Somerset NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

Somerset NHS Foundation Trust (SFT) is the first NHS trust on the English mainland to provide community, mental health, and acute hospital services. The trust was formed with the formal merger of Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust which took place on 1 April 2020. At our last comprehensive inspection of the Taunton and Somerset trust in January 2020 (the report published in March 2020) we rated the trust overall as good, with a requires improvement rating for safe. Caring was rated as outstanding. The other key questions of effective, responsive well led were rated as good. At our last comprehensive inspection of Somerset Partnership in October 2018 (published in January 2019) we rated the trust overall as good, with a requires improvement rating for safe. Effective, caring responsive and well led were rated as good.

The trust is working towards a planned merger with Yeovil District Hospital NHS Foundation Trust (YDH) to bring the trusts together to create a new, single organisation which will be responsible for running Yeovil District Hospital and Musgrove Park Hospital, the community hospitals in Somerset, all community, mental health and learning disability services in the county with population coverage of 20% of GP practices in Somerset. The two trusts are overseen by a joint board. The merger is due to complete in April 2023.

We carried out this short notice announced inspection of acute wards for adults of working age and psychiatric intensive care unit (PICU), specialist community mental health services for children and young people and community end of life care services of this trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall. At our last inspection we rated the trust good overall.

During this inspection we inspected three of the Trust's core services and rated one outstanding and two as good. We also undertook an inspection of how 'well-led' the trust was. We rated the trust as good overall. We rated each of the key questions. We rated safe as requires improvement; effective, responsive, and well-led as good, and we rated caring as outstanding.

The trust provides the following services:

Our findings

Mental health services

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

Long stay/rehabilitation mental health wards for working age adults

Forensic inpatient / secure wards

Child and adolescent mental health wards

Wards for older people with mental health problems

Community-based mental health services for adults of working age

Mental health crisis services and health-based places of safety

Specialist community mental health services for children and young people

Community-based mental health services for older people

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

Community health services

Community nursing services or integrated care teams, including district nursing, community matrons and specialist nursing service

Community health services for children, young people and families

Community health inpatient services

Community end of life care

Community dental services

Community sexual health services

Urgent Care

Acute hospital services

Urgent and emergency services

Medical care (including older people's care)

Surgery

Our findings

Critical care

Maternity

Services for children and young people

End of life care

Outpatients

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

- We rated effective and responsive as good, caring as outstanding and safe as requires improvement. We rated 'well-led' for the trust overall as good. In rating the trust, we took into account the existing ratings of the 22 previously inspected services not inspected during this inspection.
- We rated 1 of the 3 core services we inspected as outstanding and 2 as good.
- We rated specialist community mental health services for children and young people as outstanding overall, with caring and responsive rated outstanding. This had improved from the overall rating of requires improvement given at our last inspection. We rated acute wards for adults of working age and psychiatric intensive care units as good. This rating was unchanged since our last inspection. We rated community end-of-life care as good in every domain, this was an improvement as we rated the safe domain as requires improvement at our last inspection.
- During the core services inspections we saw that staff treated people with compassion and kindness, respected their privacy and dignity and understood people's individual needs. Services were inclusive, took account of patients' preferences and their individual needs. People had their communication needs met and information was shared in a way that could be understood.
- The strategy provided a focus for the work being done by the trust to prepare for the merger with Yeovil District Hospital NHS Trust and to meet the needs of local populations.
- We found that despite the challenges of the pandemic, the trust had adapted, learnt, and continued to make positive progress. We found that the trust had addressed all the areas where improvements were recommended in the specialist community mental health services for children and young people at the previous inspection. This had a positive impact for people who use services and staff working for the service.
- Staff were well supported by supportive and competent leaders across the organisation. Leaders were well supported with their career development and the provider had improved its approach to succession planning for senior leadership posts.
- We found a positive culture across the trust. Staff told us that they felt proud to work for the trust and we heard many examples of how they put the people who use services at the centre in their work. The senior leaders including the non-executive directors were open, friendly and approachable. They had worked hard during the pandemic to engage with services in person and remotely. People and teams were able to speak honestly and reflect on where improvements were needed and how this could be achieved.
- The non-executive directors provided high quality, effective leadership and delivered support and appropriate challenge to the senior executives. They all had experience as senior leaders in a range of organisations and brought skills from other sectors including NHS acute care, health organisation directorships, social care, education and local government.

Our findings

- The senior leadership team demonstrated a high level of awareness of the priorities and challenges facing the trust and the local health environment, and how they could address these and influence change in the system. The trust had well embedded clinical leadership.
- The trust's governance system effectively provided assurance and helped keep patients safe. It helped the organisation deliver its key transformation programmes and priorities outlined in the annual business plan.

However:

- There were still outstanding maintenance, refurbishment and repair issues on acute wards for adults of working age and psychiatric intensive care units to ensure they provided a therapeutic environment. The outstanding issues had been logged on the trust system by staff, but repairs had not been completed. The specific issues are described in the core service reports.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Before the inspection we reviewed a range of information we held about the services.

During our inspection of the three core services, the inspection teams:

- reviewed records held by the CQC relating to each service
- visited seven wards and ten community team bases across Somerset. We looked at the quality of the ward environments, management of the clinic rooms, and observed how staff were caring for patients
- interviewed the ward manager and/or matron for each ward or service
- reviewed 69 patient care and treatment records
- interviewed 31 patients and 13 relatives of patients
- looked at a range of policies and procedures related to the running of the service
- spoke with the Peer Support worker
- spoke with an independent mental health advocate
- looked at a range of policies, procedures and other documents relating to the running of each service
- spoke with 46 staff members including nurses, clinical practice leads, end of life coordination team, district nursing teams, rapid response service, staff proving care on community inpatient ward. support workers, occupational therapists, occupational therapy students, clinical psychologists, associate psychologists, health care assistants, activities coordinator
- spoke with 18 senior members of staff including the professional lead for the PMVA (Prevention Management of Violence and Aggression) team
- spoke with medical teams across the services including the palliative consultant leadership team, consultant psychiatrists and doctors. We also spoke to members of the LARCH team and End of life education team
- observed eight multi-disciplinary meetings, two home visits and one assessment.

Our findings

The well led inspection team comprised one executive reviewer who was an executive of an NHS mental health and community health provider, two specialist advisors with professional experience in executive roles and board-level governance, one CQC head of hospital inspection, two CQC inspection managers and three colleagues from NHS England.

What people who use the service say

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

Patients felt safe and their relatives confirmed their family member receiving care and treatment was safe.

Patients knew the reasons for their admission and the conditions of their stay. They knew their rights and how they applied to them. For example, their right to leave.

Relatives felt informed of important events and where appropriate were invited to reviews. Some relatives raised concerns about the closure of St Andrews and how this would impact on their visiting

Patients overall gave positive feedback about the staff and relatives praised staff for their patience. Some relatives had observed staff shortages when they visited. Patients in Rydon 2 said there was a lack of meaningful activities, and the activities room was often closed.

Patients felt confident to approach the staff with complaints and gave us examples of complaints they made with support of their advocates.

Patients knew about their care and treatment but were not provided with copies of their care plan.

Patients knew the routines of the ward and said the meals were of a good standard

Specialist community mental health teams for children and young people

Parents and carers gave very positive feedback about CAMHS (Child and Adolescent Mental Health Services) services. Parents and carers said that every single service responded to them in a timely way, that their children were assessed, and appropriate therapy offered quickly.

Children and young people said their appointments were flexible; they could request a digital appointment and appointments always ran on time.

Parents and carers said that communication was good. They said that staff were supportive, kind, and caring. Parents and carers said that staff always made sure they understood what was happening, they had a very open dialogue with staff and that their opinion was always sought.

Parents and carers said they were reassured by staff and included in reviews and assessments. They said that care plans were done together as a family, and they received written copies regularly.

Young people said they were fully involved in their care and understood what was going on.

Our findings

Community end of life care

Patients and families knew how to complain and felt they could raise concerns without fear of prejudice.

Patients and families described staff very positively. Some carers had fundraised following the death of patients as they had wanted to give something back to the services that they felt had cared for their loved ones very well.

Patients and families were positive about the support they received from staff, their religious and cultural needs were respected and supported.

Patients and families were supported to give feedback on their treatment and the service.

Outstanding practice

We found the following outstanding practice:

Specialist community mental health teams for children and young people

- CAMHS teams had implemented a number of strategies to decrease their wait times to access the service. This included working in partnership with voluntary sector organisations, investing in early intervention such as the mental health in schools team, developing new teams such as the intensive support team, upskilling staff so more could deliver therapy, successful recruitment into vacant posts and investment into alternative placements for young people rather than hospital admission. Their efforts over the past four years have resulted not only in achieving a no wait list for children and young people to access the service, a decrease in referrals and therefore caseloads for staff but also better outcomes for those who did not meet the criteria to access the service.
- Staff adopted multi-disciplinary working within teams and with external agencies instinctively. Staff worked openly with the voluntary sector, schools, and other local healthcare agencies to actively provide early intervention support for children and young people. Staff ensured that pathways between services were clear and well used. Staff worked within other services to provide training and support for professionals and families.
- Participation was high on this service's agenda. The young people participation group continued to provide a platform for young people to give feedback about the services they received. Young people were involved in the development of services, from choosing furniture to sitting on recruitment panels. Managers had adapted systems to better include the voice of the young person within care records. The service had also set up a parent's participation group which provided advice and support and provided training sessions for parents.
- Equality and diversity were embedded into the culture of the teams. Staff embraced an inclusive culture where requirements for adjustments to the working environment were well thought of ahead of time.
- An annual review of the service's 'jigsaw project,' where young people were offered an alternative placement to hospital, showed a 65% reduction in readmission of young people to acute wards.

Community end of life care

Our findings

- Staff had developed training and safe protocols to allow family members to administer some medicines to help treat common end of life symptoms. This meant that carers did not have to wait for home visits by a nurse or doctor to respond to breakthrough symptoms, which was especially helpful for them during the evening or out of hours. All carers were required to be signed off as competent and had access to an out of hours help line for advice and to inform staff if they had administered the medication.
- Through the services wider programme of quality improvement projects looking specifically at end-of-life care, teams had considered the specific experiences of patient groups and made improvements to the way they worked to better meet these needs. For example, teams noted that patients living with motor neurone diseases were being asked to attend multiple different appointments with specialists across different services and teams, for example SALT (speech and language therapists), Physio etc. This required patients to travel to multiple different clinics. During the covid-19 pandemic staff set up a pilot model for patients with motor neurone disease where they would have one virtual Multi-Disciplinary Team call where professionals across services would dial in to one call. Staff had received good feedback from patients.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

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

Acute mental health services for adults of working age and psychiatric intensive care units

- The trust must ensure that staff attend training that meet the needs of patients. Staff must attend training to manage situations where patients place themselves and others at risk of harm. Staff must be supported through regular individual supervision. Regulation 18
- The trust must ensure repairs are carried out in a timely manner to ensure patients have their care and treatment in an environment that maximises their recovery. Regulation 12
- The trust must ensure risks are assessed and action plans devised on how the risk is to be managed or reduced. Regulation 12

Action the trust SHOULD take to improve:

Acute mental health services for adults of working age and psychiatric intensive care units

- The trust should ensure that activities in Rydon One and Rydon 2 are regular, planned, and meaningful.
- The trust should ensure care planning systems are fully embedded and are holistic
- The trust should consider reviewing staffing levels to ensure patients have their escorted leave as prescribed.

Specialist Community Mental Health Services for Children and Young People

Our findings

- The trust should ensure that managers carry out environmental risk assessments for the clinical areas in which young people are seen. This should include a ligature point risk assessment.
- The trust should consider refurbishment at Priory House in Wells.
- The trust should ensure all supervision is recorded.
- The trust should work with young people in the participation group to make actions more visible to them.
- The trust should consider increasing the capacity for staff to have access to clinical spaces.
- The trust should ensure that all clinical rooms are sound proofed.

Community End of Life Care

- The trust should ensure records kept regarding patient care reflect the level of care delivered.
- The trust should continue work towards increasing local uptake and completion of Treatment Escalation Plan forms to ensure these forms are easily accessible to staff and patients are able to engage with this process if they wish.
- The trust should consider making End of life Care training mandatory for teams that are likely to deliver this care.

Is this organisation well-led?

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

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

With a view towards future integration, the trust had employed a joint Director of Pharmacy with its neighbouring NHS trust. The director of pharmacy reported to the Chief Medical Officer. There were clear lines of accountability and a route to board.

The trust had well embedded clinical leadership. There were two medical directors, one with a lead for mental health and the other with the lead for physical health.

Interviews held with the trust leadership team demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. People were able to speak with insight about the importance and complexities of the work with stakeholders, the development of new models of care and the workforce challenges.

Our findings

The trust board recognised the importance of visiting services in order to understand the challenges they were facing and to inform their assurance work. Executive board members also had a programme of visits, which had continued throughout the pandemic. Systems were in place to ensure that the findings of these visits were shared with the board and that action was taken to address any issues raised by the team that was visited. Most staff commented on the approachability of senior leaders in the trust. They told us they had good access to leaders and felt they had a good understanding of the challenges in their service.

Leadership development opportunities were available for staff who were aspiring to be managers as well as existing managers. During the inspections, we heard many positive examples from staff who had accessed development opportunities.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The strategy sets out the mission 'to deliver outstanding care through a culture of listening, learning and continuous improvement'. The trust had five clinical strategic objectives which had been developed and well embedded throughout the trust. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a clear vision and a set of values which staff understood. The trust vision is 'to be an organisation that gets it right for our patients, carers, colleagues and communities through an inclusive culture of partnership, learning and continuous improvement.' Leaders were well sighted on the ambition of the strategy and there was a focus on aligning the strategy with both local and national priorities.

The director of pharmacy had developed a pharmacy transformation programme to move towards integration of services across Somerset and to improve collaboration. The transformation programme described plans to restructure the pharmacy department to align with the trust service group structure, clinical and operational developments, efficiencies, workforce development, pharmacy department modernisation, digital medicines, aseptic services, and medicines governance. For example, operational actions included improving the quality of medicines information supplied when patients were discharged from services.

The trust was developing its work on population health.

There were already many examples of where the trust was working with partners including the third sector to meet the needs of local communities.

Culture

The leadership demonstrated strong strategic focus, which was values driven. The senior leaders including the non-executive directors were open, compassionate, and approachable. They had worked hard during the pandemic to engage with services in person and remotely.

Throughout the well led review we heard from people about the culture of the trust which was positive, and person centred. Staff felt respected, supported, and valued and told us they felt proud to work for the trust. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development. The trust had an open culture where patients, their families and staff could raise concerns without fear. People and teams were able to speak honestly and reflect on where improvements were needed and how this could be achieved. Freedom to speak up arrangements had been further developed and were well used.

Our findings

The 2021 NHS staff survey indicated that the trust scored better than average when compared to other trusts for indicators relating to morale, opportunities for progression, staff engagement, safe environment (bullying & harassment) and equality diversity and inclusion. 82.5% of colleagues living with disabilities felt that the Trust provided adequate adjustment. However, the trust scored worse than average for indicators relating to appraisal.

The trust had produced a joint WRES annual report and action plan in cooperation with YDH ahead of the planned merger. The data showed that although the trust had scored better than average in most indicators in the staff survey Black and minority ethnic colleagues were reporting significant issues around bullying and harassment and abuse. The trust had taken steps to ensure staff were empowered to speak up, challenge or report incivility and harassment in the workplace. The trust had committed to review SFT and YDH dignity at work / bullying and harassment policies taking the best practice from each trust to create a consistent combined policy and process.

Representation of Black and minority ethnic staff was low in non-clinical roles and varied between different staff groups, reducing in higher band roles. The trust had identified the need for a significant review of recruitment process and practices to ensure inclusive recruitment principles were embedded. The trust had developed and implemented training for recruitment managers to guide them through inclusive practice and bias mitigation strategies, this was being monitored to ensure it was fully embedded throughout the trust. There were actions planned for consultation with staff networks to explore the 2022 staff survey findings.

The board were committed to equality and inclusion. There was an active focus on equality, diversity and inclusion represented at board level. The trust had set itself a goal to become an anti-racist organisation. The trust had continued to recognise the importance of the staff networks, and they had strengthened since the last well led review. There were six staff networks who met regularly; Multicultural Network, Lived Experience Network, Women's Network, Carers' Network, Armed Forces Network and LGBT+ Network. The networks all felt supported by the trust with regular links with the chief executive and executive sponsors. The trust had set up 'conversation café' sessions for each member of executive team to meet with every Network Lead to hear colleague feedback, understand their priorities and challenges.

There were ongoing discussions with the Multicultural Network focusing on what else the trust needed to do to support Black and minority ethnic development into leadership roles.

Pharmacy staff felt supported each other to maintain their wellbeing. Limited workforce meant they often felt pressured, but they had tools in place to prioritise workload. They were supported to have breaks and work flexibly. Pharmacy staff described how the new director of pharmacy had visited different services across the whole trust and ran workshops to understand how people worked and their concerns. Staff felt this created an open environment and provided assurance about ongoing roles and structure. Pharmacy staff were aware of the trust whistleblowing policy, and how to contact the Freedom to Speak Up Guardians.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Board meetings were well led and appropriately structured. The Board was very aware of the need to use part two of the board meeting appropriately. This was mainly used to discuss individual incidents and patient safety.

The trust was organised into six clinical directorates.

Our findings

- Integrated and urgent care – including A&E, minor injuries services, community hospital beds and medical beds at Musgrove Park Hospital
- Mental health and learning disability services
- Primary care and neighbourhoods
- Surgical care
- Clinical support and specialist services
- Families and paediatric care – including Child and Adolescent Mental Health Services (CAMHS) and maternity services.

The trust had devolved governance and leadership arrangements as an essential part of the leadership structure, which they called senior leadership operational management. The committee structure for the trust supported high level board reporting, with lines of accountability and reporting mechanisms which were fit for purpose. There was a method of reporting, debating and challenging safety, risk, effectiveness, practice and performance issues and topics and this fits well with the trust's approach to implementing an organised accountability framework.

The Board Assurance Framework (BAF) for 2022-23 covers most of the required elements, however some of the risk descriptions were not described as risks and there was no clear articulation of target dates for the risks and some of the actions for the mitigation were out of date. The working format is in line with what is needed and is in easy read format. The heat map was a positive addition for board use.

The non-executive directors (NEDS) and executive directors provided high quality, effective leadership. Non-executive board members had a wide range of skills and experience. They all had experience as senior leaders in a range of organisations and brought skills such as a knowledge of finance, organisational development, legal, fire service, research, real estate, human resources, working in partnership and transforming services. The non-executive directors were well supported and provided appropriate challenge to the trust board.

An established medicines governance system was in place with a clear reporting structure. The medicines governance committee (MGC) was a multidisciplinary group chaired by the deputy medical officer and reported to the quality and governance committee, a sub-board group. The drugs and therapeutics committee had primary care, medicines formulary and integrated care board representation in order to decide which new medicines might be suitable for use. The trust had established medicines optimisation groups that reported to MGC.

There were robust arrangements to ensure that the trust discharged its specific powers and duties according to the provisions of the Mental Health Act 1983 (MHA).

The trust continued to have a process in place to manage the investigation of serious incidents.

The trust had robust arrangements for safeguarding adults and children. There was a clear governance structure for reporting to the trust board, with identified leads for child and adult safeguarding. Safeguarding matters were reported to a safeguarding committee, which in turn reported to the quality assurance committee and to board in an annual report. The chief nurse was the executive lead for safeguarding, with a director of safeguarding in post. The merger of YDH and SFT provides the opportunity to create a single Integrated Safeguarding Service. There was a combined team of 40 staff in YDH and SFT who would form the new integrated safeguarding service. From August 2022 a newly created Domestic Abuse lead post and Domestic Abuse Researcher role provided a cross county service.

Our findings

The Safeguarding Service planned to integrate with YDH Safeguarding team from November 2022, six months ahead of the trusts formally merging. This will ensure a single safeguarding service to support health providers including public health and primary care.

Management of risk, issues and performance

The trust was well-informed on areas of risk, and these were clearly articulated by members of the board. Team risk registers fed into directorate risk registers and then into a trust risk register where corporate risks were identified. The risks were all rated and actions to address them were in place. Concerns raised during the inspection correlated with what was on the risk register.

There was a clearly outlined merger strategy and financial benefits focused on corporate service savings of £22m across various directorates. Good engagement and alignment from directorate leads in planning, savings focused on removing duplication rather than cutting resources. Scoping of clinical service synergies and opportunities between Yeovil and Musgrove specialities has commenced, but merger business case does not rely on clinical service savings.

There was a positive system finance approach, leadership, and relationship with the Integrated Care Board (ICB) counterpart. There was an underlying deficit for the system, root causes of which were shared 50/50 between the trust and ICB.

The Chief Finance Officer (CFO) had developed strong joint finance team leadership and governance capabilities in advance of merger with YDH. A robust, inclusive quality impact assessment process was in place with clinical leadership sign-off for cost saving plans.

The CFO as an executive team member was knowledgeable and engaged in the wider organisation participation of Trust values development and supporting current mission and vision development for the merged organisation. The CFO was well supported by experienced non-executive directors (NEDs) at SFT and in joint finance committees from YDH NEDs. Several executive and non-executive directors had NHS finance backgrounds. A proactive approach was taken to achieve flexibility in system capital limits and external funding. Financial governance, culture and understanding was strong across the trust and joint working arrangements had improved financial governance at YDH from a prior inadequate use of resources rating in 2019.

The trust continued to be financially stable and had strong financial expertise among the executives and nonexecutive directors (NEDS).

The organisation had identified that it needed to achieve consistency in governance arrangements post-merger and plans were in place to revisit these.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

It was recognised that medicines safety risks lacked assurance across the trust. A workforce plan was in place to recruit a senior pharmacist to the medicines safety officer role. Pharmacy and medicines optimisation risks were reported on a departmental risk register, with high scoring risks escalated to the trust risk register. Risks were regularly reviewed, and controls implemented to reduce ongoing risk.

Our findings

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The pharmacy transformation programme identified that there was significant fragmentation in the way medicines were prescribed across the trust, with a mix of electronic and paper prescribing being used. Actions were identified to roll out the same electronic prescribing and medicines administration as is deployed in the acute setting to community hospitals and mental health units and used to integrate electronic discharge systems to allow referrals on discharge to community pharmacies.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had worked in partnership to develop the Open Mental Health collaboration with Local Authority, primary care and Voluntary Community and Social Enterprise (VCSE) partners. This model was built on the ethos of person first and 'record once, report light' and was aligned with the ambitions of the Long-Term Plan and Community Mental Health Services (CMHS) Framework. The partnership developed a coproduced Open Mental Health standard operating procedure with combination of traditional pathways and innovative approaches.

Patient engagement was central to the work of the trust. There were good examples of co-production, for example in the specialist community mental health services for children and young people. The trust had worked with people with lived experience to better understand their experience of care when they attend the Emergency Department in mental health distress.

The director of pharmacy engaged with other pharmacy leaders in the system to improve the safety and quality of medicines optimisation in Somerset. Plans included development of a single medication record for the Somerset population with a better interface between primary care and secondary care prescribing systems.

The trust had made a significant contribution through its delivery of the vaccination programme in Somerset, delivering 1.5 million COVID-19 vaccinations as of September 2022.

Large scale engagement was undertaken with staff across both Somerset and Yeovil trusts to establish the vision and mission which will be in place post-merger.

The trust had continued its arrangements to work with trade unions including the joint staff committee. Trade union representatives said they recognised that staff engagement had increased linked to the pandemic and that the trust had worked to be supportive for example with staff who needed to shield.

The trust managed complaints effectively. The complaints process was overseen and managed by a central complaints team. The investigation of complaints was led by appropriate locality managers with support from the central team. Information on how to complain was on the trust website. Information in relation to PALS was also available on the trust website. During our core service inspections, we saw that information on how to make a complaint was available locally.

Our findings

The trust had a complaints policy in place that was recently revised (May 2022). Following some concerns arising from a complaint this policy was reviewed, and the trust commissioned an internal audit of complaints handling. The audits analysis of all complaints raised between 1 September 2021 and 31 May 2022 showed an average response time of 52 days which exceeded the trust's target but was within national guidelines of 60 days. The audit made recommendations around training for investigators, appropriate storage of documentation relating to complaint investigations, monitoring of action plans and re-introducing complaints and concerns workshop which had been paused during the pandemic. The trust had accepted each of these recommendations and had plans to ensure implementation and embedding.

Learning, continuous improvement and innovation

The use of a quality improvement approach was central to the work of the trust. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. The trust carried out Quality Improvement Grand Rounds hosted by executive directors with presentations by staff members. Prior to the pandemic the quality improvement team led approximately 70% of the projects with 30% engagement and support of front-line staff. Now 70% of projects work is done by front-line staff and the quality improvement team offer a support function.

The trust had established a Chief Nurse Research Fellow scheme, which enabled twenty-two registered general and mental health nurses, midwives, and allied health professionals to concentrate on gaining clinical research trials experience and embedding this in clinical practice.

Pharmacy staff across the trust felt that they had good access to development opportunities, although the pharmacy procurement team felt their opportunities to external development were limited currently due to workforce pressures.

The trust had worked in partnership with Somerset Integrated Care System and Bridgwater and Taunton College (University Centre Somerset) to support the college to gain Nursing and Midwifery Council approval to deliver registered nursing degrees. This ground-breaking development had enabled Somerset residents to access career pathways into nursing and was supporting a system wide approach that linked learner numbers to workforce plans.

The trust was awarded the Health Service Journal Mental Health Trust of the Year in November 2021.

The trust was named employer of the year in the English Veterans awards and the Chair of the Armed Forces and Veteran Colleague Network was awarded a role model of the year award and awarded advocate of the year in the Ex-Forces in Business Awards 2022.

The trust was recognised for the support it gives to armed forces communities and awarded The Defence Employer Recognition Scheme (ERS) gold status. To qualify for the gold award, organisations must show that they provide 10 extra paid days leave for reservists, and have supportive HR policies in place for veterans, reserves, cadet force adult volunteers and spouses and partners of those serving in the armed forces.

The trust has Veteran Aware accreditation, is signed up to the Armed Forces Covenant, which promises to ensure that those who serve or have served in the armed forces, and their families, are treated fairly. The trust also pledged to help the armed forces community access careers in the NHS, by signing up to the Step into Health initiative. This provides a dedicated path into an NHS career for all service leavers, reservists, veterans, cadet force adult volunteers and their families.

Our findings

The trust homelessness nursing team was shortlisted for the Royal Society of Public Health (RSPH) 2022 award for 'health and wellbeing'. The team provide healthcare and support for anyone who is homeless in Somerset that has a health need.

The trust maternity team received an extension to their UNICEF gold standard baby-friendly accreditation in June 2022. Baby Friendly accreditation is a nationally recognised mark of quality care for babies and mothers, awarded to organisations that can show evidence that they provide the best possible care for new families. The team is the only NHS trust maternity service in the South West to have the accreditation, which they have held for four years.

The trust was accredited as an international centre of excellence for bariatric surgery for the fourth successive year by the Surgical Review Corporation in 2022.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Outstanding ↑ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Good	Outstanding	Good	Good	Good
Mental health	Good	Good	Good	Good	Good	Good
Community	Requires Improvement	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Outstanding ↑ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Musgrove Park Hospital	Requires improvement Mar 2020	Good Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Overall trust	Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Outstanding ↑ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023

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

Rating for Musgrove Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2020	Good Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Services for children & young people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Critical care	Requires improvement Mar 2020	Good Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
End of life care	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Outpatients and diagnostic imaging	Good Dec 2017	Not rated	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017
Surgery	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Urgent and emergency services	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Maternity	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Overall	Requires improvement Mar 2020	Good Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ↔ Jan 2023	Good ↔ Jan 2023	Good ↔ Jan 2023	Good ↔ Jan 2023	Good ↔ Jan 2023	Good ↔ Jan 2023
Long stay or rehabilitation mental health wards for working age adults	Good Jan 2019	Good Jan 2019	Outstanding Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Wards for older people with mental health problems	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Community-based mental health services of adults of working age	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Mental health crisis services and health-based places of safety	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Specialist community mental health services for children and young people	Good ↑ Jan 2023	Good ↔ Jan 2023	Outstanding ↑ Jan 2023	Outstanding ↑↑ Jan 2023	Good ↑ Jan 2023	Outstanding ↑↑ Jan 2023
Community-based mental health services for older people	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Community mental health services for people with a learning disability or autism	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Outstanding Jun 2017	Good Jun 2017
Child and adolescent mental health wards	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Overall	Good	Good	Good	Good	Good	Good

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

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community end of life care	Good ↑ Jan 2023	Good →← Jan 2023	Good →← Jan 2023	Good →← Jan 2023	Good →← Jan 2023	Good →← Jan 2023
Community health services for adults	Requires improvement Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Community health services for children and young people	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015
Community health inpatient services	Good Jan 2019	Good Jan 2019	Outstanding Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Community dental services	Requires improvement Dec 2015	Good Dec 2015	Outstanding Dec 2015	Requires improvement Dec 2015	Requires improvement Dec 2015	Requires improvement Dec 2015
Overall	Requires Improvement	Good	Outstanding	Good	Good	Good

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

Specialist community mental health services for children and young people

Outstanding ☆ ↑↑

Is the service safe?

Good ● ↑

Our rating of safe improved. We rated it as good.

Safe and clean environments

All clinical premises where patients received care were clean and well equipped. However not all areas were well furnished, well maintained and fit for purpose.

Staff removed or reduced any risks they identified. However, staff did not complete and regularly update risk assessments of all areas where young people were seen. The trust only completed these for inpatient areas. There were blind spots and ligature anchor points in patient areas, and these had not been reviewed in a risk assessment. Staff said they mitigated any risk of harm by not leaving young people alone in a room.

All interview rooms had alarms and staff available to respond. Staff had access to personal alarms which they took into clinics with them. The alarm for these sounded out in the main shared office so others in the team could respond. There were specific rooms at some sites that staff could use with two exits and alarms on the doors if they needed to.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. Equipment was regularly checked and calibrated.

All areas were clean but not all areas were well maintained, well furnished and fit for purpose. Young people from the trust's participation group had recently chosen new furniture for clinical areas at Foundation House. However, some areas at Priory House in Wells were in need of refurbishment and staff stored broken items in some patient areas. The family therapy room in Wells was not fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. An external company carried out the cleaning tasks and staff kept a sign off sheet when areas had been cleaned. Regular cleaning audits were completed.

Staff always followed infection control guidelines, including handwashing.

Staff made sure equipment was well maintained, clean and in working order. All equipment had been PAT tested and relevant equipment calibrated. Fire extinguishers were in date and checked.

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Specialist community mental health services for children and young people

Nursing staff

The service had enough nursing and support staff to keep patients safe. The teams ran with a minimum of 75% cover. There was a duty rota so staff could cover for unexpected absence within the teams. The duty and assessment rotas were produced eight to 12 weeks in advance to include annual leave. The community teams could request support from the enhanced outreach team who could follow up contact within 24 hours. Teams could also access the CAMHS liaison team for support from 8am to 8pm who worked at the two district hospitals covering the county.

The service had reducing vacancy rates. There were also new additionally funded posts out to advert.

The service had low rates of bank and agency nurses. Any agency nurses were long term workers, had completed a full induction and some had fixed term contracts.

The service had reducing turnover rates. They had reduced to 9.8% in August 2022 following some issues with retention earlier on in the year.

Managers supported staff who needed time off for ill health.

Levels of sickness were low.

Managers used a recognised tool to calculate safe staffing levels. Average caseloads were between 15 – 20 in the community teams, with specialised teams having much smaller caseloads and medics having more. Those staff with higher caseloads were due to delays in discharging young people from their caseload.

The number and grade of staff matched the provider's staffing plan.

Medical staff

The service had enough medical staff. Each area had a doctor assigned to their team. Doctors formed part of the multi-disciplinary team and joined assessment discussions with the team.

Managers could use locums when they needed additional support or to cover staff sickness or absence. Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to. Staff accessed support from the children and young people's mental health inpatient unit where there was an on-call psychiatrist every day. The CAMHS liaison service at the two acute hospitals were covered by their consultant psychiatrist who also provided out of hours support.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory training rates were good, averaging 96% across all CAMHS teams. Staff had protected time off shift to complete their training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff completed mandatory and role specific training. Nurses completed additional basic life support training and there was a first aider in each team.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept an up to date training matrix which showed how many staff had completed mandatory and role specific training. Managers received an email three months prior to a staff member's training expiry date.

Specialist community mental health services for children and young people

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Two members of staff met with young people during their initial assessment to complete their risk assessments. Staff recorded their risk screening and risk information on a shared electronic database and also documented risk in the young person's progress notes. Risk assessments were regularly updated; specifically following an incident. Staff received risk assessment training during their induction which prompted staff to record risk consistently.

Staff used a recognised risk assessment tool. Staff recorded safety plans and risk management on a recognised template used for all young people.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. Staff reviewed risks at every appointment and captured the young person's view, documenting how they had been involved in creating a safety plan that met their identified needs. Young people scored and rated their mental health during appointments, along with their satisfaction of the treatment offered. Escalation plans included input from teachers, the police and psychiatrists where they were involved and their contact details.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff recognised when young people felt their mental health was deteriorating by monitoring the rating scales used during appointments. If a young person scored over '2' on their risk screen, staff completed a risk information section to describe the risk in more detail. Staff created personalised multi agency plans for high risk young people, which included a flow chart for all involved such as children's social care, their GP and care staff.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Young people had allocated care co-ordinators and were not on waiting lists, so staff were able to respond promptly when they were aware of a change in risk. Staff reviewed young people on their caseload in caseload zoning discussions through their clinical supervision. For young people who were part of the high intensity user group (HIUG), their safety plan stated what the service would do in an emergency, along with what the police and the emergency services would do. This was all agreed in HIUG multi-agency meetings held with the involvement of the emergency department, CAMHS services, police and ambulance services.

Staff followed clear personal safety protocols, including for lone working. Staff followed the trust's lone working policy. Staff completed a form which detailed their personal. Staff made contact with their managers when they finished appointments. Staff operated a buddy system to check in with each other. Reception staff followed this up if a buddy was not in. The lone working policy with up to date contact details was recirculated when a new member of staff joined the team. Duty responsibilities were always carried out in pairs.

Specialist community mental health services for children and young people

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams were supported by the Trusts' integrated safeguarding service.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff also received three monthly safeguarding supervision.

Staff kept up to date with their safeguarding training. Staff were up to date with all levels of safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff clearly documented if they were supporting a looked after child, and how to safeguard them from potential risks.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The trust's safeguarding team reviewed every under 18 admission to the emergency department. Triage nurses flagged any safeguarding issues with the trust's safeguarding team, which was then reviewed by CAMHS and the paediatric team. The trust's participation group ran safeguarding awareness sessions with the young people who attended the group.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust's safeguarding team quality assured all safeguarding referrals and supported staff with the process of referral to children's social care. The teams worked with the looked after children teams in their area.

Managers took part in serious case reviews and made changes based on the outcomes. Team managers attended multi agency complex case panels and safeguarding assessment meetings. Learning from these panels was disseminated to team meetings via regional business meetings.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Staff recorded patient information on a shared electronic database. Any personalised paper documents were uploaded onto the same system then destroyed.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff used log in cards to access some systems and had personal usernames and passwords to access patient information on the shared electronic database. There was an audit trail on the database which showed the name of each person looking at the record and what activity had been carried out.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Specialist community mental health services for children and young people

Staff followed systems and processes to prescribe medicines safely. Staff stored prescriptions in safes held within clinical rooms. Before prescribing medication, staff had initial conversations with young people about exploring therapy and other non-pharmacological approaches and explained their choices in line with NICE guidance.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff gave young people and families information leaflets about their medication and sought consent. Staff explained dose titration and timelines, side effects and discussed any risks and benefits with young people and their families. There was evidence in young people's care plans that medical staff had regularly reviewed their medication.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Medicine reviews were included in the transitional process between children and adult services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed young people's medication in multi-disciplinary team meetings, with advice and guidance from their responsible clinician.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff used feedback from schools and families to see how clinical symptoms were being managed to deliver the most effective dose. Staff monitored young people's physical health as they grew and developed.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff reported all incidents on a centralised electronic system.

Staff raised concerns and reported incidents and near misses in line with trust policy. Every time a child attended the emergency department, staff documented an incident report which was reviewed by the CAMHS team.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff felt well supported by their managers following an incident and said they were always available to debrief. The team's psychologists and psychiatrist often led on team debriefs following an incident.

Specialist community mental health services for children and young people

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers had oversight of all incidents and reviewed all actions with staff during supervision. Incident reviews were often multi agency; involving the families involved, the police, the ambulance service and social services.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff reviewed incidents during business meetings as part of a rolling agenda and these were fed back to teams in their area team meetings. Learning from national events was cascaded across teams.

Staff met to discuss the feedback and look at improvements to patient care. As some incidents related to delays in discharge, staff met regularly to review each person's progress and if they could be safely discharged.

There was evidence that changes had been made as a result of feedback. Staff took part in a reflective session about an incident at one of the community hospitals which involved some complex young people. Staff asked young people for feedback about the incident and a sensory room was developed as a result. The young people involved gave feedback to the staff about how they responded to the incident.

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans, and most were updated when needed. Most care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. Parents and carers were involved in these assessments where appropriate, if the child was younger or not able to engage fully in the assessment. Parents and carers were encouraged to regularly review their children using 'antecedent, behaviour and consequences' (ABC) charts, to contribute to the young person's assessment.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Staff identified any physical health issues during the young person's initial assessment and followed these up with the relevant teams, such as tissue viability nurses or epilepsy nurses. There was an alert on the front page of a young person's care plan which alerted staff to any physical health safety issues. Medical staff led regular team review meetings to explain to the team what physical health signs they should be seeing in young people following treatment and to suggest why they were perhaps deteriorating. Medical staff explained any physical health side effects from medication.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Young people and staff developed care plans for any area of concern. Some young people had several different care plans which related to the treatment they were receiving, such as an eating disorders care plan, a personal safety plan, a plan of education and transition to college and an outreach care plan. Staff also worked with young people and their families to complete positive behaviour support plans.

Specialist community mental health services for children and young people

Staff regularly reviewed and updated care plans when patients' needs changed. Teams reviewed young people on their caseload in weekly team meetings. These were well attended by the whole team and by the medical staff for the team.

Not all care plans were personalised, holistic and recovery orientated. Most young people had an 'all about me' care plan, written by them then scanned and uploaded onto the shared electronic database. Most safety plans were visual, included photographs of those involved and were written with the young person or their families. However, some young people using the eating disorders service had a comprehensive initial plan but as the ongoing care plan was attached to the bottom of a letter, these were not easily reviewed and updated, and they were not young person friendly.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff often completed cognitive assessments through play and recorded feedback from monitoring expressions and interactions. Staff used 'Theraplay', a child and family therapy recognised by the Association of Play Therapy. Theraplay was used by staff to support healthy child and parent attachment. Staff were also trained to provide cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), eye movement desensitisation and reprocessing (EMDR) therapy and family therapy, amongst other more specialised therapies.

Staff delivered care in line with best practice and national guidance. Staff were aware of the recent changes in scoring risk and responding to self-harm published by the National Institute for Health and Care Excellence (NICE). Staff followed other NICE guidance for supporting young people and received training in line with NICE guidance. Other best practise guidelines were identified in operational management meetings, then fed into business meetings. The CAMHS liaison team had created a national group across the country, with plans to set up a CAMHS liaison network team. This meant leads could share best practise across regional areas of the country.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Staff were trained to complete physical observations and when needed, had support from the eating disorders team and paediatric colleagues at the local community hospitals. Staff could ask for support from the on-call paediatrician. Staff reviewed joint cases with the paediatric ward during weekly meetings. Staff worked alongside school nurses and GPs when assessing any physical observations.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Staff supported young people to better understand sleep and sleep hygiene. They asked young people about what they thought contributed to a good night's sleep and make their own plans to improve their sleeping habits.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Staff sent out nationally recognised rating scales to young people and their families prior to their initial assessment. Staff recorded the outcomes from therapy such as cognitive behavioural therapy every six to twelve sessions. Young people and their families rated their satisfaction with their treatment outcomes during sessions with their therapist.

Staff used technology to support patients. Staff used a messaging service to connect with young people and were able to send videos, memes and accessible information via this popular platform.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service had a clinical audit record of all audits completed year by year. In the past year, staff had audited personalised care planning, risk and prescribing for ADHD. Managers dip sampled cases during staff supervision. The trust's participation group were running a project with psychologists for young people who had been open to the team for more than 12 months to improve services. The mental health in schools team involved young people in audits of their school. Whole school feedback was being developed as a result.

Managers used results from audits to make improvements. Staff audited care records monthly on the shared electronic database in collaboration with assistant psychologists. The results were fed back to staff in team meetings.

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The teams comprised psychologists, art therapists, family therapists, psychotherapists, consultant psychiatrists, speciality doctors, social workers, registered nurses, paediatric nurses and family support workers.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The trust had set up a cognitive behavioural therapy trainee programme on a yearly basis and dialectical behaviour therapy training was also available each year. Staff had additional training in EMDR and positive support plan training.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Staff received an appraisal every year according to their start date. All appraisals were recorded on a shared system which staff accessed through the main intranet.

Managers supported staff through regular, constructive clinical supervision of their work. There were some gaps in recording of supervision, but staff told us they were happening regularly. Staff said they received clinical caseload supervision and management supervision separately. Supervisions were booked into managers' calendars for the rest of the year. Staff received additional safeguarding supervision every three months and peer supervision on an ad hoc basis.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff attended face to face multidisciplinary meetings every month. Staff also had the opportunity to attend monthly business meetings which included a standard agenda that mirrored the operational meeting agenda.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had protected time off rota to complete any training. Staff were offered bespoke training in family therapy, eating disorders, risk management and suicide prevention training.

Specialist community mental health services for children and young people

Managers made sure staff received any specialist training for their role. Specialist teams delivered training to the other parts of the CAMHS services, so they shared knowledge and expertise with each other. All staff were given regular opportunities to receive training in CBT, DBT, EMDR and family therapy. Staff had training in learning disabilities and positive behaviour support from the British Institute of Learning Disabilities.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers followed a trust policy around absenteeism and poor performance and carried out full investigations into any disciplinary matters.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The enhanced outreach team held daily handover meetings. Every week, the whole MDT attended virtual case discussions for which staff could add young people to the agenda ahead of time. During team meetings staff contributed to a continuous professional development slot where they held reflective discussions around recent training completed.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Care reviews took place every three months as part of a multi-disciplinary team meeting which children and their families attended. When young people approached the age of 18, staff supported them to access 'Connect 18'; a service that bridged CAMHS services and adult community mental health teams. Staff continued therapy with young people until their sessions were completed so they did not lose any continuity in their treatment. Planning for a young person' transition into adult services started six months before their 18th birthday and most of the planning was completed three months before they moved over. Staff took part in monthly transition meetings, which included 'Connect 18', staff from the CMHT and mental health team managers who made decisions for the team.

Staff had effective working relationships with other teams in the organisation. Community CAMHS teams had positive working relationships with each other, and included the intensive support, outreach, eating disorders, Deaf services, forensic and mental health in schools teams. They all worked together effectively to achieve the best outcomes for young people. Pathways between the acute hospitals and CAMHS services were well developed and well used. Staff delivered training to other teams such as emergency department staff and paediatric colleagues. Every three months the CAMHS liaison team rolled out CAMHS specific training so when new doctors were appointed at the hospital, they received this training as part of their induction.

Staff had effective working relationships with external teams and organisations. Teams had developed excellent working relationships with schools and social workers. Where young people were struggling in mainstream school, the teams worked with the school, families and social workers to open up the communication and find the most suitable pathway for that young person. Staff ran clinics within schools so that pupils did not have to miss more than they needed to for an appointment. Staff working within schools provided training and support to teachers. Staff met regularly with teachers to discuss children on their caseload or run through assessments together. The mental health in schools team worked with early mental health practitioners who worked within schools, were employed by a local voluntary, community and social enterprise provider but supervised by the CAMHS team.

Effective working relationships with other services meant the teams had been able to reduce their caseloads. For example, in order for the service to reduce wait times and increase capacity to see children with an eating disorder, they commissioned an early intervention service (the Somerset and Wessex eating disorder team (SWEDA). By working together, their volume of work was shared and by allocating work in early intervention to SWEDA, CAMHS staff were able to prioritise young people needing high intensity support more effectively.

CAMHS staff met regularly with the provider collaborative to work together to support young people who were admitted to hospital.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff could access the contact details for the trust's MHA administrator team on their intranet.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff had access to support from a Mental Health Act administrator team comprising a MHA administrator manager, a MHA team co-ordinator and three MHA administrators.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Paperwork relating to patients' Sections were present, up to date and recorded clearly in their care plans.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed. There was evidence of Section 117 aftercare in place for those young people who had been discharged back to their local area.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff requiring Mental Capacity Act Level 2 training had received this training and were up to date.

Specialist community mental health services for children and young people

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff included the young person's view in their own words when documenting their consent.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff recorded a young person's consent and capacity on the front screen of their shared electronic record. This was updated every three months.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Young people subject to a Deprivation of Liberty Safeguard (DoLS) had their views documented clearly within the document, including where wanted their safe location to be. Any restrictions under the DoLS were clearly documented and included specifics such as access to a smart phone.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Updates on the Mental Capacity Act were embedded into operational business meeting minutes then forwarded to staff by email.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Staff shared learning about young people who were Gillick competent during team meetings.

Staff knew how to apply the Mental Capacity Act to patients aged 16 and 18 and where to get information and support on this.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Young people said that staff were absolutely amazing, compassionate, kind and helpful. Young people said that communication was good, and they could get through to the team via phone, email or text.

Staff gave patients help, emotional support and advice when they needed it. Parents and carers said the team were supportive, reassuring, kind and caring.

Specialist community mental health services for children and young people

Staff supported patients to understand and manage their own care treatment or condition. Staff used easy read information to help young people understand their treatment, such as 'the neurodivergent friendly workbook of DBT skills'. Staff offered training courses to parents so they could develop strategies to protect their child at home. The parent forum had recently run a 10 week course on learning about self-harm.

Staff directed patients to other services and supported them to access those services if they needed help. Parents and carers said that communication from the teams was great, and they had a very open dialogue with staff. Parents said the service they received from the outreach team was outstanding and very specialised.

Patients said staff treated them well and behaved kindly. Patients felt fully involved in their care and confirmed they received copies of their written care plans regularly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Young people said that staff respected confidentiality and did not share information with people if they had asked them not to.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. Parents and carers said that care plans were completed together as a family, and they received a written copy regularly.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff had a one page profile document called 'about me' which detailed the likes and preferences of the staff member that they shared with young people before working with them.

Staff involved patients in decisions about the service, when appropriate. Young people were present on interview panels when recruiting new staff for their services. Young people said they would like to see more visible outcomes from the actions agreed in their participation group.

Some young people and parents or carers from CAMHS helped to co-produce a neurodevelopmental pathway. This was run by the paediatric community service and implemented in 2021. This pathway was part of the emotional health and wellbeing offer to meet the needs of children and young people. It facilitated timely triage and assessment of children and young people presenting with possible autism and attention deficit hyperactivity disorder (ADHD.)

Patients could give feedback on the service and their treatment and staff supported them to do this. The service had set up a young people's participation group which had been running successfully for a number of years. The group met fortnightly in the evenings.

Specialist community mental health services for children and young people

The young people participation group continued to provide a platform for young people to give feedback about the services they received. Young people were involved in the development of services, from choosing furniture to sitting on recruitment panels. Managers had adapted systems to better include the voice of the young person within care records.

Services that were commissioned by NHS England sent a monthly commissioning report to them which included feedback from young people, parents and carers and any learning from incidents.

Staff supported patients to make advanced decisions on their care. Young people had written letters to be shared with other young people about to start treatment about their experiences. This gave a first-hand account of what to expect from young person to young person. Following attendance at the young people's participation group, some had gone on to volunteer with the trust and some were now in paid employment.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff supported, informed and involved families or carers. Parents and carers said that staff always made sure they knew what was going on. Parents said that they could call the teams anytime and they always received a call back if they were unable to respond straight away. Parents were involved in their child's care and treatment from the start and were invited to regular reviews and follow up appointments.

Staff helped families to give feedback on the service. The service had set up a parents' participation group which ran monthly. The participation group provided advice and support and provided training sessions for parents.

Teams sent out forms which requested feedback about the parent's experience of the service. The feedback from these forms were sent to care coordinators who then shared feedback in team meetings. Parents and carers said that staff always asked them what they thought about the treatment their child received. They asked if parents and carers had any suggestions. Parents and carers said they felt at ease about raising any issues. Parents and carers said they felt heard and seen. They said that staff listened really well and valued their options.

Staff gave carers information on how to find the carer's assessment. Parents and carers could attend the participation group for advice and support. Parents and carers said staff regularly asked them if they needed any extra support.

Is the service responsive?

Outstanding ☆ ↑↑

Our rating of responsive improved. We rated it as outstanding.

Access and waiting times

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. The involvement of other organisations and the local community was integral to how services were planned and ensured that services met young people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for young people with multiple and complex needs. Young people could access services in a way and at a time that suited them.

Specialist community mental health services for children and young people

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. Pathways for children accessing the CAMHS services were well established and well used. Children and young people who were referred into the service were triaged by the trust's single point of access (SPA) team. From their first appointment, young people were allocated a care co-ordinator and booked into an appointment. Young people were seen within two to three weeks for specialist therapy. Teams met every fortnight to allocate young people a care co-ordinator.

Schools signed a contract with the mental health in schools team to clarify what the team could offer the school and what they expected from them, such as space to provide therapy and regular meetings regarding the children receiving a service. With this service, the schools held a 'consideration list' of the children they thought would benefit from low level CBT, then when the service had availability, they worked with the school's mental health lead to allocate an appointment.

The single point of access team saw approximately 300 young people referred per month. They held a live spreadsheet that they monitored throughout the day for new referrals. This spreadsheet was colour coded to identify risk (RAG rated). The SPA admin and clinicians worked effectively to screen and action a referral on the same day it came in. There was no wait for a triage assessment.

The service met trust target times for seeing patients from referral to assessment and assessment to treatment. There was no wait list to access CAMHS services. The trust had made changes since their last inspection to reduce wait times and caseloads. They had achieved this by filling vacant roles, appointing assistant psychologists to the triage and early advice roles and by working with the voluntary sector to take on early intervention and low risk work, thereby decreasing referral numbers. The service had only breached the trust expected target times for seeing patients for assessments or for treatment when there was an influx of young people referred in by schools at one time at the end of term last year. The single point of access team worked closely with the voluntary sector to establish a joint referral system and were working on establishing a self-referral system for children over the age of 13. Staff discussed discharge plans for young people during their weekly team meetings when each young person on the caseload was reviewed. The eating disorders team had the lowest rate of admission in the country.

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. The times recorded for young people to be seen by Somerset CAMHS services were lower than the national average. Young people were seen quickly and by the relevant team, such as the intensive treatment team or the ADHD team. ADHD patients were transferred in with a request for medication, had an appointment booked with a follow up appointment booked in with the psychiatrist. Emergency referrals for the eating disorder service were seen on the same day. Urgent cases were seen within seven days and routine appointments were offered within four weeks. Referrals for the CAMHS Liaison Service were seen on the same day, usually within the hour. Staff recorded the time of the patient's arrival, time of their assessment and treatment from start to end.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. The service had a mental health in schools team, an early intervention service whose aim was to include young people and their families in awareness around mental health and to provide training in schools for teachers. The team worked in most secondary schools and some feeder primary schools in Somerset. They provided low intensity cognitive behavioural therapy for children who had been identified by teachers as potentially benefiting from this treatment. There were also whole school practitioners in the teams who looked at the whole school ethos around mental health and delivered assemblies and staff training sessions and a parenting group. The support teams aim to improve the access to emotional and mental health support to children and young people within school settings. These services

were for young people with low to moderate level needs, for example anxiety, phobias, behavioural issues and low mood, with 75 schools now supported. The decision for which schools should be served by the teams was based on deprivation indices, prevalence of referrals into CAMHS and schools that were linked to pupil referral units. Tier two plus services were also put into place to provide support to those schools not covered by the mental health support teams.

Staff tried to contact people who did not attend appointments and offer support. Staff adopted a flexible and individual approach to young people who did not attend appointments. Staff adapted their communication and sent photos or texts. Staff followed a standard operating procedure for young people who did not attend appointments. If there was an imminent risk to the young person, staff contacted the intensive treatment team or the enhanced outreach team to contact them on the same day with the aim of avoiding hospital admission.

Patients had some flexibility and choice in the appointment times available. Patients could choose to be seen at clinics near to where they lived. Staff offered home visits where necessary and offered virtual appointments if required.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible.

Appointments ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists and support patients. Managers held a live spreadsheet which showed any new referrals, their referral date and the trust target time for seeing young people. Managers reviewed referrals regularly which informed them where they could be more responsive. From reviewing recent information, managers had learnt that they had previously not picked up on some important information at a young person's initial assessment. As a result, they introduced assistant psychologists to work with the single point of access team and were then able to decide more accurately if a young person needed to be seen urgently or if they required a routine appointment.

The service was introducing the keyworker project which was part of a national programme to improve the care for young people with a learning disability or Autism who were at risk of admission to hospital or out of area residential education placements. The service had purchased a property, to offer a safe, more homely environment for assessment and support plans to be implemented. The provider had developed this service following feedback from young people and families who had been inappropriately placed in 136 suites and paediatric hospitals.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Staff ran a specific transition service for young people approaching the age of 18. Staff ran monthly transition meetings where CAMHS and CMHT staff attended with invites for another professionals, parents and carers. If using the CAMHS Liaison service, young people stayed on their caseload for seven days. However, they were not discharged without a follow up appointment arranged by the team. Staff supported young people with a 'collaborative care plan from CAMHS discharge' which they developed with the young person's input. This was developed after the service received feedback that some young people were unhappy with the process. The plan identified young people's preferences and goals for transfer.

The service followed national standards for transfer. Staff started the transition process with young people three months before they moved over to other services. Staff followed a transitioning flow chart as there was a different referral processes for adult services which the flowchart helped streamline.

Specialist community mental health services for children and young people

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, but not always their privacy and dignity.

The service did not have a full range of rooms and equipment to support treatment and care. There were not always enough rooms available for staff to meet with young people. Staff said that booking rooms was sometimes problematic and inconsistent. Some therapies were unable to be carried out as the room was needed for a clinical appointment. The service had plans in place to address this issue which included building work to expand one of the main sites.

Not all interview rooms in the service had sound proofing to protect privacy and confidentiality. The service was aware of this issue and soundproofing all rooms was included in the building work plans.

Meeting the needs of all people who use the service

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included young people who were in vulnerable circumstances or who had complex needs.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The awareness to make adjustments for people who needed it was engrained in the CAMHS team's culture.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff provided information in various formats to young people in a way that they could understand.

The service provided information in a variety of accessible formats so the patients could understand more easily. Letters written to Deaf young people were accessible, using icons and visual plans. Staff recorded signed care plans in British Sign Language for Deaf young people or their families. Staff created a superhero care plan for one young person who was more responsive and involved in their plan as a result. Staff created easy read versions of reports for young people that required this.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get hold of interpreters or signers when needed. The trust supported Deaf staff to access interpreters so that their working environment was inclusive. Staff made sure interpreters were present for all appointments that involved Deaf families.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Staff sent out leaflets about how to complain to families and young people. These contained a choice of contact details for them to contact.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. All complaints went directly to the head of services then were allocated out to service managers. Managers reviewed clinical records and carried out investigations where required.

Specialist community mental health services for children and young people

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared learning from complaints during team meetings and team away days. Staff shared learning about having difficult conversations with families when the young person receiving treatment did not want them involved in their care. They shared learning about appropriate referrals to other services and picking up on safeguarding concerns.

The service used compliments to learn, celebrate success and improve the quality of care. Staff celebrated achievements in their team meetings. This included compliments for the staff or qualifications achieved by staff.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Team leaders had experienced achievable progressive routes through to management roles. Team leaders had opportunities for career progression and continued leadership and management learning opportunities.

They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Staff said that the senior leadership team had achieved an effective balance working together and were readily available, whether on-site or by phone or email. Staff said that there was a healthy and diplomatic leadership in place. Staff gave consistent positive feedback about their senior leadership team. Team managers had access to the senior leadership diaries, so they knew where they were every day. Team managers reflected that the senior leadership team had been a constant source of support during what had been pressured times throughout the pandemic.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team. The trust's vision and values were available for all staff on the intranet. The CAMHS vision following their last inspection was to break the cycle of waiting list management and caseload reallocations in order to deliver higher quality outcomes for young people and their families and for staff delivering those services. CAMHS teams worked together to enhance the single point of access pathway, shorten the gaps between assessment and treatment, ensure that the most appropriate therapy was offered to young people and reduce the admission of young people to out of area placements.

Culture

Staff felt respected, supported and valued. Staff felt that the CAMHS teams were cohesive and stable. Staff said they supported each other well and different teams learnt from each other and shared knowledge. Staff went out on team

away days for group learning and development and to focus on their wellbeing. Staff had a choice of activities they could take part in and the whole team were included. Key professionals were invited to deliver talks and training. Teams were passionate and forward thinking and held responsibility for young people together and across each other's teams, so they did not work in silos.

They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Managers supported staff to utilise their Access to Work budgets to ensure they had the same opportunities as their peers and to ensure budgets were used fairly amongst the team. Staff were empowered to share their knowledge and expertise by delivering training sessions for others in their speciality.

They could raise any concerns without fear. Staff were aware that there was a speak up guardian who they could raise concerns with. Staff said they would not hesitate to approach the senior leadership team with any concerns.

Governance

Governance processes operated effectively at team level and performance and risk were managed well.

CAMHS managers had successfully pursued investment opportunities to provide alternative placements for children to hospital admission. The teams collaborated with the voluntary sector, acute hospitals and early intervention teams to provide shared pathways for young people requiring help. This included the establishment of a county wide neurodevelopmental service for Autism and ADHD. They developed a new intensive treatment team for young people requiring more support and enhanced the CAMHS liaison service to support those needing assessments in hospital. The service had established the mental health in schools team to work within schools and offer early intervention work to young people. The trust had significantly invested in staff development and training in order to keep and attract new staff into the teams.

Managers held a live dashboard that showed referral to assessment and treatment times with the trust's expected target date next to the actual date seen. If an appointment was not immediately available for a young person, they stayed on the manager's caseload until an appointment became available. This ensured the young person was not lost on a waiting list.

Managers created a monthly assurance report that was reviewed in operational meetings. There were two steering groups for CAMHS liaison who analysed monthly data reports and any trends.

The clinical portal on the shared electronic database showed when assessments were due and were RAG rated for ease of visibility. The clinical portal showed managers when care plans and risk assessments were last updated, all family contact and when outcome tools such as routine outcome monitoring (ROMS) and revised children's anxiety and depression scale (RCADS) questionnaires were last completed. It showed information reports around the single point of access dashboard, caseload management, referrals, discharges and pathways. Managers held conversations around updating information with individual clinicians during their supervision.

Managers also completed a dashboard which meant that core patient information was made available to young people's GPs and the local authority. This pulled through onto the shared electronic database.

Managers had autonomy over recruitment. They met with the senior leadership team to discuss increases in demand and creating the right balance. Managers attended budget meetings. There was a flex in team budgets to suit the teams.

Specialist community mental health services for children and young people

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Team managers had developed an action plan to address their requirement notices from the last inspection. To improve risk documentation, managers had developed an information screen on the trust's electronic database so they could identify any gaps in recording. This audit tool included a trust wide review of risk recording. They introduced a system where the outcome of young people's assessments could be immediately shared with their GP. They also increased supervision options and held a quality improvement event focussed on risk assessments for all staff.

To address the requirement notice around the waiting list for assessment in the east CAMHS teams, managers introduced a daily waiting list triage system to ensure the safety of those young people. They implemented an emergency waiting list and caseload review process which included senior staff supporting clinicians with discharges and workload management. They established regular referral meetings between the SPA and community teams to enable a consistent approach to referral thresholds. They increased the frequency of MDT assessment clinics to address the waiting list. They worked to offer young people an immediate intervention rather than be placed on a waiting list and had successful recruitment in the east team. The trust invested heavily in upskilling staff so they could provide a greater range of interventions for young people, therefore reducing the wait times for therapy.

To address the requirement around ensuring complaints were logged, investigated and responded to, the team worked closely with the trust's patient and liaison service (PALS) to improve communication between the services and established a process for logging, investigating and responding to all complaints. Complaints were put on the rolling agenda for all operational management meetings.

To address the requirement notice around having effective systems in place to assess, monitor and improve clinical records, the service held quality improvement events, which were co-produced with young people who shared their experience around ideas to improve care plans. The service introduced a new function called 'dialogue plus' to better capture the views of young people and incorporate them into their care plan.

Managers submitted any risks onto a service wide risk register. Staff submitted risks to their managers through monthly operational meetings. Each service was reviewed during these meetings. Managers had reduced all risks on the register to a 'green' status.

Managers had the autonomy to complete maintenance tasks ahead of when they were scheduled in by the trust's estates team.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

There were some issues with duplication of work between the mental health in schools team and the early mental health practitioners (EMHPs) as they used two separate systems. To mitigate this risk, the charity that supported the EMHPs had employed someone to support the data sharing between the two services.

Engagement

Specialist community mental health services for children and young people

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. CAMHS teams worked with schools and local authorities to provide treatment to young people known to these services, but also train and educate the staff. Interventions continued throughout the school holidays so young people did not experience interruptions with their care. Teams worked with schools to use their spaces for clinical work. The teams worked together to set up pupil referral units in each area. CAMHS teams had developed and maintained positive working relationships with the local authority, the voluntary sector, children's social care, special educational needs teams, family intervention services, mental health support services and safeguarding teams.

Managers from the service participated actively in the work of the local transforming care partnership. The trust sent out consultations for all staff on the upcoming merger of services with the acute hospitals and enabled a voting system for staff to use to recognise their feedback.

Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. CAMHS teams enabled a series of away days with other organisations they worked with, such as SWEDA and their commissioners to review specific cases, look at the views of young people and set up a partnership approach with referrals and data sharing. This enabled the process of young people moving between services easily.

The trust's participation group met regularly to discuss any organisational themes coming up. A representative from the participation group was invited to be a member of the panel on all interviews.

There were local protocols for joint working between agencies involved in the care of children and young people.

Learning, continuous improvement and innovation

The National Deaf CAMHS team had researched the effects of the pandemic on the Deaf population using their services. It showed that Deaf children had increased anxiety, low mood and anger, and that they were stressed about wearing face masks. They also found that using a virtual platform enabled the service to respond more effectively to families in a way they could not do before due to the large geographical area the service covered.

A voluntary sector organisation had been commissioned to work with the CAMHS team to develop a project in Somerset called 'the jigsaw project', which was attached to the CAMHS liaison team. This project was developed following a review of frequent attenders to the emergency department who had not met the criteria for CAMHS. The result was a reduction in readmission rates for young people into hospital. In the service's annual report, they were able to show a reduction in readmission of 65%, despite the CAMHS liaison team having an approximate increase of 20% at the same time. The project received positive feedback from the young people using the service and their parents and carers.

Community end of life care

Good ➔➔

Is the service safe?

Good ➔

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust's end of life care service was part of a wider integrated model provided in collaboration with different services and providers. We only reviewed data for staff employed by the trust whose main role was related to the delivery of end-of-life care. This included the End-of-Life Care Coordination team, the Palliative Care Consultants and the End-of-life Education team.

Staff within these teams completed mandatory training. The training met the needs of patients and staff.

End of life care training was available but was not mandatory for staff. Teams delivering end of life care across the trust, for example the District Nursing team, completed additional training to ensure they delivered the service safely. This included safe management of syringe drivers.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff completed training on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns, for example suspected financial abuse.

Infection control, equipment and environment

Staff ensured the care delivery environment, whether ward based or in the community, was safe. Staff followed good infection control procedures.

Both wards we visited were clean and had suitable furnishings which were well-maintained. In the community staff also ensured the care delivery environment was clean. Staff followed good infection control principles including the use of personal protective equipment (PPE).

Following a person's death, staff followed protocols to manage the patient's body and infection control risks safely and sensitively.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff in the community carried out daily safety checks of specialist equipment in patients' homes.

The service had enough suitable equipment to help them to safely care for patients. Specialist equipment was well maintained, and staff were trained to use equipment. This included syringe drivers, teams maintained a log of serial numbers to ensure they knew which model was in place. Where patients required access to additional equipment in their homes for example stand aids and air mattresses, staff worked together to ensure this was in place.

Staff disposed of clinical waste safely.

Staff were aware of the provider's guidelines and followed safe working practices if required to carry out lone working.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks where possible. Risk assessments considered patients who were deteriorating and in the last days of their life.

Staff knew about and managed each patients' individual risks well, this included risk of falls, pressure ulcers and malnutrition.

Staff completed risk assessments for each patient, using recognised tools, and reviewed this regularly. For example, staff used the 'Waterlow Scale' to monitor the risk of pressure ulcers developing for service users with lower mobility.

Staff identified patients who were deteriorating and took action to respond to their changing needs quickly. The End-of-life Care Coordination Centre worked with local social care providers to ensure patients could access additional services to meet their changing needs such as personal care and nutrition.

The trust's rapid response team worked closely with the district nursing team to provided additional support where patient's needs changed suddenly. For example if a patient required rapid transfer from an acute hospital to ensure they could die at home, if this was their preferred place of death.

Staff had access to specialist support if they were concerned about a patient's mental health. We saw examples which included arranging psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. Daily and weekly calls across different teams took place to review patients care and treatment and identify where patients may be approaching the last days of their life.

Staff had access to specialist end of life care advice and support out of hours. The service always had a consultant on call during evenings and weekends. Staff said they could access medical advice whenever they needed it.

Staffing

The service had enough staff, including health care assistants, nurses and doctors, to provide safe care and treatment.

As with mandatory training, we only reviewed data on staffing within teams whose main role was related to the delivery of end-of-life care. This included the End-of-Life Care Coordination team and the palliative care consultants.

Across these teams there was a low turnover of staff. Sickness and vacancy rates were also relatively low.

Staff could access other specialist staff including occupational therapists and physiotherapists when needed. In the community, this was often through the trust's rapid response team.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up to date. However, some details were not always recorded clearly or easily accessible.

We reviewed records relating to the care and treatment of 11 patients.

The records we reviewed for patients receiving care in community hospital were comprehensive and staff could access them easily. Patients had up to date care plans in place to meet all their individual needs. This was an improvement since our last inspection where we found some records on wards had been incomplete.

In the community, records were kept across electronic and paper copies. For example, some paper copies of notes were left in patients' homes. Others were accessed via an electronic record keeping system. In some teams a new secure mobile phone app had been introduced to help staff manage appointments and records whilst working remotely in the community.

The level of detail in patient records varied between different teams. In the district nursing team, some records were not as detailed as others and did not always capture the level of care nurses had delivered during their visits. For example, pain assessment forms were available but were not always being used or completed in full. However, we observed that staff were assessing pain whilst delivering care and manged this well.

In four records we reviewed it was unclear if patients had treatment escalation plan in place. The Treatment Escalation Plans formed part of the advanced care planning process and were used to help patients, families and health care professionals plan emergency care and treatment. This includes decisions about whether resuscitation should be attempted. The trust had worked with other local organisations and had introduced a county wide Treatment Escalation Plan referred to as STEP (Somerset Treatment Escalation Plan).

Leaders and managers were aware of some challenges in staff accessing STEP forms remotely and that completion of STEP forms and advance care plans did not always happen across the county. They had clear plans to ensure STEP forms were more accessible to staff across the different services in the integrated care model. This included the introduction of a STEP facilitator role and aspirations to embed new digital technology so people and staff could access these plans electronically. The team monitored the progress and were seeing increasing numbers of advance care plans (STEPs) being completed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers. This included information about how medicines such as opioids and fentanyl patches may be used as part of a patient's end of life care.

Community end of life care

Processes were in place to ensure patients had access to prescribed medicines to manage sudden changes in their symptoms, sometimes referred to as 'breakthrough medication'. This meant patients and families could relieve common symptoms associated with end of life without having to wait for home visits by a nurse of doctor. This was especially helpful for patients experiencing these symptoms out of hours or who lived in secluded rural locations that were not easily accessible to staff.

The trust had also introduced training for family members and carers in the community to administer some types of medicines in patients own homes when needed. To ensure that this was done safely, the trust had developed clear protocols that ensured patients consented, families or carers received training and that the trust was informed. Before administering any medication families and/or carers had to be signed off as competent by a member of the district nursing team. A dedicated helpline was in place for families and carers to access 24 hours a day.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. In patients' homes, staff worked with patients, their families and local pharmacies to ensure medicines was delivered and stored securely.

Incidents

The service managed incidents well.

Staff recognised and reported incidents and near misses. Staff knew what incidents to report and how to report them. This now included GP prescribing errors, this was an improvement since our last inspection.

There had been no serious incidents or never events in relation to patients receiving end of life care. As well as team managers, a governance and risk group reviewed all incidents in relation to end of life care, this was led by one of the specialist palliative care consultants.

All incidents were investigated, and learning was shared across the different teams.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result. For example, the service had implemented a specific medication administration record for staff to use when managing end of life care patient's medicines in the community. This had reduced minor medication errors, recording inaccuracies and staff said it was easier to use.

Managers ensured that actions from external patient safety alerts were implemented and monitored. Managers also shared learning with their staff about incidents that happened elsewhere. This included incidents that had taken place in other providers who were part of the integrated end of life care pathways within Somerset.

Managers debriefed and supported staff after any serious incident. Given the nature of the service staff and families were given extra support when they needed it to manage the emotional impact associated with a patient's death.

Is the service effective?

Good ● →←

Community end of life care

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Senior staff checked to make sure staff followed guidance.

Senior staff mapped the integrated service against guidelines set by the National Institute for Clinical Excellence (NICE) in relation to clinical guidelines.

The service participated in relevant national clinical audits. For example, staff had audited the service against the national quality standard for 'Care of dying adults in the last days of life' and found that record keeping in relation to recording of the last days of life care plans needed some improvement. Plans had been put in place to address this. In general staff found the service met most other areas of the national quality standards including safe prescription of Anticipatory medication.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. These policies were reviewed on a regular basis to ensure they remained in line with any changes to national practice and strategies relating to palliative and end of Life care, including those set by NHS England. For example, the service had created an end-of-life care policy and care after death policy. These policies were available to professionals and members of the public via the Somerset end of life care website that the trust had created in collaboration with other local organisations.

People in the last days of life were identified in a timely way and provided appropriate care. When needed, patients could access specialist palliative nursing care, provided by a local hospice, in tandem with the trust's services.

Nutrition and hydration

Staff ensured patients food and drink needs were met.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Staff made sure patients had enough to eat and drink. Staff discussed how patient's needs might change when approaching their end of life and supported patients and their families to have choice. Staff could also access the support of dieticians and other professionals for specialist advice and treatment.

On inpatient wards staff completed patients' fluid and nutrition charts when needed. When supporting patients in their own home staff monitored patients' needs and provided advice to family and carers.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it.

Community end of life care

Staff prescribed, administered and recorded pain relief accurately. This included anticipatory medicines. Anticipatory or 'just in case' medicines are often prescribed to patients in the last weeks or days of their life. They are used to help manage predictable and distressing symptoms including pain and nausea or if the patient is no longer able to take oral medicines. Teams audited and monitored the use of these medicines to ensure they were prescribed and used appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

There was a clear approach to monitoring, auditing and benchmarking the quality of the service and the outcomes for people receiving care and treatment.

Managers and staff carried out audits to check improvement over time. This included the annual 'National Audit of Care at the End of Life' (NACEL). Following the last NACEL audit the trust had identified improvements were needed in relation to the completion of advance care plans in the community and had taken steps to improve this. This included the introduction of a STEP facilitator role and working with local organisations to train volunteers to help work with patients and families to create plans.

To allow teams time to focus on implementing improvements from the previous year's NACEL audit the trust had made the decisions to pause completion to the audit this year.

Staff referred patients for mental health assessments when needed and understood how to meet the needs and protect the rights of patients subject to the Mental Health Act 1983.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The service was part of a county-wide integrated care model delivered by a combination of teams and providers.

Staff held regular and effective multidisciplinary meetings to discuss patients receiving end of life care and improve their care. For example, the palliative care consultants joined district nursing and rapid response review meetings on a regular basis.

Staff worked across health care disciplines and with other agencies when required to care for patients. Teams worked well with clinicians from other services involved in the delivery of a patient's end of life care, such as local GPs and hospices.

The trust had implemented a new online system that allowed teams to access GP records. However, teams noted that records held by external providers were not easily accessible and further work was needed to embed the county-wide information sharing platform.

Community end of life care

Competent staff

The service made sure staff were competent in their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

We only reviewed data for staff employed by the trust whose main role was related to the delivery of end-of-life care. This included the trust End of Life Care Coordination Centre team, the Palliative care consultants and the End-of-life Education team.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received supervision and appraisals to provide them with support and identify development opportunities.

Staff had access to specific training around end-of-life care, appropriate to their role. This included e-learning and face to face training. We found examples where staff had been encouraged to skill share and use reflective practice to improve their skills in relation to end of life care. For example, at Wincanton hospital an experienced health care assistant on the ward delivered informal training to all new staff about end-of-life care on the ward as part of their induction.

The end-of-life education team supported the learning and development needs of staff. They had worked across the teams providing the integrated model to complete a training needs assessment. From this they had identified areas for improvement and had delivered targeted support to upskill staff across the county to deliver better end of life care. The team had also organised a 2 day conference and learning event in 2022 and were a planning future events including drop-in workshops to ensure staff across the system had access to training and development around end-of-life care.

Managers made sure staff attended team meetings or had access to meeting minutes when they could not attend.

Managers identified poor staff performance promptly and supported staff to improve.

Health promotion

Staff gave patients practical support to help them live well until they died.

Staff assessed each patient's overall health and provided support for any individual health needs. This included accessing support for patients with diabetes.

The service provided information around promoting healthy lifestyles and support on wards. This included information about ulcer prevention and smoking cessation. Staff working in the community were also able to provide information to patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff worked with other teams and completed mental capacity assessments with patients for specific decisions, such as a decision to go into a care home.

Community end of life care

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records.

Teams followed good practice when completing advance care plans with patients and their families, this included decisions attempting resuscitation. As previously mentioned, in 4 of the records we reviewed the electronic copy of the advance care plan (STEP) was not available. Leaders were aware that not all patients in the community had advance care plans in place and were taking action to address this across the health and social care system.

When patients could not give consent, staff worked with others to make decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good

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

Compassionate care

Patients and their families received compassionate care and support. Staff worked with patients to ensure they were comfortable and received end of life care in a dignified way.

Staff interacted with patients and those close to them in a respectful and considerate way.

In both community hospitals we visited staff had taken care to ensure that there were facilities available to allow families and carers to spend time with patients in privacy and comfort. This included the purchase of new armchairs that fully reclined for families to use to rest when waiting with patients. At Wincanton Community Hospital we saw they were refurbishing the whole visitors' suite with reclining chairs and beds and making it comfortable for visitors to stay over and getting it so patients will be access gardens in beds when needed.

Staff were compassionate and proud of the care that they delivered to patients reaching their end of life. Many staff across the community and inpatient teams, felt supporting someone at the end of their life was one of the most fulfilling aspect of their role. At Wincanton Community Hospital there was an end-of-life room that had been dedicated to a staff colleague who had previously received end of life care at the hospital.

Staff worked with families in to ensure patients were comfortable and received care in a dignified way. For example, in some community hospitals a lily symbol was placed on the door to ensure staff were aware the patient was in the last days of life or had recently passed away.

Staff understood and respected the importance of after death support and care. When managing patient's bodies staff took steps to ensure the patient's privacy and dignity was protected.

Community end of life care

Staff in community teams were committed to ensuring verification of death happened as soon as possible as they understood the both the clinical and emotional significance to families of having an accurate time recorded.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and spiritual needs of patients and how they may relate to care needs. Staff worked with patients to ensure they died in their preferred place whenever possible.

Emotional support

Staff provided emotional support to patients, families and carers. They understood patients' personal, cultural and spiritual needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and families described staff very positively. Some carers had fundraised following the death of patients as they had wanted to give something back to the services that they felt had cared for their loved ones very well.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff supported bereaved carers and families to help access emotional support by signposting them to local support groups and services. Staff found ways to ensure patients were able to see their loved ones and stay in touch with them, particularly when visiting on hospital wards had been affected by the COVID-19 pandemic. An example of this was when a patient's wife was moved to the same ward to ensure they could spend more time together.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The end-of-life education team had worked with various staff groups to develop new communication training for staff supporting end of life care patients. This training supported staff to develop new skills on how to have conversations around death.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff had conversations with patients and their families about end-of-life care and what to expect.

Patients and families were involved in advance care planning. Despite some treatment escalation plans not being uploaded to the system, we found evidence to show staff had supported patients to make advanced decisions about their care. The service was also working to train volunteers who had personal experience of bereavement to work with patients and families in the community to develop advance care plans.

The 'Talk About' advance care planning project across Somerset used volunteers to help people personalise their care and legacy. The project has enabled learning on how to engage the public with the difficult topic of death, even if it is in the future. People had an advance care plan, created with support from a volunteer and shared to their electronic GP record by the Somerset Integrated Digital e-Record (SIDeR) platform.

Community end of life care

The trust had worked with other local organisations to launch a Somerset End of Life Care and Bereavement Support Website in March 2022. The website had created a single place for professional, carers and patients to access any information they needed about end-of-life care. This collaborative effort with organisations across the county brought together all the resources, information and education needed to help care for and support the people of Somerset living with life-limiting conditions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service collected patient feedback, reviewed complaints, and presented patient stories to understand peoples experience of the service. A review of the EOLC complaints process and responses was undertaken in 2021. The team engaged with the Patient Advice and Liaison Service (PALS) and complaints teams across the county to improve multiagency complaint response timing, tone and content, where EOLC was a theme.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

Leaders planned and organised services, so they met the needs of the local population. They worked with others in the wider system and local organisations to plan care.

The service was delivered through an integrated model that utilised the strengths and shared resources of the local health and social care system to meet the needs of local people.

The trust facilitated joint working between internal teams and external stakeholders, including commissioners, when organising patient's end of life care.

For example, having identified a possible knowledge gap in local care homes the trust's LARCH (Listening and Responding to Care Homes) and End of Life Education team had worked with local care homes to organise new training for staff to better support people reaching the end of the life. This training included 'RESTORE2' champion training and training on advance care planning. 'RESTORE2' is a physical deterioration and escalation tool for care settings.

An End of Life Steering group was also in place where representatives from different teams and services could meet quarterly to discuss changes in the local system and respond to these changes to ensure people still had access to good end of life care.

Meeting people's individual needs

The service was inclusive. Patient's individual needs were understood by staff and care and treatment was delivered in a way that met them.

Staff made sure patients living with additional needs including mental health conditions and learning disabilities received the necessary care. Teams worked with local paediatric services to help support end of life care for people under the age of 25 when needed. In addition, the service had worked with other local organisations to support patients with additional needs including those who were homeless.

The service could provide paper leaflets to patients and families in different languages and for those who could not access the internet. Staff could also access interpreters or signers when needed.

In community hospitals, patients staying on wards were given a choice of food and drink. Options were available to patients that met their cultural and religious preferences.

Staff ensured patients individual spiritual beliefs in relation to death were known and delivered care and treatment in line with these beliefs where possible. A chaplaincy service was available and both community hospitals had multi faith spaces that could be used.

Premises used by the service met the needs of patients. Inpatient wards were well maintained and met the needs of patients including those who used wheelchairs. In the community staff ensured patients had access to additional equipment to support patients with specific mobility needs.

Access and flow

Patients reaching the end of their life could access services they needed without significant delays.

Teams worked together to rapidly discharge or admit patients to or from inpatient services to ensure they were able to die in their preferred place where possible. For example, the end of life care coordination team helped organise the provision of additional social care to ensure patients could be supported in the community and die in their own homes as their preferred place. The team also worked closely with the primary link service, rapid response team and community hospitals to ensure that wherever possible patients could access a hospital bed if their needs or wishes changes.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

If changes were made to patient's appointments at the last minute, staff contacted patients to let them know and if needed rearranged as soon as possible.

Staff supported patients when they were referred or transferred between services.

Patients, families and staff had access to specialist palliative care advice at any time of the day or night. A night-time service was provided by the district nursing team and the provider had worked with a national charity to implement a volunteer night sitting service.

Staff could call for support from doctors and other disciplines, including mental health service.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and information on how to complain was available on the trust's website. The trust also had a Patient Advice & Liaison Service (PALS) where families and patients could submit complaints to.

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Community end of life care

Staff could give examples of how they used patient feedback to improve daily practice. This included lessons around communication with families and relatives. The end of life education team had developed new training on communication following the review of some complaints received from families.

Leaders had worked with other services in the local area to improve the complaints procedure. Based on family feedback the service now ensured that families and patients received one coordinated response that had been reviewed and inputted by all the different teams and services that may have been involved in the end of life care provided. This collaborative approach had improved the complaints process for families and patients as it meant they received one response that looked at their concerns holistically.

People received a response to their complaint and, when appropriate, where included in the investigation of their complaint. In the 12 months prior to our inspection 32 complaints had been received relating to end of life care. Each had been reviewed and responded to accordingly.

Staff understood the duty of candour. If things went wrong, staff apologised and gave patients honest information and suitable support. Given the nature of the service leaders and managers had considered how to support complaints from grieving families in the most caring way possible.

Where needed, staff signposted families to the parliamentary ombudsman for independent review of their complaint if they were dissatisfied with the response they received.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills and abilities to run the service. Leaders were visible, provided clear direction and had raised the profile of end of life care services.

Leaders had the skills and abilities to run the service. The service was led by a team of 8 palliative care consultants and other senior staff within the trust. This team had grown since our last inspection.

Leaders provided clear direction and had raised the profile of end of life care services. The team of palliative care consultants and other senior staff members ensured the end of life care service was represented within the wider trust and local health and social care network.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service for patients and staff. All staff reported senior staff involved with the delivery of the end of life care were highly approachable.

Staff felt connected to other teams in the Neighbourhoods and Primary Care directorate and across the organisation.

Community end of life care

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. This strategy was in line with national policy and involved the wider health and social care system.

Leaders and managers had developed a clear vision and strategy to plan and deliver an integrated end of life care service. They understood the challenges of delivering an integrated service and worked well with the wider health and social care system to overcome them.

The trust had worked with local agencies and organisations involved in the end of life care pathway to create an integrated Somerset End of Life Care Strategy. This identified clear priorities for the local system to achieve. As part of this the trust was also leading on the development of bereavement and education strategies specific to the end of life care pathway across the county. Included in these strategies were plans to increase awareness of bereavement through school education sessions and provide better targeted support to families and patients with long term support needs.

Staff had the opportunity to contribute to discussions about the strategy of the service, especially where the service was changing. Staff at all levels, from across the different teams, were able to attend the quarterly end of life care steering group. Staff said they felt listened to and able to contribute to the direction of the service.

In addition, in May 2022 the trust had also held the county's first End of Life Care Conference, led by the education team, in partnership with other organisations including the local hospice. In line with the 'Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026' published by NHS England in 2021, the theme of the conference had been 'Collaboration'. At the conference staff from across the system had been able to attend and share best practice, innovations and consider future challenges.

Culture

Staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care and proud of the care they provided to patients reaching the end of their life.

Staff felt respected, supported and valued. All staff we spoke to across the teams were proud to deliver end of life care. They felt well supported by their mangers and other teams and felt their role in end of life care was valued by others.

Staff and patient wellbeing were a focus for the leadership team. There was a specific wellbeing strategy in place to support and ensure people's wellbeing. For example, the palliative medical consultants offered regular support and supervision sessions to front line staff. The provider was also reviewing its own provision of bereavement leave for all staff to ensure it was supporting bereaved staff as well as patients and their families.

Staff were focused on the needs of patients receiving care and proud of the care they provided to patients reaching the end of their life.

The service promoted equality and diversity in daily work.

The service had an open culture where patients, their families and staff could raise concerns without fear. Patient and families felt they could raise concerns without fear of prejudice. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Community end of life care

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

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A well-defined governance structure was in place to connect front line services with senior leaders including the trust's executive board. The EOLC structure included an EOL governance group which met regularly with multidisciplinary input from across both acute and community services which reported to the end-of-life steering group. These groups were responsible for recognising issues which required support and feeding into the operational and education groups for action.

Staff at all levels were clear about their roles and accountabilities. Allocated consultants within the team-maintained oversight of specific areas including education, operations and risk. These individual streams fed into a quarterly end of life care steering group. This steering group was attended by a wide range of staff from various teams which reported into the senior executive team. An action log was kept to monitor progress within the service over time and ensure improvements were made in a timely way whenever possible.

Both national and local audits were completed to measure the quality of the service and identify areas for improvement. For example, staff had completed a county wide audit to check the quality of 'just in case' medication prescribing and use of syringe drivers in patients' homes.

Staff had regular opportunities to meet, discuss end of life care and consider the performance of the integrated service. As well as the quarterly steering group, end of life care was discussed on a regular basis across the different teams within the service. Leaders and managers were passionate about ensuring end of life care was viewed as' everyone's business' and was included in everyday discussions across all teams.

Management of risk, issues and performance

Leaders and teams identified and escalated risks and took action to reduce their impact. They had plans to cope with unexpected events.

Leaders recognised risks within the service and across the local system and took action to make improvements.

Staff maintained and had access to the risk register at a team and directorate level and could escalate concerns when needed. Staff concerns matched those on the risk register. Leaders updated the risk register and were able to demonstrate action they had taken to reduce risks and future plans to address ongoing concerns.

Leaders and managers linked in with wider mortality reviews across the trust when needed to ensure and lessons learned were used to improve the service.

Leaders had plans to cope with unexpected events and seasonal challenges such as winter pressures. During the COVID-19 pandemic leaders had linked in with other services to produce a mutual aid agreement between providers to ensure in the event of any national shortages, patients reaching the end of their life in the community would still have access to care and treatment they needed.

Community end of life care

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure.

The service used systems to collect data from wards and directorates.

Quality metrics and other key pieces of information about the service were reviewed at the quarterly end of life steering group. This included an 'End of Life Care Dashboard' that was being developed to ensure staff had access to performance data about the service to make decisions and plan improvements.

Staff had access to the equipment and information technology needed to do their work. Updates to the information technology infrastructure were taking place or were planned across the service. For example, some district nursing teams had been piloting the use of new mobile technology to allow them to access and update records in patients home.

Information governance systems included confidentiality of patient records.

Leaders recognised that because of the integrated nature of the end of life care service, some data collection was not always simple and required manual input from staff. They had plans in place to improve the quality of data collected but progress was reliant on the wider technology infrastructure of other organisations across the county.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up to date information about the work of the provider and the services they used. This included a website the trust had launched in collaboration with other agencies involved in the delivery of end of life care across Somerset. The website had been launched in March 2022 and included information for professionals and members of the public.

A monthly newsletter was also generated to keep local people informed about end of life care services. The trust supported specific national campaigns including 'dying matters week' to raise the profile of end of life care.

In 2022, the End of Life Care Education team had also begun a roadshow to visit all care homes in the county to offer support and promote resources available to help them deliver better end of life care. At the time of our inspection the team had visited 25 care homes.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. This included the friends and family test and patient advice and liaison within the trust.

Leaders within the service collected feedback specific to end of life care patients and used it to make improvements. In addition, to sharing patient stories at team meeting to highlight good practice, complaints involving provision of end of life care across all teams within the trust were closely scrutinised to highlight potential areas for improvement.

Given the integrated structure of the service, staff at all levels had adopted a collaborative approach to working with other organisations involved in the delivery of the end of life care pathway across the county.

Community end of life care

Leaders were able to clearly demonstrate where they had used joint working with external services to improve quality. For example, the trust was working with other local partners including GP practices and ambulances to ensure better sharing of information for patients using electronic portals. Leaders and managers fed into the local Integrated Care Board's (ICB) wider end of life care steering group to maintain oversight and influence of the end of life care pathway across the county.

Learning, continuous improvement and innovation

Staff were committed to improving end of life care. Leaders encouraged innovation.

All staff were committed to continually learning and improving end of life care. Staff understood quality improvement methods and applied them in their teams.

The provider had adopted a clear quality improvement approach at service level to drive development. This included the 'Last 1000 days'; a program of projects delivered across the service to improve the overall experience of people in Somerset approaching the last 1000 days of their life.

Some key priorities for the programme were improving; Advance Care planning, Last days of life and both bereavement support. For example, one project had been completed focused on improving timely verification of deaths in the community. Between March and July 2022 an average of 84% of deaths were officially verified in community or inpatient settings within the agreed time frames. For community settings the agreed time frame for verifying a death was 4 hours, in the community hospitals this was 1 hour.

Improvement of end of life care services was monitored by leaders and managers. All quality improvement activity was discussed at the quarterly end of life care steering group and a driver diagram and action log was used to monitor the progress of each individual project.

Teams from the trust also supported quality improvement in the wider system. For example, a local care home for veterans completed a project with input from the trust's LARCH team to upskill their staff in how to write treatments escalation plans.

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

Good ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Wards visited used CCTV in corridors and mirrors in parts of the ward where staff were not able to monitor patients. There were parts of the wards in St Andrews and Rowan ward that were not visible from a distance by staff to easily monitor patients.

Patients were admitted to mixed sex accommodation and the provider was not fully meeting guidance of no mixed sex wards. Rydon 1 and Rydon 2 had a female only corridor for vulnerable female patients. There were separate male and female only lounges in all wards.

There were potential ligature anchor points, but action plans were not developed on how to lower risks to keep patients safe. For example, bedrooms for patients with physical disabilities in Rydon 1 and two were not free from ligature anchor points. While ward managers told us, patients admitted to the bedroom were risk assessed we saw the bedroom door was open while patients were not in the room. This meant other patients had access to the room. The male lounge on Rowan ward was lockable from the inside with a number of ligature points such as a door handle to the inside of the door, loose wires and uncovered electrical sockets. There were ligature anchor points in St Andrew's Conservatory as well as female and male only lounges.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean and housekeeping staff were following schedules of cleaning during our visits. There were repairs outstanding throughout the wards and some areas were not fit for purpose. For example, on Rydon 1 ward the kitchen doors were missing for some units, there was damp in 1 bedroom and wood panels were used to cover damage to the walls in the place of safety area. Requests to hang information boards were outstanding in Rydon two and although repaired during our visits there were bedrooms and toilets without suitable lighting.

There were ligature points in Holford's interview room and to reduce the risk, the staff were propping the fire door to enable their observations of patients while they were playing video games.

While there was ongoing extensive refurbishment to merge St Andrews with Rowan ward, there were areas in need of repair in St Andrews. For example, broken viewing panel, the door into the female lounge was broken and wooden frames were broken close to the nursing office.

Staff followed infection control policy, including handwashing. Masks were worn where there was a risk of COVID.

Seclusion room

The seclusion room in Holford the psychiatric intensive care unit (PICU) lacked basic facilities. There were no toilet facilities, which meant a patient had to be escorted to the nearest one in the ward. Repairs were needed as sometimes staff used a wooden pole to barricade patients into the seclusion room due to repairs needed to the door. Maintenance staff had made the decision that a patient if unwell and anxious could continually kick the door at the bottom and the door would give way.

The staff were told by estates that in an emergency a patient in segregation could continually kick the door at the bottom and the door would give way.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Clinic rooms across the 5 wards were clean and tidy. There were examination couches with adequate equipment for nursing treatments and interventions. For example, scales and height measurements. All cupboards were well stocked, tidy and in a logical order (alphabetical).

Clinic rooms in wards were not air conditioned and constant temperatures below 25 degrees could not be maintained during periods of hot weather. Staff were given guidance to apply yellow stickers on medicines to be destroyed when the temperatures were over 25 degrees between 5 to 7 consecutive days. Yellow stickers were not needed in St Andrews due to the pharmacy team support.

Resuscitation trollies were checked in all five wards. The resuscitation trolley in Rowan was kept in the office and checked thoroughly weekly except for 2 weeks in June and July 2022. Emergency medicines were locked in the store cupboard rather than within emergency equipment which may cause delays to patients needing emergency medicines. The trolley for Rydon 1 was kept in the utility room which was signposted on the door. Staff confirmed that they also complete a complete list check if they have had to use anything from the trolley in an emergency because the checklist did not include individual items.

There were medicines with additional requirements for storing, recording and administration in all wards. Medicines kept under additional requirements had not been checked in Rydon 2 and in Holford. For example, there were unused medicines that were expired in Rydon2 and in Holford the medicines had not been checked since July 2022.

Safe staffing

There were 3 qualified nurse vacancies, 5 health care assistant and 2 housekeeping in St Andrews. There were Occupational therapist vacancies in Rydon 1 and 2. The staffing levels for Rydon one and two and for St Andrews allowed for basic care only. Patients in Rydon 2 spoke about being bored and said their escorted leave was not happening as agreed by the consultant.

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Nursing staff

Patients were not having regular one to one sessions with their named nurse.

The staffing levels for Rydon 1 and 2 and for Holford were 2 clinical leads and 3 health care assistants. Although ward managers said staffing levels were increased depending on the acuity of patients, staff in Rydon 1 and 2 said minimum staffing levels had an impact on their roles and responsibilities. Their duties included level two observations of some patients, hourly monitoring of the place of safety suite, 3 reviews daily, up to 4 medicine administration rounds during the day and developing the new care planning system. Escorted leave was not always happening for the 5 patients with conditions placed on their leave.

Staffing levels in Holford were maintained by agency staff. The progress notes for one patient showed there were insufficient staff on duty on one day in August 2022 to carry out physical intervention for a patient needing hospital treatment. Staff were instructed to contact emergency services in the event of collapse.

Although staffing levels in St Andrews were maintained by bank and agency staff there were times when the ward was operating below minimum staffing numbers. For example, In the last 4 weeks there have been 2 day shifts and 1 night shift where 1 qualified nurse was on duty instead of 2 There was a high turnover of staff in St Andrews and the provider was struggling to recruit due to the ward move to Yeovil. There were 2 nurse vacancies, 3 healthcare and 2 housekeeping staff

There were handovers during shift changes. Handover notes gave staff current and key information about patients.

Medical staff

Daytime medical cover and a doctor was available to go to the wards quickly in an emergency. There were occupational therapy vacancies in Rydon 1 and Rydon 2 and out of hours (OOH) medical cover in St Andrews was not provided. However, there is offsite medical cover provided by Devon Doctors and the consultant on call rota.

The clinical service manager for St Andrews and staff explained that patients were assessed during admission and those identified at high risk were not admitted to the ward. No OOH medical cover at St Andrews was a long-standing arrangement, recruitment for medical staff was an issue, and the arrangements were reviewed regularly.

There were vacancies for Occupational therapists in Rydon 1 and Rydon 2. Activity plans were to be updated once the post was filled.

Psychologists were in post and their role included individual assessment, transition and brief intervention. Group therapies were also offered.

Mandatory training

The training matrix provided for 5 wards showed that the training targets were not being met. For example, Basic life Support training was below 70% in all 5 wards and medical emergency training in Holford, Rydon 2 Holford, St Andrews and Rowan was below 66%. Less than 65% of staff in Rowan, St Andrews, Rydon 2 had attended Prevention and Management of Violence and Aggression PMVA training and less than 75% of staff had attended NEWS (National Early Warning Score) 2 training.

Staff were positive about the training available. They said there was eLearning and face to face training. They said they had access to specific training relevant to the needs of patients or for their personal development.

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Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Risk assessments were completed for each patient on admission. Nationally recognised tools were used for assessing patients at potential risk of health deterioration. These included National Early Warning Score (NEWS).

Patients' risks were assessed into categories of low, significant or high risk. However, where risks were identified there was no further escalation into a management risk plan or care plan. There was a lack of guidance for 3 patients from the 4 patient records reviewed in Holford which had identified them at risk from physical health. For example, physical health care plans were missing for two patients identified at risk of deteriorating health condition.

Guidance to complete NEWS charts were not followed for 2 out of the 4 patients care record reviewed in St Andrews. The risk assessment identified a patient in St Andrews at high risk of falls and physical health conditions. NEWS charts were to be completed daily and to complete food and fluid charts. The food and fluid chart were not completed for 2 patients although identified at significant risk of physical health condition. For 1 patient the directions to complete NEWS charts weekly were not followed. For example, NEWS scores were missing between 18 August and 4 September 2022.

Physical health plans were missing for 1 patient identified at significant risk of harm of health conditions such as leg ulceration in August 2022 in Rowan. A risk management plan was not developed while the progress notes dated June 2022 detailed the management of the wound. This meant staff had to go back over 8 weeks of progress notes for the guidance from the tissue viability nurse on wound care.

Although risk assessments were up to date and clearly identified acute risks in Rydon 1 and Rydon 2, the actions on how to manage risks were missing. For example, a patient in Rydon 2 was seen by diabetic nurse in July 2022 who provided guidance on the management of diabetes, but this was not captured in care plan.

Management of patient risk

Patients were assessed by staff. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

A lead was appointed for Proactive and Reducing Interventions. The aim of the restraint reduction was to continuously improve culture and practice for patients to be cared in a safe environment where the least restrictive interventions were used. Plans for a pre-escalation system, rather than a de-escalation system was to be introduced. Staff had to attend Quality Improvement training on reducing restrictive practice. "How to reduce restraint" information leaflets were on display in Rydon 1 and 2 and in Rowan

There was a move from a medical model towards patient engagement, focusing on how staff managed behaviours that placed patients at risk of harm. The aim of the new system was to focus on patient's preferences on how their care was to be delivered. For example, positive behaviour support plans were developed from the assessment of risk and patient's voice was to be captured in the new engagement tool.

Staff knew about the reduction interventions programme and the use of primary and secondary interventions. De-escalation was the initial response from staff where there was a potential for risk of harm when patients showed signs of anxiety and frustrations in their behaviors. The comments from staff across all 5 wards indicated that documented strategies were not followed. Staff used their knowledge of the patient's triggers to manage situations and before using restraint they planned how staff were to use techniques to support the patient and others.

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

Use of restrictive interventions

While the levels of restrictive interventions were low not all staff in Rowan, Rydon 2 and St Andrews had attended Prevention and Management of Violence and Aggression (PMVA). The audit on the Management of Violence and Aggression dated 2020 listed the targets against standards for assessing risk which included de-escalation and restraint. Data showed behaviours that placed patients' and others at risk of harm were assessed during admission in all wards and de-escalation techniques were used before any restraint. The wishes and preferences of patients were not recorded for patients in Rydon 2 and 75% was recorded for patients in St Andrews. While the data provided for 5 wards showed 100% of care plans in 4 wards were updated following an incident, debriefs with the patients were not always happening.

Plans that detailed the patients' triggers along with the actions to de-escalate situations were not developed or lacked detail in 13 out of 24 records reviewed. Where positive behaviour support plans were in place, they lacked guidance on the situations where restraint was necessary, the types of restraints to be used and the number of staff. For example, a clear plan was not in place for a patient who was restrained by 6 members of staff to get them into a car to return them to the ward

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. A review of the Segregation Audit was undertaken for the period December 2017 – May 2018 to ensure seclusion carried out was monitored/reviewed in line with Trust Policy. Where there were gaps in the standards recommendations were made to meet shortfalls. For example, improving on documentation of segregation and seclusion should be reviewed every 2 hours by 2 nurses, one of whom should not have been involved in the original decision to seclude.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Ward managers had regular meetings with the safeguarding lead who offered them support and guidance. Staff attended training on how to recognise and on how to report abuse. They knew the types of abuse and the referral process for reporting abuse.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient's notes were comprehensive but the introduction of an engagement tool for planning care has meant that care plans and risk assessments lacked action plans with delays in escalation for deterioration of physical health. The engagement tool has not yet embedded into practice across the wards. There were occasions where progress notes were used to give staff guidance on care and treatment which meant staff having to read previous notes for the advice. For example, in Holford ward the medical team were recording outcomes of their visit in the progress notes which was not transferred into a care plan for easy access and reference for staff.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

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Overall, medicine systems were safe. Staff completed medicines records accurately and kept them up to date.

Patients' prescribed medicines was usually discussed in ward round and staff raised with the medical team any suggestions from patients to change their medicines. Prescribing adhered to NICE (National Institute of Clinical Excellence) guidance. Where patients were prescribed with antipsychotic, and the doses did not exceed BNF (British National Formulary) (British National Formulary) guidance**.**

Staff reviewed the effects of each patients' medicines on their physical health according to NICE guidance. For example, NEWS checks, ECG and blood tests. There was low prescribing of high dose antipsychotic medicines in Holford

Individual protocols were in place for medicines prescribed to be taken as required (PRN) which the pharmacy team reviewed weekly in four wards**.** Individual PRN protocols in Rydon Two were not reviewed for all medicines during ward rounds and it was documented PRN remained prescribed. For example, there was no discussion of PRN use in ward rounds for a patient administered with lorazepam on 8 occasions over 14 day period from 26 August 2022 to 6 September 2022 and 6 times in period between 16 to 22 August 2022. "As requested," and "given" was the staff's rational for administering PRN documented in the prescription chart or progress notes.

Track record on safety

The service managed patient safety incidents. Staff recognised incidents and reported them appropriately.

Staff knew what incidents to report and how to report them. An electronic system was used for reporting accidents and incidents. There were opportunities for learning from incidents and accidents through de-briefs, reflective practice and during handovers. De-briefs happened for serious or specific incidents and learning was shared across the trust. For example, staff contacted PMVA (Prevention Management of Violence and Aggression) trainers when they had concerns about restraint techniques used.

There were incidents in St Andrews that related to patients self-harming and for leaving the hospital without staff support. There were multiple incidents for one patient who self-harmed and for another patient leaving the unit without staff support although there were conditions on their leave. The data provided for September 2021 to August 2022 showed 72 incidents of self-harm, but no figures were collected for patients leaving the ward without staff support although there were conditions under the Mental Health Act. During our site visit we noted ligature risks which the ward manager added to the risk register once the ligature points were brought to their attention. The ward manager updated the risk register to include ligature anchor points. We noted the property was not secure which allowed for patients to leave without being observed and during our visit there was contact from the police about the number of incidents where patients were leaving the property without staff's knowledge. This meant that action to reduce reoccurrence was not sufficiently robust to reduce the number of incidents.

An incident in Rowan was documented where a male patient with a history which posed a risk to sexual safety was found in a female's bed. The actions were to tell the patient of the rules. However, female patients were at risk from this patient. We discussed with the clinical service manager that a plan on how to reduce the risk was not in place.

Is the service effective?

Good 

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

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Care plans were not always reflective of patients assessed needs.

Patients' needs were assessed during their admission. There was a move away from routine plans towards a more personalised system where patients voice and preferences were captured. Staff were more familiar with using the engagement tool as an admission assessment. However, the new system had not embedded into practice. The planning and intervention parts of the engagement tool were missing or lacked connection to the admission assessment. For example, the engagement tool lacked detail for a patient in Rydon 1 at risk of self-harm. Disinhibited behaviours were not part of the care plan for a patient in Rowan, although identified in the assessment of needs. Ward managers acknowledge the engagement tool was new and staff were not totally used to the process.

Physical health checks were carried out by the nursing staff weekly and results of the checks were documented. The intervention and planning were not developed into an action plan where deterioration of health conditions was identified. For example, a patient in Holford identified at high risk of physical health conditions such as pressure injury and respiratory condition lacked detail on how to manage their health care needs or nursing interventions.

Patients were invited and joined their care reviews with the medical team.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff delivered care in line with best practice and national guidance. For example, NICE guidance and reduction of restrictive practice.

Patients' physical health needs were assessed and recorded. Recognised rating scales were used to assess and record the severity of patients' conditions and care and treatment outcomes. For example, NEWS scores. Patients had access to specialists input such as tissue viability nurses for some of their physical health care.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. For example, restraint and segregation audits.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers provided an induction programme for new staff.

Patients had access to psychologists and patients in Rowan and Holford had access to Occupational Therapists (OT). Out of hours (OOH) medical cover was not provided at St Andrews and for this reason patients must meet admission criteria. For example, physical health care that may require urgent medical, administration of intramuscular medicines with the aim of obtaining a state of calm as soon as possible.

Rotas were organised to ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

New staff had a comprehensive induction which prepared them for the role they were employed. The induction to the ward was adequate for staff and new staff worked supernumerary while they shadowed more experienced staff.

An audit of clinical supervision within the Mental Health inpatient services was carried out during March 2021 and March 2022. Clinical supervision was for all registered and non-registered staff providing clinical care**.** Questionnaires were used to gather how clinical supervision standards were being met. For example, the frequency and the topics covered. Sixty six staff from the 39% who responded to the questionnaires confirmed they had regular clinical supervision.

Individual monthly supervision was not regular although staff said group supervision was taking place. The St Andrews supervision matrix for January to March 2022 showed 9 members of staff in February 2022 and 1 staff in March 2022 had supervision. The names listed in Rowan matrix for July/August and for September 2022 were not the same and while most staff in the July/August matrix had supervision 20 staff had not had supervision in September.

Appraisals were annual and managers identified any performance and training needs for staff to develop.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Multidisciplinary meetings were weekly with the medical team. Patients join part of the meeting to create better discussion when there were fewer medical professionals present.

Patients joined ward reviews and were able to discuss their care. Relatives were invited to ward reviews with patient's consent. Doctors, nurses, pharmacist, and staff from community mental health teams attended ward rounds. The Home treatment team/crisis team in Rydon 2 attended to help facilitate discharges.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Patients knew the reasons for their admission and the conditions of their stay on the ward. Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Patients had easy access to information about independent mental health advocacy. For example, notice boards with the complaint's procedure and local support groups and advocacy. Posters for informal patients were on display about leaving the ward.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff shortages meant that patients were not having their leave as prescribed by the consultant.

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Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Patients were encouraged and enabled by staff to make day to day decisions such as meals, activities and Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

Patients' mental capacity were reviewed during ward reviews and their capacity to consent was recorded. Patients' capacity was not always clearly and consistently being assessed in Rydon 1. "Currently under section" was recorded under "capacity" in progress notes. For example, one patient's T2 consent to treatment form was in place, then was assessed as lacking capacity to consent to treatment in August 2022 but not reflected with a Section 62. In addition to this the T2 was not for all medications prescribed. When Electronic forms were used, they were more detail about patient's capacity to consent

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

Is the service caring?

Good ➔➔

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Patients and their relatives complimented the staff on their kindness and compassion. Staff's knowledge of individual patients was demonstrated through their feedback on how they ensured patients were made to feel they mattered. For example, giving patients time to express themselves and developing trustful conversations.

Concerns raised by patients were taken seriously. Staff felt confident to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients they witnessed.

Staff followed policy to keep patient information confidential.

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Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Patients were aware of the care and treatment to expect from staff on the ward

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). For example, translators were used to ensure a patient understood their care and treatment.

Ward managers ensured patient care was within the trust's values. They gathered feedback from patients about their care, observed staff's interaction and had presence on the ward.

Staff we saw interacting with patients were friendly and approachable. They took time to interact with patients and those close to them in a respectful and considerate way.

Patients had access and were able to gain support from their advocate where necessary.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Relatives were kept informed and invited to reviews where agreed with the patient.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Admissions were organised by a bed management team although there were regular meetings with ward managers to discuss potential admissions.

The psychiatric intensive care unit had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

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Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays. There were delays with discharges and transfer of care for patients no longer in need of hospital care. For example, finalising arrangements for patients difficult to place in the community due to their complex needs.

Multi agency and planning meetings were arranged with ward managers to discuss delays for onward placements and to identify patients for early discharge on social care pathways. Home treatment team and MIND attended planning meetings for smooth transfers and discharges

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. For example, gyms, activities room and quiet areas.

The service had quiet areas and a room where patients could meet with visitors in private.

The service had outside spaces that patients could access easily.

Dining rooms had refreshment making facilities. Patients could make their own hot drinks and snacks and were not dependent on staff.

Patients said there was a variety of meals choices at mealtime and the quality of the food was good.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Activities coordinators were on duty and organised daily activities 7 days per week. There were Occupational Therapists (OT) vacancies in Rydon 1 and Rydon 2. There were no set planned activities while the OT post was vacant. Patients in Rydon 2said they were bored, and the activities room was often closed. Other professionals confirmed the comments from patients regarding boredom.

Activities observed in Rowan were meaningful. Occupational therapist and activities coordinators planned activities in Rowan and peer support workers joined in activities. For example, peer support workers were able to demonstrate to patients' a future was possible.

Patients were supported to develop and maintain relationships with relatives, in the service and the wider community.

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Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

There were accessible bedrooms and bathroom in Rydon 1 and Rydon 2. There were sensory rooms, quiet rooms and family meeting rooms in all wards. Although some rooms were used to store equipment and stock.

Notice boards displayed information on advocacy local groups and how to make complaints. However, in Rydon 2 information boards were not available due to delays from estates. A response to the request from the ward to install them remained outstanding.

Managers made sure staff and patients could get help from interpreters or signers when needed. Interpreters were used to ensure patients understood the information being shared with them.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers said they felt confident to complain or raise concerns. The complaints procedures were on display in wards.

Staff knew how to acknowledge complaints, took steps to resolve their issues or passed to the nurse in charge or ward manager more serious concerns from patients for investigation.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff in Rowan made additional comments about positive feedback from patients. They said compliment cards were available for patients and relatives to praise them where appropriate.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Ward managers were supported by their service managers and by their peers. The ward managers described their style of management which ensured leadership was within the values of the organisation and met the needs of the ward. They were aware of the challenges across the wards which included retention of staff and delays in discharges. Individual ward concerns included embedding practice, the adaptation of the building and moving wards.

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Staff and patients were positive about the ward managers. They were known to patients; they had a presence on the ward and worked hands on where needed.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Ward managers knew the vision and strategies for their wards. For example, St Andrews was to move to Rowan which was to be re-named as Rowan 1 and 2. The building was being adapted to improve the quality of care to be delivered to patients in these wards.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The staff across 5 wards said they felt valued and commented that morale was improving. For example, the recruitment and induction of new staff had raised morale. They praised their ward managers for their support and for being approachable.

Teams worked well together, there was an understanding of the values and how they were applied to their ways of working.

Ward managers were proud of their individual teams, and they described their successes. For example, psychologist input, recruitment of staff, introduction of community meetings and sensory training for staff.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The trust gathered information from ward managers on the potential risks which impacted on patient safety to identify themes. The inpatient risk register listed the risk, the level and the actions to reduce the risk.

Ward managers had contact with the wider trust such as leads who provided advice and guidance, admission teams and community teams.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The trust had a risk register which included missing budgetary targets, staff vacancies and incidents reporting.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Whereinformation was documented in progress notes it was not widely shared or easily accessed by other internal and external teams.

The provider shared data securely with the Care Quality Commission and other agencies in accordance with legislation. Serious reportable incidents were reported when they occurred in line with the National Reporting and Learning System (NRLS) requirements

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

There was peer support between ward managers. They were aware of the themes which impacted their wards. For example, delays with discharges, outstanding environmental repairs recruitment and retention of staff and the introduction of a new care planning system which had not yet embedded. Patients were benefiting from having psychology input and the input from MIND was helping with transition for patients moving into the community.

Learning, continuous improvement and innovation

Patients had good access to advocacy support in Rydon 1 and 2 having a peer support worker in Rowan providing a view on transferable skills gained during their stay into daily living in the community. Home treatment team working part of their time in Rydon 2 to facilitate early discharge.