Requires improvement

Somerset Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5AA	Trust HQ (Mallard Court)	Taunton Adult CMHT	TA2 7PQ
RH5AA	Trust HQ (Mallard Court)	South Somerset Adult CMHT	BA20 2BX
RH5Y4	Minehead Community Hospital	The Barnfield Unit - CMHT	TA24 6DF
RH5Y7	Priory Health Park	Mendip Adult CMHT	BA5 1TJ
RH5AA	Trust HQ (Mallard Court)	Bridgwater Adult CMHT	TA6 5AT

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Somerset Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Somerset Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Overall summary

We rated community based mental health services for adults of working age as 'requires improvement' because;

The number of service users awaiting allocation of a care co-ordinator across all specialities was 120.

The assessment teams and early intervention team reported delays in transferring patients to the recovery teams because of the pressure on that team's caseloads. This was confirmed by the recovery team managers we spoke with, who told us these issues were to be addressed as part of the service reconfiguration.

Comprehensive assessments were completed at each referral meeting and immediately uploaded on to the electronic record. These included ascertaining a range of details such as; the patients personal circumstances, any historical mental health issues, physical health and risk factors.

We did not see effective trust-wide processes to show how learning from incidents (including serious incidents) and complaints was shared across other teams. During our inspection we reviewed the serious incident policy and the community mental health teams (CMHTs) operational policy. Both of these needed of updating in order to reflect the latest NHS England advice on serious incidents and the current situation of the CMHTs.

However, staff treated patients with kindness, dignity and respect. They provided an empathic approach and were professional in their dealings with patients and carers.

There were systems in place which ensured staff received mandatory training, appraisals and supervision. Incidents were reported appropriately and there was evidence of some local learning as a result of these, complaints and serious incidents.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement:

- The number of patients waiting allocation of a care co-ordinator across all specialities was 120. However, the trust had difficulty identifying exactly how many patients were waiting during our inspection visit.
- Team managers told us serious incidents were reviewed by senior staff appointed via the divisional manager. They told us and we saw evidence to substantiate that these reviews took in excess of 60 days to complete. There was very little sharing of the learning from incidents across teams and policies did not reflect up to date national guidance on dealing with serious incidents.

However,

- The risk assessments we saw were comprehensive and reviewed monthly or more often if the patients risk profile had changed.
- Each team had clear safeguarding protocols place and all the staff we spoke with had a good knowledge and understanding of the process to follow when making referrals. They also showed us a thorough knowledge of the potential abuse and risks patients faced.

Are services effective?

Good

We rated effective as good because:

- Comprehensive assessments were completed at each referral meeting and immediately uploaded on to the electronic record.
- In all the care records we reviewed we saw how patients physical healthcare needs were assessed and addressed. This included an annual health check undertaken by their GP.
- All the staff we spoke to reported positive working relationships with colleagues in primary care, the police and local authority safeguarding services.

However,

- The trust should ensure that all community mental health team staff have the opportunity to attend regular training and updates on the Mental Health Act and Mental Capacity Act.

Summary of findings

Are services caring?

Good

We rated caring as good because:

- Staff provided an empathic approach, and were professional in their interactions with the patients and carers.
- Teams had a carer's support worker who carried out carers' assessments and sign-posted people to sources of help and assistance.
- The majority of patients and carers we spoke with felt included within their care planning and treatment.

However,

- At the time of our inspection there was no formal user involvement within teams and no opportunity to help recruit staff. Patients we spoke with were not aware of any plans the trust may have had to increase user involvement in the future.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- The assessment teams and early intervention team reported delays in transferring patients to the recovery teams because of the pressure on that team's caseloads. This was confirmed by the recovery team managers we spoke with, who told us these issues were to be addressed as part of the service reconfiguration.
- There were also significant delays in allocating care co-ordinators to assessed patients due to the large waiting list.

However,

- Each team had established assessments slots throughout the week which enabled them to respond to urgent referrals within 72 hours. Rapid referrals requiring same day assessment would be undertaken through the daily duty system.
- In all reception areas we visited there was a large amount of information available for patients and carers. This was on notice boards and within information racks. It included information and contact details about complaints process, patient advice and liaison service, community support groups, advocacy.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

Summary of findings

- We did not see effective trust-wide processes to show how learning was spread across other teams.
- The serious incident policy and the CMHT operational policy need updating to reflect NHS England guidance on serious incidents and the current status of the CMHTs. This showed there were not effective processes in place to ensure these were appropriately maintained and in date.
- Managers told us they felt there were limited opportunities to undertake leadership development from the training department.
- All of the staff we spoke with were keen to improve services but felt the organisational changes were having a negative impact on team development.

However,

- There were systems in place which ensured staff received mandatory training, appraisals and supervision. Incidents were reported appropriately and there was evidence of local learning as a result of these, complaints and serious incidents.

Summary of findings

Information about the service

This was the first inspection of community mental health teams employed by Somerset Partnership NHS Foundation trust under the new approach. Previously Minehead community hospital was inspected on 28 February 2014. No compliance actions were outstanding for that inspection.

There are currently five main community mental health teams in Somerset and these are made up of separate functions covering assessment, treatment and recovery functions, which include the traditional assertive outreach approach. Early intervention for psychosis services are managed through a hub and spoke model with the main office in Taunton.

All of the teams were undergoing a reconfiguration exercise at the time of the inspection, with the stated aim of merging the assessment and recovery function. along with the provision of a county wide assertive outreach function.

Our inspection team

Our inspection team was led by:

Chair: Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Head of Inspection: Karen Bennett-Wilson, Care Quality Commission

The team comprised of:

- one inspection manager
- one inspector
- one mental health act reviewer
- three mental health nurses

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of patients who use services', we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patients' needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Somerset Partnership NHS Foundation Trust and asked other organisations to share what they knew. We carried out an announced visit on 8-11 September 2015.

During this inspection we:

- Visited all 5 community mental health teams.
- Spoke with 14 patients who used the service.
- Spoke with 27 members of staff from a range of disciplines, which included; psychiatrists, psychologists, occupational therapists, registered mental nurses, social workers, approved mental health professionals, support workers.
- Attended one care programme approach (CPA) meeting, three assessments of new patients, and two multi-disciplinary planning meetings, observed 12 different episodes of care.

Summary of findings

- Looked at a range of policies, procedures and other documents relating to the running of the services.
- Looked at 37 care records.

What people who use the provider's services say

We spoke with 14 patients who used the service and all were positive about the care and support they had received from staff.

Good practice

Patients were able to access the trust-wide employment support service. This service aimed to support patients to either gain or retain paid employment. We saw evidence that 198 patients had benefited from this service over the last 12 months and achieved paid external employment.

At Taunton community mental health team, staff were now offering two evening assessment sessions for patients who had been referred and were unable to make daytime appointments.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- To further mitigate the risks of the 120 patients waiting the allocation of a care co-ordinator

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The operational policy for adult community mental health teams had not been reviewed since October 2012 and requires updating to reflect current changes and practice.
- The trust serious incident policy needs to be reviewed to reflect the current NHS England Serious Incident Framework guidance published in April 2015.
- The provider should ensure that all community mental health team staff have the opportunity to attend regular training and updates on the Mental Health Act and the Mental Capacity Act.

Somerset Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Taunton Adult CMHT	Trust HQ (Mallard Court)
South Somerset Adult CMHT	Trust HQ (Mallard Court)
Minehead CMHT	Minehead Community Hospital
Mendip Adult CMHT	Priory Health Park
Bridgwater Adult CMHT	Trust HQ (Mallard Court)

Mental Health Act responsibilities

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

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

Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Detailed findings

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

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Not all interview rooms within the community bases we visited had alarms fitted.However, there were personal alarms available on each site staff to use, along with a system enabling extra staff to be summonsed in an emergency.Although the personal alarms could be tested on site, there was no overall record log which showed that they had been tested.
- Each CMHT base had access to a well-equipped clinic room with the necessary equipment to carry out physical examinations. This included access to emergency equipment and medicines.
- All of the community health bases we inspected were adequately clean and well maintained.In Yeovil CMHT base the manager told us they had recently changed cleaning contractor due to poor performance of the previous contractor.
- We saw staff adhering to infection control principles during our visit, such as maintaining clean hands. None of the electrical equipment in any of the bases had been PAT (portable appliance testing) tested in the last couple of years by the trust facilities department. This was a trust wide issue which will be included in the provider report.Staff told us they would report any malfunctions and get these remedied.

Safe Staffing

- In the five community mental health teams (CMHT) we visited there was 60.6 qualified staff with 2.0 vacancies. There was 11.1 unqualified staff with 0.6 vacancies across the five teams.
- Staff sickness rate varied across the teams, ranging from 11% in the South Somerset team to 3% in the Taunton team, Mendip and Bridgewater teams were 5%. Staff we spoke with told us this was impacting on the teams abilities to take on new cases as care coordinators.
- Team managers we spoke with told us the establishment of each CMHT was set over five years ago and had not changed since.None of the teams had estimated staffing using a recognised tool.
- The team's operational policy indicated caseloads should be 25 – 30 per whole time equivalent with some reduction dependent on operational demands such as approved mental health practitioner roles.We found caseloads varied in every team we visited.The highest we found was in Minehead where one member staff had a caseload of 40. The average caseload for each CMHT care co-ordinator was 28 patients. All staff we spoke with confirmed individual caseloads were assessed in detail during supervision sessions.
- The number of patients awaiting allocation of a care co-ordinator across all specialities was 120. At the time of the inspection visit the trust/service had difficulty identifying exactly how many patients were waiting to be allocated. This information was provided subsequently by the trust. The team waiting list was reviewed by the team leader and senior clinical staff during weekly business meetings. They told us they would assess the risk of patients waiting mainly through telephone contact.
- Team managers told us they were able to access some support from experienced bank staff on an ad hoc basis, to cover assessments and short term support.
- All the teams had a psychiatrist attached to them working throughout the week.
- Staff were up to date with the mandatory training and managers showed us the recently introduced monitoring system where they could review this information. The average rate of training completion across the teams was 89%.

Assessing and monitoring safety and risk

- All referrals came via a single point of access and staff undertook a telephone triage of risk in the first instance.
- The risk assessments we saw were comprehensive and reviewed monthly or more often if the patients risk

Requires improvement

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profile had changed.We did find evidence of crisis plans being devised with patients and the carers; however, we only found one example of an advance decision being made.

- Staff told us that when a patient's condition deteriorated, they would be assessed via the duty system only in the absence of the individual care coordinator.
- Managers showed us the measures they used to support patients on the waiting lists which included providing a telephone contact including out of hours, weekly prioritisation within the MDT, fortnightly reviewing with the GP.
- Each team had clear safeguarding protocols place and all the staff we spoke with had a good knowledge and understanding of the process to follow when making referrals.They also showed us a thorough knowledge of the potential abuse and risks patients faced.
- There were lone working protocols in each CMHT.Staff used a range of measures to track each other's presence off site which included; notifying reception or colleagues of their whereabouts, identifying locations on a whiteboard, phoning in at the end of the day to a manager.Staff also told us where they had potential concerns about a visit they could request support from a colleague in the team.
- Generally medicines management arrangements were good except we found some issues with storage in the Bridgwater team base.One of our specialist pharmacy inspectors visited this service and worked with the team manager to ensure safe systems were immediately put in place.

Track record on safety

- There were 13 serious incidents involving community patients in receipt of community mental health services in the 12 months leading up to our inspection.
- Locally the teams were aware of serious incidents and any actions which had occurred as a consequence of the root cause analysis.An example we were shown was how assessment documentation had been changed to improve the clarity of information available.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were all aware of the electronic incident reporting system (Datix) and how/what to report.Managers showed us how they would have to sign off incidents before they were forwarded to the central risk team.
- Staff knowledge around the duty of candour varied but all were clear about the need to be open and transparent with patients if something had gone wrong.
- All of the teams had monthly business meetings and we saw the minutes which listed feedback from local incident investigation.One example we noted was extra information being provided for patients over medicines management.Staff also told us they were able to discuss learning from incidents during clinical supervision sessions.
- Staff in each team told us there were effective debrief and support arrangements available to them after incidents.
- Team managers told us serious incidents were reviewed by senior staff appointed via the divisional manager.They told us and we saw evidence to substantiate that these reviews took in excess of 60 days to complete.We reviewed the trust serious incident policy which the CMHTs were using, it had been written three years ago. This policy did not reflect current NHS England serious incident framework guidance published in April 2015.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We reviewed 37 patient care records. The care records we reviewed were up to date and personalised, with a focus on recovery.
- Comprehensive assessments were completed at each referral meeting and immediately uploaded on to the electronic record.These included ascertaining a range of details such as; the patients personal circumstances, any historical mental health issues, physical health and risk factors. Each team had access to specialist staff such as child and adolescent workers who could support staff in the assessment process.
- All patient records were stored on a secure electronic system (RiO), and staff had access to laptop computers to assist in timely retrieval of records.However, staff in all the bases told us they were concerned about the potential reduction of desk space and computer availability in each centre.

Best practice in treatment and care

- We saw how staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions and were able to access NICE prescribing guidelines via the trust website. We met with the pharmacy technician who visited the Bridgewater and other teams every two weeks to audit prescription cards, including checking maximum doses of antipsychotics. Medical staff we spoke with told us they would refer to NICE guidance when prescribing for schizophrenia, bi-polar and personality disorders.
- Psychological therapies were offered in line with those recommended by NICE. These included family interventions, cognitive behavioural therapy and dialectical behavioural therapy. In order to access these patients required a care coordinator, and in Minehead CMHT we were told this had contributed towards the increased caseload of one member of staff. Psychologists also offered advice to other disciplines when requested. However, there was a 12 week average wait for access to psychological therapies.
- Patients were able to access the trust-wide employment support service.This service aims to support patients to either gain or retain paid employment.We saw evidence that 198 patients had benefited from this service over the last 12 months and achieved paid external employment.
- All the care records we reviewed we saw contained evidence how patients physical healthcare needs were assessed and addressed.This included an annual health check undertaken by their GP.In Taunton we saw a new "health and wellbeing" group which was run for patients in that area to help improve and maintain healthy lifestyles.
- Staff used health of the nation outcome scales to measure outcomes for patients. Specific examples of other outcome measures included; psychologists measured outcomes for patients attending therapeutic groups before, during and after a course of treatment in order to assess their progress and the effectiveness of the therapy. Nurses used depression scales to measure the impact of treatment.
- Managers showed us the range of clinical audits which were undertaken.These included reviews of documents, medication practice, Mental Health Act paperwork, annual health checks. These were monitored and reviewed by the directorate management team.

Skilled staff to deliver care

- The community teams included nurses, social workers, occupational therapists; carers support workers, support workers, approved mental health practitioners and medical staff. They were supported by a range of specialist disciplines and services such as psychology, art therapy, pharmacy, child and adolescent mental health workers, older age psychiatrists, employment, early intervention in psychosis.
- All new staff underwent a formal trust induction process, with the local one devised to orientate the member of staff to their team and locality.We spoke with two staff who had undertaken an induction in the last 12 months and they told us it had been very beneficial.
- Staff received clinical supervision in line with the trust policy every six weeks.We saw the monitoring systems managers used to ensure this occurred.Staff we spoke with told us they felt they had appropriate and timely

Are services effective?

Good

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access to supervision when required.Appraisals were undertaken each April and we saw these were up to date.Each team had a monthly business meeting and we saw records of these in each base.

- Staff within each team told us it was at times difficult to access specialist training for their roles.Managers we spoke with confirmed specialist training was only available on an individual basis subject to service need and financial liability.
- Managers told us they felt supported by the human resource team whenever they had to address any performance issues.

Multi-disciplinary and inter-agency team work

- All of the teams we visited under took weekly multi-disciplinary meetings involving key staff associated with their area, such as psychologists, psychiatrists, social workers, and care co-ordinators.With the exception of Minehead team, this would also include ward managers from the adjacent inpatient ward.
- Staff worked predominantly 9 to 5 Monday to Friday so did not have a shift handover.The teams all liaised with crisis and ward teams each day to address capacity, risk and bed management issues.
- All the staff we spoke to reported positive working relationships with colleagues in primary care, the police and local authority safeguarding services.Staff told us lines of communication had improved with district nurses, now that the trust was responsible for their services.They also told us being co-located with these teams had contributed to this improvement.

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

- The trust had scheduled training sessions on the MHA but at the time of the inspection there had been limited attendance by CMHT staff. The approved mental health practitioners had received training this year from the local authority (their employers).Managers we spoke with told us they would rely on this knowledge for the whole team.
- We found in the records reviewed that consent or capacity assessments were not routinely undertaken.Staff we spoke with told us they would only undertake these if they felt uncertain about the patient's ability to consent to treatment.
- Mental Health Act administrative support and advice were available to all teams via the Mental Health Act administration team.
- Community Treatment Order (CTO) records were available on the electronic patient record system, were up to date and reflected care according to the MHA Code of Practice. Patients subject to CTOs had CTO specific care plans and notes showed that their rights were discussed with them regularly.
- Community patients had access to relevant advocacy services and tribunals. Where patients had been recalled to hospital the records showed that this process had been according to the Code of Practice.

Good practice in applying the MCA

- We found in interviews with community mental health team staff that there was limited awareness of the Mental Capacity Act and community teams there was no evidence of auditing in its use.
- Training in the Mental Capacity Act (MCA) was available on a DVD. It was recommended that staff undertook this but not part of the mandatory training.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed 12 different episodes of care and at all times staff treated patients with kindness, dignity and respect.Staff provided an empathic approach and were professional in their dealings with the patients and carers.
- We spoke with 14 patients who were positive about the support they received from staff.They told us they were able to request or change particular staff if the need arose.They also told us they appreciated the range of professionals available and access to particular programmes.

The involvement of patients in the care they receive

- The majority of patients and carers we spoke with felt included within their care planning and treatment. They said they were offered choices in relation to their care and treatment but these were limited by staffing capacity in the specialist services such as psychology. Some patients had copies of their care plans but others said they hadn't. One patient of a recovery team said they had been assisted to make an advance directive, which included their wishes should they need to be admitted to hospital in the future.In the care records we reviewed patients had been involved in the creation of care plansr within the care programme approach documentation. They were present during the discussions and signed the documents to show agreement.
- < >eams had a carer's support worker who carried out carers' assessments and sign-posted people to sources of help and assistance. They also provided short term emotional support. Contact numbers for the carer support workers and information was displayed in waiting rooms.
  Patients had access to independent advocacy services and support services with the information displayed in patient waiting areas.This was provided by an advocacy service operating out of a base in Taunton but covering the whole county.
- Patients were able to give prompt feedback about the service they had received via electronic devices using the friends and family test, which were available at the reception desks. We saw responses to patient comments and suggestions displayed in waiting rooms in "you said we did" posters.However, managers we spoke with had variable knowledge about how to access specific information relevant to their teams.

Staff and patients we spoke with told us that the user involvement within the trust had diminished over the last couple of years, following the demise of the "Somerset user network" group. At the time of our inspection there was no formal user involvement within teams and no opportunity to help recruit staff. Patients we spoke with were not aware of any plans the trust may have had to increase user involvement in the future.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- All community teams had met the target time of three weeks from referral to assessment for routine referrals and 72 hours for urgent ones. Each team had established assessments slots throughout the week which enabled them to respond to urgent referrals within 72 hours. Rapid referrals requiring same day assessment would be undertaken through the daily duty system. We saw how managers monitored these and consistently met those timescales. Assessment teams would work with patients for up to a year following allocation of a care coordinator.
- The assessment teams and early intervention team reported delays in transferring patients to the recovery teams because of the pressure on that team's caseloads. This was confirmed by the recovery team managers we spoke with, who told us these issues were to be addressed as part of the service reconfiguration. There were also significant delays in allocating care co-ordinators to assessed patients due to the large waiting list.
- Teams triaged all referrals in order to determine who was at higher risk and if necessary could arrange an urgent assessment via the daily "duty" system. Each team had one member of staff identified each day to undertake this role and not their usual care coordination tasks.
- We saw the eligibility criteria for access to the service which states it is for clients who display severe complex and enduring mental health problems.This was contained within the operational policy for adult community mental health teams.All the managers we spoke with confirmed they were still adhering to this policy however; it had not been reviewed since October 2012.
- Staff had a policy for engaging patients who did not use the service, and told us they would make at least three attempts to make contact and leave voicemail messages as well as cards at their address. After this the patient would be referred back to their GP.
- Staff operated a 'orange card' program, where patients identified as at risk of requiring the service again within a short timeframe were given orange cards with numbers of support services to contact. This was identified on the RiO records system and made staff aware so enabling easier access to the service.We spoke with two patients who had used this system and told us they had found it supportive.
- Appointments were usually offered Monday to Friday 9 to 5.However in Taunton they were now offering two evening sessions in response to patients requesting appointments after work. Staff at Mendip and Bridgewater reported cancelling appointments due to limited staffing levels and staff sickness, if the appointment was deemed to be less urgent. Across all teams the number of every cancelled appointments for the last 12 months was 774, which included those cancelled by patients.

Facilities promote recovery, dignity and confidentiality

- In all five of the bases we went to there was a range of rooms to support therapy and treatment.This included interview rooms, assessment areas, family therapy suites and clinics.Staff told us there was considerable pressure on interview room's availability due to the high number of staff wanting to use them.It was only in Yeovil and Taunton bases there was a facility for art therapy.Patients would have to travel to these areas to attend groups.
- Interview rooms were all reasonably sound proofed so confidentiality could be maintained.They also had clear signage to indicate when they were in use.
- In all reception areas we visited there was a large amount of information available for patients and carers.This was on notice boards and within information racks.It included information and contact details about complaints process, patient advice and liaison service, community support groups, advocacy. We also saw booklets about condition specific information such as depression, anxiety or substance misuse.

Meeting the needs of all patients who use the service

- Patients with mobility issues or who used wheelchairs could access community team venues via ramp access and electronic doors. Consultation rooms were available on all the ground floors.

Are services responsive to people's needs?

Requires improvement

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

- Information leaflets were available on request in a range of different languages. Staff were able to access interpretation services for patients who did not speak or were not confident in English. Waiting areas had welcome signs which displayed the word `welcome `in many different languages.

Listening to and learning from concerns and complaints

- The total number of complaints received in the last 12 months by all the community mental health teams was 24, with 11 upheld.
- Managers told us they had received training in how to conduct a complaint investigation and resolution provided by the trust.They explained how complaints would be referred to them by the divisional manager and would be given 22 days in which to complete their response.
- Team managers gave us examples about complaints made by patients and how they responded. They told us they made improvements and learned lessons which would be highlighted in team meetings.This information would also be passed on to the divisional governance group and logged by the team manager. An example of an improvement which had been made as a result of a complaint, was providing a choice of gender for the role of care coordinator. We saw complaint feedback in meeting minutes and staff we spoke with confirmed it was a regular occurrence in these meetings.

Information on how to complain was displayed in waiting rooms and reception areas, where patients visiting the premises could see it.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- Staff we spoke with were aware of the trust's values and vision, and felt this was already in line with their clinical practice.
- None of the teams we visited had any team objectives set based around the organisations values.
- Staff knew who trust senior managers were, in one team they had met the chief executive and had a picture of him with all the team on the wall. They also told us that senior members of the trust had visited several bases, although they described this as more of a social visit rather than aimed at addressing any concerns which were raised with them.

Good governance

- There were systems in place which ensured staff received mandatory training, appraisals and supervision.Incidents were reported appropriately and there was evidence of local learning as a result of these, complaints and serious incidents.However we did not see effective trust-wide processes to show how learning was spread across other teams.
- We saw good safeguarding practice and staff with skills and knowledge in how to make appropriate referrals.
- During our inspection we reviewed the serious incident policy and the CMHT operational policy.Both of these were in need of updating. The serious incident policy did not reflect NHS England guidance on serious incident framework published in 2015, and the CMHT policy did not reflect the current status of the teams.It showed there were not effective processes in place to ensure these were appropriately maintained and in date.
- There was monthly monitoring of key performance indicatorse.g. M9a. % of clients on CPA (Level 2) seen within 7 days of discharge; M9a. % of clients on CPA (Level 2) seen within 7 days of discharge; M9b. All recovery care plans (level 2) to be reviewed at least annually.
- The team managers we spoke with felt unsure about their levels of authority, due to the internal reorganisation and being in temporary acting up roles.They told us they hoped this was a temporary situation and would be resolved over the next few weeks, with the completion of the reorganisation.Managers also told us they would appreciate more administrative support in each team due to existing vacancies in this staff group.
- We saw the local risk registers which were in use for each team.Managers showed us the process which enabled risks scored above eight on this scale to be submitted to the divisional risk register.This in turn could submit significant risks to the trust risk register. Team managers told us they felt risks which they highlighted were responded to appropriately by their line managers.

Leadership, morale and staff engagement

- Staff we met spoke of an improving culture across all the teams within the trust and especially with their colleagues within physical healthcare services. They also told us they had increasing levels of respect for other disciplines providing tertiary services.
- Staff also talked of in general having good morale in their teams, but many were concerned about management changes and the impact on team working. Some felt that these organisational changes along with higher caseloads in the service made it difficult for them to maintain good morale in the longer term.
- Staff told us they knew how to report any concerns they had and felt they would be addressed at a local team level. However, they were not sure about what actions the Trust would take or how senior managers would react to any whistleblowing concerns.
- Managers told us they felt there were limited opportunities to undertake leadership development from the training department. They attributed this to tightened budgets across the service.
- Managers felt they had the opportunity to develop services and provide feedback to their senior leaders about developments. However, other staff we spoke with told us they felt services changed around them rather than being specifically involved.

Commitment to quality improvement and innovation

- All of the staff we spoke with were keen to improve services but felt the organisational changes were having

Are services well-led?

Requires improvement

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

a negative impact on team development. They were aware of plans to merge the assessment and recovery teams into fully functioning community mental health teams.However we did not see any specific improvement methodologies in use.

- Teams participated in any national quality assurance programs such as the triangle of care. We also saw in Taunton CMHT how they had developed the wellbeing clinic in response to patient need.
- Employment support workers were accessible to all teams. They supported patients to access employment and training opportunities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(b) HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment To do all that is reasonably practical to mitigate the risks of the patients waiting the allocation of a care co-ordinator. This was a breach of Regulation 12(2)(b).