Good

Somerset Partnership NHS Foundation Trust

Community-based mental health services for older people

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	Mallard Court	The Bridge	BA5 1TJ
RH5AA	Mallard Court	Magnolia House	BA20 2BN
RH5AA	Mallard Court	Foundation House	TA2 7PQ

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	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
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 older people's community mental health services as good because:

- Lone working procedures were robust, detailed and clearly structured.
- Access to a psychiatrist could be on the same day if needed because they were on the same site or nearby.
- Risk assessments were comprehensive, person centred and reviewed regularly.
- There were infrequent incidents of harm or risk of harm and few serious incidents. Staff told us about examples of learning from incidents and we saw that these were reflected in team meeting minutes.
- Psychologists worked in line with recommended guidance and offered the latest therapies, working across multiple services to ensure patients received the most appropriate treatment.
- Staff showed us detailed mental capacity assessments, which demonstrated adherence to the five statutory principles of the Mental Capacity Act.
- Staff regularly assessed standards relating to patients' involvement in their own care using the 'Triangle of Care' monitoring tool.
- Carers were closely involved in care planning and assessments. Teams employed carer assessment workers and ran practical courses for carers supporting someone with dementia. We found carers' assessments evidenced in care plans.
- We observed positive and kind staff interactions with patients during four home visits. Patients talked positively to us about staff and the service they received. Carers told us that they felt supported and praised the efforts of the older people community mental health teams. Staff supported patients and their carers to use the friends and family test following assessments. Staff included feedback from these sources in weekly team meetings.
- Patients had access to local advocacy services. We saw leaflets for these services in all reception areas and staff could show us examples of when patients had used them.
- Teams appointed a designated daily duty worker, with an additional single point of access worker, to manage large numbers of incoming referrals. Managers used support time and recovery workers to develop initial working relationships with patients who found it difficult to engage with services.
- We saw a wide range of accessible leaflets and information packs given to patients prior to their assessments.
- Staff responded effectively to complaints which staff followed up and actioned in team meetings. Patients and their carers told us they knew the complaints procedure and would feel comfortable complaining if they were unhappy with the care or treatment they received.
- Staff demonstrated a resilient approach to making sure patients were not negatively affected by service issues, and they continued to provide a high quality service to patients whenever possible. Managers had submitted a risk assessment to the trust to highlight that keeping vacancies frozen and having managers doing two jobs was having a negative effect on patient care. They had also identified these issues on their local risk register.

However:

- Staff vacancies at Stratfield Day Centre meant staff could not always deliver safe care or activities for patients and activities were reduced.
- A number of vacancies within the other services affected staff morale because they had to take on greater responsibilities. Filling vacant posts with permanent staff had not been authorised during the integration phase two process, which had resulted in high usage of bank and agency staff and a lack of qualified nurses on shift.
- Memory services were full and there was a lengthy filtering process for patients being referred to memory assessment services, as GPs were referring all their patients who were presenting with a suspected memory problem to the memory assessment team. Some annual reviews had been missed due to the high number of incoming referrals, meaning staff were not able to monitor these patients if they had stopped taking their medication.
- Consultant psychiatrists allocated to older people community mental health teams were stretched

Summary of findings

across multiple primary and secondary health services and as a result, were not embedded into the older people community mental health multidisciplinary teams. Staff felt that consultants were not part of the multidisciplinary team. Consultants did join in the weekly multidisciplinary meetings but had commitments to other services too.

- We found gaps in regular managerial supervision of staff's work performance at services where there were management vacancies or where managers were covering more than one service. In one service, nurses could not continue prescribing because they did not get the regular clinical supervision they needed.
- Staff at memory assessment services told us that they sometimes had to rely on carers or patients to update them when they were particularly busy, instead of care co-ordinators assessing progress through face-to-face visits.
- Staff told us they did not feel well led due to a lack of consistent managerial presence, or because their managers had to do two different jobs and could not focus on their managerial responsibilities. Some local managers were acting up as interim divisional managers and some divisional managers were managing local teams. Staff did not feel they had been consulted on the service changes, for example, the integration process as they had not been able to take time off to attend meetings, sometimes due to teams being short staffed.
- We heard a strong and consistent message from staff who felt their specialist mental health focus and identity would be lost, and they would not have sufficient mental health representation when they merged with district nursing and integrated care services.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Lone working procedures were robust, detailed and clearly structured.
- Access to a psychiatrist could be on the same day if required.
- Risk assessments were comprehensive and person centred. They were reviewed following changes in medication or changes in a person's presentation.
- There was low incident reporting and few serious incidents. Staff told us about examples of learning from incidents and we saw that these were reflected in team meeting minutes.

However:

- Staff sickness levels were high in each location.
- At Stratfield House, a day service under Taunton Deane, low staffing levels meant staff could not always deliver safe care or activities for patients and activities were reduced.
- Filling vacant posts with permanent staff had not been authorised during the Integration Phase Two process, which had resulted in high usage of bank and agency staff and a lack of qualified nurses on shift. Permanent staff felt extra pressure and complained of low morale due to having to take on additional workloads during this process.
- Memory services were full and staff did not know if the trust had plans in place to address the increase in referrals, with frozen staff resources. There was a lengthy filtering process for patients referred to memory assessment services, as GPs were referring all their patients who were presenting with a suspected memory problem to the memory assessment team. Some annual reviews had been missed due to the high number of incoming referrals, meaning staff were not able to monitor these patients if they had stopped taking their medication.

Are services effective?

Good

We rated effective as good because:

- Psychologists worked in line with recommended National Institute for Health and Care Excellence (NICE) guidelines and offered the latest therapies, such as cognitive function tests, memory tests, delirium toolkits and physio-spatial assessments. Psychologists would work across services to ensure patients received the most appropriate treatment.

Summary of findings

- Staff followed the Department of Health dementia strategy objectives and guidance on positive risk taking.
- We saw evidence that different groups met regularly to share best practice, such as a dementia best practise group, a memory service steering group and an older person's mental health best practise group.
- Staff completed thorough assessments that informed and involved patients and their carers. The assessments included physical healthcare checks and reviews.
- Staff showed us detailed mental capacity assessments, which demonstrated adherence to the five statutory principles of the mental capacity act and we saw evidence of best interests meetings.
- Staff could seek advice and information on the Mental Health Act (MHA) and Mental Capacity Act (MCA) easily through their MHA lead.

However:

- We found there were gaps in regular supervision at services that had management vacancies, or where managers were covering several services. In one service, nurses were unable to continue non-medical prescribing, as they were not receiving regular clinical supervision, a requirement to ensure safe prescribing practice.
- Consultants allocated to older people community mental health teams worked across multiple primary and secondary health services and as a result, not integrated within specific multidisciplinary teams.

Are services caring?

Good

We rated caring as good because:

- Patients talked positively to us about their staff and the service they received. Carers told us that they felt supported and praised the efforts of the older patient's community mental health teams. We observed positive and kind staff interactions with patients during four home visits.
- Staff regularly assessed standards around patients' involvement in their own care using the 'triangle of care' monitoring tool. Carers were closely involved in care planning and assessments. Teams employed carer assessment workers and ran practical courses for carers supporting someone with dementia. We found carers' assessments evidenced in care plans.

Summary of findings

- Staff supported patients and their carers to use the friends and family test following assessments. We saw comments boxes and feedback cards within all the services we inspected. Staff included feedback from these sources in weekly team meetings.
- Patients had access to designated local advocacy services. We saw leaflets for these services in all reception areas and staff showed us examples of when the advocacy services were used.
- Staff worked over and above their roles to ensure patients were not affected by any service delivery issues. We observed remarkably hard working, dedicated staff delivering good quality care to patients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Teams appointed a designated daily duty worker, with an additional single point of access worker, to manage large numbers of incoming referrals.
- Managers employed support time and recovery workers to develop initial working relationships with patients who found it difficult to engage with services.
- We saw a wide range of accessible leaflets and information packs that staff gave to patients prior to their assessments.
- Staff responded effectively to complaints. We saw examples that had been followed up and actioned in team meetings. Patients and their carers told us they knew the complaints procedure and would feel comfortable complaining if they were unhappy with the care or treatment they received.

However:

- Some services carried out initial triage assessments over the phone, especially those with a higher number of referrals such as the memory assessment services. Staff told us that they sometimes had to rely on carers or patients who used the service to update them when they were particularly busy, instead of care co-ordinators assessing progress through face to face visits. Staff assessing patients over the telephone ran the risk of missing physical or mental ill health that they might have otherwise spotted in person.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

Summary of findings

- Staff told us they did not feel well led as a result of a lack of managerial presence, or managers having to carry out two full time posts when acting up as an interim divisional manager or vice versa (divisional manager having to manage local teams).
- Staff did not feel they had been consulted in the integration process as they had not been able to take time off to attend meetings, sometimes due to teams being short staffed. Staff told us they did not feel secure about the permanence of their positions during the integration phase two.
- We heard a strong and consistent message from staff who felt their specialist mental health focus and identity would be lost when they merged with district nursing and integrated care services. Teams felt that they would not have sufficient mental health representation at senior management level if their divisional manager was not a mental health practitioner.

However:

- Service managers had submitted a risk assessment to the trust highlighting that keeping vacancies frozen and having managers doing two jobs was having a negative effect on patient care. They had also identified these issues on their local risk register.

Summary of findings

Information about the service

The specialist older persons community mental health teams carry out initial assessments, establish treatment plans and arrange appropriate care packages for older people with severe mental health problems.

The teams consist of team managers, consultant psychiatrists, staff grade doctors, community psychiatric nurses, specialist social workers, occupational therapists, psychologists, secretaries and administrative staff.

The teams undertake casework and review, through care management and care coordination. They also provide information, support and advice to older people who use the service and their relatives, and provide support and co-working with other agencies – for example, home care, residential and nursing homes, and local authorities.

The service provides specialist individual therapies such as cognitive behavioural therapy and other counselling services. The teams provide support groups for patients with conditions such as dementia, and support and groups for their carers.

Psychiatric nurses support specialist residential care homes throughout Somerset that have been commissioned by Somerset county council to meet the long-term needs of older patients with dementia.

The service prioritises patients with:

- severe and complex mental health problems including dementia
- evidence of risk behaviours or complex dynamics requiring specialist intervention
- marked behavioural difficulties as a consequence of mental health problems
- complex family/carer situations requiring specialist intervention.

The teams offer either a home visit or an appointment locally at the team base to begin assessing what a person needs. Staff contact carers and relatives so they can give their views and information.

In providing assessment, treatment and support, one team member is identified as the lead (called a care coordinator) for each person.

The teams access packages of care (for example, home care, home support or respite care) via the county council adult social care service, and arrange direct payments and individual packages to support older patients with mental health problems to maintain their independence in the community, and to access long-term care where necessary and appropriate.

The community mental health teams, including memory assessment services, are based across the county of Somerset and hubs are located in five areas:

Mendip Older People's Mental Health Service

- The Bridge, Priory Park, Wells, BA5 1TJ
- Frome Medical Centre, Enos Way, Frome, BA11 2FH

Minehead Area Older People's Community Mental Health Service

- The Barnfield Unit, Minehead Community Hospital, Luttrell Way, Minehead TA24 6DF

Somerset Coast Area Older People's Mental Health Services

- Glanville House, Church Street, Bridgwater TA6 5AT
- The Mulberry Centre, Berrow Campus, Brent Road, Berrow TA8 2JU

South Somerset Older People's Mental Health Service

- Magnolia House, 56 Preston Road, Yeovil, BA20 2BN
- Bracken House, Crewkerne Road, Chard, TA20 1YA
- Ridley Day Service, Wincanton Hospital, Dancing Lane, Wincanton, BA9 9DQ

Taunton Deane Area Older People's Community Mental Health Service

- Foundation House, Wellsprings Road, Taunton, TA2 7PQ
- Stratfield House, Wellington & District Cottage Hospital, Bulford, Wellington, TA21 8QQ

These services have not been inspected before by the Care Quality Commission.

At the time of our inspection, older people's community mental health teams were in the process of being integrated with the district nurse teams and independent

Summary of findings

living services in the primary care sector. This process was part of a larger trust-wide reformation of services and is referred to as 'integration phase two' or 'IP2' throughout this report.

Our inspection team

The comprehensive inspection was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Healthcare NHS Trust

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

The team that inspected this core service comprised one CQC inspector and two specialist advisors.

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 people 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 people's needs?
- Is it well-led?

Before visiting, we reviewed information we held about the older people's community mental health services. We asked other organisations and local people to share what they knew about these services. We sought feedback from patients, families and carers via our comment card box and by telephone interviews.

During the inspection visit, the inspection team:

- visited three community mental health services for older people, including memory assessment services. We visited The Bridge covering the Mendip geographical region, Magnolia House covering South Somerset and Foundation House covering Taunton Deane.
- looked at the quality of clinical areas and observed how staff were caring for patients.
- spoke directly with eight patients
- spoke with six carers of patients
- attended and observed four episodes of care, including clinical appointments
- attended and observed one multidisciplinary meeting
- spoke with five managers of the services, including team leaders and divisional managers
- spoke with 14 other staff, including doctors, nurses and other clinicians
- looked at 22 treatment records of patients
- looked at policies, procedures and other documents relating to the running of the services
- asked other organisations and local people to share what they knew about the mental health services provided by the trust.

Summary of findings

What people who use the provider's services say

We spoke with eight patients who used the Somerset older people's community mental health services and they spoke positively about the service.

Patients told us that they could access a psychiatrist quickly, that their care co-ordinators were respectful and polite, that staff were interested in their wellbeing and that staff listened without interrupting.

Patients we spoke with told us that they felt involved in their care plans and had copies of their care plans at home. They told us that choices about care options were discussed with them, including changes to their medication.

Good practice

- We saw evidence of several best practice groups in operation, such as a dementia best practice group, a memory service steering group and an older patients' mental health best practice group.
- Carers' workers were employed to ensure carers' assessments formed part of core assessments and carers groups ran practical management courses covering issues such as power of attorney, nutrition and continence.
- We saw a colour-coded assessment tool, the 'Triangle of Care', which was used to monitor standards of involvement in care in all services.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

The trust must:

- Assess and monitor the impact of staffing vacancies on safe and effective care and take action to mitigate it until Integration Phase Two is complete
- Provide an effective management structure to teams at South Somerset and Taunton Deane where vacant posts were held vacant and managers were stretched covering two full-time roles.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

The trust should:

- Provide opportunities to staff to attend consultation meetings concerning integration with other teams.
- Ensure that managers make provision for regular supervision of clinical and non-clinical staff's work performance.
- Improve service delivery issues in the memory services, working with GPs to provide a clear referral pathway for patients with a mental health diagnosis and memory problems.

Somerset Partnership NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Bridge	Mendip Older People's Mental Health Service
Magnolia House	South Somerset Older People's Mental Health Service
Foundation House	Taunton Deane Area Older People's Community Mental Health Service

Mental Health Act responsibilities

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

- Mental Health Act training was not part of the mandatory training programme. We found that most staff had training in in Section 117 of the Act. Section 117 places a duty on health and social services to provide aftercare services to patients who have previously been detained under the Mental Health Act. However, due to the integration of social workers into this team who were approved mental health practitioners (AMHPs), staff deferred to these members of the team if an issue around the MHA arose. At the time of the inspection, there were no patients on a Community Treatment Order.
- Staff told us that they had a good understanding of the MHA and we saw the trust's MHA policy had been recently updated. Staff referred to the trust's MHA lead who delivered in house updates on the MHA and advised on any MHA issues for patients. The MHA lead had a team of MHA administrators who were available to give advice and guidance and staff told us these resources were accessible easily.

Detailed findings

- We spoke with social workers who were also AMHPs and they told us they were regularly involved in MHA assessments. They were aware of relevant documentation and their responsibility to ensure documents were completed and sent to the MHA administrators. All social workers had received training in the revised MHA code of practice.
- Staff were able to give us examples of when they had read patients' rights under the MHA to them. Staff also confirmed that carers were informed of their rights under the MHA.
- Patients were signposted to appropriate local advocacy services. Information was given to patients about how to access an advocate and referred to if they needed additional independent support.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training was provided by the trust on the Mental Capacity Act (MCA) via an on-line module, although it did not form part of mandatory training. We saw a DVD being used on site to update teams on the MCA. Local authorities also provided training and MCA was discussed in team meetings.
- Social workers, who were seconded to the teams from the local authority, formed part of the multidisciplinary team and were all fully trained in the MCA and deprivation of liberty safeguards (DoLS). Other staff showed a good understanding of the MCA and described key areas such as post diagnostic appointments, where they would refer to the MCA and the act's five statutory principles. We saw evidence that managers sent their teams updates on DoLS, such as briefing papers with links to the latest legal updates.
- Mental capacity and consent to treatment were covered in initial assessments. We saw that consent to treatment was recorded in the care records that we viewed. We saw examples of decision specific mental capacity assessments, for example, living arrangements and managing finances, and records of subsequent best interest meetings. We saw reference made to the Department of Health's document 'nothing ventured nothing gained', which provided guidance on best practice in assessing, managing and enabling risk for patients living with dementia. We also saw particular attention was paid to consent to onward referral in regard to driving assessments and contact with the DVLA following assessment. We saw consent and capacity assessments were in place for patients who attended day services with restrictions around entrance and exit points, as well as consent to care and consent to trips out.
- Each team had access to a best interest assessor who updated community psychiatric nurses on up to date practice. Staff organised best interest meetings for patients who lacked the mental capacity to consent to specific decisions. We saw an example of a mental capacity assessment related to a person managing their finances. A full assessment including an impairment test and 'test your memory' was also used. We then saw documentation of a best interest meeting with outcomes detailed. Power of Attorney certificates were checked and scanned onto electronic care records on RiO so staff could cross check the authenticity of carer's decisions.
- Staff referenced policies on consent and capacity that explained legislation around Power of Attorney and carrying out capacity assessments.

Good

Are services safe?

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

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

Our findings

Safe environment

- Interview rooms used for therapies did not have fitted alarms, except at Foundation House, which was linked up to the main hospital alarm system. Staff told us that alarms were not required in interview rooms as patients using their services were generally well known to them or, when they were not, a buddy system was in operation. Staff were able to access personal alarms if required.
- Staff did not routinely undertake physical examinations on site, as a full physical screening would be carried out by the GP prior to a referral to secondary services. Staff completed the majority of assessments and therapeutic input in the person's home. We saw one clinic room that stored medication and it was clean, secure, and well monitored. All medication was labelled, dated and accounted for. All medication administration sheets viewed were completed.
- Across all services, teams displayed cleaning schedules, fire exits were clearly labelled, extinguishers were recently checked, first aid points labelled and up to date health and safety executive notices were displayed. At Magnolia House, we noticed that some electrical testing for equipment was out of date.

Safe staffing

- Mendip older patients community mental health services held 35 substantive staff with one 0.6 community psychiatric nurse vacancy at Chantry Day Hospital and one full time social worker/approved mental health practitioner vacancy (however, this post was funded by the local authority). A full time band eight manager managed the older people mental health community services, day services and the assertive outreach and recovery team. The remainder of the team comprised of band seven to band three community psychiatric nurses (CPNs) working across community and the memory assessment services, social workers who were seconded into the team from social services, administrative staff and medical secretaries. Sickness levels stood at 7.5% and two internal bank staff were regularly used to cover vacant shifts.
- The South Somerset team comprised of 54 substantive staff with a divisional manager, a band seven team manager, and a range of nursing, medical and allied health staff. There were six full time vacancies in the team and sickness levels were high, ranging from 7.1% to 12.5% in services, some of which were attributed to allegations of bullying and harassment (investigation ongoing).
- There were 29 substantive staff at Taunton Deane services with a band eight team leader who was also appointed as an interim divisional manager. The staffing mix comprised of qualified nurses, day service staff, administrative staff, an occupational therapist and social workers employed by the local authority. There were three full time vacancies, including a deputy manager vacancy, and sickness levels were high with three staff off work on long term sick. Social workers formed an allocated part of the team structure but this was an issue when they had to carry out their approved mental health professional responsibilities for patients who were supported by social services, as this then left the mental health team understaffed. As vacant posts had been frozen during the integration phase two process (IP2), bank staff had been used to backfill posts.
- The trust had frozen vacant posts until the IP2 programme was complete. Managers were authorised to fill these posts with bank staff but this left teams in South Somerset and Taunton Deane without their established levels of permanent nurses and dedicated managers. Local leadership struggled because of vacancies within management teams and managers covering more than one post. Staff had also been asked to cover the workload of vacant posts and told us they felt stretched beyond their role. Unfilled vacancies at one of the day services we visited meant that simple activities such as taking patients out for a walk was not possible, as there weren't enough staff on shift to safely cover the service. A patient with high mobility needs was no longer able to attend the service as there were not

enough staff to support them safely. It also meant there was a significant impact to patients if staff were off sick or on annual leave. This high vacancy ratio meant they were running on a skeleton staff structure supporting patients with complex needs. One member of staff at a day centre told us they had recently had to cancel an appointment with a patient in Taunton Deane as they were required to be the duty worker for the day, due to lack of available staff. Risk assessments were carried out by team where they felt at risk from low levels of staffing. These had been submitted to the trust.

- Caseloads for most staff were, on average, 35 patients per full time worker. However, staff told us that memory services were 'at breaking point' due to the high number of referrals from GPs. We checked care records for patients using one MAS and saw that six reviews out of nine checked were overdue. The manager confirmed that reviews were overdue as a result of high caseloads and ever increasing referrals. One manager identified missed reviews as a high risk, as they were not able to monitor patients if they had stopped taking their medication. Teams relied on the patients themselves or their carers to inform them of any issues.
- Managers used internal bank staff to cover vacancies throughout the community, memory assessment and day services. This arrangement helped teams continue to deliver care during sickness, leave or vacancies.
- Patients and carers told us that they were able to access a psychiatrist quickly, and most teams had a psychiatrist on site who was able to respond to patients on the same day if required
- At the Mendip services, we viewed their training record, which was colour coded to show training that was about to or had expired. Staff had received and were up to date with appropriate mandatory training and the average mandatory training rate was 85% (from July 2015). The South Somerset teams were 86% compliant with mandatory training and the Taunton Deane teams averaged 85% compliance.

Assessing and managing risk to patients and staff

- We looked at 22 care records. Risk assessments were present from initial assessments. Risk assessments were updated following a change in risk severity. An alert on RiO appeared if a risk needed to be shared with others. Checklists were in place for staff to refer to when completing risk assessments. If staff had concerns around risks, they discussed them during staff supervisions and then updated risk assessments following the meeting. Patients (except in the memory services) received routine reviews either every six months or annually and we saw evidence that they were reviewed when a patients' needs changed.
- Staff created crisis plans during the initial compilation of a patient's care plan including specifications around how to support the person out of hours. Staff told us that during a crisis, they had been able to escalate an intervention with the duty worker on the same day.
- Staff reported concerns about the sudden deterioration of a patient's health up to the manager of the service, the on call duty worker and to the GP.
- Patients on waiting lists were monitored by their GPs, who would inform the older people services if a case became urgent. The Mendip service had carried out shared learning events with their local GPs about understanding signs of deterioration with dementia.
- Staff described the safeguarding procedure and had a good working knowledge of the policy. Staff gave us examples of potential abuse and could tell us how to escalate each category. We saw evidence of safeguarding meetings when we viewed care records, which included evidence from police reports and local safeguarding reports. Safeguarding alerts were recorded on the individual care records and the trust incident recording system, Datix.
- Management teams had created robust lone working practises in use throughout the Somerset services. In each location, we saw an up to date 'in-out' board and a shared information drive which held the personal details of all staff working that day. Duty workers kept a 'safe list' where each member of staff was ticked off at the end of each day. Buddy systems were in operation and two members of staff were available for initial assessments. Staff utilised their RiO diaries every day and updated these with any changes to appointments. Staff knew the safety phrase used to indicate they needed support.
- Older people's day hospitals and day services had patients who brought in their own medication. Staff followed standards for administration laid out in the trust's medicines policy. Registered nurses working in

Good

Are services safe?

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

the older people community mental health teams also administered depot injections to patients at home. Sharps bins were available on site for the safe disposal of needles. There were no nurse prescribers at the Mendip team due to a lack of clinical supervision. However, nurses would have been able to supplementary prescribe with support from the consultant psychiatrist.

Track record on safety

- A total of three serious incidents were reported by the older people community teams during the past 12 months.
- One serious incident report detailed an adverse event between two patients. The report showed how the service worked closely with the local hospital involved to carry out a best interest meeting in response and we saw the corresponding notes of a debrief meeting two days following the serious incident , detailing the lessons learned with the team.

Reporting incidents and learning from when things go wrong

- There had been 113 reported incidents (not categorised as serious incidents) throughout older people community mental health services in Somerset in the past 12 months. These had been reported by staff members onto the trust's Datix system. Staff told us that they knew how to report incidents to their manager and how to record onto Datix.
- Staff told us that learning points from serious incidents were discussed in monthly business meetings, referencing one example of an in-service training session that was implemented in response to a serious incident. We heard about one serious incident in Mendip which detailed a lack of information updates between two services. As a result the manager of this service ran a coaching session on how to complete records so levels of risk were clearly highlighted. This was then shared in a business meeting and staff had been debriefed in supervisions.
- Team debriefs usually took place within 48 hours of a serious incident occurring. We saw examples of debriefs in team meeting minutes.

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 looked at 22 records of care. Assessments were comprehensive. Assessments detailed a person's initial presentation, risk factors including previous suicide attempts and current intent, depressive symptoms and relationship to self-harm. Personal history, including support networks and family history were detailed. Current or previous substance misuse, levels of cognitive awareness, any safeguarding issues were also included. Consent and capacity were assessed and recorded. Comprehensive assessments usually took approximately one and a half hours to complete.
- During our inspection we saw that all new referrals were allocated a care co-ordinator within three weeks. Allocated daily duty workers ensured that urgent referrals were seen on that same day.
- Staff across services told us that when their weekly multi-disciplinary team (MDT) meetings did not involve their dedicated psychiatrist, due to them working at another service, they were able to contact them over the phone to discuss urgent cases.
- If patients using older people community mental health services experienced a crisis, the out of hours arrangements consisted of two dedicated night nurse assessors, rostered from the crisis teams, who worked primarily in the role of psychiatric liaison for the two district general hospitals in Taunton and Yeovil between the hours of 20:00pm to 08:30am.
- Staff described how they explained care plans to patients and how they gave information about initial assessments to patients, so they were aware of the potential consequences of having an assessment. For example, if a person presented with memory problems, part of the memory service assessment included a driving test. Staff told us it was important to make sure patients knew that they could have their driving license revoked if there were concerns about their ability to drive safely.
- Out of 22 care plans viewed, 18 of them evidenced comprehensive person centred information and collaboration between the patient being assessed and their staff. Crisis plans were in place and care records demonstrated use of the 'wellness recovery action plan' model for recovery. A person centred document called, 'this is me', advised on a patient's functional need and how they engaged in groups. Care plans detailed a variety of appropriate interventions. However, we found that care plans from the memory assessment service were less detailed, lacked evidence of involving patients in their plans and mainly focused on medication.
- All services used an electronic records system, RIO, to record patients' notes, enabling the sharing of important information between multidisciplinary workers in a secure system. However, GPs used a separate system and we heard about one serious incident that was a result of information being lost between the two systems. There were also an issue of adult social care using a different system to the trust and some staff felt they were missing links with information sharing.

Best practice in treatment and care

- Each team received the Somerset Partnership newsletter, 'what's on SOMPAR', which highlighted current National Institute for Health and Care Excellence (NICE) guidelines. These were discussed at team meetings.
- Clinicians recognised that current recommended NICE guidelines for dementia therapies were last updated in 2007-2008 and so altered their guidelines to reflect current guidance.
- Older people's services had designated psychologists who undertook cognitive assessments. They offered a variety of psychological therapies in line with NICE guidance, such as cognitive analytical therapy, talking therapies, family therapy, art therapy systemic psychotherapy, clinical psychology and eye movement desensitisation and reprocessing therapy. Psychological therapies were offered to patients both in house and by referral to adult therapy services. There was flexibility within the services for psychologists to work across areas so patients were able to receive the most appropriate therapy from a skilled professional. The treatments offered to patients were monitored during clinical group supervision.
- Physical health was monitored in care plans and staff told us that there was good communication and work between their service and GPs and district nurses. Day

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.

care services also monitored physical health care, such as blood pressure, weight and body mass index. GPs and older people teams shared the responsibility for the monitoring of antipsychotic medication. The last trust audit of antipsychotics had been in 2014. Clinicians told us that antipsychotics were only prescribed to dementia patients as a last resort and a recent audit showed that trust were below the national average for prescribing anti-psychotics. In day services, staff used evidence based cognitive stimulation therapy that had the similar outcomes to medication. Staff used interactive technology, specialist therapy and one to one intervention to avoid prescribing medication.

- Staff implemented recognised assessment tools within the older people teams such as the Rockwood test for driving, the 'Allen cognitive level' screen test for monitoring thought disorder, the Beck depression inventory to monitor mood, Krawiecka-Goldberg-Vaughan scale to rate symptoms, health of the nation outcome scales, mild cognitive impairment scoring and test your memory assessments for the memory assessment service.
- Clinical groups within the trust took forward internal clinical audits. We saw evidence of clinical audits plans undertaken with the trust's audit department. Nurses told us that they review the efficacy of prescribed medications and pharmacists visits care homes where patients live who have been prescribed anti-psychotics. Staff were also involved in triangle of care audits.

Skilled staff to deliver care

- Older people community mental health teams included a variety of mental health disciplines, such as qualified nurses, social workers with approved mental health practitioner status, psychologists and psychiatrists. Staff told us that they were easily able to access other professionals such as speech and language therapists, district nurses, podiatrists, physiotherapists and nurses specialising in Huntington's Disease. Patients received support for employment, housing and benefits via employment support services within the trust. The team linked in with the Homeless Society in Taunton.
- The Memory Assessment Service ran a trust wide steering group which involved a multidisciplinary team sharing best practise and included teaching sessions for band five nurses. There was also a dementia best practise group and an older peoples' best practise group which ran every three months.
- All new members of staff undertook a mandatory corporate induction with a role specific local induction, for example, continuing healthcare workers had to acquire specific additional training before conducting assessments. All staff had received annual appraisals and in Mendip services we saw that staff received monthly supervisions and a manager's record was updated once completed. Staff had not been receiving regular supervisions in South Somerset and Taunton Deane due to a lack of management structure. To ensure staff were having some supervision, managers from other services were having to supervise staff from older people community teams. The use of locum psychologists and psychiatrists at the Mendip services had caused some delays in clinical supervision for nurses who were unable to continue prescribing medication without supervision from a permanent consultant.
- Staff requested external training via their appraisals and supervision. Specialist training was delivered by senior members of the team, for example, dementia training during local induction. Social workers trained the team in the Mental Capacity Act and psychologists trained the team in using assessment tools. At the Mendip service we saw that a staff library had been provided for all staff to access and use to conduct research or additional learning.
- There was one on-going formal performance investigation at one of the services. This had not been resolved at the time of our inspection. The teams in this area reflected that they were 'recovering' from this situation and we saw evidence of staff returning to work following long term sickness and a temporary manager being supported to run the team until the issue had been resolved. No other formal performance issues were seen at the older people community teams and managers were able to describe the welfare for work performance and capability system if issues did occur.
- All non-medical staff had had an appraisal in the last 12 months.

Multi-disciplinary and inter-agency team work

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- Older people community mental health teams across the region attended weekly multidisciplinary and 'memory assessment service' team meetings. Monthly business meetings, involved consultants, psychologists and included the 'memory assessment service' teams. Agenda items included recent referrals, issues around capacity, feedback from patients, deaths, medical appointments required, safeguarding issues, health and safety, training, and stress management. Managers ran meetings across separate locations if there was more than one location in a team. Staff developed links with local district hospitals and meetings were organised with them to include dementia specialist nurses and geriatricians.
- Older people community teams ran best practise groups quarterly where the manager attended and shared information with their teams during monthly business meetings. Staff told us that they received a copy of the minutes for these meetings.
- We observed a multidisciplinary meeting where staff updated the RiO system live, which allowed some scan results to be examined during the meeting.
- When reviewing care records we saw evidence of regular input and liaison from other teams such as primary care services, podiatry, speech and language therapy and neurology. MDT meetings had guest speakers to explain issues the team might not come across; for example, a mental health lead to explain the new code of practise or adult social care colleagues to explain personal budgets. We observed a good degree of liaison between community psychiatric nurses, medical staff and the care agencies when we accompanied staff on home visits. However, we did hear from one carer who reported that care was not 'joined-up'. They gave us an example of receiving support from three separate professions; a memory service, a day service and a care co-ordinator, and said that they did not communicate well with each other about managing care plans, such as day care. Older people services also had good working links with the Alzheimer's Society, AGE UK, the Homeless Society and voluntary agencies.
- Consultants allocated to older people community mental health teams worked across multiple primary and secondary health services and as a result, were not integrated within specific multidisciplinary teams. This impacted on the continuity of care offered to patients.
- One manager informed us that there was not a clear pathway for GPs to follow when they referred patients to the memory assessment services. Staff told us that patients were referred to the memory service if they had a 'suspected memory problem', without necessarily having a mental health diagnosis.
- We saw an example with the Mendip services where a patient had been seen urgently by the duty worker, as they were unable to access the memory service. The duty worker had recorded that they used test your memory, a cognitive test comprising of 10 tasks, and 'large Allen cognitive level' screen test, a functional cognitive assessment designed to provide an initial estimate of cognitive function, during the urgent visit to determine the patient's level of risk to themselves. We heard that if patients started to deteriorate, care coordinators would meet with the consultant and GP, involve other professionals or try to get a different package of care. Teams would engage other services, such as adult social care if required.
- When we visited memory assessment services we found that staff sent plan of care letters to the GP so they were up to date with patients who had been referred.

Adherence to the MHA and the MHA Code of Practice

- Mental Health Act training was not part of the mandatory training programme. Most staff had training in in Section 117 of the Act. Section 117 places a duty on health and social services to provide aftercare services to patients who have previously been detained under the Mental Health Act. However, due to the integration of social workers into this team who were approved mental health practitioners (AMHPs), staff deferred to these members of the team if an issue around the MHA arose. At the time of the inspection, there were no patients on a Community Treatment Order.
- Staff told us that they had a good understanding of the MHA and we saw the trust's MHA policy had been recently updated. Staff referred to the trust's MHA lead who delivered in house updates on the MHA and advised on any MHA issues for patients. The MHA lead had a team of MHA administrators who were available to give advice and guidance and staff told us these resources could be accessed easily.
- We spoke to social workers who were also AMHPs and they told us they were regularly involved in MHA

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assessments. They were aware of relevant documentation and their responsibility to ensure documents were completed and sent to the MHA administrators. All social workers had received training in the revised MHA code of practice.

- Staff were able to give us examples of when they had read patients their rights under the MHA to them. Staff also confirmed that carers were informed of their rights under the MHA.
- Staff demonstrated a good working knowledge of Community Treatment Orders; however, at the time of our inspection there were no patients subject to these orders.
- Patients were signposted to appropriate local advocacy services. Information was given to patients about how to access an advocate and referred to if they needed additional independent support.

Good practice in applying the MCA

- On-line training sessions were provided by the trust on the Mental Capacity Act (MCA), although it did not form part of mandatory training. We saw a DVD being used on site to update teams on the MCA. Local authorities also provided training and MCA was discussed in team meetings.
- Social workers, who were seconded to the teams from the local authority, formed part of the multidisciplinary team and were all fully trained in the MCA and deprivation of liberty safeguards (DoLS). Other staff showed a good understanding of the MCA and described key areas such as post diagnostic appointments, where they would refer to the MCA and the act's five statutory principles. We saw evidence that managers sent their teams updates on DoLS, such as briefing papers with links to the latest legal updates.
- Mental capacity and consent to treatment were gained in initial assessments. Consent to treatment was documented in the care records that we viewed. We saw examples of decision specific mental capacity assessments, for example, living arrangements and managing finances, and records of subsequent best interest meetings. Reference was made to the Department of Health's document 'nothing ventured nothing gained', which provided guidance on best practice in assessing, managing and enabling risk for patients living with dementia. We also saw particular attention was paid to consent to onward referral in regard to driving assessments and contact with the DVLA following assessment. We saw consent and capacity assessments were in place for patients who attended day services where the door was locked to keep patients safe, as well as consent to care and consent to trips out.
- Each team had access to a best interest assessor who updated community psychiatric nurses on up to date practice. Staff organised best interest meetings for patients who lacked the mental capacity to consent to specific decisions. We saw an example of a mental capacity assessment related to a person managing their finances. A full assessment including an impairment test and 'test your memory' was also used. We then saw documentation of a best interest meeting with outcomes detailed. Power of Attorney certificates were checked and scanned onto electronic care records on RiO so staff could cross check the authenticity of carer's decisions.
- Staff referenced policies on consent and capacity which explained legislation around Power of Attorney and carrying out capacity assessments.

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 four home visits during our inspection and found staff to be caring, engaging and compassionate. We observed staff engaging with patients who demonstrated challenging behaviour towards them and found that they responded respectfully and thoughtfully. Staff had excellent rapport with the patients and their carers.
- Staff demonstrated positive attitudes with professionals in front of the patients they were seeing, using good referral pathways and using caring skilled interventions. We observed assessments of care and found staff actively listened They explained in detail the process of the assessment and checked understanding throughout. We visited day centres. Every patient was involved, activity programmes promoted cognitive stimulation and staff made sure everyone was included in the sessions. There was lots of laughter heard amongst patients using the day centre and patients there told us staff were positive, friendly, helpful and open.
- Patients told us that their care co-ordinators were kind and caring, interested in their welfare and provided them with information and advice when needed. We received 'patients' opinion' cards that said the memory service and Chantry day hospital have provided amazing service and support. Other patients we spoke with said they felt their staff were very caring and interested in them and they could laugh and joke with their care coordinators. Patients told us that they felt involved in their own care and they had or could get hold of a copy of their care plan. One patient told us that they didn't think you could beat the older people team for kindness. Patients we spoke with told us that they feel they're offered choice for which they are informed and consulted on.
- However, we spoke to one patient using the memory service who told us that they felt it was short staffed and they did not return calls after the patient had left messages. When this patient did get through to the memory service they told us that they spoke to a different staff member each time and this made them feel 'abandoned'. Another patient we spoke to told us that they had noticed a significant decrease in contact time since transferring from the community mental health team to the memory service; from weekly contact to up to three to six monthly contact and they did not feel this reduced access to professionals was sufficient.
- We saw flowcharts on the walls in services about how and when to disclose information about patients.

The involvement of people in the care they receive

- We observed that staff were very clear about goal setting when on home visits and they ensured the person using the service and their carers understood their care plans. Patients told us that they had been involved in their care planning and carers confirmed that they had been involved with any significant changes to care plans.
- Older people services ran carer's groups called carers education groups that offered clinical and practical advice. Carers told us that they attended these groups following diagnosis and they gave carers the tools to manage dementia practically. All new referrals offered a carers' assessment worker and subsequent carer's assessments were included in care plans.
- We saw the triangle of care being used throughout services, which was a colour coded assessment tool to monitor standards around family care involvement that included consent and evidence of consent, leading into an action plan. We saw an audit which was colour coded to show where services needed to be improved.
- Patients using the older people community services had access to local advocacy services, which we saw clearly signposted and used during the inspection.
- We saw that staff at Magnolia House had recently renovated the patio area following feedback from carers' complaints.
- We met one person who volunteered at a day service and had previously used services. They told us they enjoyed working there and wanted to give something back to the service that had helped them to recover. They told us that the service they had used had been excellent and their staff had been interested respectful and polite.
- We saw evidence of the trust's 'you said, we did' feedback posters displayed in corridors. Services used

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the friends and family test and incorporated feedback into team meetings. Patients told us that they were aware of the feedback process and felt they could raise issues about the service with their staff. Carers told us they could give feedback during carer's groups. Services used the friends and family test and we saw feedback cards for this in reception areas. Patients and carers told us they had used the friends and family test.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The older people services offered support for patients who were over 65 years old and provided an 'ageless' service, meaning there was no upper age limit. However, within the memory assessment services, patients with young onset (pre 65 years old) of dementia attended similar services to those with late on set of dementia. We heard from carers of patients with young onset who did not think these interventions met their partner's needs.
- Staff had capacity to respond to routine and urgent referrals. All but one service employed a single point of access worker who took over the assessment process from the duty worker once the referral had come in. The service that did not have this in place had two duty workers on each day. We saw referral guidelines that these staff used which prompted the staff member to answer questions such as current presentation and cognitive or functional problems.
- Across all older people services, there was a maximum of three weeks wait time from referral to assessment. A daily duty worker prioritised urgent referrals using a colour coded risk based system to prioritise actions and draw attention to most urgent cases. Staff told us that they would call those referred to assess the urgency with which the person needed to be seen or gather more information. However, in the memory assessment services staff told us that this would often be classed as the initial assessment to avoid breaching the waiting time. Staff told us that they sometimes had to rely on carers or patients who used the service to update them when they were particularly busy, instead of care co-ordinators assessing progress through face to face visits.
- Wait times for psychological therapies were within 12 weeks from referral to treatment. Psychologists received referrals from the single point of entry worker.
- Most services we inspected employed support time and recovery workers to form initial relationships with patients who were finding it difficult to engage with mental health services. Services worked with GPs and carer assessment workers to support families.
- Services offered flexibility around times of appointments and we saw that in Mendip, evening appointments were available to patients when their relatives wanted to attend.

The facilities promote recovery, comfort, dignity and confidentiality

- Cleaning schedules were in place across all building where patients were seen. The environments had good furnishings and were well maintained. However, we saw one interview room in the Taunton memory service that had no natural daylight, there was a constant humming sound and was a distance to walk from the main entrance. One patient we spoke with complained about this room and said it had been this way for some time. Staff were aware of this issue and acknowledged it had not yet been resolved.
- Clinic rooms were available to the older people community mental health services but shared with other services. Each service had a range of rooms available for therapy, including art therapy and workshops. We saw that day services had a wide range of dementia related support equipment such as, orientation clocks, chair and bed leaving kits, medication carousels, 'wandering' alarms and day and night time clocks.
- Rooms appeared to be sound proofed and signs showed when they were in use. This ensured patients were not disturbed during therapy sessions.
- There were a wide range of leaflets available to patients about local services, advocacy, assisted living, safety at home, voluntary and support services available, the trust's values and how to complain, in all reception areas. There were posters for activity workshops including classes in arts and craft, woodwork and computing. When we accompanied staff on home visits, staff gave patients information on memory walks, local swimming, poetry reading and arts and crafts events, activities all specific to the person's own interests. We spoke with carers who told us they were provided with information.

Meeting the needs of all people who use the service

- Services had ensured sites were accessible for patients using wheelchairs and toilets were accessible. There was ramp access to all the buildings we visited and

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Good

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some locations had lifts to transfer between floors. There were loop systems fitted in family group rooms so people using hearing aids could cut out background noise and focus on speech. We saw that environments were 'dementia friendly' displaying easy read posters and pictures on doors.

- Staff could access interpreters for patients through the trust.

Listening to and learning from concerns and complaints

- There were seven complaints for the older people community services in the past 12 months. Three of these were upheld and none had been referred to the Ombudsmen.
- We spoke with patients and their carers who either knew how to make a complaint or told us they felt comfortable raising complaints with their care co-ordinators.
- Staff knew how to process complaints and we saw complaint action plans which were colour coded, showed if the complaint was upheld and were discussed in monthly business meetings. We saw examples of complaints that had been resolved and also reflections of how staff responses are seen by patients.
- Monthly business meetings were used as a forum to discuss complaints.

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

- We saw the 'commitments to care' pledge displayed on the walls in all services along with the trust's vision and values and their strategic plan for 2015-16. Some staff at day centres said they did not feel connected to the trust.
- Staff reflected that the chief executive had visited their services but that they did not feel connected to the executive management team. Some staff told us that it felt as though they should 'do as they're told' and that trying to change culture under this directive was difficult.

Good governance

- Staff teams had gaps in training, where training was available but refresher dates had expired. Teams averaged 85% compliance with their mandatory training. Staff were responsible for booking their own training and were reminded via email. However, escalation letters were sent out to staff who's training was about to expire and the administration teams followed up on expired training. At the Mendip service we saw that training matrices were updated once a month following the Mendip divisional operational meetings which looked at trends and levels of training compliance.
- Teams had 100% completion of annual appraisals but some teams were lacking regular supervision due to a lack of management structure.
- Staff maximised their shift-time on direct care activities and typed up their notes on return to the base.
- Incidents were reported and learning from adverse events was reflected in team meetings.
- Although the trust led and carried out clinical audits, we saw that staff were aware of them and took part when possible. Staff learnt from incidents, complaints and feedback from patients.
- Feedback from patients was discussed in team meetings and we saw evidence that actions had been completed during the inspection.
- All staff were aware of safeguarding procedures and had good working links with social services when processing an alert. MHA and MCA procedures were followed and staff had access to guidance when required.
- The manager for the Mendip services worked towards payment by results, care cluster work and filled in score cards to complete local key performance indicators (KPIs) at the Mendip divisional operations monthly meetings. Managers used KPIs to monitor training, wait times, performance through supervision, appointment times, caseloads and record keeping.
- One team manager told us that there was a lack of consistent administrative support due to vacant posts being frozen by the trust during the IP2 process. In Taunton Deane, their full time secretary left last year and a replacement was not authorised which meant the team struggled with their administrative support.
- The pressure of increasing referrals and frozen staff posts within memory assessment services meant that care and treatment was not always provided in a safe way for patients. We saw evidence in care records that teams had not effectively assessed the risks to all patients and that medication and care plan reviews were overdue.
- We viewed local risk registers that identified levels of risk using a colour coded system. Issues identified included poor mobile signal when lone working, the impact of staff vacancies and risk to staff from patients. In Taunton Deane, the issues concerned staffing shortages, leadership and management of the team, supervision, efficiency of the referral process, risk to missing safeguarding, long term sickness levels, effectiveness of emergency responses and dealing with high referral numbers and a lack of representation with the local authority had been identified is a high risk on their risk register. We saw an accompanying risk assessment to these issues which the manager had submitted to the trust.

Leadership, morale and staff engagement

- Sickness and absence rates were high in one service due to previous allegations of bullying and harassment. This was no longer having an impact on the team but had impacted on these rates earlier on in the year. At the time of the inspection, this case was not fully resolved.

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.

- Staff knew where to find the whistleblowing policy and could refer to it if needed for the process.
- The majority of the staff we spoke with felt they could raise issues without fear of victimisation. However, we heard some references made to the bullying and harassment case.
- Relationships between team members were positive and all staff we spoke to said they felt supported by each other. Staff attended team away days where they had the chance to get together and discuss how to improve their services. Staff were very positive about their managers who had to take on additional roles, or of managers who have stepped in to support them.
- The staff teams we interviewed demonstrated a resilient approach and delivered good care to patients. We did not see any evidence of management issues impacting on the patients.
- We heard consistent concerns from staff at all levels that they were worried they would lose the specialisms provided by their services, when they merged with district nursing and integrated care teams. Staff felt that there had been a lack of recognition from the trust about the complexities of the older people community mental health services. Staff shared concerns about the loss of mental health management and the possibility of operating under a primary health care directive instead of a secondary mental health specialist service.
- The trust had set up consultation groups, for all staff to feedback about 'integration phase two'. However, only managers and consultants that we spoke with had attended. Other staff said they had not been able to attend these groups due to their work commitments, being short staffed or not having enough notice to attend. Staff told us they felt they have 'been done to', not listened to and there was a lack of provision made for them to attend the consultation groups.

Duty of candour

- Managers across the service were aware of their responsibilities under the duty of candour. All staff we spoke to were aware of the trust's 'see something say something' scheme and wore badges to demonstrate they had received the training. Some staff told us that they had been trained in the duty of candour and told us that patients would be informed of any incidents or changes to their service by a manager or most appropriate person.
- Staff told us that patients received feedback from incidents after investigations had taken place. We saw one example on Datix where there had been a medication error, written by the nurse who identified the error. The manager had been informed and that the staff member had contacted the person using the services to inform them. We then saw feedback from the Datix process reflected in the next week's team meeting.

Commitment to quality improvement and innovation

- Managers were involved in local quality improvement programmes such as the `triangle of care', a colour coded assessment tool used to monitor standards around involvement in care. Services were also involved in trust-led quality improvement programmes. We saw minutes from business and innovation meetings where the service structure was agreed, a review of the service took place and an action plan was set.
- Managers had established quality improvement plans for day hospital therapeutic groups, assessment groups, anxiety management groups, cognitive stimulation groups and memory strategy groups. In the Mendip services, the manager was offering training to staff, as identified in an action plan for 'my teams quality improvement programme' following the triangle of care audit. It was called the 'family and carer inclusive' practice training programme.
- Teams had been involved in recent research into anxiety disorders audits and dementia research. Memory assessment services were part of a research project signed up to by the trust to carry out specialist assessments.

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 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated activities) Regulations 2014 There were not always sufficient numbers of adequately experienced and skilled staff to ensure patients were safely looked after and teams were well led. This is a breach of Regulation 18 (1):