staff tried not to move patients at night and the table below shows this happened 13 times in the year leading up to our inspection.

Ward name	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Coombehaven												1	1
Delderfield			1		1		1						3
Haytor				1			1						2
Moorland View				1		1							2
Ocean View						1		1		3			5
Core service total			1	2	1	2	2	1		3		1	13

The wards had dedicated discharge planners to facilitate moving patients on from the service. There were display boards for each ward highlighting any barrier to discharge for each patient and how these were being managed. Wards gave patients discharge packs with information about future care arrangements, signposting and a letter of hope from a group of people with lived experience of mental health difficulties.

There were no psychiatric intensive care beds in Devon but the trust had purchased beds out of county for patients to go to if needed. The bed management team arranged beds for patients and the staff on the ward arranged transport. The trust commissioned six beds in psychiatric intensive care units out of Devon County. The trust was in the process of building a psychiatric intensive care unit and a mother and baby unit in Exeter.

[5] RPIR Universal vFinal – transfers

Managers felt the bed management team was helpful but that they did not relieve any work from them. One manager said they had to be assertive with the bed management team and that sometimes staff felt pressured to accept referrals they felt were unsuitable. If a patient was admitted and staff felt the admission was inappropriate, they completed an incident form. The trust told us the central bed management service in partnership with the Crisis Resolution and Home Treatment Teams undertake their duties in a way to provide the safest, most responsive and most timely access to beds possible, also ensuring that we minimise distress to the person and their families. The trust acknowledged this could put additional pressure on services as they receive admissions. The trust were reviewing their bed numbers and they were in consultation with their commissioners about the lack of inpatient beds

Haytor wards had three delayed discharges and the main reason was a need to find appropriate accommodation for the patient.

Discharge and transfers of care

Delayed discharges[6] (Remove before publication)

Discharge planners worked on each ward to make arrangements for patients when they left the ward. Ward managers said they were helpful in liaising with placements, making arrangements for patients to continue their medicines and preventing delayed discharges.

Between 1 August 2016 and 31 July 2017 there were 1277 discharges within this core service. This amounts to 72% of the total discharges from the trust overall.

In total, 9% of the discharges within the core service were delayed with Delderfield ward having the most (30) which is 34% of all delays within the core service.

When patients were transferred, the ward staff arranged suitable transport for them.

Facilities that promote comfort, dignity and privacy

Patients could personalise their rooms. They had their own bedrooms and on some wards they had en-suite facilities.

Staff and patients had access to a range of rooms and equipment. The wards were spacious and had numerous spaces for patients including gyms, large craft spaces, occupational therapy assisted kitchens, computer access rooms, music rooms, pool rooms and several lounges on each ward. However, on Haytor ward, the dining room for patients did not have enough seats for all the patients to eat their meals at once, therefore, mealtimes were staggered to allow all the patients room to eat their meals.

All of the wards had gardens to enable patients to have access to outside space. The gardens were locked at night or in response to incidents.

Patients could access their bedrooms during the day unless there was an identified risk.

PLACE Assessments[7] (Remove before publication)

PLACE-2017-data-report1

North Devon District Hospital scored better than other similar trusts with 94.4% whilst Torbay Hospital scored worse with 74.2% when compared to other similar trusts in the 2017 PLACE assessment for ward food.

Site name	Core service(s) provided	Ward food
North Devon District Hospital	Acute/PICU MH Older people wards Crisis services	92.4%
Torbay Hospital	Acute/PICU Crisis services MH Older people wards Community adults of a working age	74.2%
Trust overall		92.5%
England average (mental health and learning disabilities)		89.7%

Feedback about the food was mixed. Patients we spoke to said they like the food. Two carers we spoke to said patients did not like the food. The food supplied met the dietary requirements for patients including vegetarian, gluten free and dairy free options. There were choices for all patients. Daily menus were displayed for patients to see. Patients could make drinks and snacks on all the wards. Haytor ward patients had a white board advertising refreshments and snacks.

Patients' engagement with the wider community

Moorland View and Ocean View wards had links with the local college and with links centres that support people back to work. Haytor ward staff were supporting a patient to complete their university degree.

Staff supported patients to have visits from their families. There were systems in place for visits to be booked so that a suitable space could be arranged for the visit to take place adjacent to the ward.

Meeting the needs of all people who use the service

Wards were accessible and had been adapted to enable patients with disabilities requiring adaptations to access the service including adapted bathrooms and bedrooms. Corridors were wide enough to allow wheelchairs to pass through easily. In the event of a fire there was an alternative exit for wheelchair users.

All wards had information leaflets available to patients and carers. These included; chaplaincy services, depression and anxiety support, emotional support services and information about medication and the Mental Health Act. Haytor ward kept this information outside the ward due to problems with vandalism.

There was access to interpreters through the trust and signers were available.

Wards provided for patients dietary needs, including Halal, Vegan and gluten free food. Patients had a nutritional screen on admission. Coombehaven and Delderfield ran cooking groups for patients. Moorland View and Ocean View wards had a vegan supper cooking group for patients.

Chaplains visited the wards at least weekly and by request to support patients' spiritual needs. Patients were assisted to go to places of worship.

Staff and patients created 'mutual expectations' together. These included some restrictions such as the use of alcohol or illicit substances.

Listening to and learning from concerns and complaints

Complaints were managed by patient advice and liaison services. Staff on the wards tried to resolve complaints informally. The managers told us complaints were discussed in learning from experience meetings and disseminated in business meetings with staff

This core service received 23 complaints between 1 August 2016 and 31 July 2017. Delderfield and Haytor wards accounted for seven complaints each – the most of any ward in the core service.

Patient care was the most common complaint type with five complaints followed by 'values and behaviours' of staff and 'clinical treatment' with four complaints each.

Ward	Admissions & Discharges (Exc Delayed Discharge)	Clinical Treatment	Communications	Facilities	Patient Care	Prescribing	Restraint	Values And Behaviours (Staff)	Grand Total
Coombehaven			1	1	1			1	4
Delderfield	1	1	1	1	1	1	1		7
Haytor	1	1			2		1	2	7
Moorland View		2			1			1	4
Ocean View	1								1
Core service	3	4	2	2	5	1	2	4	23

Staff received information about the results and investigations of complaints through business meetings and supervision. The trust have a 'see something say something' policy that encouraged staff to speak up about anything that concerned them.

This core service received 65 compliments during the last 12 months from 1 August 2016 to 31 July 2017. This accounted for 10.4% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Managers had the skills, knowledge and experience to perform their roles. They were all experienced in their current roles and understood the needs of patients and staff.

Managers were motivated to provide a high standard of care. Managers knew the challenges faced by the service and worked together to overcome challenges. Ward managers were supported by senior nurse managers. Managers spent time working on the wards, were familiar with the challenges staff faced and could explain how the teams were continuously improving.

All managers were visible and approachable to patients and staff. Managers had an open door policy for staff and patients. Senior managers were visible and on the wards and familiar with the staff team and the patient group.

The managers on Haytor ward told us senior management regularly visited and the director of nursing also did shifts on the wards. The director of nursing had completed shifts on Haytor Ward. On Haytor ward, during our visit, the Chief Operating Officer was visiting the ward. The Senior Clinical Nurse told us that the Chief Operating Officer regularly visits the ward.

Coombehaven and Delderfield managers said directors visited the wards and did occasional shifts.

Ocean View and Moorland View wards said senior staff had cancelled several visits and they could not remember when they last visited. However, a recent visit by the director of finance had led to money being released for painting and notice boards.

Leadership development opportunities were available and staff were given opportunities to gain experience to enable them to progress in their careers.

Vision and strategy

Staff knew and understood the provider's values and they were displayed on the wards. Staff felt the values were relevant to their work.

Coombehaven and Delderfield managers said that to some extent the team objectives were based on the vision and values of the trust but there was more work to do to embed the vision and values.

Culture

Teams worked well together and most staff felt respected, supported and valued. Wards held informal staff meetings for staff. For example, Haytor, Coombehaven and Delderfield wards had a tea and cake meeting for staff once per week.

Haytor ward had previously had difficulties with their culture. Haytor managers and the psychiatrist told us the culture and morale had improved and that the ward was friendly and warm with an open and honest culture that most staff were signed up to. However, four Haytor ward staff said it was difficult to challenge management and some staff complained about how the ward management spoke to them. These staff felt they could voice their concerns about this.

Coombehaven and Delderfield managers said they felt respected and that generally the team were happy at work, compassionate and dedicated. The manager for Haytor wards said staff were generally happy. The occupational therapy team at Haytor ward were undergoing a consultation which was stressful for them.

Staff were motivated to provide high quality care and worked well together. Managers dealt with staff performance issues.

All staff felt able to raise concerns without fear of retribution and they all knew the where to find information about the whistle-blowing process.

Staff felt that they were offered opportunities for personal development and training. However, appraisals were not consistent across the wards and many were not of a good standard. There was a lack of input by the appraisee in the appraisals for Haytor staff. Many of the appraisals lacked action planning or discussions about career progression and lacked discussion of training needs.

Staff sickness and absence was 6% for the year leading up to our inspection and this was similar to the average for the provider which was 5%.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The trust motivated staff by running a celebrating achievement awards scheme each year. Delderfield ward staff and a member of staff from Coombehaven won celebrating achievement awards in December 2017 for their work with two patients with complex needs.

Suspension and supervised practice[8] (Internal use only - Remove before publication)

When staff were suspended or dismissed there were examples of managers learning from what went wrong and providing training for teams.

During the reporting period there were four cases where staff had been suspended and one moved to a different ward.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward name	Suspended	Under supervision	Ward move	Total
Coombehaven Ward,	1			1
Delderfield Ward, Cedars	1			1
Ocean Ward	1			1
Haytor	1		1	2
Core service total	4		1	5

Governance

The governance of the service lacked sufficient oversight of staff and their development. Wards struggled to recruit adequate staffing numbers but they were advertising jobs and offering incentives. The lack of nurses meant ward managers often worked on the wards and this took

[8] 20170614 RPIR Universal vFinal - Suspension or supervised

them away from their management duties. Managers did not all provide regular, good quality supervision and appraisals in line with trust policy. Some staff on Coombehaven ward had waited several months between supervision, one staff member waiting up to six months. There was a lack of oversight of the issues affecting patients being unable to go on escorted leave and the extent to which patients were affected. Haytor ward manager had not addressed the need to evaluate the risk associated with community treatment order patients attending Haytor ward for depots despite this being in our previous report. The ward managers did not have a consistent approach to blanket restrictions across the wards and they did not sufficiently monitor to ensure patients did not have access to items that were unsafe. There was a lack of procedures to ensure out of date items were removed from clinic rooms and replaced as required and this caused a potential risk to patients. Some ward environments were not clean and were in a poor state of repair, for example, a seclusion window had not been repaired and areas of Coombehaven and Delderfield were mouldy and had this had not been addressed.

However, patient care was prioritised which meant patients were assessed and treated well. Physical health monitoring was good. The wards adhered to the Mental Health Act and Mental Capacity Act and staff had good knowledge. The Mental Health Act administration teams enabled compliance to be monitored. Beds were managed well with a separate team coordinating bed capacity. Discharge planners enabled discharge planning. Incidents were reported, investigated and learnt from but changes were not always made to prevent future incidents.

Ward business meetings all included an item on quality that included space to discuss essential issues such as safeguarding, infection control learning from incidents and complaints. There was evidence of learning from deaths and other incidents being embedded on the wards and some developments were still in discussion.

Management of risk, issues and performance

The wards had key performance indicators including completing the Health of the Nation Outcome Scale, regular physical examinations, medicines reconciliation, appraisals, supervision and complaints .

Ward managers kept risk registers for each ward and these linked to directorate level risk registers with items being automatically added to the directorate risk register if managers rated the risks and likelihood as high.

Haytor ward lacked a procedure and risk evaluation of the practice of patients on community treatment orders attending Haytor ward for depots. Patients remained on the ward with other patients for four hours following their depot. This changed the ratio of staff to patients and this was not taken into account. Staff did not search patients attending for depots.

There was a risk of patients leaving the Ocean View and Moorland View wards without permission and although there were plans to address the risks, the risks were not being mitigated in the meantime.

Information management

Staff said they had access to the equipment and information technology they needed. However, some staff said they would benefit from the use of the tablets, for example, when working with patients on their care planning.

The trust had a dashboard system managers could use to download information about their wards' performance. The system was not burdensome on staff because data was collated centrally. However, data such as training completion rates were often out of date. Managers used reports to help them in their role. However, managers said the information in the reports were out of date. They said they could also ask for bespoke reports.

Ward level recording was lacking, for example, there was no recording or monitoring of issues affecting patients being unable to go on escorted leave and we could not be assured that wards were staffed to enable patients to take their leave. At our previous inspection the nurses and nurse assistants told us patients could not always have leave when they wanted it and that leave on Haytor Ward was sometimes cancelled.

Board assurance framework[9] (Internal use only - Remove before publication)

The trust have provided their board assurance framework, which details any risk scoring 16 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The two strategic ambitions outlined by the trust relating to this core service are as follows:

1 – To deliver consistently high quality care and treatment/to build a reputation as a recognised centre of excellence.
2 – To be an efficient, thriving and successful organisation with a sustainable future.

Corporate risk register[10] (Internal use only - Remove before publication)

The trust has provided a document detailing their 11 highest profile risks. Five have a current risk score of 16 or higher. The following three of the five relate to this core service.

Key:

High (16-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
31 December 2012	258	IF the number of out of area acute/PICU admissions isn't managed within Trust agreed bed numbers. THEN this will increase financial pressures and impact quality of patient experience.	9	16	Moderate		18/08/2017

Engagement

Staff received bulletins and had access to information such as policies and news on the staff intranet.

There were regular opportunities for patients and carers to give feedback on the service and patients took part in recruitment. Managers and staff used the feedback to develop the service and

[9] RWV P112a CAF Aug 17 Final
[10] RWV p112e Adult Risk Register Directorate Aug 17

made people aware of the changes that had been made in response to their feedback. Staff could feedback using an online forum and through business meetings.

Learning, continuous improvement and innovation

Innovations were taking place in the service, for example, Ocean View and Moorland View wards were trialling the 'self-accessed flexible treatment intervention' project. Managers took steps to introduce quality improvement mechanisms. Staff, patients and previous patients ran small service quality improvement projects, for example, they managed the introduction of a trial of new nurse uniforms.

One of the ward managers was taking part in policy reviews.

Accreditation of services[11] (Exception reporting only) (Internal use only - Remove before publication)

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services in the core service which have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
AIMS - WA (Working Age Units)	Moorland View - Accreditation confirmed in July 2017. Awaiting certificate. Ocean View - Accreditation confirmed in July 2017. Awaiting certificate. Coombehaven Ward - Accreditation process completed. Awaiting certificate. Delderfield Ward. Accreditation until 9 October 2018. Haytor – To re-commenced Accreditation approx. October 2017	
AIMS - PICU (Psychiatric Intensive Care Units)	None	Not provided
AIMS - AT (Assessment and triage wards)	N/A	Not provided

At the time of our inspection Delderfield Ward, Ocean View Ward and Moorland View Ward had accreditation for inpatient mental health services. Coombehaven Ward was awaiting accreditation.

[11] 20170614 RPIR Universal vFinal - Accreditation

Haytor ward was not accredited. They failed their previous submission because they did not have a psychologist in post. This was still the case.

The Consultant Psychiatrist for Haytor ward was a principle investigator in a research programme with the University Oxford called ‘Prevalence of Pathogenic Antibodies in Psychiatric Illness’. The study aimed to understand if some cases of psychiatric illness are caused by immune system problems. They were also recruiting patients to a trial led by Cambridge University Hospitals NHS Foundation Trust and the University of Cambridge to explore the usefulness and safety of using immunotherapy for patients with acute psychosis associated with anti-neuronal membrane antibodies.

Moorland View and Ocean View wards had won a big lottery grant to set up activities for patients to take part in at weekends. They were using the funding that was also added to by the trust, to work with a local community arts company to provide patients with visual arts, dance, creative writing and music at weekends and in the evenings.

Wards for people with a learning disability or autism

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Additional Support Unit	Additional support Unit (Inpatient)	5	Mixed

Is the service safe?

Safe and clean care environments

The unit's layout enabled staff to observe most parts of the unit. The unit was split into two wards, a male ward and a female ward. There were some restricted lines of sight across both wards, which were managed by staff observations.

Safety of the ward layout

The service complied with guidance on same sex accommodation. The unit had two separate wards, a female ward and a male ward.

Over the 12 month period from 1 August 2016 to 31 July 2017 there were no mixed sex accommodation breaches within this core service.

Each ward had a patient accessible kitchen, dining room, lounge and quiet/multi faith room. Bathroom/shower and toilet facilities were not en-suite. There was one bathroom, one shower room and a separate toilet on each ward. The unit manager told us that only in an emergency would the service admit a patient into the ward designated for the opposite sex. We were told that there was a policy in place with a clear escalation process.

The service had a safety alarm system. All staff carried personal alarm fobs, which when activated alerted other staff that assistance was needed and in what location. However, there were no call bells in patients' bedrooms for them to be able to alert staff should they need assistance. An application to install patient calls bells was with the capital funds team. The call bell system would provide wall switches in bedrooms as well as a call bell for patients to carry on their person. The team had identified call bells, which were a low ligature risk. A ligature is something that can be used to tie or bind tightly and cause harm to an individual.

Ligature risk assessments were in place. Staff used an assessment tool to rate risks and developed action plans to minimise environmental risks. A brief ligature risk assessment was given to staff each shift to ensure awareness of ligature risks on the unit. Staff had access to ligature cutters. Ligature risks include items that can be used to ligature as well as points ligatures could be tied to.

There were ligature risks on one ward within this core service. The trust had undertaken recent

(from August 2016 onwards) ligature risk assessments at the Additional support Unit.

The ward presented a lower risk due to non-ligature window furniture.

The trust had taken action by implementing a programme of works to replace window furniture with a ligature free design in order to mitigate ligature risks. The work has been completed. However, after installation the unit manager felt that the new windows contained ligature points. These were included in the ligature risk assessment and management plan.

Maintenance, cleanliness and infection control

Patient-led assessments of the care environment (PLACE) are self-assessments undertaken by NHS providers, and include patient assessors who are members of the public. They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services.

Patient-led assessments of the care environment (PLACE)[12] (Remove before publication)

For the most recent Patient-led assessments of the care environment (PLACE) assessment (2017) the location scored better than the similar trusts for three of the four aspects overall. There was no score for 'dementia Friendly' as it had not been assessed.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
ADDITIONAL SUPPORT UNIT (WHIPTON HOSPITAL)	Ward for people with LD & Autism	100%	99.4%	-	92.6%
Trust overall		**98.2%**	**96.1%**	**89.3%**	**86.4%**
England average (Mental health and learning disabilities)		**98.0%**	**95.2%**	**84.8%**	**86.3%**

During the inspection, the unit was clean and maintained to a high standard, as were the fixtures and fittings. This mirrors the PLACE score of 100% for cleanliness and 99.4% for condition, appearance and maintenance.

We saw that staff carried out environmental risk assessments and ward audits. There were notices, which clearly displayed hand washing techniques. Infection control information was displayed on communal notice boards and a member of staff was the infection control champion for the unit.

Seclusion room (if present)

The seclusion suite had undergone refurbishment work since the last inspection. The room met the requirements set out in the Mental Health Act Code of Practice. The seclusion room contained a bed, toilet and sink. There were three observation panels as well as an intercom system to allow for communication with the patient when the door is locked. The room had two windows in the ceiling, staff could electronically open the window for ventilation and close the blinds. There was externally controlled lighting and heating and a clock was visible to the patient from within the room. However, the shower was located across the hall from the seclusion room. A protocol was in place for the use of the shower during periods of seclusion.

The unit also had an extra care area that had one bedroom, a lounge and a bathroom. At the time of our inspection, the extra care area was in use by a patient who benefited from a less stimulating environment.

Clinic room and equipment

The unit did not have a dedicated clinic room. Medications were stored and dispensed from the nursing station on the female ward. The nursing station was fully equipped and emergency medications were all in date. Resuscitation equipment was in good working order, readily available and checked regularly to ensure it was fit for purpose. Staff conducted physical examinations of patients, including taking bloods, in their bedrooms.

[12] 20171121 PLACE 2017

Safe staffing

Nursing staff

Staffing vacancies were high but were well managed to ensure safe staffing levels on the ward. Information provided by the trust showed the Additional Support Unit was under the established staffing level for qualified nurses and above the established level for nursing assistants.

Definition

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 July 2017	30	N/A
Total number of substantive staff leavers	1 August 2016–31 July 2017	4	N/A
Average WTE* leavers over 12 months (%)	1 August 2016–31 July 2017	11%	14%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 30 July 2017	3	N/A
Total vacancies overall (%)	At 30 July 2017	10%	12%
Total permanent staff sickness overall (%)	Most recent month (At 30 July 2017)	12%	5%
	1 August 2016–31 July 2017	13%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 30 July 2017	13	N/A
Establishment levels nursing assistants (WTE*)	At 30 July 2017	18	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 July 2017	5	N/A
Number of vacancies nursing assistants (WTE*)	At 30 July 2017	-4	N/A
Qualified nurse vacancy rate	At 30 July 2017	37%	18%
Nursing assistant vacancy rate	At 30 July 2017	-22%	1%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 August 2016–31 July 2017	603 (11%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 August 2016–31 July 2017	183 (3%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 August 2016–31 July 2017	181 (3%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2016–31 July 2017	0 (0%)	N/A

Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2016–31 July 2017	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 August 2016–31 July 2017	0 (0%)	N/A

*Whole-time Equivalent

Establi**shme**nt, Vacancy, Levels of Bank & Agency Usage[13] **(Internal use only - Remove before publication)**

This service reported an overall vacancy rate of 37% for registered nurses at 31 July 2017.

Across the 12 months, vacancy rates for registered nurses have been above 30%, the highest rates occurring in October 2016 with 59% and from April 2017 to July 2017 the team have been reporting over 40% vacancy rates for registered nurses.

This service reported an overall vacancy rate of -22% (over established) for registered nursing assistants.

Across the last 12 months, the nursing assistants have been over established every month.

This service has reported a vacancy rate for all staff of 10% as of 31 July 2017. LD Inpatient – ASU had vacancies above the trust levels for nine of the 12 months reported. March 2017 reporting the highest vacancy rate with 17.8%. From May 2017 to July 2017, their vacancy rates have been below trust levels and have been steady at 9.7%.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
LD Inpatient – ASU	5	13	37%	-4	18	-22	3	34	10%
Core service total	5	13	37%	-4	18	-22	3	34	10%
Trust total	**131**	**739**	**18%**	**3**	**597**	**1%**	**292**	**2396**	**12%**

NB: All figures displayed are whole-time equivalents

At the time of our inspection, the unit manager reported a vacancy rate of 3.88 (whole time equivalent) for qualified nurses. The recruitment of qualified nurses was a challenge for the unit. To overcome this, the team attended a recruitment fair in Birmingham and had nine newly qualified nurses' recruited to start work on the unit from September 2018. The trust was looking into accommodation for nursing staff to help nurses relocate to Devon.

The trust used innovative ways to overcome qualified nurse shortages. They had implemented training and support to develop the skills of nursing assistants. This allowed skilled nursing assistants to take on some of the roles of qualified nursing staff. The Additional Support Unit had two vacancies for nursing assistants who had completed extra training and competencies.

Between 1 August 2016 and 31 July 2017, bank staff filled 11% of shifts to cover sickness, absence or vacancy for qualified nurses.

[13] 20170627 Vacancy template

Please comment on any trends over time across the 12 months.

In the same period, agency staff covered 3% of shifts for qualified nurses. 3% of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
ASU	5681	603	183	181
Core service total	561	603 (11%*)	183 (3%*)	181 (3%*)
Trust Total	**88812**	**10747 (12%*)**	**7181 (8%*)**	**2936 (3%*)**

***Percentage of total shifts

Between 1 August 2016 and 31 July 2017, no data was provided by the trust for bank and agency usage to cover nursing assistant shifts.

When there was not enough permanent staff to meet the needs of the unit, bank and agency staff covered shifts. Staff told us that deputy unit managers and nursing assistants would cover shifts where possible.

This core service had four (11%) staff leavers between 1 August 2016 and 31 July 2017.

The turnover for LD inpatient – ASU ward has been below trust levels for eight of the 12 months reported. Months, which they were above, included November and December 2016 with 3% and 2% respectively (vs 0.9% and 1% for the trust) and March and May 2017 both with 3% (vs 1.8% and 1% for the trust).

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
LD Inpatient – ASU	30	4	11%
Core service total	30	4	11%
Trust Total	2187	298	14%

The sickness rate for this core service was 13% between 1 August 2016 and 31 July 2017. The most recent month's data [31 July 2017] showed a sickness rate of 12%.

Staff sickness for LD inpatient - ASU has been above the trust levels for the entire 12 months. December 2017 reported the highest sickness rate of 22.3%, January 2017 followed with 19.1%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
LD Inpatient – ASU	12%	13%
Core service total	12%	13%
Trust Total	5%	5%

The below table covers staff fill rates for registered nurses and care staff during June, July and August 2017.

LD Inpatient - ASU ward was below the fill rate for registered nurses for all day shifts across all three months.

Ward ASU was above the fill rate for care staff for night shifts for July and August 2017.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	August				July				June			
LD Inpatient – ASU	73.09%	95.50%	100.54%	132.55%	70.08%	94.42%	103.23%	132.21%	67.75%	95.65%	100.76%	121.77%

Training rates for staff on the Additional Support Unit were low.

The compliance for mandatory & non-mandatory training courses at 31 July 2017 was 74%. Of the training courses listed 14 failed to score above 75%. Three of these were mandatory courses and 11 were non-mandatory.

There were five courses which had a trust target (of 90%) that was not met. The target for non-mandatory courses was not stated but there were a further 26 courses that did not meet 90% compliance.

The 14 courses, which failed to reach above 75%, included, Safeguarding Children level 3, Safeguarding Adults level 3, and Medicine Optimisation – Controlled drugs – skilled non-registered staff all with 0%. Mental capacity act followed with 11%, Medicine optimisation – rapid tranquilisation with 16%, Prevent level 2 with33%, Immediate life support and Mental capacity Act level 2 both with 38%, Fire Safety (2 years) with 55%, Manual handling – object with 58%, Personal safety breakaway with 61%, Basic life support with 65% and Infection prevention control – inpatient with 69%. Finally Safeguarding adults level 2 with 72%. Training reporting is shown as those in date as of a rolling period end. Some courses are one-off; others have a one, two or 3-year validity

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trustwide training total %
Basic Life Support (BLS)	65%	tbc	72%
Business Continuity Planning	100%	Tbc	89%
Clinical Risk	97%	90%	97%
Clinical Risk (Level 2)	78%	Tbc	80%
Clinical Risk Basic Awareness - Non Clinical	100%	Tbc	88%
Conflict Resolution	90%	90%	90%

Equality and Diversity	97%	90%	98%
Fire Safety 2 years	55%	90%	83%
Food Hygiene - Level 1	78%	Tbc	85%
Health and Safety (Slips, Trips and Falls)	100%	90%	95%
Immediate Life Support (ILS)	38%	Tbc	38%
Infection Prevention (Level 1)	100%	90%	95%
Infection Prevention and Control - Inpatient	69%	Tbc	75%
Information Governance	87%	90%	94%
Manual Handling - Object	58%	90%	90%
MAPPA (Level 1)	88%	Tbc	94%
Medicines Optimisation - Administration of Injectables	75%	Tbc	71%
Medicines Optimisation - Administration of Medicines	75%	tbc	71%
Medicines Optimisation - Anaphylactic Shock	75%	tbc	74%
Medicines Optimisation - Basic Awareness (Level 1)	88%	tbc	83%
Medicines Optimisation - Controlled Drugs - Inpatient	75%	tbc	78%
Medicines Optimisation - Controlled Drugs - Skilled Non Registered Staff	0%	tbc	39%
Medicines Optimisation - Introduction (Level 2)	75%	tbc	83%
Medicines Optimisation - Rapid Tranquilisation	16%	tbc	32%
Medicines Optimisation - Safe Use of Insulin	75%	tbc	68%
Medicines Optimisation - Shared Decision Making	75%	tbc	74%
Medicines Optimisation- Administration of Homely Medications	75%	tbc	82%
Mental Capacity Act (Level 2)	38%	tbc	32%
Mental Capacity Act (Level 3)	11%	tbc	11%
Mental Capacity Act Level 1	100%	90%	97%
Mental Health Act - Level 2 - Inpatient	75%	tbc	70%
MEWS	87%	tbc	83%
Personal Safety Breakaway - Level 1	61%	90%	80%
Physical Health and Wellbeing	94%	tbc	88%
PREVENT (Level 2)	33%	tbc	62%
Restraint	89%	90%	93%

Safeguarding	100%	90%	98%
Safeguarding Adults (Level 2)	72%	tbc	87%
Safeguarding Adults (Level 3)	0%	tbc	27%
Safeguarding Children (Level 2)	78%	tbc	90%
Safeguarding Children (Level 3)	0%	tbc	58%
Total (all courses)%	**74%**	**-**	**82%**
Total (mandatory only)%	**86%**		**94%**

The unit manager acknowledged that complying with staff training requirements was difficult due to being a small standalone unit and staff shortages made it difficult to release people for training. Plans were in place to improve training compliance, such as booking training at the unit during the handover period. Breakaway and restraint training was seen as a priority. Ward staff had completed basic life support training after July 2017. The training data was not reflective of training rates at the time of inspection.

The Additional Support Unit provided regular in house training for staff with a specific focus on working with patients with a learning disability and autism. At the time of inspection, a number of staff had completed the positive behaviour support diploma provided by an external agency.

Assessing and managing risk to patients and staff

Assessment of patient risk

Care records contained comprehensive risk assessments. We reviewed three patient risk assessments and saw that staff had completed a comprehensive risk assessment for all patients. Staff completed risk assessments on admission and updated them as required, including after any incident. Staff used an electronic risk assessment tool.

Staff managed identified risks where possible. Risks highlighted in the risk assessment tool had a corresponding care plan to manage and reduce the risk. This included ways of managing the risk on the unit and after discharge.

Management of patient risk

Clear notices were in place for patients and visitors explaining the rationale for restricting items such as cigarette lighters and sharps from the unit. There were no unwarranted blanket restrictions.

There were good policies and procedures in place for observations, including minimising risk from ligature points. There was a high staff to patient ratio. This allowed for high levels of observations to manage patient safety. Staff explained that although patients were on high levels of observations, they ensured these were the least restrictive option based on the patient's needs. Nursing staff reviewed the observation levels of patients during each shift.

The majority of staff were up to date with physical restraint training and all staff understood that physical restraint was a last resort.

Staff completed 'PUMA' physical restraint training. However, this training is generic not specific for staff working with patients with learning disabilities and autism.

Use of restrictive interventions

Staff were committed to reducing the need for restraint by using de-escalation techniques and positive behaviour support. Despite this, there was an increase in the use of restraint and seclusion between September 2016 and August 2017 compared to the previous year.

Restrictive Interventions[14]: (Internal use only - Remove before publication)

This core service had 97 incidents of restraint (on 11 different service users) and 43 incidents of seclusion between 1 September 2016 and 31 August 2017.

Over the 12 months, there was an increase in the incidence of restraint in January 2017 with 17 and seclusion with 15 in July 2017.

The below table focuses on the last 12 months' worth of data: 1 September 2016 to 31 August 2017.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
LD Inpatient – ASU	43	97	11	1 (1%)	0 (0%)
Core service total	43	97	11	1 (1%)	0 (0%)

Restraint[15]: (Internal use only - Remove before publication)

There was one incident of prone restraint, which accounted for 1% of the restraint incidents.

Over the 12 months, there were peaks in the use of restraint in January 2017, where there were 17 incidents. There were further peaks, which occurred in June 2017 with 16, the number of restraint incidents continued to increase over the next few months with 23 in July and 24 in August 2017.

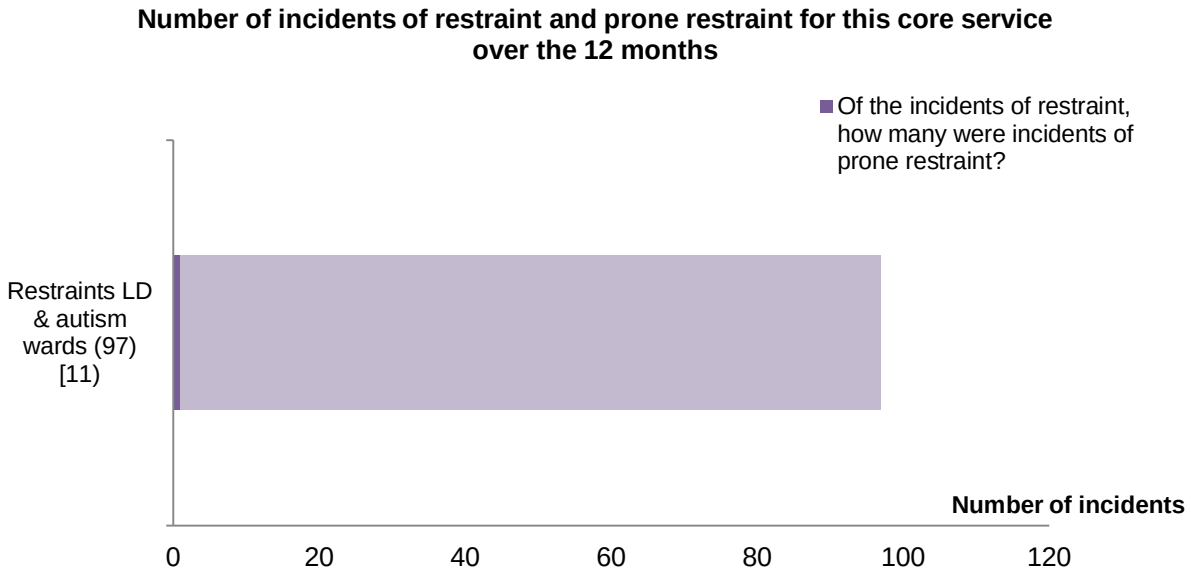
Incidents resulting in rapid tranquilisation for this core services seem to have been static, with no instanced of rapid tranquilisation being used at all in the last 12 months.

There have been no instances of mechanical restraint over the reporting period.

The number of restraint incidents reported during this inspection was higher than the seven reported in the previous 12 months (1 September 2015 to 31 August 2016).

[14] 20171016 Analysis - seclusion, segregation and restraint

[15] 20171016 Analysis - seclusion, segregation and restraint



Please note the figures in square brackets ,after the total number of restraints, are the number ofdifferent service users restraint was used on during this time period.

Staff explained that the number of restraints had increased over the previous 12 months because the needs of patients admitted to the unit had increased. We saw staff supporting patients in a proactive and therapeutic way to reduce the need for physical interventions.

Seclusion[16]: (Internal use only - Remove before publication)

Over the 12 months, there was an increase in the use of seclusion in July 2017, where there were 15 instances. This increased to 25 the following month (August 2017).
The number of seclusion incidents reported during this inspection was higher than the one reported the previous year 1 August 2015 to 31 August 2016.
Staff followed the seclusion policy. Patients were secluded for the shortest time possible. Staff kept appropriate records of incident leading to seclusion and of the time spent in seclusion.

Segregation[17]: (Internal use only - Remove before publication)

There have been two instances of long-term segregation over the 12-month reporting period.
The number of segregation incidents reported during this inspection was higher than the zero reported in the previous year.
The extra care area was used for long-term segregation. This consisted of a bedroom, lounge and bathroom with access to a small walled courtyard.

All patients had a personalised positive behaviour support plan. This included an assessment of the functions of behaviour in order to identify meaningful activities and preventative techniques for the patient. Staff were trained in 'interactive training', which focuses on how staff interact with each other and with patients to help manage aggression.

Safeguarding

There were appropriate systems embedded for safeguarding vulnerable adults and children.

[16] 20171016 Analysis - seclusion, segregation and restraint
[17] 20171016 Analysis - seclusion, segregation and restraint

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Safeguarding referral data has been provided at trust level only

Staff discussed safeguarding concerns as part of individual supervision and in team meetings. Staff received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy.

Staff had an understanding of safeguarding issues and their responsibilities in relation to identifying and reporting allegations of abuse. They told us of the steps they would take in reporting allegations within the trust. Staff spoke about recent safeguarding concerns and the steps they were taking to protect the patient from further harm.

The trust had a dedicated safeguarding team who review safeguarding incidents and liaise with the local authority safeguarding team as appropriate.

Devon Partnership NHS Trust has submitted details of two serious case reviews commenced or published in the last 12 months [2016/2017] neither relates to this core service.

Staff access to essential information

Staff used an electronic records system to record patient information. However, some members of the multidisciplinary team kept paper records. All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. This included when patients moved between teams.

Medicines management

We found evidence of good medicines management at the service. Medication was stored securely in the nursing station. Staff completed temperature checks for the medicines fridge, to ensure medication remained fit for use.

Track record on safety

The additional support unit reported no serious incidents between 1 August 2016 and 31 July 2017. In the year before this there were no serious incidents reported.

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 August 2016 and 31 July 2017 there were zero STEIS incidents reported by this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report. They reported incidents through an electronic reporting tool and staff were confident in how to report incidents.

Staff understood the duty of candour. The duty of candour states that every healthcare professional must be open and honest with patients when something goes wrong with their care or treatment that has the potential to, or causes harm or distress. They were open and transparent, and explained to patients and families a full explanation if something went wrong.

Staff received feedback from investigations of incidents that occurred both within the service and in other services across the trust. Points of learning from incidents were shared via monthly team briefs and newsletters. Team leaders would also raise learning points at team meetings, shift handover and during supervision.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been three 'prevention of future death' reports sent to Devon Partnership NHS Trust. None of these related to this core service.

Is the service effective?

Assessment of needs and planning care

Staff assessed patients' needs and care was delivered in line with their individual care plans. Staff assessed patients' needs on admission and continued to assess patients for the length of their stay on the unit.

Care plans were holistic and recovery focused. We reviewed the care records of four patients, all contained up to date personalised care plans covering a range of needs and were recovery oriented. Some care plans were designed specifically as guidance for staff with comprehensive guidelines in place to help staff fully support patients in all aspects of their daily living and care and treatment needs.

Where possible, staff recorded patients' views on their care plans in the documents on their system. They worked with some patients that did not have the ability to understand some of their needs, or the ability to weigh up decisions about their care. Where patients were unable to communicate their views staff documented how their behaviour demonstrated their views on care delivered.

Records showed that all patients received a physical health assessment on admission and that risks to physical health were identified and managed effectively. There was ongoing monitoring of physical health and staff followed the trust's physical health monitoring policy. Staff were trained to use to the Modified Early Warning Signs tool to observe changes in patient's presentation. Where staff identified physical health concerns, care plans were put in place to ensure the patient's needs were met and the appropriate clinical observations were carried out.

Staff were able to access patient records through the electronic care records system. All teams within the trust use the electronic care records system ensuring patient information is accessible and readily available to staff.

Best practice in treatment and care

The trust had prescribing guidelines and psychiatrists referred to these and to National Institute for Health and Care Excellence (NICE) guidance when prescribing medication.

Patients had access to psychological therapies recommended by the National Institute for Health and Care Excellence as part of their treatment on either a one to one or group basis. The patient's individualised treatment programme was innovative and tailored to their needs.

There was good access to physical healthcare. Records demonstrated that staff kept an overview of the physical health needs of patients. Staff kept physical health care plans up to date. Access to specialist services was available by referral when staff identified a need. Staff told us that referrals to speech and language therapy, physiotherapy and dieticians were common.

Staff used recognised rating scales and other approaches to monitor the effectiveness of care and treatment. Unit staff assessed all patients using the Health of the Nation Outcome Scales for Learning Disabilities (HoNOS-LD). Staff also used nationally recognised outcome measures and assessment tools for specific conditions. For example, the Glasgow Antipsychotic Side Effect Scale for patients on psychiatric medication.

The trust had a comprehensive clinical audit programme. Staff participated in a variety of audits to monitor the effectiveness of services provided.

This core service participated in two clinical audits as part of their clinical audit programme 2016 – 2017.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Self-Assessment Toolkit for Occupational Therapists	Occupational Therapy, Learning Disability Service (IATT Teams)	Learning Disability Service	Self-assessment toolkit for occupational therapists and managers to audit practice against recommendations in "Occupational therapy and people with learning disabilities – findings from a research study" (Lillywhite and Haines 2010).	10/08/2017	The next audit would include OT services at the ASU. There will be continued work on clarification and consistency of OT processes and documentation via development of OT Care Pathways. Work will be undertaken to underpin all client involvement with the evidence base and be clear we are contributing towards national drivers for the learning disability service. We will continue to work with partner organisations to offer clarity of the OT role and remit and to support them to work with people with learning disabilities. We have a clear work plan for the OT service for the year ahead, have identified who

					needs to contribute to this and where recommendations need the support of others.
Challenging Behaviour Learning Disability Service	Learning Disability Service	Learning Disability Service	The audit was to measure the Learning Disabilities Service compliance with NICE Guidelines - NG11 around Challenging Behaviour and people with Learning Disabilities.	June/July 2016	CB Care Pathway and standards to be reviewed by the service to establish if they are fit for purpose: Martin Ayres, Senior Manager (IATTS; CHC) and Community Team Leads have developed a revision to implement as soon as possible, 3 months Depending on if the Care Pathway/Standard is decided to be fit for purpose… Correct completion of 'Triage Forms' and the other NG11 standards, to be promoted within the service and standards of completion monitored with peer to peer monthly auditing: Delia to ask Community Team Leads to implement, the audits to be reviewed by Martin in the monthly Community Team Lead IATT meetings, 6 months Exploration with Care Notes to see if tweaks could be made to the areas identified as 'not possible to record' in the audit: Amanda Royal (Care Notes Champion Lead) to liaise with Care Notes Team, 6 months Exploration of practicalities of standards for naming care plans e.g. 'initial care plan' etc. to reflect stages of the care pathway: Senior Management Team, 6 months

Unit staff participated in local audits to assess and monitor performance over time. The audits covered topics such as involvement of family, positive behaviour support plans and adherence to infection control procedures.

Skilled staff to deliver care

The team included, or had access to, the full range of specialists required to meet the needs of the patients. The multidisciplinary team consisted of a consultant psychiatrist, junior doctors, nurses, occupational therapists and psychologists.

Unit staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Where newly qualified nurses were employed they were supported by experienced staff and offered training to develop skills and knowledge.

All staff completed a comprehensive standard local induction.

Staff received an annual appraisal where personal development objectives were set for the coming year. All staff we spoke with confirmed they had received their annual appraisal.

The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for non-medical staff within this core service was 94%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
LD Inpatient – ASU	33	31	94%
Core service total	33	31	94%
Trust wide	2095	**1763**	84%

The Additional Support Unit were above the trusts target rate for appraisals at 31 July 2017, at the time of our inspection the unit reported that all staff had received an appraisal within the last year.

The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for medical staff within this core service was nil, there was no data for medical staff.

The consultant psychiatrist confirmed that medical staff had an annual appraisal with their line manager.

All staff received clinical supervision in line with trust policy. Staff received monthly clinical and managerial supervision. The unit had implemented a supervision hierarchy with qualified nursing staff supervising nursing assistants. The unit had plans to introduce group clinical supervision.

The trust's target for clinical supervision is 90% (sessions delivered, hours of supervision delivered etc.)

Between 1 August 2016 and 31 July 2017, clinical supervision rates ranged between 6% and 100%. February 2017 is the only month where the team achieved the 90% trust target with 100%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision rate (%)
LD Inpatient – ASU	**6% to 100%**
Core service total	**6% to 100%**
Trust Total	**0% to 100%**

The unit manager explained that staff were not always good at recording supervision using the trust's electronic reporting system. The unit used a 'core team' approach to patient care and would often have informal supervision with members of each core team. These informal supervision meetings were not recorded using the electronic reporting system.

Multi-disciplinary and interagency team work

A multidisciplinary team meeting is composed of health and social care professionals. The multidisciplinary team worked together to make individual treatment recommendations for patients. The unit had two multidisciplinary meetings each week, a small overview meeting on a Monday followed by a full meeting on a Thursday. Half of the patients were discussed during each Thursday multidisciplinary meeting to ensure detailed and comprehensive discussion could take place.

We observed a clinical handover meeting and found this to be highly effective and structured. Occupational therapy and psychology staff attended the handover meeting with nursing staff. Staff demonstrated excellent in depth knowledge of the patients. Staff considered risk assessments and care plans for each patient as well as discussing patient presentation over the previous 24 hours.

There were effective working relationships with other teams in the trust. Care co-ordinators attended care review meetings with the multidisciplinary team. Staff discussed patients at the set times during multidisciplinary meetings to make it easier for care co-ordinators to attend.

There was evidence of interagency working taking place, with care and treatment reviews taking place for all patients. The unit worked closely with the clinical commissioning group and local authority adult services to identify suitable placements and support packages for patients.

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

Staff at the Additional Support Unit had access to the trust's Mental Health Act administration team for support and advice when needed. The Mental Health Act Administration team oversaw renewals of detention under the MHA, consent to treatment and appeals against detention.

The trust had relevant policies and procedures for the Mental Health Act that reflected the most recent guidance.

Staff received training in the Mental Health Act. As of 31 July 2017, 75% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is non-mandatory for all core services for inpatient and all community staff and renewed every three years. Staff demonstrated knowledge of the Mental Health Act Code of Practice and the guiding principles.

At the time of our inspection, three patients were detained under the Mental Health Act. Detained patients were informed of their rights monthly in accordance with section 132 of the Mental Health Act and the Code of Practice. Consent to treatment and capacity requirements were adhered to and attached t medication charts.

Information was displayed on the unit noticeboards regarding the independent mental health advocate and how to contact them. This was displayed in an accessible format that was easy to read. Staff referred patients who lacked capacity to the advocacy service.

Good practice in applying the Mental Capacity Act

Staff received training in the Mental Capacity Act. Staff had ongoing discussions regarding Mental Capacity Act and the five statutory principles.

As of 31 July 2017, 100% of the workforce in this core service had received training in the Mental Capacity Act Level 1, 38% for Mental Capacity Act Level 2 and 11% for Mental Capacity Act Level3 training. The trust stated that Level 1 is mandatory and Level 2 and 3 are non-mandatory for all core services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was the same as the compliance reported at the last inspection.

The trust told us that nine Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2016 and 31 March 2017.
The greatest numbers of DoLS applications were made in October 2016 with two.
CQC received one direct notification from the trust between 1 April 2016 and 31 March 2017[18]. (Provide some commentary to indicate whether or not the numbers match what the trust has submitted in the PIR. Under HSCA legislation, all DoLS applications should also be sent to the CQC in the form of a direct notification so it is important to point out if the numbers are different).
Include any contextual information that trust has provided. For example, some local authorities have a back log of DoLS applications and the application may expire before it has even been looked at/approved.

	Number of DoLS applications made by month												
	Apr 16	**May 16**	**Jun 16**	**Jul 16**	**Aug 16**	**Sep 16**	**Oct 16**	**Nov 16**	**Dec 16**	**Jan 17**	**Feb 17**	**Mar 17**	**Total**
Applications made	1	1	1	1	0	1	2	0	1	1	0	0	9
Applications approved	0	0	0	0	0	1	0	0	0	0	0	0	**1**

At the time of our inspection, one patient was subject to a standard Deprivation of Liberty Safeguard. The unit had made a standard and an urgent application for a second patient two weeks prior to our inspection that was yet to be authorised. The urgent application had been extended by a further week. Unit staff explained that the local authority was very busy and had a backlog for authorising Deprivation of Liberty Safeguard applications.

The trust had a policy on the Mental Capacity Act including Deprivation of Liberty Safeguards which staff were aware of and followed.

We reviewed two patient files and found that both had an assessment of capacity to consent to treatment.

Staff followed the principles of the Mental Capacity Act to enable patients to make their own decisions wherever possible. Where patients were unable to make decisions themselves, staff held best interest meetings to make decisions about certain aspects of their life or care and treatment. Staff clearly documented the outcome of the best interest decision in patient care records.

The trust Mental Health Act administration team offered support and advice on the Mental Capacity Act to staff. They also monitored the adherence to the Mental Capacity Act, including applications for Deprivation of Liberty Safeguard authorisations.

[18] 20171121 PAN01 DoLS Applications

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patient showed that they were responsive, passionate and caring. Staff provided patients with practical help and emotional support at the time they needed it. We observed staff continuously interacting with patients in a positive, caring and compassionate way and they responded promptly to requests for assistance whilst promoting patient dignity.

When staff spoke with us about patients, they discussed them in a respectful manner and demonstrated an extremely high level of understanding of their individual needs. They showed that they genuinely cared for the patients that they worked with. Staff spoke with pride about the journeys patients' had been on and the huge changes in behaviour they had seen.

Staff supported patients to understand and manage their care, treatment or condition where possible. Easy read information leaflets were available and staff produced easy read care plans.

The unit was operating an active support model to ensure patients were actively involved in their day. This was occupational therapy led but the whole team were responsible for supporting patients to be active in their daily plan.

The 2017 PLACE score for privacy, dignity and wellbeing was higher than both the trust average and the national average. PLACE assessments are self-assessments undertaken by NHS providers, and include patient assessor who are members of the public. They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services.

The 2017 PLACE score for privacy, dignity and wellbeing at the Additional Support Unit location(s) scored better than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
ADDITIONAL SUPPORT UNIT (WHIPTON HOSPITAL)	Wards for people with LD & Autism	93.3%
Trust overall		**91.8%**
England average (mental health and learning disabilities)		**90.6%**

The involvement of people in the care they receive

Involvement of patients

Ward staff involved patients in their care from the point of admission. Staff we spoke with told us they showed patients around when they arrived on the unit. Staff demonstrated an understanding that touring the ward on admission may not be beneficial for distressed patients. Staff continually worked to orient patients to the ward. New signs had been put onto every door to help patients identify rooms and find their way around. Patients received a patient information pack, which was in pictorial format and was easy read. The information pack included details of the multidisciplinary team, activities and mealtimes.

There was a strong person-centred culture at the Additional Support Unit. We observed staff supporting patients as partners in their care to manage their health needs as independently as

possible. Staff spoke about plans to involve patients further in care planning. They ensured that where patients were unable to participate in care planning, they documented behavioural responses to care delivered.

The unit held a weekly patient meeting and patients were invited to attend the multidisciplinary team meetings. Prior to the multidisciplinary team meeting staff would support patients in completing a form to help them participate in the meeting. The form included questions about emotional wellbeing, medication, patient and carer views on care and treatment and discharge plans. For patients who did not wish to attend, staff would discuss any issues they would like raised with the multidisciplinary team and then feedback the outcomes to the patient in a one-to-one meeting.

Staff would discuss risk assessments with patients where they could.

Involvement of families and carers

Families and carers were encouraged to provide feedback to staff on a weekly basis. Staff followed they 'you said, we did' process for feedback from patients, families and carers.

Staff involved families and carers where appropriate and information was shared according to the patient's wishes or in accordance with their best interests.

Plans were in place to implement an outstanding service approach initiative. This would involve workshops held over three days with staff, patients past and present, families, and carers in attendance. The workshops would involve a review of the service and look at future service development.

Is the service responsive?

Service Planning

Ward Moves

Staff kept patient movement between wards to a minimum. If staff felt the patient would be better cared for in a different environment then staff would arrange to move the patient. However, this was rare as the unit tried to manage all patients and would only move patients if risks increased significantly. Movement between wards often involved movement between service providers as the Additional Support Unit is the only inpatient unit for people with learning disability and autism operated by the trust.

Moves at Night

There is nothing to insert under this heading at this present time.
Patient movement between wards happened during the day. Any ward move was planned by staff and completed at an appropriate time for the patient.

Access and discharge

Bed management

Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by patients. At the time of inspection the unit had an occupancy level of 100%.

The trust provided information regarding average bed occupancies for one ward in this core service between 1 August 2016 and 31 July 2017.
Exeter ASU within this core service reported average bed occupancies ranging between 80% and 129% over this period. March and April 2017 reported the highest bed occupancy figures with 129% each month.
We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	**Average bed occupancy range (**1 August 2016 – 31 July 2017**) (current inspection)**
Exeter ASU	80% - 129%

Occupancy levels of over 100% were recorded when patients were on leave to new placements. Patients spent time on leave from the unit prior to discharge to ensure placements were appropriate and able to support the needs of the patients.

Staff told us patients on leave from the unit had their bed allocated to them and this remained available to them throughout their absence from the service. However, bed occupancy levels of over 100%means that beds did not remain available to patients during periods of leave.

Beds were available on a referral basis. Referrals for admission came from the community learning disability teams and other professionals involved in the care and management of patients with learning disabilities and autism. Admissions were usually planned. However, the unit would also consider emergency admissions.

The trust provided information for average length of stay for the period 1 August 2016 to 31 July 2017.
Exeter ASU reported high length of stay (days) in four months, August 2016 with 451 days, November 2016 with 360 days, April 2017 with 347 days and July 2017 with 225 days.
We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	**Average length of stay range (**1 August 2016 – 31 July 2017**) (current inspection)**
Exeter ASU	17 - 451

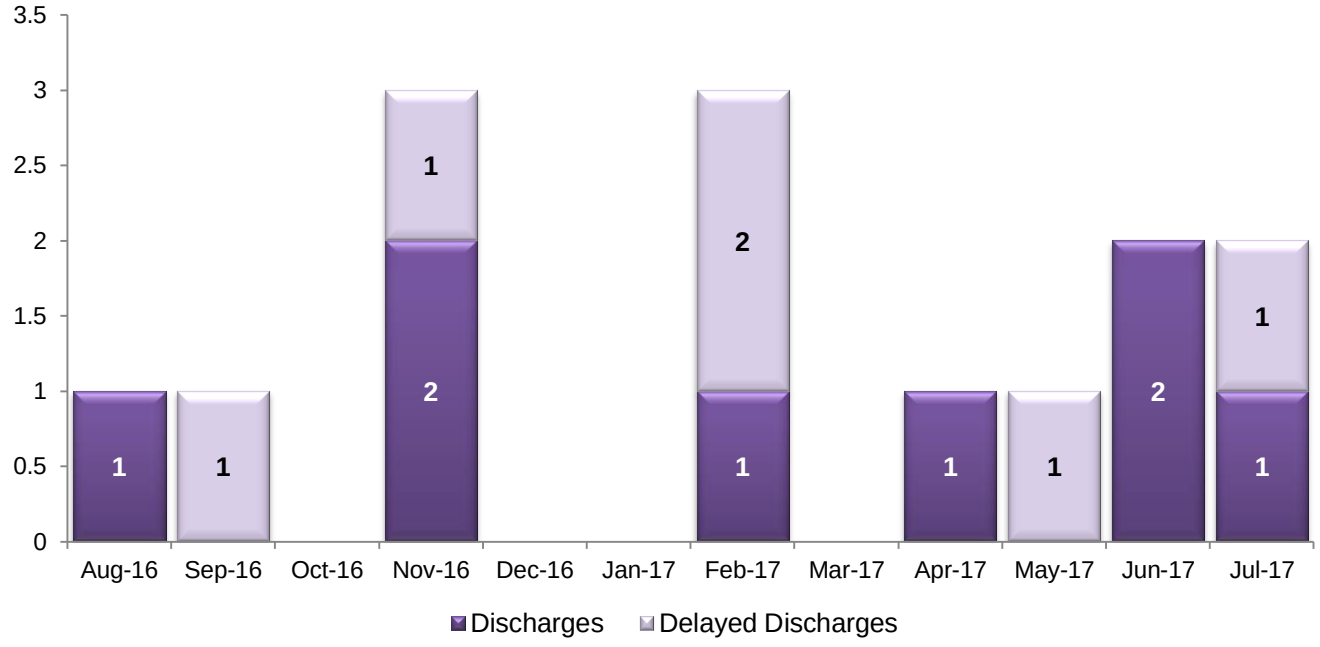
The average length of stay was reducing. Staff told us discharge was often delayed due to a lack of suitable accommodation or support. This increased the average length of stay.

This core service reported no out area placements between 1 August 2016 and 31 July 2017.
This core service reported no readmissions within 28 days between 1 August 2016 and 31 July 2017.

Discharge and transfers of care

Between 1 August 2016 and 31 July 2017, there were 14 discharges within this core service. Of the 14 discharges, six were delayed discharges. This amounts to 0.5% of the total discharges from the trust overall (1766).
The graph below shows the trend of delayed discharges across the 12-month period.

Unit staff and care coordinators planned discharge. When patients were discharged this happened during the day to ensure their wellbeing during the discharge process.



The graph suggests a spike in February 2017. August, October, December 2016, January, March April and June 2017 were the months with no delayed discharges within this core service.

The most common reason for a delayed discharge was the lack of appropriate community support for patients. Staff told us that community support for people with a learning disability and autism diagnosis was extremely difficult to find. The unit worked closely with local care services to support staff training in order to reduce delayed discharges. Ward staff visited local care services to provide training sessions for the staff. Prior to discharge, ward staff would complete a thorough handover of care of the patient to community care providers.

Facilities that promote comfort, dignity and privacy

The unit had a full range of equipment to support treatment and care. However, the unit did not have a full range of rooms. The activity room was large with a wide variety of equipment. However, staff used the activity room for handover, multidisciplinary team meetings and other meetings. The unit did not have a clinic room to examine patients. Staff told us they examined patients in their bedrooms and took equipment to the patient.

Both the male and female wards had a dedicated quiet room. Patients could also access a quiet room off the unit to meet with visitors. Visitors were allowed in the communal ward areas if preferred, this was risk assessed by staff.

Patients had free access to one of the unit's portable telephones to enable them to make and receive calls in private. Staff supported patients to maintain contact with relatives, carers and friends. Patients were able to use their own mobile phones on the unit.

There was unrestricted access to the unit garden for patients. Staff supervised patients in the garden to ensure their safety.

Patients were allowed to personalise their bedrooms. Staff wanted patients to feel comfortable on the unit and encouraged them to personalise their bedrooms with their belongings. Each bedroom contained a lockable cupboard for the secure storage of possessions.

Activities were available to patients seven days a week. Whilst the unit operated an activity timetable, this was flexible depending on patient engagement and preference. Activities were available in the evenings as well as during the day.

Apart from the front door being locked, the service was unlocked throughout and patients were able to make drinks and snacks when they wished to do so. Patients also had access to their bedrooms at any time.

In relation to food, the PLACE score was above the England average. The PLACE score for food in 2017 was 92%. PLACE assessments are self-assessments undertaken by NHS providers, and include patient assessors who are members of the public. They focus on different aspects of the environment in which care is provided, as well as support non-clinical services.

The 2017 PLACE score for ward food at the locations scored better than similar trusts.

Site name	Core service(s) provided	Ward food
ADDITIONAL SUPPORT UNIT	Wards for LD & Autism	90.7%

(WHIPTON HOSPITAL)	
Trust overall	**90.7%**
England average (mental health and learning disabilities)	**89.7%**

The Additional Support Unit received the same score as the overall trust score.

Patients' engagement with the wider community

Staff at the unit supported patients to access the community and use leave from the ward. There was a culture of positive risk taking with patient access to the community. Staff worked with the local community to make patient leave successful. The unit had a good relationship with staff at the local corner shop who were understanding of patient needs. One of the patients went on a daily two mile walk in the local area. The unit had a car to transport patients during trips away from the unit.

Meeting the needs of all people who use the service

The unit was accessible for people requiring disabled access. The physical environment of the ward supported the needs of the patients, making it easy for them to complete tasks of daily living.

Staff gave patients information leaflets which contained information on treatments, local services and the complaints procedure. Information was clearly displayed on communal noticeboards in an accessible and easy to read format.

Interpreters and leaflets explaining patients' rights under the Mental Health Act 1983 were available in different languages and could be requested from the trusts Mental Health Act administration team when required.

A choice of meals was available to patients. The unit was able to cater for people with dietary needs connected to their religion or individual needs through the varied menu. It was also possible for patients to purchase food from local shops.

Listening to and learning from concerns and complaints

Formal complaints

This core service received no complaints between 1 August 2016 and 31 July 2017.

Compliments

This core service received no compliments during the last 12 months from 1 August 2016 to 31 July 2017.

Patients were given information about how to make a complaint on admission and information was clearly displayed on the notice boards. Staff gave relatives and carers information on how to complain. In addition to the trust's complaints procedure patients were able to raise concerns during the weekly community meeting.

Staff told us that learning from complaints was discussed at team meetings, via trust emails and with individuals in supervision.

Staff were aware of duty of candour requirements which emphasise openness and transparency. The duty of candour requires NHS trusts to notify the relevant person of a suspected or actual reportable patient safety incident.

Is the service well led?

Leadership

Managers had the skills, knowledge and experience to perform their roles. The ward manager had received a 'highly commended award for outstanding leadership' from the trust board.

We found the wards to be well-led and there was clear leadership at a local level. Staff told us that managers were approachable, responsive and understanding. They worked directly on the wards and were accessible to staff, patients and carers. Staff described strong leadership across the service and said they felt respected and valued.

Managers had a good understanding of the services they managed and the current challenges. They spoke with excitement, passion and enthusiasm about plans to move the service forward and improve outcomes for patients.

Leadership and development training opportunities were available, including opportunities for staff below ward manager level. The trust offered the NHS leadership programme and standalone courses on leadership.

Vision and strategy

Staff had an awareness of the trust's values and knew where to find information about them on the intranet.

Senior management were visible to staff at the Additional Support Unit. Staff told us that senior managers had visited the unit. The ward manager explained that the unit worked hard to raise their profile within the trust.

Culture

Staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for patients on the unit. There was high staff morale across the service. All the staff we spoke with were enthusiastic and proud of their work and the care they provided for patients on the unit.

Staff felt able to raise concerns without fear of retribution. All staff felt listened to by their managers. The whistleblowing process was clearly displayed on posters and the trust intranet. Staff knew the process and the role of the Speak Up Guardian.

Poor performance was addressed when appropriate. Managers followed trust policies and procedures for poor staff performance.

During the reporting period 14 August 2016 – 14 august 2017), there were one case where staff was suspended.

The one case for the core service resulted in the staff member (Band 5) being suspended and ultimately dismissed.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward name	Suspended	Timeframe	Grade	Comments
Specialist Services	Yes	**18/1/17 – 24/5/17**	**5**	Individual dismissed, NMC involved

Governance

There were systems and processes in place to ensure patients received good quality, consistent care. The patient pathway was well managed with new processes developed to assist with the timely discharge of patients. Staff received sufficient training and supervision. Incidents were reported, investigated and learned from. Shifts were covered by a sufficient number of staff of the right grades and experience and staff worked hard to maximise time spent on direct patient care activities.

The trust's policies and procedures reflected the strategic ambitions for the organisation.

The trust provided its corporate assurance framework/risk register. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined two strategic ambitions:

1 – To deliver consistently high quality care and treatment/to build a reputation as a recognised centre of excellence.
2 – To be an efficient, thriving and successful organisation with a sustainable future.

The trust regularly collected data on performance. Performance was measured against a range of indicators, which included complaints; serious incidents and clinical performance such care plans and risk assessments. Where performance did not meet the expected standard action plans were put in place and implemented to improve performance.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both expected and unexpected risks.

The trust has provided a document detailing their 28 highest profile risks. Each of these has a current risk score 6 and 16 or higher. The following two relate to this core service.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
11 November 2013	108	If – the ASU admit patients who do not require treatment in hospital for a mental health problem but require a competent environment THEN – Capacity at the ASU is negatively affected, people are placed far from home making it difficult to maintain relationships and a presence in their community.	12	4	2	11 August 2017
1 June 2015	639	If there are insufficient staff to provide high quality, safe, & effective care then patients and staff are put at risk of harm.	16	12	2	2 August 2017

Key risks for the Additional Support Unit were inappropriate admissions and staffing levels. Procedures and plans were in place to address these.

Management of risk, issues and performance

Team managers had access to the risk register and could escalate concerns when required from a team level.

Information management

The trust used systems to collect data that were not over-burdensome for staff. The use of electronic systems for data collection including patient information, incident reporting and staffing levels made it easy for the trust to complete audits and performance reports.

Engagement

Staff had access to up-to-date information about the work of the trust. Information was available through the intranet, email bulletins and newsletters. Patients and carers had access to up-to-date information about the work of the trust through the trust's website.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff would record verbal feedback for patients unable to complete written feedback.

Patients and carers were to be involved in decision making about changes to the service through the 'outstanding service approach'.

Learning, continuous improvement and innovation

Staff participated in national audits relevant to the service and learned from them. Staff still monitored medication prescribing after participating in the STOMP-LD audit.

The trust participated in research within the learning disability service. Staff had aspirations to publish research conducted on positive behaviour support.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Quality Network for Inpatient Learning Disability Services (QNLD)	N/A	Not Quality network accredited currently due to seclusion works that had to be completed.

At the time of our visit, the Additional Support Unit had submitted evidence to the quality network for inpatient learning disability services following completion of the seclusion works in order to obtain accreditation.

Forensic inpatient/secure wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Langdon	Ashcombe -Dewnans Centre (medium secure)	15	Male
Langdon	Avon (low secure)	14	Male
Langdon	Chichester House (low secure)	15	Male
Langdon	Cofton Ward - Dewnans Centre (medium secure)	15	Male
Langdon	Connelly House (low secure)	6	Male
Langdon	Holcombe Ward - Dewnans Centre (medium secure)	15	Male
Langdon	Owen House (low secure)	16	Male
Langdon	Warren Ward - Dewnans Centre (medium secure)	15	Male

Is the service safe?

Safe and clean care environments

Safety of the ward layout

The Dewnans centre was purpose built and the four wards had clear lines of sight for staff to safely observe patients. Parabolic mirrors were used in areas where full sight was not possible. Staff followed the trust's observation policy. The four other wards were stand alone, in separate, older buildings and had areas which were not clearly visible to staff. This presented some challenges for clear observation of the patients. Staff managed these challenges through individual risk assessments, having a presence in areas of the wards where they could view the bedroom areas and regular checks of patients. There were sufficient staff available to increase the observation of patients at a high risk of self-harming, for example. However, these staff may have to be moved from their own ward to facilitate this cover.

Staff carried out regular environmental risk assessments which were up to date and reviewed regularly.

Same sex accommodation breaches[19] (Remove before publication)

As all of the wards were for male patients only, there were no mixed sex accommodation breaches reported within this core service.

Ligature risks[20] (Remove before publication)

There were ligature risk assessments for all eight wards within this core service. The assessments were completed within the preceding year.

The trust had an ongoing maintenance and capital build programme in order to mitigate ligature risks on the older wards, such as the fitting of anti- ligature fixtures and fittings.

Staff had received training on managing ligature risks and staff knew where the high-risk ligature anchor points and ligatures were and how these risks were reduced and managed. Staff had carried out ligature risk assessments using the trust's ligature audit tool at least once each year. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Induction packs for new staff included clear guidance on how ligature risks were managed and how to report new risks. Staff had identified high-risk areas such as the bathrooms, lounges and dining rooms and ensured they regularly monitored these areas.

Alarms were available throughout the wards in bedrooms, bathrooms and toilets. Staff carried individual alarms. Additional two way radios were available for staff to use for communication and to summon an across hospital site emergency response team. Staff and patients said that alarms were responded to quickly, however they had concerns about the distance staff had to cover to respond to an across hospital emergency call. The hospital site was large and covered 150 acres of land. The four stand-alone low secure units were some considerable distance from the medium secure wards, in the Dewnans Centre. Staff had not carried out emergency drills to check on the length of time it would

[19] Universal PIR Mixed sex tab
[20] MH PIR Ligatures tab

take to respond, during the day and night. This meant managers could not be confident that emergencies were responded to quickly.

Maintenance, cleanliness and infection control

Patient-led assessments of the care environment (PLACE)[21] (Remove before publication)

For the 2017 patient-led assessments of the care environment (PLACE) assessment the Langdon Hospital scored better than similar trusts for one of the three aspects overall. The location received a score slightly below other similar trusts for cleanliness, scoring 97.9% compared to 98% nationally and in disability, scoring 85.8% compared to 86.3% nationally.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Langdon Hospital	Forensic IP/Secure wards Other	97.9%	97.2%	-	85.8%
Trust overall		**98.2%**	**96.1%**	**89.3%**	**86.4%**
England average (Mental health and learning disabilities)		**98.0%**	**95.2%**	**84.8%**	**86.3%**

All of the wards were clean, were well maintained and had good furnishings and fittings. Cleaning schedules were available to guide staff. In addition there were audits of infection control and prevention and staff hand hygiene to ensure that patients and staff were protected against the risk of infection.

Seclusion rooms

The Dewnans centre had two seclusion rooms and two extra care areas that were used for patients who needed to be nursed away from the wards. Seclusion is the supervised confinement of a patient to contain severely disturbed behaviour which is likely to cause harm to others. Patients in the seclusion rooms could see a clock to keep them oriented to the time of day and had some natural daylight. They could communicate with staff outside the rooms with a two-way intercom and staff could see patients clearly to make sure they were safe. However, the seclusion rooms did not have an en suite shower, so bathing arrangements for secluded patients were problematic because they had to share the same shower facilities as the patients who were placed in the extra care areas. The extra care areas were used for de-escalation and provided a quiet, low stimulus space, for patients experiencing high levels of arousal who did not require a period of seclusion. The areas were used appropriately and in keeping with the Mental Health Act Code of Practice guidance.

We had concerns at our previous inspection that the seclusion rooms at Avon house and Chichester house did not have toilet facilities. The seclusion room on Avon house was not being used pending a planned refurbishment to address this problem. The Chichester house seclusion room was newly refurbished and now had access to toilet and shower facilities. A de-escalation room was available with access to private outside space. A two

[21] 20171121 PLACE 2017

way intercom enabled communication between staff and patients. Natural light was available, there were no blind spots and a clock was visible.

Clinic room and equipment

All wards had a dedicated room for administering medicines. In addition, each ward had a clean and tidy clinic room. Staff kept appropriate records of both rooms, for example, these showed regular checks took place to monitor the fridge temperatures for the safe storage of medicines. Emergency equipment and medicines were stored on the wards in the clinic rooms. An automated external defibrillator and anaphylaxis pack was in place on each ward to use in an emergency and staff knew how to use the equipment. Each ward had a rapid tranquilisation grab bag available to access quickly. The wards had access to an electrocardiogram machine. An electrocardiogram is a test which measures the electrical activity of the heart to show whether it is working normally. Equipment such as weighing scales and blood pressure machines were regularly calibrated and the equipment was checked on a regular basis. There was however no hospital wide equipment lists or audits available so each ward had different equipment and checks made. In addition the hospital had recently opened a fully equipped health and well- being centre, the Stour. A fully equipped dentist clinic was available in the Dewnans centre.

Safe staffing

Nursing staff

Staffing overview at a glance[22] (Internal use only - Remove before publication)

Nursing vacancy rates were being managed through the use of bank and agency staff and moving staff between wards.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31 July 2017	293.74	N/A
Total number of substantive staff leavers	1 August 2016 – 31 July 2017	44.11	N/A
Average WTE* leavers over 12 months (%)	1 August 2016 – 31 July 2017	15%	14%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 July 2017	38.92	N/A
Total vacancies overall (%)	At 31 July 2017	13%	12%
Total permanent staff sickness overall (%)	At 31 July 2017	6%	5%
	1 August 2016 – 31 July 2017	6%	5%
Establishment and vacancy (nurses and care assistants)			

[22] 20170614 RPIR Universal vFinal - Sickness, Turnover & Vacancy

Establishment levels qualified nurses (WTE*)	At 31 July 2017	79.54	N/A
Establishment levels nursing assistants (WTE*)	At 31 July 2017	125.82	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 July 2017	24.98	N/A
Number of vacancies nursing assistants (WTE*)	At 31 July 2017	-6.81	N/A
Qualified nurse vacancy rate	At 31 July 2017	31%	18%
Nursing assistant vacancy rate	At 31 July 2017	0% - over established by 5%	1%
Bank and Agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 August 2016 – 31 July 2017	4,716 (15%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 August 2016 – 31 July 2017	2,805 (9%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 August 2016 – 31 July 2017	1,418 (4%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2016 – 31 July 2017	N/A	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2016 – 31 July 2017	N/A	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 August 2016 – 31 July 2017	N/A	N/A

*Whole-time Equivalent

Establi**shme**nt, Vacancy, Levels of Bank & Agency Usage[23] **(Internal use only - Remove before publication)**

This core service reported an overall vacancy rate of 31% for registered nurses at 31 July 2017. All teams with the exception of Owen House reported a vacancy rate of at least 26% for registered nurses. This core service reported an over establishment of 5% for nursing assistants at 31 July 2017. This core service has reported an overall vacancy rate of 17% rate for all staff as of 31 July 2017.

	Registered nurses			Health care assistants		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Ashcombe	4.66	12.66	37%	2.86	23.74	12%
Avon House	3.66	10.34	35%	-2.89	10.11	-29%
Chichester House	2.74	10.54	26%	-3.08	11.26	-27%
Cofton	3.54	10.14	35%	-3.13	10.11	-31%
Connelly House	0.00	0.00	-	3.44	12.00	29%
Holcombe	6.31	13.06	48%	-2.37	20.23	-12%
Langdon Central	0.00	0.00	-	0.00	0.00	0%

[23] 20170627 Vacancy template

Langdon Control Base	-	-	-	-	-	-
Langdon Dewnans Centre Reception	-	-	-	0.76	16.00	5%
Owen and Connelly	-	-	-	-	-	-
Owen House	0.74	9.34	8%	-1.91	11.26	-17%
Physical Health - Langdon	0.60	0.60	100%	1.00	1.00	100%
Warren	4.86	12.86	38%	-1.49	10.11	-15%
Core service total	**24.98**	**79.54**	**31%**	**-6.81**	**125.82**	**-5%**
Trust total	**131.39**	**738.50**	**18%**	**3.12**	**597.48**	**1%**

NB: All figures displayed are whole-time equivalents

		Overall staff figures	
Ward/Team	Vacancies	Establishment	Vacancy rate (%)
Ashcombe	8.27	37.15	22%
Avon House	0.77	21.45	4%
Chichester House	1.66	23.80	7%
Chichester O.T.	0.00	0.00	-
Cofton	1.36	22.00	6%
Connelly House	2.49	15.85	16%
Holcombe	4.69	34.04	14%
Langdon Catering	1.00	8.00	13%
Langdon Central	-0.50	1.50	-33%
Langdon Control Base	-	-	-
Langdon Dewnans Centre Reception	0.76	17.00	4%
Langdon Domestic	4.20	28.00	15%
Langdon Secure Services Redevelopment	0.00	0.00	-
Medical Staffing Forensic	-0.33	14.60	-2%
OT Service - Langdon	8.80	27.81	32%
Owen and Connelly	-	-	-
Owen House	-1.17	22.60	-5%
Physical Health - Langdon	2.80	2.80	100%

Physiotherapy- Langdon	0.00	0.00	-
Warren	4.12	23.72	17%
Core service total	**38.92**	**300.32**	**13%**
Trust total	**291.78**	**2395.91**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 August 2016 and 31 July 2017, bank staff filled 15% of shifts to cover sickness, absence or vacancy for qualified nurses.

Over the 12 months, Warren ward has used the most bank staff to cover qualified nurse shifts (1258), Ashcombe followed with 782 shifts filled. However, Ashcombe used more agency staff in the reporting 12 months to cover qualified nurse's shifts, with Warren ward following with 591. Out of all the wards, Warren ward reported the highest number of shifts not filled with 321, Holcombe followed with 259 shifts not filled.

In the same period, agency staff covered 9% of shifts for qualified nurses. 4% of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Ashcombe	4925	782	801	169
Avon	3725	574	318	186
Chichester	3856	286	174	148
Cofton	3864	342	267	112
Connelly	2366	64	3	31
Holcombe	5559	686	562	259
Owen	3898	724	89	192
Warren	3978	1258	591	321
Core service total	**32171**	**4716 (15%*)**	**2805 (9%*)**	**1418 (4%*)**
Trust Total	**88812**	**10747 (12%*)**	**7181 (8%*)**	**2936 (3%*)**

***Percentage of total shifts

Between 1 August 2016 and 31 July 2017, bank or agency staff to cover sickness, absence or vacancy for nursing assistants filled no shifts. There was no data provided by the trust.

Turnover[24] **(Internal use only - Remove before publication)**

This core service had 44 (15%) staff leavers between 1 August 2016 and 31 July 2017.

Ward/Team	Substantive staff (31 July 2017)	Substantive staff Leavers (12 months)	Average % staff leavers (12 months)

[24] 20170627 Turnover analysis

Admin - Langdon	19.24	2.50	13%
Ashcombe	29.38	5.60	18%
Avon House	20.68	3.00	15%
Chichester House	21.64	2.00	10%
Cofton	20.64	0.00	0%
Connelly House	13.36	0.40	6%
Holcombe	29.85	3.29	12%
Langdon Catering	7.00	3.00	40%
Langdon Central	2.10	0.00	0%
Langdon Dewnans Centre Reception	16.24	3.00	21%
Langdon Domestic	23.80	1.60	7%
Medical Staffing Forensic	14.93	3.00	22%
OT Service - Langdon	19.01	7.00	38%
Owen House	22.77	2.92	11%
Physiotherapy- Langdon		1.00	52%
Psychology - Langdon	13.50	3.00	22%
Warren	19.60	2.80	14%
Core service total	**293.74**	**44.11**	**15%**
Trust Total	**2187.01**	**298.12**	**14%**

Sickness[25] **(Internal use only - Remove before publication)**

The sickness rate for this core service was 6% between 1 August 2016 and 31 July 2017. The most recent month's data (31 July 2017) showed a sickness rate of 6%.

Across the 12 months, the core service had sickness levels above the trust levels for nine months with November 2016 reporting the highest sickness level with 7.7%.

Ward/Team	Total % staff sickness	Ave % permanent staff sickness

[25] 20170627 Sickness analysis

	(at latest month)	(over the past year)
Admin - Langdon	0%	3%
Ashcombe	8%	4%
Avon House	10%	7%
Chichester House	9%	7%
Cofton	10%	6%
Connelly House	6%	6%
Holcombe	7%	4%
Langdon Catering	1%	11%
Langdon Central	0%	0%
Langdon Dewnans Centre Reception	1%	7%
Langdon Domestic	6%	7%
Medical Staffing Forensic	0%	2%
OT Service - Langdon	1%	5%
Owen House	5%	7%
Physiotherapy- Langdon	0%	11%
Psychology - Langdon	0%	2%
Warren	10%	10%
Core service total	**6%**	**6%**
Trust Total	**5%**	**5%**

The table below covers staff fill rates for registered nurses and care staff during June, July and August 2017.

Avon, Cofton, Holcombe, Owen and Warren wards did not have enough registered nurses for all day shifts.

Warren ward had too many care staff for night shifts and not enough registered nurses for night shifts for all months reported.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	August 17				July 17				June 17			
Ashcombe	91.33%	98.85%	50%	120.16%	95.16%	88.63%	100%	99.19%	116.74%	86.35%	100%	100%
Avon House	65.48%	110.48%	96.77%	100%	67.90%	119.68%	100%	98.39%	83.33%	110.83%	100%	100%
Chichester	99.35%	120.54%	109.68%	135.78%	80.27%	111.88%	100%	110.85%	93.22%	109.89%	99.17%	110.91%
Cofton	65.32%	106.77%	100%	100%	73.12%	94.25%	100.29%	98.39%	61.83%	102.50%	100%	100%
Holcombe	65.97%	82.26%	96.77%	97.58%	79.30%	77.74%	96.77%	98.39%	99.67%	89.00%	100%	97.50%
Connelly	102.90%	89.03%	0%	98.39%	117.1%0	71.61%	0%	98.39%	75.83%	90.83%	0%	83.33%
Owen	65.48%	109.03%	93.55%	100%	64.84%	108.06%	87.10%	98.39%	68.50%	107.67%	93.33%	98.33%
Warren	78.76%	107.37%	52.79%	141.94%	80.81%	120.16%	52.79%	158.21%	76.94%	113.94%	55.30%	155.00%

The number of nurses and healthcare assistants identified in the staffing levels set by the trust matched the number on all but 4% of shifts across all wards. The staffing establishment on each of the wards were individually set to meet patients' needs. The agreed staffing establishment enabled the ward staff to provide the day-to-day care of patients safely. Two lead nurses were available across the wards who directly supervised each of the ward managers. Ward managers were additional and not counted in the numbers three out of every four weeks each month. In addition, a supernumerary night shift co-ordinator was available.

The nurse in charge of each ward entered the planned staffing numbers for the shift and the actual numbers on duty for that shift. These were then reviewed every morning with an across the whole hospital conference call. If any particular ward was deemed to be short staffed, staff from another ward would be deployed to cover.

We spoke with 85 staff and 18% of those spoken with said there were not enough staff to meet all of the patients' needs. These staff said, at times, activities and some patient leave had to be deferred until a later time or day. Staff told us this was often due to how unwell some of the patients were on some of the wards, often known as 'high acuity'. This meant patients may be put onto enhanced observations such as one staff to one patient and up to three staff to one patient. In order to facilitate this staff could be called on to move from their own ward to assist on another ward.

Staff told us it was not always possible to escort patients on leave at the particular time they required. Staff prioritised arranged appointments and family visits. Staff tried to keep cancellations of escorted leave to an absolute minimum, however there were occasions when leave had to be deferred. When this happened, the provider kept a record of the incident. Staff showed us these records and in the most recent three month period, October-December 2017 three patients, all from Avon ward had one episode of cancelled leave which is a low level of cancelled leave reported. The hospital senior management

team had recognised that incidents of deferred leave were increasing although this trend is not supported by the incidents reported. The managers had visited the wards to talk to staff and patients about this and to put plans in place to reduce incidents of deferred leave, such as increasing staffing. We spoke with 41 patients and, of these, 32% of patients highlighted leave as an issue for them.

The total number of substantive staff across the four wards was 293.74 and there had been an ongoing programme of recruitment which had seen a recent reduction in staff vacancies across the wards. However, managers told us that vacancies in the human resource team had led to protracted recruitment timescales which delayed new staff starting to work on the wards.

When bank and agency staff were needed managers used temporary staff who were familiar with the wards. At the time of our inspection four full time agency staff were covering nurse vacancies.

Staff told us senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required. We saw examples during our visit of extra staffing being made available from other wards. For example, to provide one-to-one observation of patients in response to the changing needs of patients.

Qualified nurses were present in communal areas of the wards at all times. There were sufficient qualified and trained staff to safely carry out physical interventions. 79% of all staff were trained in basic life support. However, only 27% of nurses had up to date intermediate life support training.

Staff were available to offer regular one-to-one support to their patients. Patients told us they were offered and received a one-to-one session with a member of staff most days. Information from the patients' daily records showed that this was the case.

Medical staff

There was adequate medical cover over a 24 hour period, seven days a week across all of the wards. Out of office hours and at weekends, on-call doctors were available to respond to and attend the hospital in an emergency. Consultant psychiatrists provided cover during the regular consultant's leave or absence.

Training data summary[26] **(Internal use only - Remove before publication)**

The compliance for mandatory and non-mandatory training courses at 31 July 2017 was 80%. Of the training courses listed 30 failed to achieve the trust target of 90% and of those, 15 failed to score above the Care Quality Commission target of 75%. Of the courses that failed to achieve 90%, three were mandatory courses and of the courses that failed to achieve 75% all were non-mandatory courses. During this inspection period, January 2018, the mandatory training compliance had risen to 91.5%, above the trust target of 90%.

Training within the trust is reported as those in date as of a rolling period end. Some courses are a one off, other have one, two or three year validity.

As of July 2017, four wards failed to score above the Care Quality Commission recommended minimum threshold of 75%, this included Owen house with 66%, Warren ward with 73%, Chichester house with 74% and on the cusp of 75% Ashcombe house. As of January 2018 all wards had achieved above 75%.

[26] 20170711 Training analysis template V2

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trustwide mandatory training total %
Basic Life Support (BLS)	79%	tbc	72%
Business Continuity Planning	96%	Tbc	89%
Clinical Risk	98%	90%	97%
Clinical Risk (Level 2)	68%	tbc	80%
Clinical Risk Basic Awareness - Non Clinical	93%	tbc	88%
Conflict Resolution	92%	90%	90%
Equality and Diversity	98%	90%	98%
Fire Safety 2 years	84%	90%	83%
Food Hygiene - Level 1	78%	tbc	44%
Food Hygiene - Level 2	39%	tbc	95%
Health and Safety (Slips, Trips and Falls)	95%	90%	95%
Health and Safety (Slips, Trips and Falls)	99%	90%	96%
Immediate Life Support (ILS)	27%	tbc	38%
Infection Prevention (Level 1)	95%	90%	95%
Infection Prevention (Level 1)	98%	90%	97%
Infection Prevention and Control - Inpatient	75%	tbc	75%
Information Governance	95%	90%	94%
Manual Handling - Object	84%	90%	90%
MAPPA (Level 1)	97%	tbc	94%
Medicines Optimisation - Administration of Injectables	86%	tbc	71%
Medicines Optimisation - Administration of Medicines	85%	tbc	71%
Medicines Optimisation - Anaphylactic Shock	75%	tbc	74%
Medicines Optimisation - Basic Awareness (Level 1)	79%	tbc	83%
Medicines Optimisation - Controlled Drugs - Inpatient	77%	tbc	78%
Medicines Optimisation - Controlled Drugs - Prescribers	69%	tbc	62%
Medicines Optimisation - Controlled Drugs - Skilled Non Registered Staff	19%	tbc	39%
Medicines Optimisation - Introduction (Level 2)	86%	tbc	83%

Medicines Optimisation - Rapid Tranquilisation	**30%**	**tbc**	**80%**
Medicines Optimisation - Safe Use of Insulin	**56%**	**tbc**	**68%**
Medicines Optimisation - Shared Decision Making	**70%**	**tbc**	**74%**
Medicines Optimisation- Administration of Homely Medications	79%	**tbc**	**82%**
Mental Capacity Act (Level 2)	**27%**	**tbc**	**32%**
Mental Capacity Act (Level 3)	**10%**	**tbc**	**11%**
Mental Capacity Act Level 1	**97%**	**90%**	**97%**
Mental Health Act - Level 2 - Inpatient	**63%**	**tbc**	**70%**
MEWS	**93%**	**tbc**	**83%**
Personal Safety Breakaway - Level 1	86%	**90%**	**80%**
Physical Health and Wellbeing	**97%**	**tbc**	**88%**
PREVENT (Level 2)	**59%**	**tbc**	**62%**
Restraint	**91%**	**90%**	**93%**
Safeguarding	**98%**	**90%**	**98%**
Safeguarding Adults (Level 2)	85%	**tbc**	**87%**
Safeguarding Adults (Level 3)	**41%**	**tbc**	**27%**
Safeguarding Children (Level 2)	86%	**tbc**	**90%**
Safeguarding Children (Level 3)	**53%**	**tbc**	**58%**
Softcuff	**28%**	**tbc**	**28%**
Total % (all courses)	**80%**	**-**	**82%**
Total % (mandatory only)	**94%**		**94%**

Assessing and managing risk to patients and staff

Assessment of patient risk

Risk assessments were comprehensive and up to date. They were completed for all patients on admission to the hospital and followed the format in the electronic care record system. Staff used nationally recognised risk assessments and tools such as the 'historical, clinical and risk management scales' and the 'structured assessment of protective factors for violence risk'. This is a set of comprehensive guidelines for assessing risk of violence. Risk assessments were updated following any incidents. The percentage of clinical staff that had received risk assessment and management training was 98%, which was just over the trust average compliance of 97%.

Management of patient risk

Staff told us, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased in response to increased risks. Risk assessments were detailed, complete and comprehensive.

Staff discussed and shared risks in the daily handover meetings and in a written handover to all staff. Ward managers discussed risks on each ward at the daily conference call. In

addition each ward carried out a daily ‘zoning’ meeting where risk issues for each patient were discussed and rated high, red risk, medium, amber risk or low, green risk. The meetings involved all available staff to discuss specific patients’ risks and any potential harm that may affect patients.

Staff on all wards followed the trust’s observation policies and procedures to manage risk from potential ligature points.

Any restrictions on the wards had been thought through with staff and patients before implementation or had a clear rationale. For example, patients admitted to the wards underwent searches to ensure no contraband was brought into the ward. This was to ensure a safe environment for patients and staff and this had been put in place following incidents of contraband being brought onto the wards. Contraband is an item which is banned from the ward such as weapons, drugs or alcohol. A list was displayed showing these banned items. Staff told us that patient searches were done in a supportive and dignified way, ensuring it was conducted in a private area of the ward and by the appropriate gender of staff. Staff told us blanket restrictions were always revisited and reviewed.

The low secure wards and in particular Connelly ward, the pre-discharge ward, had negotiated less restrictive environments for their patients. All patients on this ward had free access into and out of the ward. Patients were individually risk assessed to be able to prepare their own meals and develop skills to enable a successful discharge into the community. We spoke with patients on this ward who told us they were supported by staff to have autonomy in managing their own lives as independently as possible.

All wards followed best practice in implementing a smoke-free policy as the trust grounds were a smoke-free zone. Staff explained the policy to patients on admission and it was outlined in their ward welcome booklets. Staff offered patients smoking cessation support sessions, nicotine replacement therapy and they could purchase e-cigarettes if required.

Use of restrictive interventions

Following the introduction of the ‘4 steps’ programme the service had reduced the number of violent and aggressive incidents. Langdon hospital had 64 incidents of restraint (on 31 different patients) and 46 incidents of seclusion between 1 September 2016 and 31 August 2017.

Over the 12 months, there was a decline in the incidence of both restraint and seclusion in October and November 2016. Ashcombe has seen an increase in the number of restraints when compared to the previous year (38 in 2015/2016 versus 51 in 2016/2017), Holcombe ward also followed with an increase reporting 17 restraint incidents the previous year compared to 23 in the current year (2016/17).

All staff received training which included the management of actual and potential aggression. Staff practiced relational security and promoted de-escalation techniques to avoid restraints where possible. Relational security is the way staff understand their patients and use their positive relationships with patients to defuse, prevent and learn from conflict.

The trust had implemented an initiative called the ‘4 steps to safety’. This was developed jointly by clinicians, patients and carers to address the issue of safety with a specific focus on reducing violence and aggression. Part of this process was a patient led assessment of

key behaviours called the 'dynamic appraisal of situational aggression'. The initiative was being evaluated as part of a research project with another trust. In the preceding year there had been a 52% reduction in incidents of physical violence.

The below table focuses on the last 12 months' worth of data: 1 September 2016 to 31 August 2017.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Ashcombe Ward - Dewnans Centre	13	38	18	12 (32%)	4 (11%)
Avon House	1	2	2	1 (50%)	0
Chichester House	8	2	2	1 (50%)	0
Cofton Ward - Dewnans Centre	1	0	0	0	0
Holcombe Ward - Dewnans Centre	13	17	6	5 (29%)	1 (6%)
Langdon Control Base	1	0	0		
Owen House	1	0	0	0	0
Warren Ward - Dewnans Centre	8	5	3	0	0
Core service total	**46**	**64**	**31**	**19 (30%)**	**5 (8%)**

Restraint[27]: (Internal use only - Remove before publication)

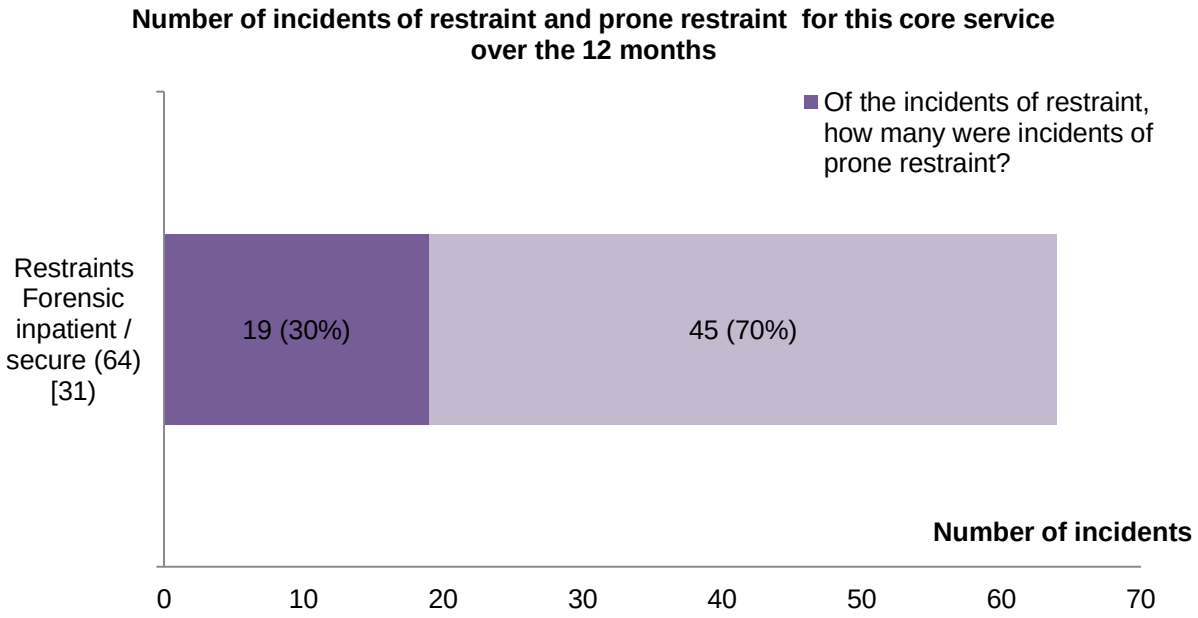
There were 19 incidents of prone restraint, which accounted for 30% of the restraint incidents. Prone restraint is a face towards the floor position which should be avoided as it can compress a person's ribs and limits an individual's ability to expand their chest and breathe. Additionally, a person who is agitated and struggling needs extra oxygen and they are unlikely to get sufficient oxygen in the prone position. Staff said patients would be moved out of the prone position as soon as it was safe to do so and appropriate physical healthcare monitoring took place when rapid tranquilisation was administered.

Incidents resulting in rapid tranquilisation for this services seem to have been static, with the highest numbers in September 2016 (2) and December 2016 (2).

There have been no instances of mechanical restraint over the reporting period.

[27] 20171016 Analysis - seclusion, segregation and restraint

The number of restraint incidents reported during this inspection was lower than the 101 reported the previous year.



Please note the figures in square brackets ,after the total number of restraints, are the number ofdifferent service users restraint was used on during this time period.

Seclusion

Over the 12 months, there was a decrease in the use of seclusion in January 2017, where there were three instances. In November 2016, there were 16 instances of seclusion reported and this fell to 10 in December 2016. The number of seclusion incidents has continued to fall and the numbers have been static around two to three incidents per month up until August 2017.

The number of seclusion incidents reported during this inspection was lower than the 57 reported the previous year.

Segregation

There were 14 instances of long-term segregation (LTS) over the 12-month reporting period. The number of segregation incidents reported during this inspection was lower than the 119 reported the previous year. We looked at these instances in detail. All had a clear rationale for the commencement of LTS, with evidence that it was necessary as a 'last resort' of managing disturbed behaviour. Detailed care plans were in place and focussed on what needed to be achieved to end LTS, by patients and by staff. Considerations had been made on how to nurse the patients in the least restrictive manner possible in the circumstances, including access to fresh air, occupational therapy input, activities and opportunities for human contact.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each local authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children's services, adult services or the police should take place.

This core service made no safeguarding referrals between 1 August 2016 and 31 July 2017.

All of the staff we spoke to knew how to raise a safeguarding issue or concern. Staff said they completed an electronic incident form and informed the nurse in charge or the ward manager. All staff were aware of who the trust's safeguarding lead was and how to contact them. The safeguarding team contact details and flow charts of the safeguarding procedure were placed in all of the wards both in the nurses' office and also on the patients' notice boards. All staff had up to date safeguarding training.

Staff told us how they keep patients safe from harassment and discrimination by observing behaviours on the wards and between patients and visitors. All wards had strong working relationships with the local safeguarding teams and with the trust's safeguarding lead.

All wards had access to family rooms where patients met family members, children and friends if it was risk assessed as safe to do so. All patients due for visits were risk assessed on the day to assess if the visit could take place safely. Family rooms were located off the wards.

Staff access to essential information

Staff used an electronic care record system and information was available to all relevant staff when they needed it. Information was available between different teams across the trust.

Medicines management

There were appropriate arrangements across all eight wards for the management of medicines. Staff gave patients information about their medicines. There were no errors or omissions in the recording of medicines dispensed. If patients had allergies, these were listed on the front of the prescription chart. We looked at the ordering process and saw the process for giving patients their regular medicines. All medicines checked were available and in date. There were good processes and procedures in place on the ward in relation to medicines reconciliation. This is where the ward staff would contact general practitioners on admission, to confirm what medicines and dosages the patient was taking so that these medicines could continue while the patient was on the ward. Staff discussed medicines in multidisciplinary care reviews. A pharmacist visited each of the wards and carried out routine audits to ensure that staff were managing medicines safely. Patients at risk of side effects from taking high dose antipsychotic medicines were monitored. Medicine to be given when required were prescribed for patients appropriately. Staff regularly reviewed and discontinued them if no longer needed. Medicines to be given to patients detained under the Mental Health Act were documented accurately. Forms were always signed by the consultant overseeing the patient's treatment, and by the patient, if they had capacity to do so or by a second opinion appointed doctor.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 August 2016 and 31 July 2017 there was one STEIS incident reported by this core service. Of the total number of incidents reported, the most common type of incident was disruptive/aggressive/violent behaviour meeting serious incident criteria with one.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

	Number of incidents reported	
Type of incident reported on STEIS	Ashcombe Ward	Total
Disruptive/aggression/violent behaviour meeting SI Criteria	1	1
Total		**1**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been three 'prevention of future death' reports sent to Devon Partnership NHS Trust. None of these related to this service.

Staff knew how to recognise and report incidents on the providers' electronic recording system. Incidents and lessons learnt from incidents were shared at the wards' daily handover meetings, regular team meetings and the lunchtime learning meetings which took place monthly. Incidents were presented in a monthly summary report which detailed when incidents took place and what had occurred. Staff gave us examples of incidents reported and lessons learnt relating to safeguarding patients, the use of rapid tranquilisation, self-harm, assault and verbal abuse. Staff were able to discuss recent incidents and concerns from across the hospital and action taken to avoid re-occurrences. The trust implemented a debriefing policy following incidents and staff confirmed these took place. This was called, the 'trauma risk management practice'. Staff also debriefed patients following incidents.

Staff understood the Duty of Candour and told us they were open and transparent with patients and their families, if something went wrong. Managers said they had received training, paying particular attention to the quality of the incident investigations, how they engaged families and carers in reviews when things go wrong. It also covered how they identify lessons, share learning and demonstrate change in practice.

Is the service effective?

Assessment of needs and planning of care

The care plans were recovery focused, holistic and demonstrated good practice. We reviewed 61 care records and all patients had detailed and timely assessments of their current mental state, previous history and physical healthcare needs. A care planning good practice tool called, 'my shared pathway' was used and assisted staff and patients to plan care, set goals and monitor progress. Patients told us that they were included in the planning of their care although not all of them chose to keep a copy of their care plan. All patients, where they had agreed to, had a physical health screening. All patients had a 72 hour care plan completed following admission. A physical examination was carried out for all patients on admission and included a routine blood test and electrocardiogram. Care plans were updated in at least weekly clinical review meetings.

Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring the highest standards of physical health care delivery. Staff also used NICE in the delivery of the therapeutic programme that included nationally recognised treatments for patients. Patients had access to a range of psychological therapies such as cognitive behaviour therapy, mindfulness, occupational therapy, drama and movement therapy, music therapy, art therapy, dialectical behavioural therapy and these were delivered via one to one sessions and in groups. The service delivery model was called the, 'relational discovery model'. Patients told us therapies had helped them to gain insight and to decrease their anxiety and had equipped them to address their issues and journey to recovery. Psychologists were helping staff set up behaviour support plans for patients who had challenging behaviour.

Staff described how they developed complex physical health care plans and effectively managed physical health care needs. The trust had set up a physical therapies team and recently refurbished a building into a primary care facility, called Stour. This team consisted of a doctor, a physiotherapist, a dietician, a team of five sports and leisure co-ordinators and a senior nurse had recently been appointed. Staff supported the integration of mental and physical health and staff developed comprehensive care plans that covered a range of physical health conditions such as diabetes, cardiac conditions, cancer, addictions and breathing problems. Staff carried out physical health observations for all patients using the national early warning score and used the 'Lester' assessment tool to identify patients at risk of premature mortality.

A number of physical health quality improvement projects had been set up. A pharmacist, supported by a dietician and the sports and leisure team had set up a weight gain group for patients starting on anti-psychotic medicine to plan early intervention should the patient gain weight. Staff had developed an educational healthy lifestyle pack. A 'get healthy challenge' led by a dietician and the sports and leisure team provided expert knowledge on diet and exercise and regular groups were held for patients to talk together about how to improve and maintain health and fitness in a secure environment.

Occupational therapists provided specialist psychological and social based educational groups. A wide range of additional activities were also available including a range of arts and crafts, music, cookery and trips to the local community. All patients were assessed using the nationally recognised 'model of human occupation screening tool'. Connelly house was led by a team of occupational therapists and offered interventions including, basic activities of daily living, behavioural interventions, community living skills, educational, developmental and health promotion knowledge and skills.

The hospital was a smoke-free environment and staff supported patients with smoking cessation groups and nicotine replacement therapy. Staff also encouraged patients to improve their health by offering a range of health and well-being courses at the Discovery centre.

Staff used the recognised rating scales known as the 'health of the nation outcome scale' to assess and record outcomes. These covered 12 health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.

Staff engaged in clinical and management audits. These included ensuring good physical healthcare for patients, risk assessing ligature risks on the wards, reviewing enhanced observations, ensuring patients had positive behaviour support plans and medicine management. Staff audited risk assessments and care plans to ensure quality and completion. Each ward carried out a regular audit to ascertain the ward climate or atmosphere.

Staff representatives from each ward, senior clinicians and managers attended monthly meetings to review clinical effectiveness and looked at, for example, models of care, quality of care records, physical health promotion, consent, audit and research.

This core service participated in seven clinical audits as part of their clinical audit programme 2016 – 2017.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
High dose antipsychotics audit	Ashcombe, Avon, Chichester, Cofton, Connelly, Holcombe, Owen, Warren	Secure Services	This re-audit was part of the Drugs & Therapeutic Committee Audit Programme	June 2017	Data gathering has been completed; waiting for report to be finalised and will then be presented at drug and therapeutic meeting.
POMH 16a Rapid Tranquilisation	Coombehaven, Delderfield, Haytor, Moorland View, Ocean View, Russell Clinic, Ashcombe, Holcombe	Adult/ Secure Services	POMH UK	Report received and being reviewed by associate director for medicines optimisation and the Trust drug and therapeutic committee.	In the last 12 months, the trust has reviewed and relaunched guidelines on rapid tranquilisation, additional training has been provided to staff which has been instrumental in designing and launching a rapid tranquilisation improvement program within the South of England Mental Health Collaborative. Next steps based on the POMH UK report will be determined by the drug and therapeutic committee.
Langdon Leave Procedure	Langdon	Secure Services	This audit was to review the newly implemented Langdon leave procedure and measure against these new standards.	29th December 2016	Task and finish group to be reconvened to address the identified areas for improvement; this will include re-audit and quality improvement led initiatives.
Activity Support Worker	Langdon	Secure Services	The audit was completed in order to review	25 February 2017	Activities at weekends could be more routine as this would support patient recovery and maximise opportunities

Project			the impact of the project to implement an activity support worker role to work within the occupational therapy team at Langdon		to move through their care pathway. From February, the activity support workers are working a consistent weekend pattern. The project requires further embedding within the LSU. This project should be re-audited in August 2017 to identify any further impact and progress following a further rotation of the activity support workers, the introduction of weekend working of both the activity support workers and the sports coordinators and giving the LSU activities time to embed. This re-audit will include any further impact of the activity support worker role being extended to the low secure services. This re-audit will be completed by the Senior Occupational Therapist.
Audit of Pharmacological Treatment for Management of Seizures	Ashcombe, Holcombe, Warren, Cofton, Chichester, Avon, Owen, Connelly	Secure Services	This audit was to establish whether current prescribing practice was in accordance with DPT Clinical Protocol (CP22) for the pharmacological treatment for management of seizures in Langdon hospital.	October/November 2016	Clarify term of specialist prescriber in Clinical Protocol. To review the detail of current standard for 'Management of seizures for patient without known history of epilepsy' within CP22. Review need of seizure management care plan for those not diagnosed with epilepsy. To ensure adequate documentation of indication and rationale documented in medical notes. To include shared decision making between prescribers and patients and to review rescue medication yearly. Circulate audit report highlighting improvement in accurate and comprehensive record-keeping, timely review of treatment. Training (Learning and Development) To complete a larger survey with nursing staff to determine confidence in administering both routes of rescue medication. Medicines Optimisation team to consider offering training. Re-audit across all In-patient wards within Devon Partnership Trust.
Lone Working in Pathfinder and FIND	Pathfinder and FIND Teams	Secure Services	This audit summarises the Pathfinder and FIND teams' compliance with specific aspects of the Devon	13 April 2017	Data is currently being collected on number of service users with relevant alerts on care notes and presence of HCR-20s. This will be presented in the next report along with further information regarding adherence to 'lone' and 'joint' working

			Partnership Trust Lone Working, Community Lone Working and Agile Working policies.		arrangements.
Langdon Patient Forum	Langdon	Secure Services	The audit was completed in order to review the efficacy of the patient forums and identify further support or recommendations that will ensure a robust process for patient opinion and feedback to be identified and guide the agenda for the Patient Council.	27 February 2017	The expectation is that the Clinical Team Manager will attend nine out of twelve of the patient forums on their ward, this means attendance at 75% of the forums that are held. All ward CTM's staff champions and ward support coordinators to be provided with up to date paperwork for recording minutes. Staff champion training to be incorporated in the local staff induction to increase awareness and knowledge of the forums, the importance and the process for all staff regardless of professional group as they enter roles at Langdon. Staff champion training to include expectations and guidance regarding forum documentation requirements that support audit, clear communication and good record keeping. Staff training to include support on Staff champion training to be facilitated by patients and patient and carer liaison worker to support and promote working together. N.B. this has commenced form 24th February 2017. Forum minutes for each ward need to be stored in one centralised place on the drives, so that they can be accessed by anyone, as needed, and so they are not lost. Promotion of the ward forums to ensure that staff are aware, the date and time is in the diary and the Forum had been raised at planning meeting. A consistent time for forums on the ward (chosen a time to best suit the needs of the ward) Protected time on the ward, with all available staff joining in and CTM and other disciplines commitment and support. A brief summary of the Terms of Reference which could be displayed on wards and in nursing offices would be a reminder for staff and patients, and help staff and patients to understand expectations and accountability in regards to the forums.

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Skilled staff to deliver care

The staff across the wards came from various professional backgrounds, including medical, nursing, nurse independent prescribers, social work, occupational therapy and psychology. Staff were experienced and qualified to undertake their roles to a high standard.

All staff, including bank and agency staff received a thorough induction into the service. Trainee assistant practitioner posts had been developed to provide a career pathway for health care assistants.

Staff received appropriate training, supervision and professional development. Staff were encouraged to attend additional training courses. For example, ward managers were encouraged to undertake leadership courses and staff on the wards had received training in cognitive analytic therapy. All ward teams attended at least yearly development days.

The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for non-medical staff within this core service was 93%.

The wards/teams failing to achieve the trust's appraisal target were OT Service - Langdon with an appraisal rate of 72% and Admin-Langdon at 74%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Avon House	19	19	100%
Chichester House	21	21	100%
Connelly House	13	13	100%
Holcombe	27	27	100%
Langdon Catering	6	6	100%
Langdon Central	2	2	100%

Medical Staffing Forensic	2	2	100%
Owen House	20	20	100%
Psychology - Langdon	14	14	100%
Cofton	21	20	95%
Langdon Dewnans Centre Reception	13	12	92%
Langdon Domestic	24	22	92%
Warren	20	18	90%
Ashcombe	25	22	88%
Admin - Langdon	23	17	74%
OT Service - Langdon	18	13	72%
Core service total	**268**	**248**	**93%**
Trust wide	**2095**	**1763**	**84%**

The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for medical staff within this core service was 27%. The trust updated this figure during our inspection and 95% of medical staff had a completed appraisal.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
Medical Staffing Forensic	11	3	27%
Core service total	11	3	27%
Trust wide	84	**40**	48%

The trust's target for clinical supervision is 90%

Between 1 August 2016 and 31 July 2017, clinical supervision rates ranged between 9% and 100%. As of January 2018 supervision compliance rates were 89.5%, just above the trust target of 85%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision rate (%)
Ashcombe	**11%-100%**
Avon House	**9%-100%**
Chichester House	**10%-100%**
Cofton	**14%-100%**
Owen and Connelly	**10%-100%**

Owen House	**50%-100%**
Warren	**9%-100%**
Core service total	**9% to 100%**
Trust Total	**0% to 100%**

Preceptorship training was offered to newly qualified nurses. This helped ensure that they had the skills needed to complete their role and they were well supported.

Volunteers and peer support workers were working with patients at the Discovery Centre, co-producing and delivering on the courses and workshops offered.

Multi-disciplinary and interagency team work

Well-staffed multidisciplinary teams worked across the wards. Regular team meetings took place. We observed care reviews and staff handover sessions and found all of them to be effective.

Staff worked with other agencies. There were links the local authority, Exeter College, local primary care teams and housing organisations being particularly positive examples.

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

We looked at care records of patients who were detained under the Mental Health Act. The Mental Health Act documentation was present and available in the records. Each ward maintained an updated patient board that detailed when rights should be repeated for each patient. This information was audited every week.

There was active involvement of the independent mental health advocacy service, and information about the service was displayed on information boards in communal areas.

Patients were encouraged to contact the Care Quality Commission if they chose to about issues relating to the Mental Health Act. This was contained in the induction folders given to all new patients.

Each ward had access to Mental Health Act administrators who monitored requirements and compliance with the Act and Code of Practice.

Copies of up-to-date section 17 leave forms were kept electronically and in files accessible in the nurses' offices. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave. These were regularly reviewed and updated. Staff recorded who had been given copies of the section 17 leave forms.

Assessments of patients' capacity to consent to treatment were available. We found that both T2 and T3 certificates were reviewed in line with the trust's policy. These certificates show that patients detained under the Mental Health Act had the proper consent to treatment in place.

Mental Health Act training figures[28] (Internal use only - Remove before publication)

As of 31 July 2017, 63% of the workforce in this core service had received training in the Mental Health Act – level 2 - Inpatient. The trust stated that this training is non-mandatory for all core services for inpatient and all community staff and renewed every three years.

Good practice in applying the Mental Capacity Act

The trust had a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy in place. Staff had a good understanding of the MCA and 97% of staff had updated training. Staff knew where to get advice regarding MCA, including DoLS, within the hospital. Where required, Deprivation of Liberty Safeguards applications were made.

There were arrangements in place to monitor adherence to the MCA within the provider.

For patients who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions, and patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the patients' wishes, feelings, culture and history.

Specialist independent mental capacity advocacy was available to all patients.

As 31 July 2017, 97% of the workforce in this core service had received training in the Mental Capacity Act – level 1, 27% had received training for Level 2 and 10% of the workforce had received training for Level 3 of the Mental Capacity Act. The trust stated that Mental Capacity Act – level 1 training is mandatory for all core services for inpatient and all community staff and Level 2 and 3 are non-mandatory and all are renewed every three years.

Between 1 April 2016 and 31 March 2017, no DoLS applications were made for this core service.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Patients we spoke with on all of the wards were complimentary about the staff providing their care. Patients told us they got the help they needed. Patients told us they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us staff were pleasant and were interested in their wellbeing.

Patients told us staff were consistently respectful towards them. Patients said the staff tried to meet their needs, that they worked hard and had patients' best interests and welfare as their priority. During our inspection, we saw nothing other than positive interactions between staff and patients. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.

Staff assisted patients to access other services to help meet their needs. For example staff promptly referred patients to a variety of primary care healthcare professionals.

[28] 20170711 Training analysis

Staff showed patience and gave encouragement when supporting patients. When patients became distressed and agitated, staff intervened gently and in kind and pleasant ways. We saw these interventions calmed patients considerably. The atmosphere throughout the wards was calm and relaxed.

All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences. Staff understood the individual needs of their patients, including their personal, cultural, social and religious needs.

Staff said they could raise any concerns about disrespectful, discriminatory or inappropriate attitudes or behaviour towards patients without fear of the consequences.

Staff ensured information about patients was kept confidential, however on Ashcombe ward a patient information board in the nursing office had patients' full names and Mental Health Act status visible which could compromise anonymity.

The 2017 PLACE score for privacy, dignity and wellbeing at Langdon Hospital core service location(s) scored better than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Langdon Hospital	Forensic IP/Secure Wards Other	93%
Trust overall		**91.8%**
England average (mental health and learning disabilities)		90.6%

The involvement of people in the care they receive

Where patients had a planned admission to the wards they had already received information about Langdon hospital before admission. Staff and patients had co-produced a DVD for prospective patients and their families to view. Patients had created the sound track to the DVD. The DVD showed patients' progression through the service to discharge and showed the hospital facilities, activities available and links the hospital had with the community. In addition each ward had information booklets which welcomed patients and gave detailed information about health needs, the multidisciplinary team providing care, treatment options, medicine and physical health needs, daily life on the ward, recreation and leisure needs .The booklet orientated patients well to the service and patients we spoke to about the booklet had received a copy and commented on it positively.

There was evidence of patient involvement in the care records we looked at, particularly captured in the 'my shared pathway' documentation on the electronic care notes. This approach was person centred, individualised and recovery orientated. We also saw that all patients reviewed their care plan once every month with the multi-disciplinary care team and in regular meetings with a member of the ward nursing team.

During our inspection, we joined a number of multidisciplinary care review meetings on a number of the wards where the views and wishes of the patients were discussed with them. Options for treatment and therapy were given to the patients to consider at all of the meetings.

The trust had funded a specific patient & carer engagement post and there was evidence of regular audits carried out to ensure all wards were adhering to a person centred approach when care planning with patients.

There was a scheme in the hospital which provided and trained peer supporters who were existing patients. We met with several peer supporters and they told us about their role which included, for example, acting as buddies for new patients, sitting on committees and participating in staff recruitment. Patients were paid for their contributions made. Information was advertised on all of the wards about local advocacy services available.

Patients had a number of ways of being actively involved in giving feedback about the service and also getting involved in shaping services. For example, each ward held a daily planning meeting and a monthly community meeting which was attended by the patients and representatives from the clinical team and managers. Each ward had a patient representative who attended ward and hospital wide meetings to take forward any issues which they wanted addressed. A well-established patients' council met regularly with all patient representatives from each ward. A patient open forum meeting was held four times a year. A patients' forum was available monthly and attended by the senior management team. The patients' council had brought about changes, such as the introduction of pets as therapy dogs, quiet spaces in the Discovery centre and on the wards, improved access to sporting activities, improved availability of hairdressers. Patients could join a range of fund raising initiatives and co-produced a patients and family and carer newsletters. Patients could additionally be trained as peer tutors to assist in delivering the Discovery Centre workshops and courses.

Patients were trained and encouraged to join the recruitment process to appoint all substantive staff. Patients attended an interview panel skills course. Patients were paid for their time.

Involvement of families and carers

Patients told us that, where they had wanted to, their families were included in their care planning. Information leaflets and regular newsletters were made available to relatives and friends and regular information and educational sessions were available at the hospital. The wards had embedded the 'triangle of care' initiative that attempts to improve carer engagement in inpatient units by ensuring staff worked closely and in partnership with families and friends.

Carers told us about the various ways they could give feedback on services. 60% of carers had been contacted for feedback on what their needs were. Staff encouraged active involvement by families and carers. For example, a family and friends event was held at the new health and well-being centre, the Stour. Monthly drop in sessions were held for family and friends. A number of carers said they had been offered a carer assessment.

Is the service responsive?

Service Planning

Ward Moves

There is nothing to insert under this heading at this present time.

Moves at Night

There is nothing to insert under this heading at this present time.

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for eight wards in this core service between 1 August 2016 and 31 July 2017. Of the wards within this core service, they reported average bed occupancies ranging between 89% and 100%. We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	**Average bed occupancy range (**1 August 2016 – 31 July 2017**) (current inspection)**
Ashcombe	91%-100%
Avon	92%-100%
Chichester House	92%-100%
Cofton	99%-100%
Connelly House	89%-100%
Holcombe	92%-100%
Owen House	95%-100%
Warren	90%-100%

The trust was leading a group of eight regional mental health providers from Cornwall to Gloucestershire (excluding Dorset) to deliver improvements in secure care. The service commenced on 1 April 2017 and the plan was to reduce the number of patients having to travel long distances for their care, increase the number of community-based alternatives to hospital, reduce lengths of stay in hospital and increase the efficiency of the secure care system for people with mental health needs.

Beds were always available when patients returned from leave.

Staff we spoke with told us that patients were not moved between wards during an admission episode unless it was for a clinical reason, for example requiring more or less intensive nursing care.

The trust provided information for average length of stay for the period 1 August 2016 to 31 July 2017.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	**Average length of stay range (**1 August 2016 – 31 July 2017**) (current inspection)**
Ashcombe	27-332.7
Avon	17-1666
Chichester House	26-858.7
Cofton	80-959
Connelly House	221-1582
Holcombe	8-591
Owen House	67-703

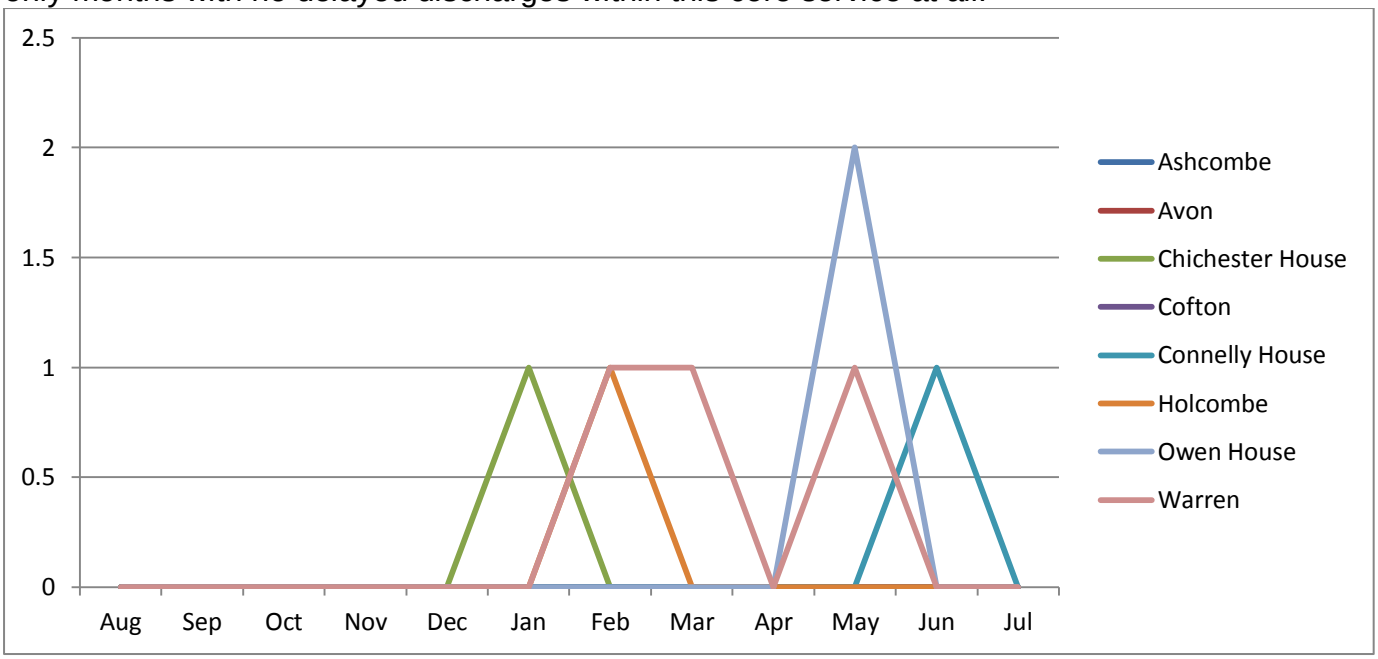
This core service reported no out area placements between 1 August 2016 and 31 July 2017.

This core service reported no readmissions within 28 days between 1 August 2016 and 31 July 2017.

Discharge and transfers of care

Between 1 August 2016 and 31 July 2017, there were 125 discharges within this core service. This amounts to 7% of the total discharges from the trust overall (1766).

The graph below shows the trend of delayed discharges across the 12-month period. The graph suggests a spike in May 2017. Months August to December 2016, April and July 2017 were the only months with no delayed discharges within this core service at all.



Patients told us how staff helped them to achieve the goals set in their discharge plans. Examples included staff accompanying patients back to their homes to assess what additional support they may need to aid their recovery. Staff actively assisted patients towards their discharge. For example, on Connelly ward the average length of stay had reduced from 344 days to 186 days in the preceding year. Patients told us that courses and workshops undertaken at the Discovery centre had prepared them well for life in the community. For example, managing medication in hospital and after discharge, manging stress and moving on from hospital.

A bed management and referrals meeting was held weekly attended by key clinical and managerial staff. This meeting oversaw the forensic inpatient and secure care pathway. We noted that in the meeting, all current ward bed occupancy was scrutinised as well as transitions into, through and move on from the service. The bed management meeting monitored and tracked appropriate bed usage and identified any pressures on the system. Key clinical discussions took place at the meeting to enable the entire senior management and clinical team to be aware of updated information. The bed management meeting also monitored all actual and potential inpatient delayed discharges.

We heard from patients who had progressed through the secure care pathway, from being admitted to a medium secure ward at Landon hospital, to living in Connelly house. Patients told us that they appreciated the opportunity to exercise much more independence, despite still receiving treatment under the Mental Health Act and in many cases being restricted on hospital orders.

Facilities that promote comfort, dignity and privacy

All eight wards had a full range of rooms and equipment available, including spaces for therapeutic activities and treatment. Every patient had their own bedroom, at the Dewnans centre these were all ensuite. Patients were able to store their possessions securely in their bedrooms. All patients had access to their bedrooms and communal areas of the ward at any time. Many patients across both the medium and low secure wards had wider access across the hospital site and access in and out of their own ward areas.

The Discovery centre was a spacious, well equipped area with a gym, kitchen and training rooms. Two cafes were available across the hospital site. The health and well- being clinic, Stour, was a fully equipped primary care clinic with a gym, kitchen and horticulture area. A fully equipped dentist clinic was available in the Dewnans centre.

Quiet rooms were available where patients could meet visitors. Patients had access to multi-faith rooms and a variety of spiritual support.

All wards had access to private pay phone facilities.

All wards had direct access to extensive garden areas and a variety of horticultural endeavour was underway, with garden sheds, flower pots, baskets, herb gardens and vegetable plots, all maintained by patients. All patients were able to enjoy the outside facilities, albeit many with staff supervision.

We received mixed feedback from patients and some staff about the quality and range of food. Negative comments included the food being bland, tasteless and portion sizes inadequate. Patients told us there were restrictions on how much food they could take and they were unhappy about this restriction as they did not see this as a collaborative approach to heathy living and eating. Patients on all of the wards had access to snacks and hot and cold beverages.

The 2017 PLACE score for ward food at the locations scored better than similar trusts.

Site name	Core service(s) provided	Ward food
Langdon Hospital	Forensic IP/Secure Wards Other	94.5%
Trust overall		**90.7%**
England average (mental health and learning disabilities)		89.7%

Patients' engagement with the wider community

There was a good range of activities and groups available to patients on all of the wards. Daily and weekly activities were advertised widely and available on all of the wards, at the Discovery centre and the Stour health and well- being centre. The activities were varied, recovery focussed and

aimed to motivate patients. Staff provided activities in the evenings and across weekend periods. Examples of activities on wards included healthy lifestyle sessions, exercise, cycling, walking, cooking, arts and craft.

The service had set up the Discovery centre as part of their recovery college. Staff from Exeter College came into the hospital to offer numeracy and literacy course and other educational courses at the hospital site which enabled patients on hospital restriction orders and with no leave to engage in education pursuit. Staff and patients co-produced and delivered courses and workshops which covered topics such as, understanding mental health, recovery, developing new skills and how to get involved.

Patients had the opportunity to participate in a range of voluntary work opportunities to learn new skills, knowledge and work experience. These included working in the hospital shop, the kitchen, the Discovery centre, the gym, the patient run cafés, estates and grounds maintenance. We spoke with one patient who had started volunteering at the hospital and was now volunteering in the community. Staff had made links with local business, enabling patients to apply for paid employment following a volunteer placement.

Staff encouraged strong community links. For example at staff and patients held monthly football matches with local teams to improve links in the community. Pets as therapy trained dogs visited all wards every week. Physical health clinics held at the hospital helped prepare patients for attending clinics in the community. Patients told us this improved their confidence to ask for help and advice regarding their physical healthcare needs. Staff assisted patients on Connelly ward to spend 80% of their activity off the hospital site in the community.

Staff encouraged patients to develop and maintain relationships with people who mattered to them, both within the service and the wider community. Staff supported patients to maintain contact with their families and carers. For example some patients had been assisted to record themselves reading children's stories which were then sent to their children. Patients told us this motivated them and gave them great hope and aspirations for the future.

Staff had developed links with a local radio station and music recorded by patients had been aired. A fund raising project had been initiated between the music technician and a number of people in the music industry to raise £60,000. The initiative was to fund facilities and equipment to expand the availability of electronic music across the hospital. The initiative was being researched by a local academic music professor. In addition links had been made with a local weather forecast station and the hospital had set up its' own weather station. Staff had made links with Exeter museum and Exeter Cathedral.

Meeting the needs of all people who use the service

The provider was not always ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients. For example, patients did not always have access to their section 17 leave and activities according to their care plans. 32% of patients we interviewed said deferred or cancelled leave was an issue for them. However records showed only three incidents of cancelled leave on Avon ward.

The staff respected patients' diversity and human rights. All staff had received training on equality and diversity. The provider provided a training course for patients looking at spirituality, beliefs and values. Attempts were made to meet people's individual needs including cultural, language and religious needs.

Staff went the extra mile to meet patients' unique needs. For example, staff put together some culturally appropriate music recordings for a withdrawn patient to listen to. This made a significant difference to the patient who is now progressing well.

There was a dedicated multi-faith room. A Christian chaplain regularly visited the wards every week. Links with leaders of other denominations and faiths were made through the chaplain or multi-disciplinary staff.

Interpreters were available to staff and were used to help assess patients' needs and explain their rights, as well as their care and treatment. Leaflets explaining patients' rights under the Mental Health Act were available in different languages.

We saw up to date and relevant information on the wards detailing information, which included, information on mental health problems and available treatment options, my shared pathway information. In addition, local services available, benefits advice, information on legal and illegal drugs, help-lines, legal advice, advocacy services and how to raise a concern or make a complaint.

Listening to and learning from concerns and complaints

There was effective oversight of and learning from complaints. This core service received 12 complaints between 1 August 2016 and 31 July 2017. Ashcombe ward and Chichester House both received the most number of complaints with three each. Of the 12 complaints received, the highest numbers of complaints were related to patient care, with four and values and behaviours (staff) followed with three.

Ward	Count of Department/ ward/area
Ashcombe Ward - Dewnans Centre	3
Avon House	1
Chichester House	3
Cofton Ward - Dewnans Centre	1
Holcombe Ward - Dewnans Centre	1
Owen House	1
Warren Ward - Dewnans Centre	1
Unknown	1
Grand Total	**12**

Staff met regularly to discuss learning from complaints. This informed a programme of improvements and training, for example, improving communication between staff and carers in relation to care planning.

Copies of the complaints procedure were on display on the information boards on the wards and in the ward welcome packs. Patients we spoke with all knew how to make a complaint, should they wish to do so. Information was also available on how patients could contact the Care Quality Commission should the patients wish to do so.

Staff knew how to handle complaints. Staff told us they tried to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns. Informal complaints were logged and tracked as well as formal complaints.

A community meeting was held every day on each ward and patients could raise any concerns they had. Staff were responsive to suggestions made by patients, for example increasing leisure activities over the weekend periods and during the evening.

This core service received 14 compliments during the last 12 months from 1 August 2016 to 31 July 2017, which accounted for 2% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Ward managers and lead nurses had the skills, knowledge and experience to perform their roles to a high standard. The managers knew their staff and patients well and were able to confidently describe their services.

The wards' senior management team had regular contact with all staff and patients. The senior management and clinical teams were visible to staff and staff said senior management regularly visited the services. All staff and patients knew who the senior management team were and that they felt confident to approach them if they had any concerns. Staff knew who the trust's executive team were and said they visited the wards.

Vision and strategy

The trust's vision, values and strategies for the service were evident and on display on information boards throughout the wards. Staff we spoke to understood the vision and strategic objectives of the organisation. Staff said the trust's vision was to provide an inclusive society where the importance of mental health and wellbeing is universally understood and valued. Staff described the trusts' mission was to become a recognised centre of excellence in the field of mental health. With one or two exceptions, staff felt very much a part of the service and were able to discuss the philosophy of the wards. Staff had opportunity to contribute to discussions about their service in regular team meetings and yearly development away days.

Culture

With one or two exceptions, staff told us they felt respected, supported and valued in their work. They commented in particular about the support they received from their ward managers. Staff were proud to be working for the trust.

The physical therapies team offered joint patient and staff exercise sessions in the gym as well as circuit training, yoga, running groups and online education. Staff commented positively about these sessions.

All staff we spoke with felt confident to raise any concerns and they knew how to do this, including the availability of the whistle-blowing process should they want to use this.

Managers dealt effectively with poor staff performance appropriately and in a timely manner.

During the reporting period, there was one case where staff had been suspended.

Teams worked well together for the well-being of patients, we saw this happening in clinical care reviews and discharge planning meetings.

Staff appraisals included discussions on personal and professional development needs and action plans to achieve this development. All staff commented on how their professional development needs had been supported.

Staff reported that the trust promoted equality and diversity in its day to day work and provided opportunities for career progression. For example, staff described being able to have flexible working practices which enabled them to maintain a good work life balance.

Governance

Ward staff provided clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised and presented monthly in a report which all staff could see. These reports were looked at in regular team meetings. Ward managers, senior managers and senior clinicians attended meetings where they looked at patient safety, patient experience and staff management. This meant that the management teams were able to receive assurances and apply clear controls to make sure the services ran effective.

Staff received their mandatory training, supervision and appraisals. There were sufficient suitably trained staff available on every shift in each ward to deliver safe care to patients. However training compliance fell below the trust target and the provider was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients. For example, patients did not always have access to their section 17 leave and activities according to their care plans.

Staff were confident that they learnt from incidents, complaints and patient suggestions and feedback.

The trust provided its corporate assurance framework/risk register. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined two strategic ambitions:

1 – To deliver consistently high quality care and treatment/to build a reputation as a recognised centre of excellence.
2 – To be an efficient, thriving and successful organisation with a sustainable future.

The trust has provided a document detailing their 14 highest profile risks. None of the 14 risks has a risk score of 15 or higher. The following relate to this core service.

As the core service does not have any current risks which score 15 or above, the ones listed in the table are the next level below, risk rating of 12.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
26 June 2017	1853	If trespassers enter the site then there is a risk to them, patients, staff and visitors plus to confidentiality of their service	12	4	1	11 August 2017

1 June 2017	1901	If staff are not competent to complete manual BPs then patient health will be put at serious risk	12	1	1	16 August 2017
Unknown	1370	If the band 5 nursing posts are not recruited to, then this could lead to compromised quality of care	12	8	1	11 August 2017
11 April 2016	1374	If future requirements for resus training are not clarified then patient care will be adversely affected as staff will not be adequately trained	12	3	1	11 August 2017
23 November 2015	1376	If secure services do not meet their targets for core learning then there may be a financial penalty attached. This is due to staff not being adequately trained which could lead to the service being adversely affected	12	3	1	11 August 2017
24 April 2017	1781	If DPT staff don't have access to the full suite of DPT computer systems then they cannot work in a safe and effective manner	12	4	1	4 August 2017

Management of risk, issues and performance

Staff showed us the ward operational risk registers. Staff told us they could submit items of risk for inclusion on the risk register. The risk register had inclusions from all the wards and support services, which showed that risks were escalated appropriately from all areas of the service.

Information management

Staff had access to information and technology to support them in their work. Staff said that now the electronic care records system was embedded, they were seeing real improvements in the information accessible to them and their patients, for example the personalised care plan template.

Information governance systems ensured of confidentiality of patient records across all wards.

Ward managers we spoke with had access to information to support them in their role, for example clinical quality audits, human resource management data and data on incidents and complaints. We reviewed documents which indicated this information was being used across all wards to monitor provision and identify areas for improvement.

Staff had processes in place to ensure that notifications were made to external bodies as required, for example to the Care Quality Commission and local authority.

Engagement

Staff, patients and carers had access to timely and relevant information about the trust. For example through the trust's website, newsletter and open day sessions.

Patients and carers had opportunities to give feedback, through regular surveys, satisfaction questionnaires, comment cards and via meetings arranged by managers.

Learning, continuous improvement and innovation

Patients had received a number of Koestler awards for music, art, film and poetry pieces submitted. The Koestler Trust is a charity who runs an arts awards scheme for patients in secure mental health services.

Langdon hospital was nominated for the national, 'most innovative flu fighter' campaign awards. Flu vaccinations were offered alongside mobile physical health checks involving body mass index checks, weight checks, health checks and other vital sign tests.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Quality Network for Forensic Mental Health Services	Wards for people the mental health problems detained in medium or low secure.	Member since 2007 – Low and Medium Secure units at Langdon Hospital

Trust-wide leadership

Facts and data about this trust

The trust had six locations registered with the CQC (on 13 November 2017).

Registered location	Code	Local authority
North Devon District Hospital	RWV12	Devon
Torbay Hospital	RWV5S	Torbay
Wonford house Hospital	RWV62	Devon
Langdon Hospital	RWV73	Devon
Franklyn Hospital	RWV98	Devon
Whipton Hospital	RWVEE	Devon

The trust had 295 inpatient beds across 25 wards. No data was submitted for the number of day case beds, number of inpatient beds which were for children (MH or CHS). The trust could not provide information for the number of outpatient and or community clinics held. A narrative was provided by the trust giving reasons for this.

Total number of inpatient beds	295
Total number of inpatient wards	25
Total number of day case beds	-
Total number of children's beds (MH setting)	-
Total number of children's beds (CHS setting)	-
Total number of outpatient clinics a week	-
Total number of community clinics a week	*

*Community clinics are not recorded in an extractable way. Community clinics are not a regular defined thing within Care Notes, different teams utilise them in different ways, and so there would not be a number available to be attributed to the trust.

Is this organisation well-led?

Leadership

The trust had an experienced leadership team with the skills and abilities to deliver mental health services. Several members of the board had experience of working clinically in mental health settings. Where the board members' background was not clinical mental health, for example the finance director, they had commitment to carry out clinical shifts to aide decision making.

Senior leaders made sure they visited all parts of the trust regularly. Staff, staff representative and the freedom to speak guardian told us senior managers were visible and approachable. Staff fed back, via the staff survey, an increase in the percentage of staff reporting good communication between senior management and staff from 30% in 2015 to 35% in 2016. This is line with the national average of 35% for mental health trusts nationally.

The trust was committed to support and train its leadership team. They were introducing a values based leadership framework for leaders from board level to service delivery leads. Delivery of the programme started in June 2017 via 'leadership development centres'. The trust were also able to describe future plans to include their new leadership framework into recruitment and promotion processes. Examples of ongoing leadership coaching were provided in particular to clinical directorate leadership teams.

The arrangements for ensuring the senior leadership team were fit and proper were mostly in place. We reviewed the personal documentation of five non-executive directors and eight members of the board. All had up to date appraisal, declaration of interest forms and DBS checks. However, the trust had already identified it did not have a robust process for recording when gifts or hospitality was received, however this was under construction. In addition, the trust recorded the dates of any supervisions carried out in individual folders, however supervision discussions and outcomes were not being recorded.

The leadership team had a comprehensive knowledge of current priorities and challenges within the trust and across the broader health economy in Devon. They understood that staffing and vacant posts were the trust's key challenges. Everyone interviewed from board to directorate leads could identify or were involved in initiatives that were underway or being developed to support ways of addressing this risk. For example, working with universities, developing innovative care pathways in particular for allied health professional and they were currently developing an assistant practitioner programme to support where there were psychiatrist vacancies.

Senior leaders, including board members, were able to discuss the contemporary challenges of the health & social care system and identify for the future provision of mental health & learning disabilities services, across the footprint of the Sustainability & Transformation Partnership.

The chief executive officer and chair described proactive plans for succession-planning. For example the replacement of professional and practice leads within the specialist services when DPT took over commission of forensic service in the south west of England and the positive planning for the current board due to its age demographic.

The make-up of the board was broadly representative of the local Devon population. Currently, data shows us that the executive board had 0% black, minority ethnic (BME) members, and 62.5% women. The non-executive board had 0% BME members and 42.8% women.

	BME %	Women %
Executive	0%	62.5%
Non-executive	0%	42.8%
Total	0%	50%

Vision and strategy

The Trust had clearly set out a clear vision, strategy and plans for the delivery of services. All staff were committed to DPTs mission to become a centre of excellence and expertise in mental health and learning disability by 2021.

Staff from board to ward understood the vision and understood the six steps plans to deliver the strategy. Staff on the wards could describe and provide examples of how the plans in the 5 year strategy were impacting positively on service delivery. For example, the new programme, the '4 Steps' programme to reduce restraint, the single point of contact for GPs and the new care pathways across community mental health. As well as, the building of a new mother and baby unit and psychiatric intensive care unit (PICU) units 3 new wellbeing hubs were newly operational.

The triumvirate leads for each clinical directorate interviewed could demonstrate how they had their own 6 point plans to reflect the trust's 6 key aims.

Partners and patients were able to contribute to the development and delivery of the trust's strategy. DPT have an engagement ethos called 'together', those who were engaged in the programme told us this was an exceptional example of co-delivery and co-deign in service improvement. Members of the 'together' team told us they could influence the vision and strategy in particular they were supported and funded to support key strategy projects such as the suicide reduction programme.

During the focus groups staff told us they were committed to the trust's vision and 6 key objectives to deliver high quality care and become a centre of excellence and expertise. However, the staff felt the impact of the improvements at pace left gaps and place strain on the delivery of core services. For example, staff felt the development of new service and developmental posts left gaps and vacancies in core services. We found during our inspection that continued vacancies placed pressure in several of the services and in particular pressure on care co-ordinators caseloads in the adult community mental health services.

The trust had developed and implemented an estates strategy. Estates service management transferred to DPT in April 2017 from the Royal Devon and Exeter NHS Foundation Trust. Subsequently the trust had produced an estates strategy to reflect the broader strategy and supporting governance arrangements.

The trust was an active member of the strategic transformation programme (STP) in Devon. They were actively promoting mental health and its importance within the broader health economy, for example the chief executive officer and director of nursing had given a presentation to the STP on the parity of mental health in the health economy.

The trust has a physical health strategy in place, however there are plans and consultation ongoing to create an enhanced strategy by August 2018. DPT recognised in a 2016/17 CQUIN audit that most people receiving care from DPT did not receive the level of physical health monitoring it wished to deliver, physical health was a key strategic priority in DPT; it had plans and were monitoring delivery to improve physical health for patients. The data highlighted that 60% of inpatients and 25% of community patients met all parameters of the CQUIN 2016/17. Following the results from the audit, they have produced a business case to increase support. The trust has also reviewed the physical health monitoring policy clinical protocol, continues to promote the wellbeing passport, opened wellbeing hubs and has interim measures in place for physical health checks relating to anti-psychotic meds while steps were being put in place to develop robust shared care agreements. The last CQUIN progress report in October 2017 to the quality and safety committee showed their progress as red, project not met or off plan. Despite this, DPT demonstrated it was on a positive journey to improve physical health in its service.

The trust were planning their services to take account of local populations health needs. The trust's plans were forward thinking and long term. They were enhancing the inpatient and community pathways to support patient's experience and reduce out of area placements. The trust were currently working on improving the pathways for patients with personality disorders to ensure it was in line with national guidelines. The provision of acute adult inpatient rehabilitation had been under review for two years, leaving the trust with limited access to rehabilitation inpatient beds. The current unit, Russell ward had both rehabilitation and patients with psychosis on the ward as was classed as a step down service. The trust was confident that the new model had been approved and implementation was underway.

Culture

The trust have a very positive, open and honest culture. Staff strongly advocated in focus groups that the trust were open and this was further evidenced in DPT's processes surrounding serious incidents. External partners and stakeholders further echoed that the trust had been on a journey on the last 18 months and were now very open resulting in positive relationships. Staff representatives supported the view of the open and honest culture, with direct access to the CEO if needed.

The leadership team were driven, extremely positive and committed to delivering the trusts vision and values. All of the leadership team interviewed demonstrated a passion for working in DPT, delivering its vision and strategy and mental health.

DPT was a local advocate for their patients in other services and media. Patients were central to the trusts vision and plans. For example they had or were developing broader services such as building a new care pathway for patients with borderline personality disorder, they had designed services for veterans, and were proud of their national gender service.

The trust had appointed a freedom to speak up guardian via an external provider and implemented positive governance arrangement to support the role. There were clear lines of governance in the trust supported by Director of human resources with further oversight and supervision by a neo-executive director. The trust and guardian had been working to raise the profile of the role. The team were able to provide analysis of the data and examples of challenge form the non-executive director. The trust had a variety of plans and programmes in place to provide wellbeing and mental

health support for their employees. They are committed to meeting the national CQUIN targets, commission for quality and innovation targets set by NHSE on staff health and well-being. There is an action plan and evidence of clear progress against the plan. There are papers to the senior management board and quality and safety committee on a quarterly basis for oversight. Example, of work to meet the health and well-being plan include; 24 hour helpline for staff, promoting their wellbeing work through you tube videos, 'my journey leaflets, our journey roadshows, creating a health and wellbeing advisory group in January 2018 to oversee projects, world café and health and wellbeing champions being in post.

The trust were committed to support and promoted equality. The make-up of the staff group was 92% of staff are from white heritage, approximately 3% from BME (including white European). This was broadly representative of the local population in Devon. EDI report was published using the EDI national framework to inform the board. The CEO is a national lead for the EDI national framework. Some example of inclusive include staff focus groups, equality champions and leads as well as steering group.

DPT have implemented a new EDI training plan for staff. The staff survey showed a positive trend between the 2015 and 2016 survey for staff believing that the organisation provides equal opportunities for career progression or promotion which is at 89%, above the MH trust national average of 79%. Also the data for the 12 last months for the questions, 'have you personally experienced discrimination at work from manager/team leader or other colleagues?' for BME staff went down from 11% in 2015 to 9% in 2016 and is under the national average of 14%.

Staff told us they were proud to work for DPT, changes in the provider over the last couple of years had been positive. Numerous examples were provided while on site to highlight how staff felt valued in line with the survey feedback for the 14 key questions below. For example, allied health professional teams were re-organising progression structures to provide development opportunities, there were new roles for staff in older peoples' services and the '4 steps' project had reduced incidents of violence staff were experiencing.

In the 2016, NHS Staff Survey the trust had better results than other similar trusts in 14 key areas:

Key finding	Trust score	Similar trusts average
KF 20: Percentage experiencing discrimination at work in the last 12 months.	12%	14%
KF 21: Percentage believing the organisation provides equal opportunities for career progression/promotion	89%	87%
KF 18: Percentage attending work in last three months despite feeling unwell because they felt pressure	47%	55%
KF 15: Percentage satisfied with the opportunities for flexible working patterns	65%	59%
KF16: Percentage working extra hours	69%	72%
KF22: Percentage experiencing physical violence from patients, relatives or the public in the last 12 months	17%	21%
KF23: Percentage experiencing physical violence from staff in the last 12 months	2%	3%
KF25: Percentage experiencing harassment, bullying or abuse from patients,	29%	33%

relatives or the public in the last 12 months		
KF27: Percentage reporting most recent experience of harassment, bullying or abuse	63%	60%
KF31: Staff confidence and security in reporting unsafe clinical practice	3.75	3.67
KF19: Org and mgmt. interest in and action on health and wellbeing	3.77	3.71
KF9: Effective team working	3.94	3.85
KF5: Recognition and value of staff by managers and the organisation	3.64	3.56
KF10: Support from immediate managers	4.02	3.88

*KF – Key Finding

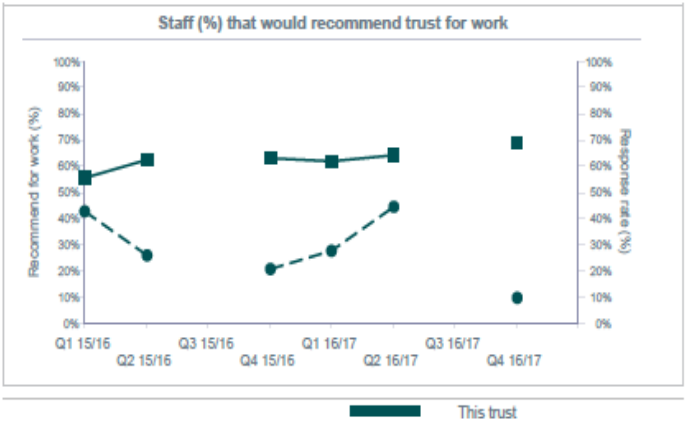
In the 2016, NHS Staff Survey: the trust had worse results than other similar trusts in four key areas below. One of these areas, KF 3: roles making a difference to patients and service users was lower than national average.

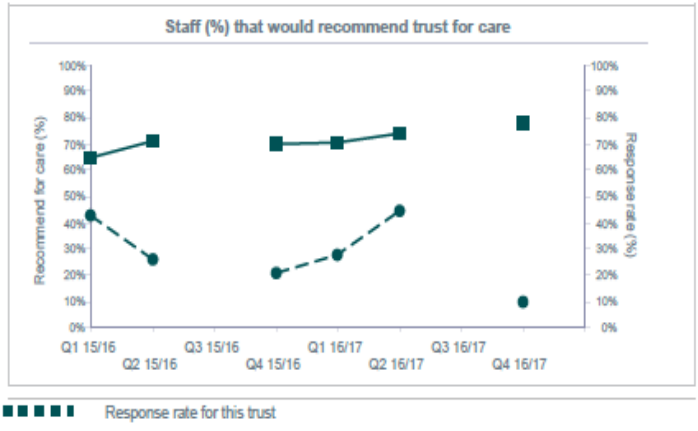
Key finding	Trust score	Similar trusts average
KF 3: Percentage agreeing that their role makes a difference to patients/service users	86%	89%
KF 13: Quality of non-mandatory training, learning or development	3.99	4.06
KF 2: Staff satisfaction with the quality of work and care they are able to deliver	3.76	3.85
KF 32: effective use of patient/service user feedback	3.64	3.70

*KF – Key Finding

However, the staff friends and family test asking staff members whether they would recommend the trust as a place to receive care and as a place to work showed an improving trend over the last six quarters contradicting the staff survey results. Quarter 4, 16/17 had the highest score for staff recommending the trust as a place to receive care and work for both 2015/16 and 2016/17. Response rates were the highest in these quarters and are therefore more likely represent the staff views overall.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.





The Patient Friends and Family Test ask patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 2% and 5% better than the England average for patients recommending it as a place to receive care for all of the six months in the period (April – September 2017). Also,

the trust was lower than the England average for percentage of patients who would not recommend the trust as a place to receive care in five of the six months.

	Trust wide responses				England averages	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
Sep 17	3643	275	91%	3%	89%	4%
Aug 17	3387	417	93%	3%	88%	5%
Jul 17	3675	322	91%	5%	89%	4%
Jun 17	3437	210	90%	4%	88%	4%
May 17	3624	344	94%	3%	89%	4%
Apr 17	3634	158	93%	2%	89%	4%

Staff at all levels consistently told us they were proud to work with DPT and that it was a patient focussed organisation. However, staff did tell us of the pressures the continuing vacancies had on their ability to deliver their service. For example committed and caring matrons and ward managers told us they were regularly filling shifts to ensure consistency in patient care to a detriment of their own work. We saw the impact of this on the acute inpatient wards.

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31 July 2017	2187	N/A
Total number of substantive staff leavers	1 August 2016–31 July 2017	298	N/A
Average WTE* leavers over 12 months (%)	1 August 2016–31 July 2017	14%	N/A
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 July 2017	292	N/A
Total vacancies overall (%)	At 31 July 2017	12%	N/A
Total permanent staff sickness overall (%)	Most recent month (At 31 July 2017)	5%	N/A
	1 August 2016–31 July 2017	5%	N/A
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 July 2017	739	N/A
Establishment levels nursing assistants (WTE*)	At 31 July 2017	597	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 July 2017	132	N/A
Number of vacancies nursing assistants (WTE*)	At 31 July 2017	3	N/A
Qualified nurse vacancy rate	At 31 July 2017	18%	N/A
Nursing assistant vacancy rate	At 31 July 2017	1%	N/A
Bank and agency Use			

Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 August 2016-31 July 2017	10747 (12%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 August 2016-31 July 2017	7181 (8%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 August 2016-31 July 2017	2936 (3%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2016-31 July 2017	0 (0%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 August 2016-31 July 2017	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 August 2016-31 July 2017	0 (0%)	N/A

*Whole-time Equivalent

Vacancies were identified as one the trusts key risks, however, DPT were carrying a variety of positive initiatives to address vacancies including a new staff development process, training into posts, working with universities and creating attractive career development opportunities. DPT was also reviewing the work to be delivered and not just the vacancies. This had resulted in identified were admin support or upskilling others could address vacancies. The trust had been successful in appointing several social workers and psychologists using the methods outlines above in the last few months. Everyone at board level and directorate leads interviewed stated that the implementing innovative and holistic approaches to vacancies was part of their responsibility.

DPT staff have a good understanding of Duty of Candour (DoC) requirements and its application. The trust has launched a new DoC policy in 2017 and there are IT systems to remind and support staff recording the outcomes of DoC interactions with others. Stakeholders told us there had been a dramatic improvement over the last 12 months in the trust's management of DoC.

The trust was continuing to improve its overall training compliance rates in line with its own targets. As at 31 July 2017, the training compliance for trust wide services was 82% against the trust target of 90%. Of the training courses listed 38 failed to achieve the trust target and of those, 20 failed to score above 75%.

Core services with the lowest performance across the trust included; wards for people with learning disabilities or autism with 74% (14 of the 41 courses eligible for were below 75%), Long stay/rehabilitation wards followed with 77% (19 of the 42 courses eligible for were below 75%). Wards for older people followed with 79% with 15 of the 42 courses eligible to take were below 75%)

The training data provided by the trust is shown as those in date as of a rolling period end. Some courses are one-off; others have a 1, 2 or 3 year.

The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for non-medical staff was 84%.

Three of the 11 teams (27%) achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target were 'Provider wide' with 76%; 'Community based mental health services for adults of working age with 79%; 'Wards for older people with mental health problems' with 81%; Mental health crisis services and health based places of safety with 83%; Other with 84%; Community based mental health services for older people with 85%; Long

stay/rehabilitation mental health wards for working age adults and Community mental health services for people with learning disability or autism both with 88% each.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% of non-medical staff who have had an appraisal
MH - Wards for people with learning disabilities or autism	33	31	94%
MH - Forensic Inpatient	268	248	93%
MH - Acute wards for adults of working age and psychiatric intensive care units	151	137	91%
MH - Community mental health services for people with a learning disability or autism	91	80	88%
MH - Long stay/rehabilitation mental health wards for working age adults	25	22	88%
MH - Community-based mental health services for older people	184	156	85%
Other	572	482	84%
MH - Mental health crisis services and health-based places of safety	103	85	83%
MH - Wards for older people with mental health problems	123	100	81%
MH - Community-based mental health services for adults of working age.	237	188	79%
Provider wide	308	234	76%
Total	**2095**	**1763**	**84%**

The trust was meeting its appraisal target of 90% for its medical staff. The data below provided by the trust stated that only 48% had received appraisal. During the inspection, the medical director produced a medical re-evaluation report that provided very different appraisal data for the senior management team. The report listed the causes for any missed appraisals and plans for re-validation of medical staff over the next two years. There was no clear explanation as the difference in the data provided and data produced the above mentioned report.

Core Service	Total number of permanent medical staff who have had an appraisal within the last 12 months	Total number of permanent medical staff who have not had an appraisal in the last 12 months	% appraisals
Provider wide	68	37	54%
MH - Forensic Inpatient	11	3	27%
MH - Community mental health services for people with a learning disability or autism	1	0	0%

MH - Community-based mental health services for older people	4	0	0%
Total	**84**	**40**	**48%**

The trust's target rate for clinical supervision is 90%. As at 31 July 2017, the overall clinical supervision compliance for medical staff ranged between 30% and 100%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it is important to understand the data they provide.

The trust have not provided the actual number of sessions identified and undertaken, they have provided the percentage by month of staff (medical and qualified nursing staff, Band 5 and above) in date under trust clinical supervision polices. The ranges are outlined in the table below:

Core Service	Clinical supervision rate (%) as at 31 July 2017
Community based mental health services for older people	100%
Other	50%
Community mental health services for people with a learning disability or autism	100%
Provider wide	30% - 100%

The trust's target rate for clinical supervision is 90%. As at 31 July 2017, the overall clinical supervision compliance for non-medical staff ranged between 0% and 100%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it is important to understand the data they provide.

The trust have not provided the actual number of sessions identified and undertaken, they have provided the percentage by month of staff (medical and qualified nursing staff, Band 5 and above) in date under trust clinical supervision polices. The ranges are outlined in the table below:

Core Service	Clinical supervision rate (%) as of 31 July 2017
Acute/PICU	81.8% - 100%
Community LD & Autism	0% - 100%
Community older people	0% - 100%
Community adults of working age	55.6% - 100%
Forensic IP	50% - 100%
Long stay/rehab	70%
Crisis & HBPoS	6.7% - 100%
Wards for OP	36.4% - 93.3%
Wars for LD & Autism	50%
Other	0% - 100%

The processes for investigating, recording and completing complaints had improved. Staff told us they were confident and well supported in processing complaints. The trust had increased its complaints and compliments team 2015. The team had reduced the number of open complaints. The data below highlights that 96% of complaints are responded to within 3 days and the average complaint length, 79 days is below the trust target of 90 days.

	In Days	Current Performance
What is your internal target for responding to* complaints?	Acknowledgement is expected within 3 days of receipt	96% in the year
What is your target for completing a complaint?	As agreed with the complainant but if not recorded on CRP 3 months	Average for the year is 78 days 102 within 60 days 77 over 90 days 52 between 61-90 days 154 within 90 days
If you have a slightly longer target for complex complaints please indicate what that is here	Not normally longer than 6 months	10 cases over 6 months

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months *(this includes contacts categorised as a concern or enquiry)*	144	01/08/16 – 31/07/17
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	8	July 16 to August 17

***Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

This trust received 627 compliments during the last 12 months from 1 August 2016 to 31 July 2017. 'Other' had the highest number of compliments with 45% (280), followed by 'Community based mental health services for older people' with 21% (134) and 'Acute wards for adults of working age and PICU' with 10% (65). The IT system revised it system for recording complaints in 2017. We reviewed 3 months of secure services' complaint reports; there was a robust process to collate compliments. Staff's recognition of others work and support were regularly recorded and shared.

Governance

There were clear and established governance arrangements in place. The governance team's structure had been reviewed resulting in an increase in the team size. Stakeholders told us since the introduction of the new team systematic improvements in governance were being made. For example since the introduction to the new safeguarding lead, the trust had improved reporting and we saw new processes to oversee the risks such as introduction of thematic reviews.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. Papers for board meetings and other committees were of a reasonable standard and contained appropriate information.

Physical health for mental health patients had an established governance pathway. The oversight of physical health was monitored through the CQUIN quarterly board papers and an annual paper provided to the trust from the quality and safety group. The board had a physical health plan in place which was approved at senior management board. The nursing director is the lead for physical health supported by the medical director.

Medicines optimisation had strengthened its own governance process and was increasing its oversight. They had their own governance process, however they felt there was integrated working within broader governance and they were able to support governance in areas such as physical health.

There was an established and well-functioning board, consisting of seven executives, seven non-executive directors (NEDs) and chair. The chair and NEDs interviewed were clear on the roles and responsibilities. They all felt they were well informed through the governance process and were able to challenge the executive team when necessary.

Governance arrangement around the Mental Health Act (MHA) administration were mostly robust. We saw evidence of joined up working and clear lines of communication from ward to board through clinical team meetings, intranet and training and other bulletins. The trust scrutiny committee had attendances form safeguarding, managing partner, clinical director, and assistant director of nursing and training lead and MHA manager. Along with carer and user representation. The trust produced an annual MHA. The board reported on recent of audits on for example recent audit of holding powers, section 117 care plans and prone restraint. Learning from the audits was fed into the MHA and MCA training and disseminate learning to clinical business teams.

Most directorates had robust and clear structure for sharing information and managing risks. In particular, processes within the secure service were embedded. We also evidence of team meetings and learning being shared. The wards were clear about their roles in audits and how they were fed into the IT database for oversight.

The trust provided its corporate assurance framework/risk register. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined two strategic ambitions:

1 – To deliver consistently high quality care and treatment/to build a reputation as a recognised centre of excellence.
2 – To be an efficient, thriving and successful organisation with a sustainable future.

The trust provided a document detailing its highest profile risks. Each of these had a current risk score of 15 or more

Of the 11 risks highlighted with risk scores 15 or above, the themes coming from those risks include, inadequate staffing levels for nursing and medical staff, retaining staff, shortage in staff to resource services, accessing services, financial pressures and investment into services.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.
Nov 2016	S33	If we are unable to meet the current high demand across are acute care pathway then patients may experience a delay in treatment (particularly out of hours care) or may not be able to access elements of the urgent care pathway in their local area	20	20	8	1
May 2017	S35	If the inadequate levels of staffing for nursing and medical staff, for the Meadowview OPMH service, are not resolved then this will negatively affect the safety and quality of the services provided. Additionally this may result in a temporary suspension of the service.	15	15	6	1
May 2017	S36	If there is not a significant investment in to the development of a community eating disorder services then this could negatively affect individual's health, wellbeing and safety. Leading to inappropriate admissions and readmissions to acute general and MH services.	16	16	8	1
July 2017	S37	If people cannot access gender identity services in a timely way then people may experience psychological distress and have a poor experience of the services.	16	16	12	1
March 2017	SU35	If the trust is unable to effectively re-profile the workforce, given the national shortage of staff in specific professional groups, then we will find it increasingly difficult to ensure there is sufficient workforce supply to resource services. The resulting gaps could have an adverse impact on the provision of care.	16	16	8	2
March 2017	SU36	If the trust is unable to recruit and retain sufficient numbers of clinical staff, then this could impact on our ability to deliver services and to build a reputation as a recognised centre of excellence and expertise.	16	16	12	2
April 2017	SU37	If the 2017/18 CIPs programme is not achieved recurrently then this will result in a cost pressure in 2018/19.	16	16	12	2

April 2017	SU38	If the SMART Recovery Programme is not fully implemented then this may not deliver revenue CIPs 2017/18	15	15	5	2
May 2017	SU40	If the Devon wide financial plan is not resolved satisfactory with the regulators then the trusts contractual income may be at risk	15	10	10	2
July 17	SU41	If the Mother and baby unit cannot be built and opened by the end of March 2019, then there is a risk that the capital funding will not be available.	15	15	10	2
July 17	SU42	If the number of new admissions to high dependency inpatient services and PICU activity continues to exceed the forecasted plan then this will affect the delivery of Financial Plan (2017/18)	16	16	8	2

Devon Partnership NHS Trust has submitted details of two external reviews commenced or published in the last 12 months [2015/2016].

In 2016, Enable East was commissioned to conduct a review of Devon Partnership NHS Trust core services in preparation for their December 2016 CQC inspection. Key outcomes of the visit were – Pre inspection review visits with a team of eight people to ensure adequate time for detained review of 32 sites, reporting, review and reprinting of staff handbook, development and printing of new A0 staff preparation posters, delivery of four one day staff preparation workshops in partnerships with trust CQC lead and support to response to report following CQC inspection if required.

In 2015 the trust were asked to participate in a homicide review being undertaken by the Health and Social Care Advisory Service (HASCAS) following a serious incident in September 2013 in which a service user was arrested on murder charges following a fatal stabbing. The service user had been in receipt of care and treatment from the local Recovery and Independent Living Team (RIL) until September 2011 when he was discharged back to his General Practitioner. At that time, he was also in receipt of services from the Devon Drug and Alcohol Service (DDS). DDS were aware that the service user had been in receipt of treatment from RIL and were aware that he had been discharged by the team. HASCAS have produced a draft report following the completion of their review however, this has not yet been finalised and the report remains confidential at this stage. The Trust has reviewed the draft report and has been able to provide evidence to HASCAS of significant work progressed since the original incident.

Management of risk, issues and performance

The trust had a system in place to identify learning from incident, complaints, compliments and safeguarding. However, the governance team was relatively new in is structure and the team were on a journey to ensure all systems were robust. We looked at how the trust captured its data and reviewed the quality of the data but some examples showed that data quality processes needed further improvement. For example, we identified during our visits to inpatient areas that restraint and prone restraint did not correlate with the data provided to CQC by the trust. DPT have been very responsive and carried out a review into restraint data. The review identified that prone restraints were not always been recorded correctly. Also, on Haytor Ward, different trend patterns in the use of prone

restraint had not been highlighted by the data review process. As wellas that the data collection process on their IT system needed to be improved. They also identified during the review that restraint in particular in ASU learning disability inpatient ward had increased over the last 6 months. We also identified an example of discharge data for Russell Ward not being captured in the trust's dashboards.

Despite the above concerns regarding the quality of data, the process of investigation and learning from serious incidents was established and comprehensive. We saw numerous positive examples of learning from incidents such as the trust commissioning a review of five recent incidents involving risks around sexual safety. Safeguarding had improved it data collection and the number of incident reported had been dramatically increased.

The trust had a robust and comprehensive number of board reports they reviewed. The trust received regular reports from it sub committees including the governance and safety committee as well as annual reviews into numerous areas such as annual audit committee report or engagement report.

Between 1 August 2016 and 31 July 2017, the trust reported 67 STEIS incidents. The most common type of incident was Apparent/actual/suspected self-inflicted harm meeting SI criteria with 46. Twenty-eight of these incidents occurred in community based mental health services for adults of working age and mental health crisis services and health based places of safety with 14 each.

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Devon Partnership NHS Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly comparable with the number the trust reported to STEIS. From the trust's serious incident information, 38 of the unexpected deaths were instances of Apparent/actual/suspected self-inflicted meeting SI criteria, 13 of these occurred in mental health crisis services, and health based places of safety.

Type of incident reported on STEIS	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Community-based mental health services for adults of working age.	MH - Community-based mental health services for older people	MH - Forensic Inpatient	MH - Long stay/rehabilitation mental health wards for working age adults	MH - Mental health crisis services and health-based places of safety	MH - Wards for older people with mental health problems	Other	Provider wide	Grand Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	5	14	2			14		11		**46**
Disruptive/ aggressive/ violent behaviour meeting SI criteria	3	1		1	1					**6**

Unauthorised absence meeting SI criteria	4	1								**5**
Slips/trips/falls meeting SI criteria							2			**2**
Confidential information leak/information governance breach meeting SI criteria								1	1	**2**
Abuse/alleged abuse of adult patient by staff	2									**2**
Pressure ulcer meeting SI criteria							1			**1**
Sub-optimal care of the deteriorating patient meeting SI criteria							1			**1**
Pending review (a category must be selected before incident is closed)	1									**1**
Medication incident meeting SI criteria								1		**1**
Total	**15**	**16**	**2**	**1**	**1**	**14**	**4**	**13**	**1**	**67**

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 August 2016 to 31 July 2017 were Self-harming behaviour, Access, admission, transfer, discharge (including missing patient) and Medication. These three categories accounted for 2745 (61%) of the 4463 incidents reported. Other accounted for 49 of the 58 deaths reported.

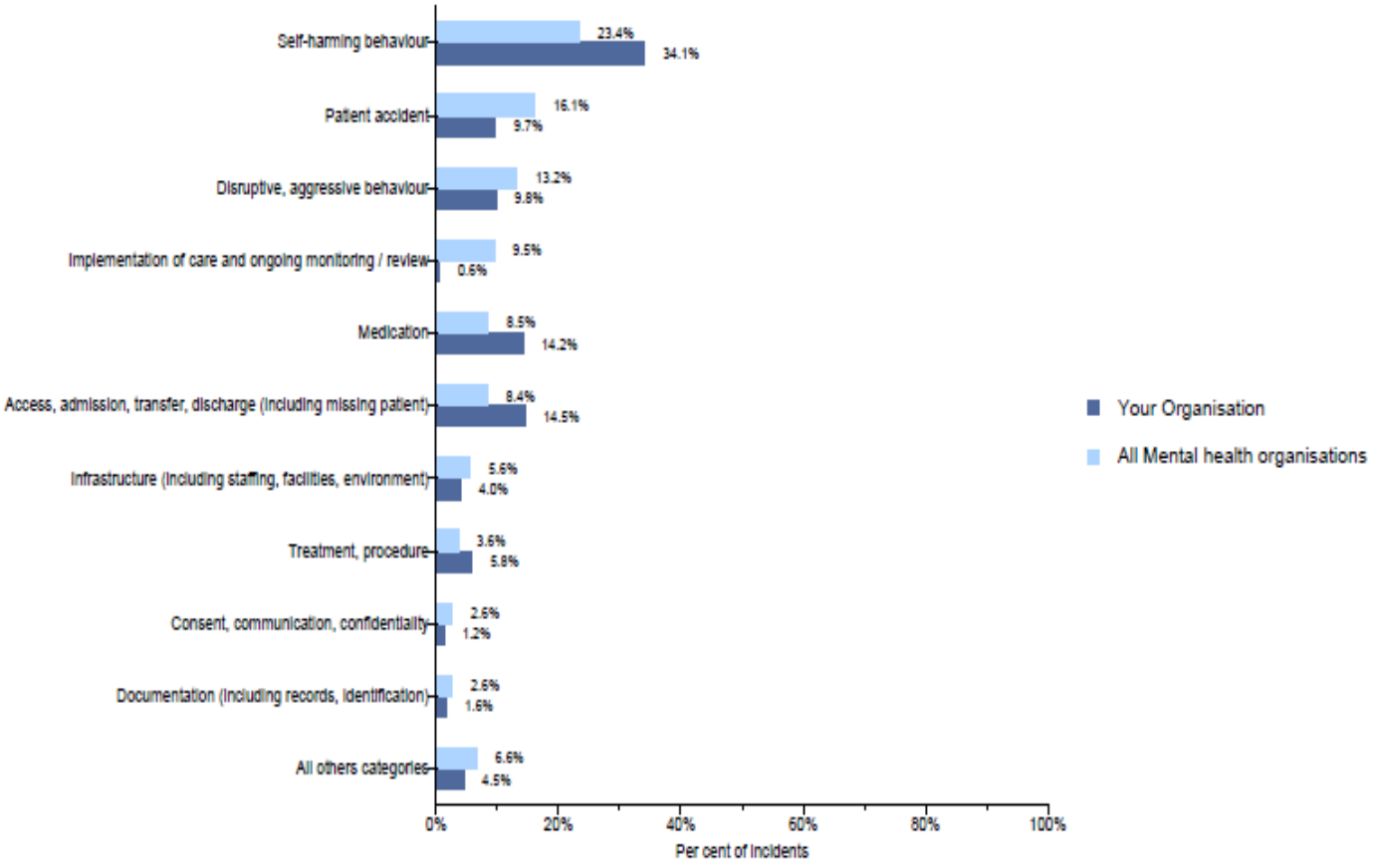
Ninety-three percent of the total incidents reported were classed as no harm (48%) or low harm (45%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Self-harming behaviour	398	996	87	13	8	**1502**
Access, admission, transfer, discharge (including missing patient)	483	155	28			**666**
Medication	413	157	5	2		**577**
Patient accident	201	254	13			**468**
Disruptive, aggressive behaviour (includes patient-to-patient)	231	172	15	2	1	**421**
Treatment, procedure	151	90	36	3		**280**
Infrastructure (including staffing, facilities, environment)	88	77	21			**186**

Other	17	27	4		49	**97**
Documentation (including electronic & paper records, identification and drug charts)	65	14	2			**81**
Patient abuse (by staff / third party)	16	26	9	5		**56**
Consent, communication, confidentiality	36	15	2			**53**
Implementation of care and ongoing monitoring / review	14	18	3			**35**
Clinical assessment (including diagnosis, scans, tests, assessments)	13	7	1			**21**
Infection Control Incident	9	9	1			**19**
Medical device / equipment	1					**1**
Total	**2136**	**2017**	**227**	**25**	**58**	**4463**

According to the latest six-monthly National Patient Safety Agency Organisational Report (1 October 2016 to 31 March 217), the trust was in the middle 50%/ of reporters nationally for similar trusts.

Self-harming behaviour and Access, admission, transfer, discharge (including missing patient) accounted for a higher proportion of the total number of incidents reported compared to similar trusts.



Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Devon Partnership NHS Trust reported more incidents from 1 August 2016 *to* 31 July 2017 compared with the previous 12 months. The number of moderate incidents increased by 32 incidents, the number of severe incidents stayed the same and the number of death incidents increased by 36 incidents when compared to the previous 12 months.

Level of harm	**1 August 2015 – 31 July 2016**	**1 August 2016 – 31 July 2017 (most recent)**
No harm	**1509**	**2136**
Low	**1193**	**2017**
Moderate	195	227
Severe	25	25
Death	22	58
Total incidents	**2944**	**4463**

We saw evidence that the trust had effective corporate risk escalation processes. The risk registers were accessible by most staff. Ward managers were able to escalate risks via their IT system to their managers. Staff from board to ward's understanding of key risks matched those in the local and corporate risk registers.

The trust has a comprehensive programme of internal audits.

The trust's financial picture is stable. DPT had a surplus of £4.7m in 2016/17, which was £2.2m favourable to plan. The trust reported a surplus of £4.7m in 2016/17. The finance team is well-established, finance team, and particularly the finance director, to have the capacity and capability effectively discharge their responsibilities in a mental health environment. The trust were using their strong financial position to enhance service provision such as the new mother and baby unit and physiatrist intensive care unit being built in Exeter. The trust had a plan in place to upgrade therapeutic environments to comply with legal requirements. Plans to continue being financially stable include the rationalisation of the estate. NHS Improvement told us that DPT reported less spending than the previous years on agency, and less than the ceiling set by NHS Improvement for 2017/18.

Information Management

The trust had processes in place to monitor its performance, although we evidenced some quality issues in data being pulled into reports and dashboards. Committees and the board reviewed performance reports, of which we saw in board meeting minutes. The boards had a corporate dashboard which reported progress against key performance indicators (KPI). Any exceptions had supporting narrative to explain the deviation from the KPIs. The board also regularly monitored it progress against its CQUIN targets, commission for quality and innovation targets set by NHSE which included more holistic targets including staff well-being and physical health for DPT patients. The trust had clinical information hubs at ward level, leaders told us this was scattered and difficult to find information. However, it had imminent plans in place recently extended the dashboard to provide ward level live information. While reviewing the dashboard with members of the board it

was identified that discharge data for the Russell ward was not being captured and therefore escalated. The trust was also aware that DoC information recorded on its IT system was lower than level of compliance when checks are made on carenotes.

The new estates team provide DPT board a broad oversight of performance via a quarterly report. However, there were no clear key performance indicators in place in lien with the trust's expectations. The quarterly report provides broad trends and RAG rating of compliance against, compliance, workforce and capital schemes. The 2017/18 quarter 2 report broadly describes a decreasing ability to meet estates request via the estates helpline sue to staff shortages. Evidence of the impact of estates capacity was seen in clinical areas staff told us broken seclusion room toilet windows not being fixed inhibiting the observation of very unwell patients. The trust had commissioned a review in January 2018, final internal audit report: community estates service review, it recommended the development of service pertinent KPIs to coincide with the service development and expectations and a performance dashboard.

Staff had access to IT systems across the trust. We saw improvements were being made to the It system to promote better care planning and risk assessing. Guidance and local leads were available to support staff while changes were underway.

The process for on-going monitoring of compliance against the National Institute for Health and Clinical Excellence (NICE) was comprehensive. The work is co-ordinated via the programme management office (PMO). The quality improvement team triage all new guidance on a monthly basis. The clinical effectiveness and assurance group then meet, monthly, to review DPT response to the new guidance, assess compliance and provide assurance. The PMO are currently triaging and where appropriate escalating all NICE guidelines back to 1999.

There were robust governance systems to ensure confidentiality of patient records. The medical director is the trusts Caldecott guardian. We were provided with examples of where complex decisions were being made to ensure the safety of patients. We also saw evidence of thematic deep dives into information governance incidents by the information governance cause group.

Engagement

DPT was actively engaged in the health economy locally. Actively involved in the STP, raising the profile and position of mental health in the wider health economy.

Partners, stakeholder and commissioners told us they had very positive and collaborative relationship with the Nursing Director. The trust worked with different enforcement agencies in the emergency care steering group, 'Together', partners have produce a leaflet, letter of hope, for those who were acutely unwell and were placing these in high risk suicide risk areas across the

'Together', 'in everything we do', is a successful engagement ethos. The ethos and ethos work designed to bring those with lived experience including carers and develop true co-design of services. Working with carers, persons' with lived experience and patients from board, ward to community settings. Numerous examples were seen across the trust services where carers and patients were running quality improvement groups for example small projects such as trialling traditional nursing uniforms in the Cedars unit, while others had effective patient councils. The project has tools and guidance to support the clinical teams to improve engagement. In 2016/17 it published it first annual together report, and have introduced a together award via the DPT awards programme. However, carer's and patients interviewed not directly involved in the programme felt they were not well informed and were unaware of the work going on.

The trust seeks patients' feedback and were working towards improving the volume of feedback they captured. The trust has signed up to national feedback mechanisms for patient feedback across the trust such friend and family test. However, the annual experience report states that they are not meeting the commissioners' target of 15% patient responding to patient friends and family test. Progress is shown, during 2015/16 there were 1,446 responses received compared with 3,676 in 2016/17. Trials to use patient feedback kiosks were trialled but did not have a significant impact on the volume of recipients. On the wards, we saw tools such as community meetings, you say, we did boards at ward level. However, feedback from the staff survey highlights that they fall below national average for MH trust for effective use of patient / service user feedback despite an upward trend form 2015 survey.

There is a structured plan for seeking feedback from staff at DPT, although DPT recognises the feedback loops need improvement. The trust throughout the year use staff survey, national friends and family test and our journey events. These result in quarterly engagement reports to the board as well as an annual report. The trust staff engagement plan, dated October 2017 outlines plans to feedback the information and enhance the feedback loop for staff through a variety of media.

Learning, continuous improvement and innovation

The trust had embraced and was starting to successfully imbed a quality improvement (QI) methodology. We observed small and large quality improvement project being run by a variety of staff, patients and persons' with lived experience across the trust. The trust had developed a structure approach and QI directorate leads managed by the committed project management office. Via this team, the trust supported and promoted the use of this methodology on the wards for learning, for example the cedar's academy. The medical director was a key driver and promoted and supported junior doctors and consultants to use QI methodology. Staff were trained in the use of QI. The only exception was the newly developing estate team.

Staff used data to improve review and improve services. The trust carried out thematic reviews internally for example for information governance. Where necessary the trust brought independent reviewers such as the ongoing review into several incident of a sexual nature across acute inpatient wards. The trust could provide several examples of where they learnt from complaints and services had been improved.

The trust had a robust and thorough process to learn from deaths. We carried out a review of several incidents with trust team and established they used learning from deaths to improve services; for instance, changes in the process for receiving calls to the emergency duty team.

The board were proud of the improvements being carried out at DPT, they had their own award system. There were several different awards including awards for improvement, innovation, and involvement. Notably staff were exited while we were on the wards about the awards or the 4 steps to safety programme run by the trust. The trust had received several awards for its services from external

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago) (2015/16)	Last financial year (2016/17)	This financial year (2017/18)	Next financial year (2018/19)
Income *(actual)*	£139,976.00	£148,534.00	£222,359.00	£221,834.00
Surplus *(pre-impairment surplus)*	£2,451.00	£4,061.00	£2,604.10	£2,772.00
Full costs *(actual expenditure)*	£137,525.00	£144,473.00	£219,754.90	£220,326.00
Budget *(planned expenditure)*	£136,027.00	£143,615.00	£218,563.06	£220,326.00

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The trust promoted the use of accreditation schemes. For example they are part of the national benchmarking programmes such as mental health benchmarking NHS benchmarking network. Also they promoted and supported wards to be involved in accreditation schemes such as AIMS and quality network for forensics services.
The table below shows services across the trust awarded an accreditation (trust-wide only) and the relevant dates.

Accreditation scheme	Core service	Service accredited
Accreditation for Inpatient Mental Health Services (AIMS) – WA (Working Age Adults)	Moorland View - Accreditation confirmed in July 2017. Awaiting certificate. Ocean View - Accreditation confirmed in July 2017. Awaiting certificate. Coombehaven Ward - Accreditation process completed. Awaiting certificate. Delderfield Ward. Accreditation until 9 October 2018. Haytor – To re-commenced Accreditation approx. October 2017	Acute wards for adults of working age and psychiatric intensive care units
Quality Network for Forensic Mental health Services	Member since 2007 – Low and Medium Secure units at Langdon Hospital	Wards for people with mental health problems detained in medium or low secure
Quality Network for Prison Mental Health	Member since 2017 – Mental health Services for HMP Exeter, Dartmoor and Channings Wood.	Prisoners with mental health problems detained in prison
ECT Accreditation Scheme (ECTAS)	Torbay ECT Clinic, Torbay Hospital Lawes Bridge Torquay 24 November 2016 Exmouth ECT Clinic, c/o Exmouth Hospital Claremont Grove, Exmouth 16 June 2017	N/A

Psychiatric Liaison Accreditation Network (PLAN)	Exeter and North Devon Liaison Awarded: 16 June 2017	Torbay - awaiting outcome
Memory Services National Accreditation Programme (MSNAP)	Programme of self-review commenced on 01/08/17. Peer review by royal college is booked for 05/12/17.	Devon Memory Service is engaged with this scheme and an accreditation review is scheduled for December 2017
Network for Offender Personality Disorder Services	Pathfinder service	Alternative care pathways to avoid admissions to hospital