Somerset Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute and PICU	Rydon Wards 1 and 2 and Holford Ward Rowan Ward St Andrews Ward	RH576 RH572 RH502
Community End Of Life Care	West Mendip Community Hospital Frome Community Hospital Wincanton Community Hospital Williton Community Hospital	RH5F8 RH5G5 RH5G2 RH5X7
Community Health Inpatients	Bridgwater Community Hospital West Mendip Community Hospital Dene Barton Community Hospital Wellington Community Hospital Wincanton Community Hospital Frome Community Hospital Burnham On Sea War Memorial Hospital South Petherton Community Hospital Chard Community Hospital Williton Community Hospital Shepton Mallet Community Hospital Minehead Community Hospital Crewkerne Community Hospital	 RH5K6 RH5F8 RH5X5 RH5X9 RH5G2 RH5G5 RH5X2 RH5Y8 RH5W6 RH5X7 RH5F7 RH5Y4 RH5X4

Summary of findings

Long stay/rehabilitation mental health wards for working age adults	Willow ward	TA6 5LX
Sexual Health	7 The Crescent	RH5Z2
Minor Injuries Unit	West Mendip Community Hospital Shepton Mallet Community Hospital Minehead Community Hospital Frome Community hospital Chard Community Hospital Burnham on Sea War Memorial Hospital Bridgwater Community Hospital	RH5F8 RH5F7 RH5Y4 RH5G5 RH5X3 RH5X2 RH5X1
Child and adolescent mental health wards	Wessex House	RH5Y5
Specialist community mental health services for children and young adults	Mendip CAMHS Balidon Centre Fountain House Taunton	RH5AA
Forensic inpatient/secure wards	Ash ward	RH5Y5
Mental health crisis services and health-based places of safety.	Wellsprings Hospital site, Taunton 136 Summerlands Hospital site, Yeovil 136 Taunton Deane / West Somerset crisis and home treatment team Yeovil / South Somerset crisis and home treatment team Bridgwater / Somerset Coast crisis and home treatment team Wells / Mendip crisis and home treatment team	RH5AA RH5AA RH5AA RH5AA RH5AA RH5AA
Older persons inpatient mental health services	Magnolia Ward Pyrland 2 Pyrland 1	RH572 RH576 RH576
Community-based mental health services for older people.	Mendip Older People's Mental Health Service South Somerset Older People's Mental Health Service Taunton Deane Area Older People's Community Mental Health Service	RH5AA RH5 RH576
Community based services for adults	Taunton Adult CMHT South Somerset Adult CMHT The Barnfield Unit - CMHT Mendip Adult CMHT	RH5AA RH5AA RH5Y4 RH5Y7

Summary of findings

	Bridgwater Adult CMHT	RH5AA
Community and Specialist Dental Services	Bridgwater Dental Access Centre Glastonbury Dental Access Centre Taunton Dental Access Centre Yeovil Dental Access Centre	RH548 RH5H3 RH5Y9 RH5X6
Community health services for adults	Dene Barton Community Hospital Park gate House, East Reach, Taunton West Mendip Community Hospital Priory House, Priory Heath Park, Wells Charter House, Bartec 4, Yeovil Chard Hospital Frome Medical Centre South Petherton Community Hospital Crewkerne Community Hospital Williton Community Hospital Shepton Mallet Community Hospital Wellington and District Cottage Hospital Bridgwater Community Hospital Burnham on Sea Community Hospital Castle Cary Surgery Dulverton Surgery Frome Community Hospital Wincanton Community Hospital Minehead Community Hospital	 RH5X5 RH5F8 RH5Y7 RH5 RH5X3 RH5G5 RH5Y8 RH5X4 RH5X7 RH5F7 RH5X9 RH5K6 RH5X2 RH5G5 RH5G2 RH5Y4
Community Learning disabilities	Frome Enterprise Resource Centre Sedgemoor and West Somerset CTALD South Somerset CTALD Taunton area CTALD	RH5AA RH5 RH5 RH5

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Requires improvement** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Requires improvement** 
Are Mental Health 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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Summary of findings

Overall summary

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

We found that the provider was performing at a level which led to a judgement of **requires improvement** because:

Information specific to the community services for adults with learning disabilities

- The community teams for adults with learning disabilities did not provide care and treatment in a way that would prevent avoidable harm or the risk of harm. The community teams for adults with learning disabilities did not always respond appropriately to patients' individual needs so as to ensure patient welfare and safety. Due to this we took enforcement action by serving a warning notice.
- We found a a lack of robust assessment of individual patient risks and of person-centred care planning. There was also limited evidence of behavioural support plans being in place where needed. Documentation was often not completed appropriately and there was limited evidence that reviews of the risks and outcomes of care and treatment had been carried out. There was limited evidence that patients had been involved in developing their care planning and care plans were not always formatted in a way that patients could understand easily. In addition, there was ineffective working practice with other services/organisations where responsibility for care was shared or transferred. There was a lack of appropriate reporting of incident through the datix system (electronic incident reporting system); incidents and safeguarding concerns were not always logged on datix, and consequently there was a failure to identify and mitigate risks and learn from incidents that had occurred. The trust did not operate a waiting list for the community learning disabilities services or the rapid intervention team; as a consequence there was no understanding of the number of patients requiring the service or their needs or risks. Additionally, the trust failed to assess the needs of people with a learning disability who required a service but who did not meet the eligibility criteria for community learning disability services. This meant that people were not directed to appropriate services and put people at significant risk of not receiving the care and treatment that they needed. Prior to the CQC inspection the trust had failed to recognise the scale of the issues identified.
- We asked the trust to take immediate action to address concerns. The warning notice required the trust to undertake an immediate review of service caseloads, which it must have completed by early November 2015. The warning notice also required the trust to commence a comprehensive review of assessment and care planning which it must have completed by the end of March 2016.

Information about the trust as a whole

- We found significant variation in the quality of care delivered by teams and across the trust.
- We had serious concerns about community health services for adults due to significant staff shortages that placed excessive strain on the district nursing workforce. Nurses did not consistently complete baseline observations and clinical risk assessments relating to nutrition, pressure care and falls. There were two record-keeping systems in operation. However, neither system could be relied on as a complete patient record presenting a potential risk of omissions of important information essential for safe patient care.
- The trust's governance systems failed to adequately identify key issues that allowed it to assess, monitor and improve the quality and safety of services provided. For example, there was variation in management of informal complaints and limited learning from complaints at a local service level; variation in medicines management and use of risk registers and limited learning from incidents generally. Understanding of governance systems and their application and importance in monitoring the quality of services was patchy across the services.

Summary of findings

- There was variation in the management of risks across services. Risks were not consistently identified or effectively managed to ensure recommendations were addressed promptly. Risks were not consistently shared between local teams and senior management. In several services, risks had been identified at service level that did not correspond with risks identified at trust level.
- A number of services did not have systems to mitigate risks to people who were waiting to access care and treatment. Some services had long waiting lists. The trust did not adequately monitor patients who did not attend appointments or mitigate risks for people who required services but could not access them due to not meeting eligibility criteria.
- In a number of services there were insufficient numbers of staff to meet patient needs. Although the trust faced a number of challenges because of the area in which it was situated it recognised it needed to be more imaginative in addressing staffing shortages. However, there was no clear workforce recruitment and retention strategy to address staffing issues. The trust informed us that it was waiting for a new director of human resources to commence in post; this person would be responsible for developing a comprehensive organisational development and workforce strategy.
- The quality and detail of patient records varied across services and teams. Care plans were not always person-centred and lacked the detail required to demonstrate an understanding of an individual's circumstances and needs. Capacity, consent and details about who information could be shared with were not always recorded and patients in a number of services, particularly mental health services, did not always feel involved in planning their care.
- The trust's vision and set of values were displayed on posters throughout the trust. However, many staff could not clearly explain these and some staff were unaware of them. Staff were able to describe principles such as working in partnership and providing quality care, but some staff felt that they had not been involved in development of the trust vision.
- The trust had been through a period of considerable change since 2011 when it merged with Somerset Community Health, the community health service provider of NHS Somerset. The trust's vision for the service was to provide a fully integrated service across the three counties and it had begun a process of transformation of services which it called 'integration phase two'. The trust advised that the public and patient engagement aspect of integration phase two project was informed by the National Voices survey, the joint mental health strategy and Somerset's community services review. However, there had been little public or patient engagement following the development of the transformation plans. Implementation was at an early stage at the time of our inspection.
- While the majority of staff were aware that the implementation of 'integration phase two' was taking place and many were positive about the perceived benefits of further integration, some staff felt there had not been enough consultation and engagement. In addition, many staff we spoke with across the services felt the process of change had not been effectively managed. The majority of mental health staff felt that the emphasis of the integration was on physical health care services to the detriment of mental health services.
- The board were aware of some of the concerns staff had about the service redesign and managerial changes. However, the trust did not have a clear plan to support staff and monitor the impact of the service re-design, location and management changes on staff health and wellbeing.
- At the time of the inspection many of the managers of services were new in post (some only days or weeks) and had not yet had time to develop a detailed understanding of the service or chance to identify key issues of good practice or areas for improvement.

However,

- The trust responded positively when we raised issues about community learning disability services. It quickly provided an action plan following receipt of the warning notice and provided regular updates on

action taken. In the update of 13 November 2015 the trust indicated that all actions required by early November had been completed. (see below for additional information)

- Under the leadership of its current chief executive who was widely respected, the trust had maintained its foundation trust status since May 2008 and retained financial stability throughout. The chief executive was leaving the trust at the end of the year. At the time of the inspection his successor was in the process of being appointed.
- The majority of the trust board and senior management team acknowledged there was a need for the culture within the organisation to change from the 'top down'. The board was committed to ensuring that the trust changed and successfully implemented its change programme. It also recognised and was fully committed to significantly improving engagement with staff to ensure staff felt valued and fully supported.
- Local leadership was seen to be good by staff in most of the services inspected. Staff reported good morale and felt well supported by their immediate managers for operational support and career development. We were told that generally there was a good level of openness and honesty at a local level, although staff identified a disconnect between what happened locally and the senior leadership
- The trust had developed a new governance framework and put in place a number of committees and meeting structures to implement and oversee both the governance framework and the wider transformation of services. The trust had also developed a new dashboard to monitor performance, and the board now received regular quality reports. The executive team had commissioned audits of some of the risk and governance systems and were committed to implementing change. However, the new governance framework and dashboards were at an early stage of implementation and therefore it was too early for us to assess their impact.
- We found many areas of good practice across the services, with a caring, enthusiastic and committed workforce that in the main treated patients with dignity and respect. Staff in all services took time to interact with patients and it was evident that good relationships were in place between patients and staff. In community dental services we found staff cared for patients in an outstanding manner, delivering care with thoughtfulness and consideration.
- The trust had a carer's charter; a 'triangle of care' steering group worked hard to ensure this charter was applicable and meaningful to carers in the trust's community health and mental health services. The trust worked effectively in partnership with voluntary organisations to support patients and carers.
- In July 2014, the trust executive team created 'employee of the month' and 'team of the month' staff awards. Their aim was to celebrate a team or individual that went "above and beyond their role to deliver great patient care". Quarterly 'voicebox' meetings were established in January 2015 as a staff-led engagement forum for raising key areas of concern.
- The trust had progressed a number of innovative initiatives and several services had received nominations or recognition from national organisations. The trust was committed to participation in research and development and was involved with 15 national research projects.
- There was a range of audits conducted in the trust including national, local clinical and commissioning and quality innovation audits. The outcomes of these audits were used to influence and improve practice.

Somerset Partnership NHS Foundation Trust requires improvement. The trust recognised that it needed to change in order to deliver contemporary, high-quality services to patients. It also recognised that it needed to engage much more effectively with its staff and organisations that it works in partnership with. The board was committed to ensuring it brought about these changes and recognised that it needed to conduct its business with renewed focus and energy in order to realise its vision in a timely and collaborative manner.

Summary of findings

We will be working with the trust to agree an action plan that assists in improving standards of care and treatment. We will also return to the trust to ensure it has taken the action necessary to fulfil the requirements of our warning notice.

Additional information about community learning disability services

- In September 2015, we inspected the services delivered by the community teams for adults with learning disabilities as part of the comprehensive inspection. During the inspection we found that the trust was not meeting the standards expected in this service as it did not have appropriate measures in place to prevent avoidable harm, or risk of avoidable harm to patients using the service.
- We found that the trust was in breach of Regulation 12 (1)(2)(a)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice on 28 September 2015. We told the trust it must comply with requirement detailed as part one of the warning notice; to take an immediate review of caseloads and put in place safety plans to mitigate risk, within six weeks of serving the warning notice and comply with requirement detailed in part two of the warning notice; to undertake a comprehensive review of the assessment and care planning, within six months of CQC serving the warning notice. The trust sent us an action plan and later confirmed that it believed it was compliant with the requirements of the first part of the warning notice.
- We carried out an unannounced, focussed inspection on 24 November 2015 to assess if the trust had addressed the concerns and to check the progress that had been made. During our inspection we spoke with three staff; two clinicians and a manager and reviewed 17 care records.
- The trust had set up an improvement group to lead its response to our concerns. Action taken by the trust included identifying a learning disability community service in another trust with a similar population that had been rated 'outstanding' for caring and 'good' overall by the CQC. Staff from this trust had agreed to advise and support a review of practice and for it's nurse consultant to work with staff from Somerset Partnership NHS Foundation Trust to help develop their practice. Staff in the service told us that they felt positive about the support and training that was now being provided. They said they could see that there was now a sense of energy in addressing the improvements the CQC inspection had identified.
- On the day of our inspection staff within the services were receiving training that included incident reporting and safeguarding. The trust had also provided staff with training on clinical assessment and the management of risk.
- The trust had undertaken a review of all 900 open patient cases and had identified the key risks for each patient. All 17 records that we sampled had been reviewed and the risks identified. However, despite the detailed action plan and progress made, we were concerned that in 14 of the 17 records we viewed the care plans had not been updated to reflect the risks or risk information identified during the review. The care plans in these records were of poor quality. Patients' physical health risks had not been addressed and staff had not considered the impact of patients' previous histories, for example, if there had been a history of aggressive, disturbed or inappropriate behaviour that could pose a risk for the patient or to others. The risks identified by the trust had focussed on the risks to patients but had not considered risks to staff or others.
- Although some good progress had been made and the new service director had put in place several positive changes that in time would result in significant improvement in services for patients we found that the trust had not met all the requirements of the first part of the warning notice. However, at this time we will not be taking any further enforcement action but will continue to monitor the work being undertaken by the trust to comply with the warning notice.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Overall, we found that there was variation in the identification and management of risks across the services provided by the trust.
- We had serious concerns that the community services for adults with learning disabilities disabilities did not always respond appropriately to meet peoples' individual needs to ensure the welfare and safety of service users. These concerns included the lack of risk assessments, mitigation of risks, incident reporting and working with others where responsibility for care is shared or transferred.
- In addition, some other services did not consistently identify or effectively manage risks. The lack of effective risk management prevented these services from promptly implementing recommendations. In addition to community learning disability services we found particular issues with the urgent care, sexual health and community inpatient services, where staff identified risks at the service level that did not correspond with risks identified at the trust level. Local teams and senior management did not consistently share risks. Incident reporting varied and there was a lack of consistent learning from incidents across the trust.
- A number of services lacked sufficient staff numbers to meet patient needs. There were high staffing shortages (predominately band 5 and 6 nursing staff) in the community inpatients service and the community adults service. There were staffing vacancies in the older person's mental health in-patient and community services. A particular risk within the mental health services was that although there was a doctor on-call system in place, some staff in a number of different services told us that it was not always easy for staff to access adequate medical cover, and a doctor might not always be able to attend the ward quickly in an emergency. The trust recognised it needed to address staffing shortages, but there was no clear workforce recruitment and retention strategy to monitor and address staffing issues
- Many mental health and community health services did not have effective systems for monitoring and checking safety and emergency equipment, including resuscitation equipment. There were examples across some services where maintenance

Summary of findings

and monitoring of equipment were overdue or checks were irregular. The trust advised that a programme for portable appliance testing was on-going during the inspection and reported that a new contract and system for managing medical devices and equipment was being introduced.

- A small number of buildings and facilities did not meet an acceptable standard of cleanliness or suitability. For example, the Mendip child and adolescent mental health community kitchen was unsafe. We asked the trust to take immediate action to rectify this issue, which it did in a timely manner. There were also a number of issues related to the design and layout of the older people's wards. At Magnolia ward, an older person`s mental health ward, we found the whole section of a far end of the ward was unused and not visible to staff, but also not closed off to patients. Risks posed by the unused section of the ward were not effectively mitigated. There was also no suitable access to fire escapes or training for staff in emergency equipment use at Chard Community Hospital.

However:

- Most wards and facilities were well maintained and visibly clean. The trust had infection control policies and procedures in all services.
- The trust had a lead for safeguarding and senior representation at the multi-agency safeguarding adults board. The multi-agency safeguarding hub (MASH) was established formally earlier in 2015. Trust staff worked alongside the local authority and other agencies to promote collaborative safeguarding arrangements. We found that staff had a good understanding of the safeguarding process and their responsibilities within it.
- The trust had introduced the 'see something, say something' initiative to encourage staff to speak out about any good practice or any practice which they felt was not of an appropriate standard. Staff across all services were aware of this initiative.
- The trust had commissioned an audit of its risk management system and implementation of the Duty of Candour regulation in order to identify required improvements.

Are services effective?

Requires improvement

We rated 'effective' as requires improvement because:

- We had serious concerns that the community services for adults with learning disabilities disabilities did not always respond appropriately to meet peoples' individual needs to ensure the welfare and safety of service users. These concerns

included the lack of risk assessments, person-centred care planning, and working with others where responsibility for care is shared or transferred. We issued a warning notice in response to these concerns, this meant that the trust was required to take action within a specific timescale.

- The quality of patient records varied in detail and quality across the services and teams. Assessments and care plans were not always person centred and in some instances they lacked the detail required to demonstrate an understanding of the individual`s circumstances and needs.
- We found that the collection of information demonstrating outcomes was limited across the trust. Outcome measures were not used to benchmark the performance of the many services. Therefore, the teams did not know how effective their care was in comparison to similar services in other organisations.
- Mental Health Act and Mental Capacity Act training did not form part of the trust's mandatory training programme. We were not assured that the current training and numbers of staff who have undertaken it enabled staff to have a good understanding of the legal framework and application in practice.
- All information was stored securely on an electronic records system called RIO, which was available across the trust. Some services, such as the district nursing teams also kept paper records in patient`s homes, for example, observation and medication charts. Community health services had moved from paper records to the RIO electronic system approximately 18 months previously. Due to connectivity issues with computers, electronic patient records were not always available so staff also kept paper records. This meant some records were incomplete. Some services could not access records completed in other services when patients' moved between them. For example, there were serious concerns raised within the learning disabilities service due to poor access to information held by the local authority.

However:

- Overall, patients' care needs and risks were fully assessed and care plans had been put in place. There were some excellent examples of comprehensive and person centred care plans.
- There was evidence that the trust was already working to, or working towards providing care and treatment in line with relevant national guidelines, such as those produced by the

Summary of findings

National Institute for Health and Care Excellence (NICE). The trust had set its own target to assess all NICE guidance for relevance/compliance within three months of publication. To support this there were a number of best practice groups across the trust. These were made up of senior staff, from a range of services, that met quarterly to review incidents, share good practice and review relevant NICE guidance.

- Across all areas of the trust, care and treatment was provided by multidisciplinary teams of competent staff who were qualified and trained for their roles. Most staff had regular supervision, appraisals and development opportunities.
- Staff participated in a range of clinical audits, including national clinical audits. Local audits included looking at quality of handovers, falls and pressure ulcers.

Are services caring?

Good

We rated 'caring' as good because:

- We observed a range of staff providing care to patients in a respectful and considerate manner. Patients dignity and privacy was respected. For example, doors were closed when staff left clinic rooms and where a curtain was used, it was drawn across. Reception staff took patients details in a confidential manner and reception areas were suitable for carrying out conversations that would not be overheard.
- Staff in all services took time to interact with patients. We observed laughter between the patients and staff and it was evident that good relationships were in place between them meaning that difficult procedures were undertaken with consideration and respect for each other. We observed personal care being provided and saw patients were treated with dignity and respect. On the mental health wards, the activities coordinators demonstrated a good rapport with patients and offered choice to accommodate patients' preferences. We saw staff being respectful and responsive to patients' needs, for example, during lunchtime, patients were encouraged to choose what they wanted to eat. We saw a patient who was being verbally aggressive calmed by staff using calming, de escalation intervention.
- The trust carer's charter was reviewed and updated in 2013. The 'triangle of care' (a therapeutic alliance between patients, staff and carer that promotes safety, supports recovery and sustains

Summary of findings

well being) steering group had undertaken this work and the charter was applicable to carers in the trust's community health services as well as the trust's mental health services. The trust worked effectively in partnership with voluntary organisations.

However:

- Some patients in the acute, rehabilitation and forensic in-patient mental health services did not always feel involved in planning their care.
- The trust advised that the public and patient engagement aspect of integration phase two project was informed by the National Voices survey, the joint mental health strategy and Somerset's community services review. However, there had been little public or patient engagement in following the development of the transformation plans and implementation was at an early stage at the time of our inspection.

Are services responsive to people's needs?

Requires improvement

We rated 'responsive' as requires improvement because:

- Patients needing non urgent care in the community adults service waited too long for treatment. Patients who required a review of their continuing healthcare or funded nursing care needs waited a long time for this to occur.
- We found that although dental services were planned and delivered to meet the needs of patients the available resources were not meeting the demand for service. There were excessive waiting lists for vulnerable adults and children who had been referred to the service and were waiting for their first assessment appointment.
- In the sexual health service there were staffing shortages which affected the skill mix. Not all nurses were trained to provide all care and treatment.
- There had been no instances of people detained in police custody rather than a place of safety in Somerset as reported at September 2015. However, there were long waits for assessment in the health-based place of safety out of hours. For example, we found evidence that four people admitted out of hours had waited between seven and 15 hours for assessment. This practice was contrary to the trusts own joint health based place of safety protocol and the Mental Health Act code of practice.

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- Prior to the inspection, concerns were raised with the inspection team about how the trust responded to complaints. We undertook a comprehensive review of the complaints process during our inspection and found there were areas for improvement.

However:

- Patients who required urgent care, in the community adults service, received it in a timely way. In the urgent care service 61% of patients were seen within one hour and less than 0.5% of patients were seen outside of the 4 hour limit. District nurse teams were available 24 hours per day, seven days per week.
- In community inpatients services we saw 'primary link' running a telephone service to help prevent admissions to the local acute hospitals. Patients were referred to them (usually from GPs) who needed some support at home or admission to a community hospital until they were fit for discharge. We saw the 'primary link' services were flexible in trying to place people who needed admission to a community hospital.
- Mental health beds were generally available within the trust. Patients were actively reviewed to see whether they could be supported at home with the help of the home treatment team. Community mental health teams had capacity and systems to respond to routine and urgent referrals.
- All staff within the national deaf child and adolescent mental health service received training in British sign language, including the administrative staff.
- The trust had undertaken work to improve the environment of the wards in the community hospitals to meet the needs of the increasing numbers of people living with a dementia.

Are services well-led?

Requires improvement

We rated 'well-led' as requires improvement because;

- The trust had failed to identify the number and severity of issues relating to risk to patients that we found during the inspection in community learning disability services. We asked the trust to take immediate action to address concerns and also took enforcement action, serving a warning notices. The warning notice served notified the trust that CQC had judged the quality of care being provided as requiring significant improvement
- Although the trust had a clear vision and set of values which we saw displayed on posters, these were not always clearly

explained by staff and some staff were unaware of them. Staff were able to describe principles such as working in partnership and providing quality care but some staff felt that they were not involved in development of the trust vision.

- The trust had been through a period of considerable change since 2011 when it had merged with Somerset Community Health, the community health service provider of NHS Somerset. The trust vision for the service was to provide a fully integrated service and it had begun a process of transformation of services which it called 'integration phase two'. However, this was at an early stage of implementation.
- Whilst the majority of staff were aware that the implementation of 'integration phase two' was taking place and many were positive about the perceived benefits of further integration some staff felt there had not been enough consultation and engagement. Many staff across all services that we spoke with felt the process of change had not been effectively managed. The majority of mental health staff felt that the main emphasis was now on physical care and that they were losing the identity of being a mental health service.
- The board recognised that there was a significant need for improvement in staff engagement to ensure staff felt valued and fully supported. Most of the senior and executive team acknowledged that there was a need for the culture to change from the 'top down'. They recognised that some staff may not have always felt empowered to challenge and contribute; this included several senior managers.
- Risks identified on the risk registers did not always reflect risks facing the trust. We found inconsistency across the trust in how local risk registers were used to record and escalate risks to the divisional and corporate risk register. We were concerned that there appeared to be inconsistency in how effective local governance processes were and how they linked in with the wider trust processes. For example, there was variation in management of complaints, medicines management, learning from incidents and use of risk registers.

However:

- Local leadership in most services we inspected was good and staff felt well supported by the service leaders for operational support and career development. In many services, staff reported good morale.

Summary of findings

- There were a number of committees and meeting structures in place to implement and oversee the governance framework. The trust had developed dashboards in order to monitor performance and the board received regular quality reports.
- The trust was committed to participation in research and development. There was a range of audits conducted in the trust including national, local clinical and commissioning and quality innovation audits with the outcomes of these being used to influence and improve practice.
- The trust had progressed a number of innovative initiatives and several services had received nominations or recognition from national organisations.
- The executive and senior team had commissioned audits of some of the risk and governance systems and were committed to implementing change.

Summary of findings

Our inspection team

Our inspection team was led by:

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

Team Leader: Karen Bennett-Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team included CQC inspection managers, inspectors, Mental Health Act reviewers, pharmacists, an analyst and inspection planners.

There were also specialist advisors from a variety of mental health and community health service backgrounds, including consultant psychiatrists, psychologists, consultants in community health services, senior nurses and social workers.

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

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced in sharing of their experiences of the quality of care and treatment at Somerset Partnership NHS Foundation Trust.

How we carried out this inspection

We always ask the following five questions of every service and provider:

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

Before the visit, the inspection team:

- reviewed information that we hold on the trust
- requested information from the trust and reviewed that information
- asked a range of other organisations that the trust works in partnership with for feedback these included NHS England, Somerset clinical commissioning group, Monitor, Healthwatch, overview and scrutiny committees, professional bodies and user and carer groups
- held three listening events before the inspection to hear the views of local people
- reviewed information from patients, carers and other groups received through our website.

During the announced inspection visit from 7 to 11 September 2015, the inspection team:

- visited a total of 88 registered locations
- visited all 27 wards in community hospitals and mental health inpatient units, 52 locations where community services were delivered
- observed how people were being cared for in wards and clinics and accompanied community teams on visits to people's homes, seeing 110 episodes of care.
- reviewed 368 care or treatment records of people who use services
- spoke with 178 people who used the services and 75 carers or family members
- we received 119 comment cards that we had left in a range of patient areas before our inspection. We were also contacted by five people via our public website
- spoke with 423 staff who worked within the trust, such as nurses, doctors, therapists and support staff
- interviewed the chief executive and all the members of the executive team and three of the non executive directors of the board

Summary of findings

- attended and observed a council of governors meeting and spoke with four governors
- interviewed other senior managers in the trust, including 83 managers of services, such as ward managers and divisional team leaders
- held 40 staff focus groups
- spoke with 14 external stakeholders, for example, commissioners, other care providers
- attended 37 meetings held by the various teams and services, such as ward rounds, care planning review meetings.

Information about the provider

- Somerset Partnership NHS Foundation Trust provides a wide range of integrated community health, mental health, learning disability and social care services to people of all ages. The trust provides services from 13 community hospitals across Somerset, and four hospital sites from where it provides mental health inpatient services. The trust also provides services to people in the community team bases, in GP surgeries and local clinics, in a range of non-NHS community settings and at home.
- The trust provides community dental services on the Isle of Wight and in the County of Dorset and dental services to the prison populations of Bristol and Dorset. The trust is commissioned by NHS England to provide mental health services to deaf children and young people who have mental health needs. This service is based in Taunton and covers the South West region of England.
- Somerset Partnership NHS Foundation Trust was authorised as a foundation trust on 1 May 2008, building on the success of its predecessor organisation, Somerset Partnership NHS and Social Care Trust which was the first integrated health and social care partnership trust in England. The trust is regulated by Monitor. The main commissioners for the trust are Somerset clinical commissioning group and Somerset county council. On 1 August 2011, the trust acquired Somerset community health, the arm's length community health service provider arm of NHS Somerset. The trust provides 420 inpatient beds, across 22 locations, providing community health and mental health services. In 2014/15, the trust reported a total income of £166,951,000 and a total expenditure of £161,644,000.
- There have been 13 inspections across nine locations registered to Somerset Partnership NHS Foundation Trust . There was one location non-compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 at the time of our visit (12 March 2015): Frome Community Hospital: Improvement action related to staffing. Somerset Partnership NHS Foundation Trust has had seven visits from Mental Health Act reviewers from 30 June 2014 to 1 July 2015.
- At the time of our inspection Somerset Partnership NHS Foundation Trust was undergoing a comprehensive review of service delivery and management structures, as part of the service re-design, called `integration phase two`. There had been a number of significant changes to the management structure. The community services were moving towards a hub and spoke model of care; where a range of services could be provided by central point (the hub) over a defined geographical area to people in the community. Some mental health and community services had been integrated at the time of the inspection, for example, older person`s services. The trust reported the key elements of the changes were:

Mental Health – the proposals related to the merging of recovery and assessment teams in adult mental health, the creation of a 24 hour county wide crisis team and the redeployment of support workers into teams.

Integrated Teams – this related to older people's mental health, district nursing and the independent rehabilitation teams joining under a single manager and creating new complex care hubs to manage the most vulnerable and complex patients.

0-25 Pathway – the creation of an improved pathway for young people in mental health, the bringing together of a percentage of adult services with child and adolescent mental health services.

Summary of findings

Medical and Clinical Leadership – to achieve greater partnership working between medical staff, other clinical leadership and teams, to promote the role of medical leadership within the organisation.

- After nine years leading the trust the chief executive had announced his retirement and was due to leave at the end of this year.

What people who use the provider's services say

- We spoke with 178 patients , 75 carers and we received 119 comment cards, from 10 clinical areas, or ward locations. Fifty eight responses were from the contraceptive and sexual health services (CASH) service. None of the comment cards were wholly negative; 17 were mixed negative and positive comments and the rest contained positive comments. Overall, the majority of the comments were positive about the care, staff and services provided. The negative comments included patient access difficulties and contradictory advice given at the CASH service. Other comment cards noted poor staffing levels, or use of agency staff that were not familiar with the wards or patients.
- Feedback from the three listening events we held was mixed, with some people reporting negative experiences with the mental health service.
- In dental services we spoke with 20 patients and received 30 CQC comment cards. All patients we spoke with and the comments received reflected that patients were very satisfied with the assessments, explanations, the quality of the dentistry and the outcomes of the treatment provided.
- Patients we spoke with in community health services commented positively on the compassion and caring nature of the staff. They said that staff showed an interest in them and asked about visitors and interests. One patient in Bridgwater hospital said, “staff are very kind to me, marvellous. I feel like they are old friends". Patients also commented about the positive attitude of the therapies teams. One patient said, "I have a fear of falling and they do try to give you confidence but you have to take some risks”.
- Parents we spoke with, in the children and young people`s service, were positive. One parent explained how they felt a pivotal part of the care plan with an emphasis on the priorities for their child and the family. They were always kept informed of options about treatments. We spoke with parents of young people that were admitted to Wessex ward, the child and adolescent mental health ward, and were told it was a caring environment and that the standard of care was 'fantastic'.
- Patients and carers told us they were happy with the mental health inpatient service. They liked the staff and said they were caring, kind and helpful. Patients said they felt safe on the wards. Patients said staff listened to them and explained what was happening. Patients liked the ward environment, activities and facilities and they liked the food. However, some patients said staff spent a lot of time in the office and that they were slow to respond when they knocked on the office door. Some patients said they could not go on leave when they wanted to because staff were not available to take them. Some patients said they had not received information about their rights while detained under the Mental Health Act, or how to complain.
- People told us they were kept safe and their different care needs were met on the older adult’s mental health wards. They told us they were treated with kindness, dignity and respect. One person told us that staff were polite and compassionate, and that they cared about them. They told us how staff respected their privacy. One person told us staff were always willing to help them, were respectful and polite, were caring and that they looked after them. Relatives of people who used the services all spoke positively about the kindness and respectfulness of staff and how caring they were.
- We received very positive feedback from people who were currently using the mental health home treatment service. They told us they all knew how to contact them if they needed and found the teams helpful and supportive in a crisis. Some people told us they had not felt involved in developing their care plan.

Summary of findings

- We spoke with eight patients who used the Somerset older peoples' community mental health services and they spoke positively about the service. We spoke with 14 patients who used the service and all were positive about the care and support they had received from staff in community mental health services.
- Patients on the forensic ward told us they were well cared for by staff and that staff treated them with respect and dignity, although they weren`t always involved in developing their care plan. Patients also said that they did not feel comfortable with staff wearing a uniform when they went out into the community.
- There were several positive comments about the staff and the focus on recovery and freedom from patients on the mental health rehabilitation ward. However, two patients said they did not like staff wearing uniform especially on accompanied leave as they felt this was stigmatising.
- The NHS friends and family test (FFT) was introduced in 2013 to gauge patients' experience of their care and levels of satisfaction. The test asks patients how likely they would be to recommend the service to friends and family if they needed similar treatment. The trust annual report and accounts 2014/15, stated it received nearly 4,000 FFT responses each month, and more than 90% of respondents would recommend trust services to their friends and family members. The completion of FFT varied across the services, the board had noted there was a lower level of return within the mental health services.

Good practice

Mental Health Services

Acute wards and psychiatric intensive care

- A psychiatrist on Rowan ward was providing a weekly psychotherapy clinic and was trained in eye-movement desensitisation and reprogramming, a NICE recommended treatment for trauma.
- Rowan ward had developed a wellbeing practitioner role to meet commissioning for quality and innovation targets for wellbeing. They assessed height, weight and blood pressure and offered advice and help on diet, smoking cessation, exercise and drugs and alcohol.

Community based mental health services for older people

- 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.
- Carer's workers were employed to ensure carer's 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.

Forensic inpatients/secure wards

- There were fortnightly 'have your say' meetings for patients to express their views. An Independent advocate facilitated these meetings and fed back to the ward staff.
- There was a 'substance misuse lifestyle addiction and mental health' (SLAM) dual diagnosis treatment plan that the ward was involved in developing.

Community child, adolescent mental health services

- The deaf service introduced DVDs with letters and care plans translated into British sign language to help people understand them fully.
- There was a group for the young people coming into the service. This was run with a young person using the service and a psychologist. Young people referred to the service were told about what CAMHS was and were given the opportunity to ask questions and play a game to help understanding.
- We found excellent examples of family involvement. A CAMHS information session for parents and carers took place. Parents were invited to the one off information session explaining how CAMHS worked

and what it did. An overview of different therapy models was given and the process of therapy. There was an interactive psychoeducational session to get attendees to think about how they may be able to help. There was information on useful apps, websites and leaflets.

Rehabilitation services

- There were two weekly facilitated 'have your say' meetings with an independent advocate.
- The ward was committed to the principles of the triangle of care in supporting carers. Ward staff had been part of the trust initiative to sign up to a 'triangle of care' accreditation scheme committing to involving carers and families in mental health care.
- Ward staff facilitated a dual diagnosis therapy group called SLAM (substances, lifestyle, addiction and mental health) which was being rolled out for use on other wards.

Community Health Services

Inpatient services

- The new community hospitals and newly refurbished community hospitals embraced the needs of people living with dementia and incorporated best practice around this in the design of the hospitals.
- Activities at some of the community hospitals, which were run by the league of friends, were imaginative and innovative and were tailored to the patient's needs.
- The primary link service managed the needs for patients both being discharged and admitted to the community hospitals and always worked hard to put patients in their preferred hospital.

Dental services

- The dentists and support staff were skilled at building and maintaining respectful and trusting relationships with patients and their carers. The dentists sought the views of patients and carers regarding the proposed treatment and communicated in a way which ensured people with learning disabilities were not discriminated against. For example, staff had learnt sign language and had made extensive efforts to communicate dental care and treatment options in language individual patients could understand.

End of life care

- The end of life care coordination centre enabled patients to be discharged from hospital very quickly with the support of other health and social care professionals to make sure patients were able to die in their preferred place of death, their home.
- The palliative care medical team was hosted by this trust but they worked across a number of other providers to include hospices and the acute trusts. This enabled them to maintain continuity of care for patients being cared for by any of these service providers.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

We identified regulations that were not being met and the provider must:

Mental Health Services

Community mental health services for people with learning disability and autism

- The trust must monitor and improve the quality and safety of services provided and improve its governance processes.
- The trust must assess, monitor and mitigate risks for people who use services and staff.
- The trust must seek feedback from people who use services, relatives and carers and engage them in evaluating and improving services.

Specialist community mental health services for children and young people

- The trust must ensure that the fire risk at Mendip is addressed and that the service adheres to the fire risk assessment that was completed.

Summary of findings

- The trust must ensure that risk assessments are updated and ensure that when risks are identified there is clear information available.

Long stay/rehabilitation mental health wards for adults of working age

- The trust must ensure that capacity to consent to medication is undertaken and recorded for all detained patients.
- That trust must ensure that section 17 leave assessments are undertaken and recorded for all detained patients.

Community mental health services for older people with mental health problems

- The trust must assess and monitor the impact of staffing vacancies on safe and effective care and take action to mitigate risks until integration phase two is complete
- The trust must 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.

Wards for older people with mental health problems

- The trust must ensure risks associated with the physical ward environments must be fully assessed and addressed. Until the necessary changes are made to make the environments as safe as possible, appropriate measures must be implemented to mitigate effectively the risks to people using the service.
- The trust must ensure that the training staff receive is adequate to be able to safely manage aggressive, physically fit and strong older adults.
- The trust must take appropriate steps to demonstrate that care and treatment are provided with the consent of each patient or other relevant person, and be able to demonstrate that they act in accordance with the Mental Capacity Act 2005 (MCA) in all instances where a patient lacks mental capacity to make specific decisions and to consent to their care and treatment. Specifically, the trust must ensure they act in accordance with the MCA in all instances where a formal instruction to not attempt resuscitation (DNR) is in place.

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

- The trust must ensure that all staff have sufficient knowledge of safeguarding procedure and that all safeguarding incidents are correctly identified and raised. Safeguarding alerts and concerns were not being raised on Holford ward when they should and some staff were not aware of their responsibilities with regard to alerting safeguarding authorities.
- The trust must ensure that consent for treatment is gained, and that this is clearly documented.
- The trust must ensure that all sites where rapid tranquillisation is used hold the appropriate medicines to reverse the effects of benzodiazepine medication.
- The trust must ensure resuscitation equipment and refrigerators are checked and maintained.

Mental health crisis services and health based places of safety

- The trust must take action to address and resolve problems around accessing section 12 doctors out of hours for Mental Health Act assessments, in order to work within the trust's Section 136 joint protocol and the Mental Health Act code of practice.
- The trust must ensure that the senior managers in the trust clarify procedures and joint working arrangements when the section 136 joint protocol is reviewed, so that staff can be confident and assured of support out of hours and clear on their responsibilities and expectations.

Forensic inpatient/secure wards

- The trust must ensure patient's capacity to consent to medication; is assessed, reviewed and recorded regularly.
- The trust must ensure patients are given their Section 132 rights on admission and at regular intervals
- The trust must share the outcome of a second opinion appointed doctor (SOAD) visits with patients.

Summary of findings

Community mental health services for adults of working age

- The trust must ensure it mitigates the risks for the 120 patients waiting the allocation of a care coordinator

Community health services:

- The trust must ensure that patients receive a thorough and timely assessment that includes essential observations and risk assessments that are necessary to detect deterioration in patients' health and wellbeing.
- The trust must deploy sufficient staff to meet the demand in the district nursing service.
- The trust must ensure that a safe protocol for lone working at night time is actioned and embedded and audited regularly.
- The trust must ensure that record keeping is of a consistently safe standard.
- The trust must ensure that there is suitable access to fire escapes and training for emergency equipment to all at Chard Community Hospital.
- The trust must ensure that risk is properly assessed at the community hospitals and that this is recorded and escalated appropriately.
- The trust must strengthen governance arrangements in the urgent care service to ensure that maintenance logs for equipment used on and with patients are up to date and show where equipment is not maintained.
- The trust must strengthen governance arrangements to ensure that all risks to service delivery are outlined in the urgent care service local risk register, and where appropriate are included on the corporate risk register. Also ensure that there are clear management plans to address risks and that these management plans are regularly reviewed.
- The trust must strengthen supervision or one to one arrangements in the urgent care service to ensure that all staff receive one-to-one management and clinical supervision in line with trust policy. Ensure that the minor injury unit service is compliant with statutory and mandatory training.
- The trust must ensure the cleaning contractor is in accordance with published National Patient Safety Association (NPSA) guidance regarding cleaning of dental premises.
- The trust must implement recommendations in the legionella risk assessment carried for the trust in 2013.

Summary of findings

- The trust must ensure immunisation status is recorded for all staff who have received hepatitis B immunisation as directed by the Code of Practice on the prevention and control of infections, appendix D criterion 9(f).
- The trust must ensure when carrying out domiciliary visits they take appropriate emergency equipment as advised by the British Society for Disability and Oral Health (BSDH) August 2009.
- The trust must ensure staff are recruited safely according to the trust recruitment policy and Schedule 3 of the Health and Social Care Act 2008. Particularly ensuring references and gaps in employment were evidenced during the recruitment process.
- The trust must ensure all equipment is regularly serviced and evidence available to demonstrate it is safe and fit for purpose.
- The trust must ensure the services in Dorset are properly staffed and supported to be able to provide the additional activity expected by the commissioners of services.
- The trust must ensure there are open and effective lines of communication between the senior management team and the staff in Dorset.
- The trust must ensure the concerns of the staff in Dorset are listened to and acted upon in a timely manner with respect to operation issues that arise on a day to day basis
- The trust must ensure staff providing care and treatment to children and young people have paediatric life support training.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

Mental Health Services

Community mental health services for older people with mental health problems

- The trust should provide opportunities to staff to attend consultation meetings concerning integration with other teams.
- The trust should ensure that managers make provision for regular supervision of clinical and non-clinical staff's work performance.
- The trust should improve service delivery issues in the memory services, where caseloads were very high, working with GPs to provide a clear referral pathway for patients with a mental health diagnosis and memory problems.

Specialist community mental health services for children and young people

- The trust should ensure that there is a cleaning rota for the toys in the service to ensure there are effective infection control precautions in place.
- The trust should ensure that all incidents are reported in a timely manner.
- The trust should ensure the environment at Mendip is suitable for young people

Forensic inpatient/secure wards

- The trust should ensure medical equipment checks, include expiry dates, re-ordering occurs when necessary.
- The trust should ensure all appropriate training relating to the Mental Health Act, Mental Capacity Act and to patients' conditions is undertaken by staff.
- The trust should ensure it reviews the style of uniform and whether it should be worn when supporting patients in the community.
- The trust should take action to ensure patients have access to appropriate toileting facilities whilst they are in seclusion.
- The trust should ensure the Mental Health Act Code of Practice, and trust policy, is followed in relation to seclusion.
- The trust should ensure on-call psychiatrist can attend the ward within the agreed timeframe.
- The trust should ensure it adheres to the agreed minimum safer staffing levels.
- The trust should ensure patients' are involved in planning their care and record when this has happened.

Mental health rehabilitation wards:

- The trust should consider the appropriateness of clinical uniform on accompanied visits to the community.
- The trust should ensure that regular formal one to one management supervision is undertaken in line with trust policy.

Summary of findings

- The trust should ensure that when patients offered copies of their care plans that this is documented.
- The trust should ensure that patient's involvement in their care plan is always documented.

Community-based mental health services for adults of working age

- The trust should update the operational policy for adult community mental health teams, it had not been reviewed since October 2012 and requires updating to reflect current changes and practice outlined in the NHS England Serious Incident Framework 2015/16.
- The trust should ensure that their serious incident policy is reviewed to reflect the current NHS England Serious Incident Framework guidance published in April 2015.
- 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 the Mental Capacity Act.

Child and adolescent mental health wards

- The trust should ensure that Mental Capacity Act and Mental Health Act training is undertaken by all staff. Whilst knowledge on the ward was good in the nursing staff we interviewed there was no guarantee that this correlated across disciplines and skill mixes or that staff would remain up to date with relevant changes to legislation.
- The trust should ensure that consent for care and treatment of all patients admitted to the ward is sought from the relevant person and clearly recorded in their care records. Staff should ensure that information is stored in the part of the notes that is specified. Essential information was missing from the admission section of the notes and was therefore not easily accessible.

Wards for older people with mental health problems

- The trust should ensure every effort is made to recruit nursing staff to identified vacancies in order to address issues in relation to the lack of qualified permanent staff. If unsuccessful in recruiting the necessary nursing staff, the provider should take further steps to ensure the workload for existing staff is manageable and safe.
- The trust should ensure all front line staff have updated Mental Capacity Act training in order to help ensure teams work in line with statutory requirements at all times.
- The trust should assess, clarify the purpose and monitor the use of the de-escalation rooms.
- The trust should ensure staff understanding and practice in relation to de-escalation and seclusion are in line with the trust's own policy and procedures.
- The trust should consider how to better provide staff with all of the specialist training they require to carry out their roles effectively.
- The trust should review the provision of on-call and out of hours support to ensure ward staff are able to receive medical support promptly at all times.
- The trust should increase focus, through effective and holistic care planning and joined up MDT working, on patients' recovery and rehabilitation.
- The trust should review the provision of psychological therapies and psychosocial interventions to ensure it meets people's treatment needs.
- The trust should involve ward staff fully in any future redesign and refurbishment of the ward environments.
- The trust should engage effectively with staff and ensure their views and concerns are included in the future shaping and structure of this core service.

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

- The trust should ensure mixed sex accommodation is managed to ensure patients' dignity and safety are protected.
- The trust should ensure patients are being actively informed how to complain.
- The trust should provide a clear process for staff to receive feedback and learn from the complaints and incidents.
- The trust should take action to ensure patients have access to appropriate toileting facilities whilst they are in seclusion.
- The trust should ensure that arrangements are in place to provide adequate medical cover at all times on St Andrew's ward and that staff are aware of the arrangements.

Mental health crisis services and health based places of safety

Summary of findings

- The trust should ensure all physical health issues are considered. That clear communication and liaison with physical health providers, for example, general practitioners, takes place and is documented consistently. Particularly where medication is prescribed by their general practitioner.
- The trust should ensure evidence of consent is explicit and discussion around consent issues is documented in all clinical records and care plans.
- The trust should ensure all care plans reflect the risks detailed in the risk assessments.
- The trust should explore joint training with external agencies including ambulance service, police, accident and emergency to recognise and improve standards around use of the health-based places of safety and ensure clear pathways, including up to date Mental Health Act new code of practice.
- The trust should ensure a clear and consistent approach to documenting mental state examination in all crisis and home treatment teams, so information can be found quickly and easily.
- The trust should ensure the crisis and home treatment teams ensure people's views and wishes are clearly included in care plans as well as in the progress notes.
- The trust should ensure there are working clocks in the health-based places of safety, as well as access to activities to promote comfort and distraction.

Community Health Services

Action the provider SHOULD take to improve

- The trust should review best practice in relation to recordings of wound assessments and ensure that this is embedded within wound care in the district nursing service.
- The trust should ensure that essential patient information stored using the electronic record keeping system is accessible to workers when visiting patients.
- The trust should ensure that medicines and dressings are stored in accordance with manufacturers' instructions.
- The trust should ensure that the minimum level of training for safeguarding children for staff in the community services is compliant with intercollegiate guidelines from the Royal College of Paediatrics and Child Health in March 2014.
- The trust should use an outcome measure to facilitate benchmarking of performance of the district nursing service and independent rehabilitation teams.
- The trust should encourage involvement of patients in the planning and design of service delivery in the district nursing service and independent rehabilitation teams.
- The trust should consider ways to reduce the waiting times for patients requiring non-urgent assessments and treatment. This should include review of the resources allocated to complete continuing health care and funded nursing care reviews.
- The trust should improve the availability of activities to patients at the community hospitals and ensure they are better engaged.
- The trust should work to improve staffing levels in the community hospitals
- The trust should ensure equipment used in the delivery of care and treatment is maintained and checked in accordance with the manufactures guidelines and trust policy.
- The trust should ensure patient records are consistently completed in full.
- The trust should ensure the trust database which identifies mandatory training completed by staff is kept up to date and provides an accurate record.
- The trust should ensure emergency medication and equipment is clearly labelled for use in an emergency.
- The trust should the staffing levels and skill mix of the service is reviewed to ensure a consistent and timely service can be provided to patients. The main booking line should be accessible to patients when they telephone.
- The trust should ensure that patients with mobility requirements are provided with the means to access the service.
- The trust should ensure that all staff report GP prescribing errors via the incident reporting system.
- The trust should provide all staff with end of life training.
- The trust should appoint a member of staff whose role is purely end of life care to make sure the service moves forward
- The trust should appoint a lead palliative care consultant to lead the team.
- The trust should ensure staffing deficits in health visiting continue to be actively reviewed to ensure a safe and consistent service is maintained.

Summary of findings

- The trust should take steps to strengthen the clinical audit process in the urgent care service through clear action plans which are implemented based on audit recommendations. This strengthening will help to ensure that evidence is available that could improve care and show that best (evidence-based) practice is consistently followed.
- The trust should develop a triage policy in the urgent care service that sets out how initial patient assessments should be carried out. Include who should carry out the assessments within what timescale. Also review the time that a patient is first seen by a registered healthcare practitioner after arrival in the department and ensure that there are systems in place that follow national recommendations for urgent care settings.
- The trust should take steps in the urgent care service to ensure that there is objective evidence available in patient records of all adults and children receiving appropriate safeguarding assessments.
- The trust should ensure that in the urgent care service non-controlled resuscitation drugs (including intravenous fluids) are stored ready for use in tamper-evident containers in line with relevant legislation.
- The trust should review the arrangements for moving and handling patients from chairs or the floor to trolleys in minor injury unit settings.
- The trust should ensure the location managers and senior clinicians are empowered to make local decisions.
- The trust should ensure the whistle blowing policy includes information about who staff could raise concerns with externally such as the Care Quality Commission (CQC).
- The trust should ensure there are clear communication channels for good leadership and management of the service and the safety and well-being of patients.

Somerset Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

Mental Health Act responsibilities

- Appropriate arrangements were in place for the safe management and administration of the Mental Health Act in accordance with the Code of Practice. Administrative and legal support was provided by the mental health legislation manager and his team. In addition to dealing with issues relating to the Mental Health Act, the team were also responsible for work relating to the Mental Capacity Act.
- Seven wards were subject to a Mental Health Act monitoring visit as part of the comprehensive inspection; Willow, Magnolia, Pyrland 2, Ash, Holford and St Andrews.There were detained patients on all of these wards and two wards (Magnolia and Pyrland 2) also had patients who were subject to DoLS
- All of the Mental Health Act paperwork was available for scrutiny and was in order. However, we found consistent concerns raised by these wards. These related to: care planning, Section 17 leave, capacity assessments, section 132 rights, and lack of training for staff.
- Code of practice guidance states at 1.7 'Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. Wherever possible, care plans should be produced in consultation with the patient.'We found that patient views were not recorded in care plans. Some patients stated that they had not been involved in their care plans.
- We found a lack of evidence that patients and relevant others had been given copies of their section 17 leave authorisation. Code of practice guidance states at 27.22 'Copies of the authorisation should be given to the patient and to any carers, professionals and other people in the community who need to know. A copy should also be kept in the patient's notes.'
- The code of practice guidance at 24.41 states: 'during this time, the patient's consent to treatment should still be sought before any medication is administered, wherever possible.The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes. If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment.' We found a lack of evidence that the clinician in charge of the patients' treatment had recorded their assessment of the patients' capacity to consent to medication for treatment for mental disorder.
- Code of practice guidance at 4.9 states 'The Act requires hospital managers to take steps to ensure that patients who are detained in hospital under the Act, or who are subject to a community treatment order, understand important information about how the Act applies to them.This must be done as soon as practicable after the start of the patient's detention'. Section 132 states that

the hospital managers have a legal duty to give person detained under the Mental Health Act information about their rights. We found a lack of evidence that patients were given their rights upon first detention, level of understanding often not recorded, and lack of evidence that further attempts to give rights had taken place.

- Within the health-based place of safety, the wait for assessment when people were detained under a Section 136 (S136) was excessively long out of hours. For example, we found evidence that four people admitted out of hours had waited between seven and 15 hours for assessment.This practice was contrary to the trust's own joint S136 protocol and the Mental Health Act code of practice. Some staff in the crisis and home treatment teams were unable to describe the protocol or pathway for people detained under S136 of the Mental Health Act, and displayed inconsistent knowledge of their own internal procedures or agreements for accessing Mental Health Act assessments out of hours.
- Mental Health Act training was not part of the trust`s mandatory training programme. We found staff across the wards said that they had not had any training in relation to the new code of practice. The training information for the Mental Health Act showed that 66.5% of staff within mental health teams had undertaken the online training, this equated to 626 out of 942 staff. Sixty two percent of community health staff had undertaken the training which equated to 1044 out of 1684 members of staff. We were not assured that the current training enabled staff to keep updated and have a good understanding of the legal framework and application in practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to describe responsibilities in relation to capacity assessments and keeping patients' safe. Staff described how to assess capacity and were aware that a person's capacity to make decisions and choices changed and as a result their capacity assessments had to be reviewed regularly. However, it was not always clear that capacity to consent had been assessed and consent to treatment and information-sharing was not consistently recorded.
- We identified a number of specific issues in relation to the trust meeting its legal obligations under the Mental Capacity Act 2005 (MCA) on the older people`s mental health in patient wards. Staff had not identified an instance when a patient should have had the input of an independent mental capacity advocate (IMCA) to support them through the process of along term move. In relation to 'do not attempt resuscitation' (DNR) forms, we were concerned that for some patients the DNR decision appeared to have been reached without discussion with the person or their relatives and that the DNR decisions were also not being regularly reviewed.
- However, we also saw examples of comprehensive capacity assessments and best interest meetings in the older people`s mental health in-patient and community services. 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.
- Mental Capacity Act training was not part of the trust`s mandatory training programme. Training was via an online DVD. Information provided by the trust showed 61.5% of the staffing establishment of mental health teams had completed the Mental Capacity Act training, this equated to 579 out of 942 members of staff. 66% of the community health staff had completed the training, which equated to 1109 out of 1684 staff. We were not assured that the current training enabled staff to have a good understanding of the legal framework and application in practice.

Detailed findings

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

Summary of findings

See above

Our findings

Safe environment

- We found that most of the wards and facilities were well maintained and visibly clean. The trust had infection control policies and procedures in all services. We reviewed the annual 'audit of trust-wide infection prevention and control practice', published in March 2015. This included evidence of auditing of the environment and staff practice. We saw that actions were identified where appropriate.
- The average PLACE score for cleanliness was above the national average at 99% compared to 98% for the national average. The average PLACE score for condition, appearance and maintenance was also above the national average at 97%, compared to 90%. PLACE stands for patient-led assessments of the care environment. This is a system involving local people going into hospitals each year to assess how the environment supports patients' privacy and dignity, also covering food, cleanliness and general building maintenance.
- However, a small number of buildings and facilities that did not meet an acceptable standard of cleanliness or suitability. For example, the Mendip child and adolescent community mental health staff kitchen was unsafe. We asked the trust to take immediate action to rectify this issues, which it did in a timely manner There were also a number of issues related to the design and layout of the older people`s wards. At Magnolia ward we found the whole section of a far end of the ward was unused, not visible to staff but also not closed off to patients. Risks posed by the unused section of the ward were not effectively mitigated at the time of our inspection. There was not suitable access to fire escapes and training for emergency equipment to all staff at Chard Community Hospital
- Many services did not have effective systems in place for monitoring and checking safety and emergency equipment, including resuscitation equipment, across the inpatient wards in the mental health and community hospitals. There were examples across some services where maintenance and monitoring of equipment was out of date, or checks were irregular. For example, on the mental health rehabilitation ward, we found that the scales were regularly calibrated but there was no record that regular calibration of any other medical appliances had taken place. The forensic ward and community mental health teams up had not had electrical equipment tested since 2012. The trust advised us that they were undertaking a programme of electrical testing during the inspection. We found there were gaps of several weeks in the recording of checks of resuscitation equipment and the resuscitation bag on Holford ward and found some out of date items in the Rowan ward resuscitation bag. These were removed by the manager and a new checking schedule was implemented just after our visit. In the community health service at two locations we found nursing

equipment within portable syringe driver sets was past the expiry date. Bladder wash bags were also found to be past the expiry date. This meant that the sterility of these items could not be assured.

- The clinical governance group was responsible for monitoring ligature incidents and reducing ligature risks to provide a safe environment, as part of the trust patient safety programme (ligature points are places to which patients intent on self-harm might tie something to strangle themselves- ligature risks are the risks of such harm). In the majority of areas, ligature risks had been identified and were being managed. Ligature points were audited annually on each mental health ward. We reviewed ligature audits and found that where ligature points were identified, mitigating factors were also listed. There was a ligature management policy which required managers to ensure action plans were executed following ligature audits. However, on the older people`s mental health wards, while many of the ligature risks had been identified by ward staff through health and safety checks and risk assessments, we found the trust had not taken steps to effectively mitigate or address those risks at the time of inspection.
- The health-based places of safety were monitored well by ward staff; their locations were safe with good access and exits to and from the facility. Areas were secure, well-lit and had observation windows and panic alarms fitted. There were no ligature points within the assessment suites or areas where people were detained under S136.

Safe Staffing

- In line with guidance issued by NHS England, the trust published the staffing levels for each of its wards on its public website. The monthly 'safer staffing' report was discussed during the public session of the board meeting. The safer staffing report for August 2015 displayed on the trust public website showed the percentage of time that actual staffing levels were the same as, or higher than the recommended staffing levels.
- While the trust supplied some information about bank and agency usage, it did not enable the inspection team to have a detailed understanding of usage at team or service level. It was unclear how the trust could accurately understand the issues around resources and staffing in order to assess the capacity of the service to cope with an increase in demand, or the impact of the integration plan. However, in the six weeks prior to inspection the overall agency use for the community hospitals, as a percentage of their overall staffing establishment, was 17.%, with some hospitals having a much higher usage, such as Crewkerne community hospital at 40% and Wellington community hospital at 30%. The mental health inpatient wards reported 21% of the overall staffing establishment as agency, with the highest usage at Holford ward, reporting 37% and Pyrland ward 34%.
- The trust reported 3,827 substantive staff as at 31st March 2015 with 556 leavers in the preceding 12 months. The percentage staff turnover reported in the time period was 14%. Shepton Mallet minor injury unit had the highest staff turnover (where more than five people were employed) with 44% followed by south Somerset older peoples community mental health team (41%) and cardiac rehabilitation service (39%).
- The trust provided sickness rates as at 31 March 2015 for the preceding 12 months. The overall sickness rate reported for this time period was 5% for 3,827 substantive members of staff. Bridgwater assertive outreach team has the highest sickness rate at the trust with 15% followed by south Somerset crisis resolution and home treatment team with 12%. In some community health and district nursing teams, sickness impacted upon the capacity of the teams to cover shifts and caused high levels of stress amongst staff.
- The lack of sufficient numbers of staff to meet patient needs was a concern in a number of services. There were high levels of staffing shortages (predominately band 5 and 6 nursing staff) in both the community inpatients service and the community adults service. Staffing establishments in the community inpatients service were regularly below safer staffing standards resulting in bed closures. Staffing was recognised as a significant risk for the community hospitals, with 40% registered general nurse vacancy rates. Although many shifts were being filled by bank and agency staff there were a high number of shifts which did not meet safer staffing guidelines. As a result of this the trust agreed with the clinical commissioning group to reduce the number of beds provided by the trust. At the time of our inspection 61 beds were closed with an additional 20 beds in use by the local acute trust.

- In the community health adult staffing levels were not planned using a robust method that ensured patients received safe care and treatment at all times but relied on professional judgement. The district nursing service capacity review stated that the introduction of a tool had been deferred due to the pressures of staffing within the service. Staff in the community adults' service told us that the lack of staff stretched them. The lone working protocol for twilight and overnight nursing shifts was not consistently employed due to lack of staff to facilitate visiting in pairs. Due to staffing shortages in the sexual health service not all clinics had the appropriate staff mix to deliver the full range of services required.
- Staffing levels were also having a negative impact on the learning disabilities, child and adolescent mental health ward and older adult's mental health services. We found that they did not have enough staff to consistently provide a safe and effective service. For example, the rosters on Pyrland ward showed that on the weekends there were often no permanent qualified nursing staff working at nights and that cover was provided solely by agency nursing staff. The child and adolescent in-patient ward, Wessex House, was not able to increase capacity to 12 beds due to difficulties recruiting registered nurses.
- We identified a potential risk within the mental health services with the doctor on-call system, which meant it was not always easy for staff to access adequate medical cover and that a doctor might not always be able to attend the ward quickly in an emergency. There was an on call psychiatrist support throughout the day and night. Staff told us they had no problem accessing rapid support from a psychiatrist during daytime working hours. However, during the night the psychiatrist support was mainly by telephone. Records showed that in hospital based place of safety people were not always reviewed as required, particularly at night time. The forensic ward had reported difficulty with timely attendance out of hours to review a patient in seclusion. St Andrews ward in Wells relied on the out of hours GP and would not receive any overnight support from a psychiatrist if required; they would need to call 999. Staff in the older people`s mental health service were concerned that there were times when they didn't know who the on-call doctor was, and there had been occasions when they were unable to get hold of them quickly.
- The trust pharmacy provided a weekly ward visit by a pharmacy technician. Pharmacists were available to provide support to the technicians and ward staff. Ward staff told us they could access support when they needed to. Clinical pharmacist input to the wards, including multidisciplinary team meetings, was limited by current staffing levels. There was insufficient staff to cover wards when the allocated technician was on holiday. This could have an impact on the safe and effective prescribing of medicines for patients.
- The trust had recognised the need to address staffing shortages. However, there was no clear workforce recruitment and retention strategy in place to address staffing issues. We found that some vacancy posts were not being recruited to as part of the implementation of the 'integration phase 2' project; however, it was not clear how the impact of these vacancies was being monitored. Staff in the community adults' service had used the incident reporting system to report severe staff shortage. The trust advised us that an improvement action plan was in place for district nursing and included staffing. The increase in the number of patients being seen by the community health service for adults had been raised with commissioners.
- The trust provided a programme of mandatory training for staff which included basic life support, anaphylaxis, infection control, consent, equality and diversity, information governance, safeguarding children, moving and handling and fire training. The trust reported that overall 89% of staff had completed mandatory training but this was lower for the senior operational management directorate (84%) and medical directorate (83%).

Assessing and monitoring safety and risk

- The trust used the NHS national safety thermometer to collate a range of safety information in relation to care provided to patients at home and in community hospital wards. The NHS safety thermometer provided a monthly overview of the occurrence of a range of concerns, these included new pressure ulcers, venous thromboembolism (VTE), and falls. The head of patient

safety undertook regular ward walkarounds and reviewed information arising from the national safety thermometer, as well as attending relevant `best practice groups`. Best practice groups were held quarterly and provided a forum where noted risks and actions could be discussed. However, the head of patient safety did not have any involvement in, or awareness of, what was recorded on local or divisional risk registers, or risk assessments, for example, ligature audits.

- Our pharmacist inspectors looked at medicines management processes on seven wards in six community hospitals, four wards at two mental health hospitals and one community mental health clinic. We found that medicines were ordered, stored and used safely within legal frameworks.
- The trust benefited from a well informed risk manager, who had reviewed and revised the trust risk management policy and strategy. The roles and responsibilities for risk management had been clearly defined, including the relevant committees who will have responsibility of oversight. Both the strategy and policy had been signed off by the trust board in June 2015. The trust had recently introduced local and divisional risk registers to help identify and monitor risks.
- However, there were several areas of concern at the present performance of the risk management system. Escalation and management review of risks was not consistent or effective. Appropriate action plans and targets were not assigned to identified risks which meant mitigating actions were not always clear or effective. We found evidence from a number of areas across the trust that risks were not being identified, recorded, appropriately rated or escalated. For example: 1) the risk to quality of care in learning disability community services arising from the lack of access to patient records because they were held and controlled by the local authority: trust staff in the team were fully aware of the risk and associated issues, but it was not being addressed, 2) elevated risks emerging from clinical audits, for example, high risk medicines were not recorded locally. This absence of local action plans was a matter that was known to the chief pharmacist, but this had not been raised either as a risk through the risk management system.
- We looked at the quality of the individual patient risk assessments across all the services we inspected. Overall, we found that patient risk assessments were undertaken appropriately and up to date. Within the community health services staff followed processes for assessing risks such as pressure ulcers, falls and malnutrition. Staff developed care plans to manage the risks effectively in both community and inpatient settings. There were excellent examples of risk assessments and information sharing within the national deaf child and adolescent mental health team. However, we found that risk assessments were not regularly updated in the generic child and adolescent mental health community teams and had serious concerns about the quality of risk assessments within the learning disabilities service. Risk assessments had not always been updated for people, or did not contain all identified risks. In community learning disability services we found no consideration of risk of intervention, treatment or therapy to people who used services documented in any of the 28 case notes reviewed. There was no evidence in the risk assessments or risk formulations that consideration of risk to staff had taken place. For example, where a person had a history of physical or sexual violence what action should be taken to protect staff. There were limited emergency plans in place to inform staff what to do in the event of a crisis.
- Overall, we found there was variation in the management of risks by the services provided by the trust. Risks were not consistently identified, or effectively managed to ensure recommendations were addressed promptly. Risks were not consistently identified across the organisation resulting in a disconnect between some local teams and senior management. In particular, the learning disabilities service, urgent care, sexual health and community inpatient services identified risks at service level that did not correspond with the risk identified at trust level.
- Most teams across each service held regular multidisciplinary meetings (MDT). We reviewed samples of meeting minutes and these showed a range of risk issues, such as safeguarding, staff safety and clinical risks, were regularly discussed within the MDT.
- During 2014/15 the trust had reviewed the safeguarding polices and undertaken an audit of systems and procedures. The trust had a lead for safeguarding and

senior representation at the multi-agency safeguarding adults' board. The multi-agency safeguarding hub (MASH) was established formally this year, trust staff worked alongside the local authority and other agencies to promote collaborative safeguarding arrangements.

- Overall, we found that staff had a good understanding of the safeguarding process and their responsibilities within in it. Staff were trained in recognising and acting upon safeguarding concerns and this training made up part of their yearly mandatory training. However, we found on Holford ward, that staff said that they would not report patient on patient assaults as a safeguarding issue, and records indicated that no such incidents had been reported as safeguarding alerts.

- There were 21 incidents of use of seclusion reported across two locations across the trust in the 12 months ending 31 March 2015. The highest number of seclusion incidents were in the Holford Ward, with 20 recorded incidents, followed by Ash Ward with one recorded episode of seclusion. The seclusion facilities met the recommendations of the Mental Health Act Code of Practice, although Ash ward did not have toilet facilities within the seclusion facility; this seclusion room was due to be refurbished over the winter period. However, on the older people`s wards, we were concerned there may have been episodes of seclusion that were not recognised or recorded as such by staff. At Pyrland 1 ward the purpose and use of the de-escalation room was not clear.

- There were 171 incidents of restraint recorded between 1 April 2014 and 31 March 2015. These occurred within nine patient wards, units or teams. Of the 171 incidents of restraint, 90 different service users were restrained. Fifty five of the total number of restraints were in the prone position. On Ash ward, there were nine incidents of restraint recorded between April 2014 and March 2015 on five different patients, none of the incident involved the use of prone restraint. The highest numbers of restraint were undertaken on Holford ward where there were 50 episodes of restraint involving 24 different patients. These included 23 prone restraints. There were also 16 prone restraints on St Andrews ward. Rapid tranquillisation had been administered to 22 Holford patients and 16 St Andrews patients whilst in the prone restraint position. Rydon wards had used rapid tranquillisation it in eight cases. Information supplied by the trust prior to the inspection identified that there had been 24 recorded episodes of restraint across the three older people`s mental health wards in the 12 months from April 2014 to the end of March 2015. This involved 17 different patients. Magnolia ward recorded 15 episodes of restraint involving 10 patients. The trust had set a target to reduce the use of restraint by 10% in 2015/16.

- There were no incidents of long-term segregation reported between 1 April 2014 and 31 March 2015 but there was a patient in long-term segregation during our inspection. Rowan ward had not undertaken any prone restraint or rapid tranquillisation.

- The trust policy on the use of rapid tranquilisation referred to National Institute of Health and Care Excellence guidance. Lorazepam may be used to tranquilise patients rapidly and we found prescription records to show that it was in use. Only one staff member out of three we spoke to on Holford ward on the day of our visit knew what the medication flumazenil was used for and if it was stored on the ward. Flumazenil should be stored for use in an emergency as it and should be given if a patient suffers respiratory problems as a result of being given lorazepam. St Andrews ward did not have flumazenil on site despite having patients prescribed for lorazepam. The acting ward manager ordered flumazenil ordered immediately after we raised our concerns.

Track record on safety

- The number of incidents reported to the national reporting and learning system (NRLS) was 2,859 between 1 July 2014 and 30 June 2015. This was comparable to other mid-range reporting trusts. The incident category which was most frequently reported was 'patient accident' (46%), followed by 'implementation of care and ongoing monitoring / review' (18%) and 'self-harming behaviour' (12%). The most common speciality was 'care of older people' (43%) followed by 'community nursing' (17%), 'adult mental health' (17%) and 'older adult mental health' (16 %). The average time taken to report incidents to NRLS was 32 days, which was average when compared to similar trusts nationally.

- The trust reported that a total of 82 serious incidents which required further investigation occurred between

15 April 2014 and 24 March 2015. The majority (46%) of incidents reported were categorised as 'pressure ulcer followed by death (suicide) (17%) and 'serious injury' (13%).

- We reviewed the medicines management report dated August 2015, and noted that one of the components of this was missed doses, this could mean administration record was unsigned, the medicine was unavailable or the patient was unable to take the solid or oral form. However, there was no action plan associated with this. In July 2015 there were 1787 missed doses, including 11 related to insulin, and in August 2015 there were 1551 missed doses, with one related to insulin. We also found a significant number of gaps in the administration records in the community hospitals; 22 gaps in 27 records looked at. Staff had not recorded that they had not given the medicine and had not recorded the reason if it had been omitted. Staff we spoke with could not say if the omitted doses had been noticed and we did not see any evidence of actions taken following a missed dose.

Reporting of incidents and learning when things go wrong

- Staff across the trust were aware of how to use the trust incident reporting system and the clinical commissioning group found that incidents which were reported had robust investigations carried out. For example, falls in the community hospitals. The trust had been flagged as a risk for 'potential under-reporting of patient safety incidents`, and the trust recognised that there were issues with under reporting of incidents in some areas. We found that the numbers of incidents being reported was low in the community adult, and community inpatients services, resulting in a lack of awareness by senior staff of the themes and therefore a lack of dissemination learning. However, in other services we found a positive culture of incident reporting. In the urgent care, sexual health, children's and young people, older adults' mental health services, we found that staff were encouraged to report incidents and received regular feedback.
- The trust had introduced the `see something, say something` initiative to encourage reporting. Staff across all services were aware of this initiative. This campaign was designed to encourage staff to speak out about good practice, or practice which they feel is not of an appropriate standard. This initiative recently won a national award for 'innovation and best practice'. The trust published a fortnightly newsletter to staff called 'whats-on@SomPar`, which included a section on sharing lessons from incidents. It was also a function of the various `best practice groups`, to disseminate learning through their divisions. Some teams reported regular reflective practice sessions as a forum for reviewing and learning from incidents but these were not in place in all services.
- Overall, there was limited learning from incidents across the trust. Staff did not receive timely feedback following serious incidents. The board recognised that there was an unacceptable delay in completing investigations and giving feedback to the teams involved. The trust planned to introduce interim reporting to share initial findings. At the time of inspection 64% of the serious incident investigations were ongoing and of these, all were overdue (as at 23 July 2015). The oldest serious incident investigation ongoing had been open for more than 12 months (created on 17 July 2014) and was a 'suspected suicide'. The trust had a monthly serious incident group where it reviewed incidents. The trust serious incident policy reviewed at the community mental health teams did not reflect the current NHS England serious incident framework guidance published in April 2015.
- Systems were in place for staff to record medicines errors. Staff we spoke with confirmed they knew how to report medicines errors. Senior nurses told us how they gave feedback to staff, to ensure learning from incidents. However, the pharmacy inspectors were told of concerns of a low rate of reporting. On one inpatient ward we saw four occasions where a patient's prescription and administration record showed they had been given their medicine incorrectly. There was no evidence staff had noticed these errors. They had not been recorded in the patient's care records or on the error reporting system. There were inconsistencies in what individual staff considered a medicine risk. There was a very low reporting rate for medicine incidents in Minehead, Burnham on Sea, Wiliton, Bridgwater, and Crewkerne. South Petherton had a higher occurrence of reporting (23 incidents August 2014 to July 2015 compared to one incident at Burnham on Sea for the same period). Some senior nurses reported that there was a 'fear culture' around medicine incidents which discouraged individuals from reporting. Our pharmacy

inspectors highlighted many medicine incidents that had not been reported. It was not possible to conclude if the incidents had not been noticed or had been noticed and not reported.

Potential risks

- Under the requirements of NHS England guidance: emergency planning resilience and response (EPRR), all trusts must have planned for and be able to respond to a wide range of incidents and emergencies that could affect health or patient care. The trust paper presented to the board in September 2015, detailed its current statement of EPRR compliance, using the assurance framework assessment against the NHS England EPRR core standards. The trust had declared compliance against the majority of the core standards, with actions in place to deliver full compliance by 31 March 2016, following agreement of final 'integration phase two' service structures. This would ensure that local and new divisional business continuity plans were completed in line with changes.
- Staff told us during bad weather they would get to their nearest hospital to work if at all possible. There was access to four wheel drive vehicles that would help get staff into work. Staff were able to sleep on site if necessary to ensure they were available for their shift the next day. Staff said they would ensure there were extra supplies of food, drinks and medications if bad weather was anticipated to ensure they could continue to meet patient's needs.
- The trust had pledged to reduce avoidable harm by 50% over the next three years within its quality improvement programme. The trust identified four keys where it wanted to reduce avoidable harm by 50% by 2018: falls with harm, avoidable pressure ulcers, medicines management and restrictive practice (restraint). This reflected a number of safety improvement initiatives that the trust was part of, including the south west patient safety collaborative, sign up to safety and the patient safety thermometers.

Duty of Candour

- The trust had a `being open and duty of candour` policy in place. The policy was ratified by the regulation governance group in May 2015, was due for review in May 2018 and was available to all staff on the trust's intranet. The trust had highlighted implementing the duty of candour requirements as one of their priorities for quality improvement for 2015/16.
- The trust advised that it had introduced the `duty of candour` through a series cascade briefings, for example via the newsletter 'What'sOn'. Duty of candour information was included in the induction pack for new employees. As at 31 August 2015, 57 staff had been trained through the induction process. In July 2015 the trust commissioned an internal audit of its duty of candour procedures which included some recommendations for improvements. For example, ensuring risk management training included information about the duty of candour.
- Staff understood the principles of the duty of candour and could describe to inspectors their understanding of the importance of being open and transparent. However, staff were not always aware it was a legal requirement or whether the trust had a formal process in place that should be followed. Some staff commented that they had not received training in the implementation of duty of candour.

Requires improvement

Are services effective?

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

Summary of findings

See above

Our findings

- Somerset clinical commissioning group was the trust's main commissioner of services. The Commissioners set annual targets under the framework for commissioning for quality and innovation (CQUIN), the aim of which is to improve the quality of services delivered to patients. For example, on Rowan ward there was a wellbeing practitioner whose objective was to meet physical health 'commissioning for quality and innovation' (CQUIN) targets for wellbeing. The wellbeing practitioner saw all new patients' and did a range of tests including ECG, height, weight and blood pressure and provided advice and help on diet, smoking cessation, exercise and drugs and alcohol.
- Overall we found that people`s care needs and risks were fully assessed and care plans had been put in place. However, the quality of patient records varied in detail and quality across the service and teams. We saw some excellent examples of comprehensive and person centred care plans. However, we also saw care plans were not always person centred and they lacked the detail required to demonstrate an understanding of the individual`s circumstances and needs. For example, we found at the community learning disabilities service that care plans did not always reflect changes in people`s circumstances, and were not always clearly linked to assessment of needs and identified risks. In the community adults service records clinical observations (such as blood pressure, pulse, temperature, and respiration) were regularly not recorded. In the community inpatients service medication doses were regularly not recorded in case records and in the end of life service advance planning documentation was not used.
- All information was stored securely on an electronic records system called RIO, which was available across the trust. Community health services had moved from paper records to the RIO electronic system approximately 18 months previously. Due to connectivity issues with computers, electronic patient records were not always available so staff also kept paper records. This was time consuming and resulted in incomplete notes in both systems. Some services could not access records completed in other services when patients' moved between them. For example, there were serious concerns raised within the learning disabilities service due to poor access to information held by the local authority.

Best practice

- We saw evidence that the trust was already working to, or working towards providing care and treatment in line with relevant national guidelines, such as those produced by the National Institute for Health and Care Excellence (NICE). The trust had set its own target to assess all NICE guidance for relevance/compliance within three months of publication of the guidelines. To support this there were a number of best practice groups across the trust. They were made up of senior staff, from a range of services that met quarterly to review incidents, share good practice and review relevant NICE guidance. For example, the falls best practice group reviewed all incidents of falls across trust and developed actions plans.
- The children and young people's service provided all the core requirements of the Department of Health's healthy child programme to deliver personalised care planning. This included early intervention, screening, immunisation, health and development review, provision of information and guidance to support parenting and healthy choices. The trust was also part of the national chlamydia screening programme and staff was aware of and operated within the standards provided by the national programme. Mental health services offered a variety of psychological therapies in line with NICE guidance, such as cognitive analytical therapy and family therapy.

- However, within the learning disabilities service we found limited awareness or implementation of evidence based guidance from NICE or the use of effective outcome measures. For example, the green light toolkit had not been effectively implemented. The green light is a toolkit for improving mental health support services for people with learning disabilities and ensuring reasonable adjustments are made in other mainstream services.
- The trust had a proactive clinical audit manager in post to support and oversee the implementation of the audit programme. The trust policy was up to date and clearly described how the clinical audit programme was devised, approved and monitored. The trust formed part of a southwest audit network (SWANs), through which best practice and ideas were shared. An annual report detailed the audit findings, impact and lessons learned was presented to the clinical governance group and integrated governance committee.
- Staff participated in a range of clinical audits, including national clinical audits. Local audits included looking at quality of handovers, falls and pressure ulcers. There were a total of 38 audits on the trust clinical audit plan for 2014/15, including three national audits. Some services told us that they were expected to undertake the full range of trust wide audits, even where they may not have direct relevance to their clinical practice, for example, acute mental health wards undertook audits for faecal incontinence.
- There was a range of audits conducted in the trust including national, local clinical and commissioning and quality innovation audits. We saw examples where outcomes of these were being used to influence and improve practice. For example, we saw audits from the dental services which demonstrated their activity of fluoride application to children's teeth across the county had improved their dental health. In urgent care services staff monitored people's care and treatment outcomes through auditing notes and treatment plans and through monitoring the rate of assessment and treatment and with numbers of patients discharged home.
- The responsibility for the implementation of audit findings was delegated to one of a number of best practice groups. However, the trust recognised that the processes and arrangements for devising action plans to implement findings was an area that required improvement. Findings of clinical audits were not being systematically implemented, for example a number of audits were in place in relation to medicines management. The pharmacy technicians collected data on missed doses. This information was reported in the medicines management report (August 2015) but we did not see any action plans relating to addressing this issue. Ward managers we spoke with were unaware of the report.

Outcomes for people using services

- Staff used a number of different tools and measures to monitor the outcomes of implementing best practice in the care of patients'. Examples included the Allen cognitive level screen test for monitoring thought disorder, the Beck depression inventory to monitor mood and an integrated risk assessment tool to manage risk of falls in community settings. Patient outcomes in community health children and young people's services and community health services for adults were primarily based on contact measures and patient satisfaction surveys.
- The national deaf child and adolescent mental health service used a variety of assessment tools to measure the effectiveness of their interventions. Commissioners required them to use the health of the nation outcome scales for children and adolescents (HONOSCA). The mental health wards used the health of the nation outcome scale (HoNOS) to assess and record the severity of patients' symptoms but they were not using it to review outcomes.
- However, overall across all trust services; the mental health services, community inpatients' and community adults' services, we found that the collection of outcomes was limited. Outcome measures were not used to benchmark the performance of the service. Therefore, the teams did not know how effective their care was in comparison to similar services.

Skilled staff

- Across all areas of the trust, care and treatment was provided by multidisciplinary teams of competent staff who were qualified and trained for their roles. 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. Community health services included a variety of nursing, medical, administrative and allied health professionals.

- Data provided by the trust showed that most staff had received an appraisal in the last year. There were systems for the revalidation and appraisal of doctors. New staff were supported in their roles and underwent local, specific induction as well as the trust wide induction. Some wards also had a mentoring system in place for new staff on the ward**.** Most staff confirmed that they received regular supervision, including reflective practice sessions.
- Most staff confirmed that they had received the necessary specialist training for their role. Clinical staff had the opportunity for continuing professional development sessions and leadership training. However, some staff told us they had received insufficient specialist training to be able to respond effectively in all instances. For example, on Pyrland 1 ward staff felt the managing violence and aggression training they received concentrated on staff breakaway techniques, which was positive and in line with trust policy; but that the training was inadequate for learning how to safely restrain aggressive, physically fit and strong older adults.

Multi-disciplinary working

- With the exception of the community learning disabilities teams, where there was limited active partnership working, both internally and externally, to make sure that the care and treatment remained safe for people who used the services; there was good multidisciplinary working in all of the services we inspected. Mental health 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, when required. Within the community health service, staff in nursing and therapy teams provided examples of multidisciplinary team-working, such as the joint approach to management of a patient with a grade four pressure ulcer that required intervention from the tissue viability nurse and the social care team. At MDT meetings many of the community hospitals had input from a mental health nurse who was able to provide specialist knowledge in the management of mental health conditions.
- There was effective collaboration between staff in the trust and other services to provide care. Local partner organisations, including local authorities, care homes, police and ambulance services, were generally positive about the working relationships with the trust and staff delivering its services.
- There was limited assessment capacity in the learning disability (LD) service to work with other services. For example, with the child and adolescent mental health service, there was one learning disability nurse available for the whole of each area and they had the maximum capacity to undertake two assessments per month which meant the service was limited. The LD assessment was a joint assessment conducted with a paediatric care team.

Consent to care and treatment

- Staff across the trust demonstrated a good understanding of the need to obtain consent to treatment, although this was not always documented in line with best practice. We found that the recording of capacity and consent to treatment and best interest assessments varied. For example, we found that there was no consent recorded for any of the patients' on the child and adolescent mental health ward. However, in the sexual health service staff followed the faculty of sexual and reproductive health service standards in obtaining valid consent in sexual health services, July 2014, in conjunction with the trust policy. Most people using the mental health home treatment service told us they were consulted about their care on an ongoing basis and that staff respected their wishes about consent and information sharing.
- In the children and young person's service we saw staff explaining the assessment and consent process and the need to share information with other professionals, such as the GPs, nurseries and schools, before obtaining written consent. We observed staff discussing the treatment and care options available to children, young people and their parents.

Good practice in applying the Mental Capacity Act

- Staff were able to describe responsibilities in relation to capacity assessments and keeping patients' safe. Staff described how to assess capacity and were aware that a person's capacity to make decisions and choices changed and as a result their capacity assessments had

to be reviewed regularly. However, it was not always clear that capacity to consent had been assessed and consent to treatment and information-sharing was not consistently recorded.

- We identified a number of specific issues in relation to the trust meeting its legal obligations under the Mental Capacity Act 2005 (MCA) on the older people`s mental health in patient wards. Staff had not identified an instance when a patient should have had the input of an independent mental capacity advocate (IMCA) to support them through the process of a long term move. In relation to 'do not attempt resuscitation' (DNR) forms, we were concerned that for some patients the DNR decision appeared to have been reached without discussion with the person or their relatives and that the DNR decisions were also not being regularly reviewed.
- However, we also saw examples of comprehensive capacity assessments and best interest meetings in the older people`s mental health in-patient and community services. 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.
- Mental Capacity Act training was not part of the trust`s mandatory training programme. Training was via an online DVD. Information provided by the trust showed 61.5% of the staffing establishment of mental health teams had completed the Mental Capacity Act training, this equated to 579 out of 942 members of staff. 66% of the community health staff had completed the training, which equated to 1109 out of 1684 staff. We were not assured that the current training enabled staff to have a good understanding of the legal framework and application in practice.

Assessment and treatment in line with Mental Health Act

- Appropriate arrangements were in place for the safe management and administration of the Mental Health Act and the Code of Practice. Administrative and legal support was provided by the mental health legislation manager and his team. In addition to dealing with issues relating to the Mental Health Act, the team were also responsible for work relating to the Mental Capacity Act.
- Seven wards were subject to a Mental Health Act monitoring visit as part of the trust's inspection – Willow, Magnolia, Pyrland 2, Ash, Holford and St Andrews. There were detained patients on all of these wards and two wards ((Magnolia & Pyrland 2) also had patients who were subject to DoLS.
- All of the Mental Health Act paperwork was available for scrutiny and was in order. However, we found consistent concerns raised by these wards. These related to: care planning, Section 17 leave, capacity assessments, section 132 rights, and lack of training for staff.
- Mental Health Act training was not part of the trust`s mandatory training programme. Training was via an online DVD. The training information for the Mental Health Act showed that 67% of staff within mental health teams had undertaken the online training, this equated to 626 out of 942 staff. 62% of community health staff had undertaken the training which equated to 1044 out of 1684 members of staff. We were not assured that the current training enabled staff to have a good understanding of the legal framework and application in practice.

Good

Are services caring?

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

Summary of findings

See above

Our findings

Dignity, respect and compassion

- We observed a range of staff providing care to patients in a respectful and considerate manner. Patients dignity and privacy was respected, for example, doors were closed when staff left clinic rooms and where a curtain was used, and it was drawn across. Reception staff took patients details in a confidential manner and reception areas were suitable for carrying out conversations that would not be overheard.
- Staff in all services took time to interact with patients'. There was laughter between the patients and staff and it was evident that good relationships were in place between them meaning that difficult procedures were undertaken with consideration and respect for each other. We observed personal care being provided and saw patients were treated with dignity and respect. On the mental health wards, the activities co-ordinators demonstrated a good rapport with patients and offered choice to accommodate patients preferences. We saw staff being respectful and responsive to patients needs, for example, during lunchtime, patients were encouraged to choose what they wanted to eat. We saw a patient who was being verbally aggressive calmed by staff using verbal intervention.
- Patients we spoke with commented positively on the compassion and caring nature of the staff. They said that staff showed an interest in them and asked about visitors and interests. One patient in Bridgwater hospital said "Staff are very kind to me, marvellous. I feel like they are old friends." Patients' also commented about the positive attitude of the therapies teams. One patient said "I have a fear of falling and they do try to give you confidence but you have to take some risks".
- We spoke with 20 patients and received 30 CQC comment cards in relation to the dental services provided by the trust. All patients' we spoke with and the comments received reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and the outcomes of the treatment provided.
- PLACE score for privacy, dignity and well-being was above the national average at 98%. In most services we were told that the food was of good quality. PLACE scores for the trust supported this. The trust had performed better than the national average for food in the 2015 survey.

Involvement of people using services

- The trust launched a patient and public involvement best practice group in 2014, made up of staff from across operational divisions, with the aim to share learning and best practice in involvement and engagement. The NHS Friends and Family Test (FFT) was introduced in 2013 to gauge patients' experience of their care and levels of satisfaction. The test asks patients' how likely they would be to recommend our service to friends and family if they needed similar treatment.
- We saw positive involvement of patients and those close to them in their care. Staff we spoke with in the children and young person's service said they tried to ensure parents and children were fully involved and as informed as possible about their care and treatment. Parents we spoke with were positive about this aspect of the service. One parent we spoke with explained how they felt a pivotal part of the care plan with an emphasis on the priorities for their child and the family. They were always kept informed of options about treatments.
- We found excellent examples of family involvement in the child and adolescent mental health community service. There was an information session for parents and carers. The service had a patient participation group that gave existing service users the opportunity to feedback on the service; they were also able to join interview panels for new staff. All mental health wards were holding 'have your say' meetings for patients. This gave them the opportunity to talk about the day to day running of the ward. Some of these meetings were attended by the patient, advice and liaison service (PALS) or independent advocates. Patients had been

informed about our visit and patients had been encouraged to talk to us and be honest about their experiences. There was a 'you said, we did' board showing improvements made in response to feedback.

- In the end of life service, patients we spoke with all acknowledged that they had been involved in their care, their wishes had been taken into consideration and they had an understanding of what was happening to them. One patient told us they saw a doctor nearly every day and they could ask any questions they had and they felt they had honest answers from them.
- In the urgent care services, through observation and discussion with patients, we found that patients and carers were given sufficient time for explanations of the assessments made, treatment and outcomes.
- However, some patients using adult mental health services told us that they had not been involved in agreeing their care plan and we did not always see evidence of involvement in care records.

Emotional support for people

- The trust carer's charter was reviewed and updated in 2013. The 'triangle of care' steering group had undertaken this work and the charter was applicable to carers in the trusts community health services as well as the trust's mental health services. The 'triangle of care' was launched in July 2010 as a joint piece of work between Carers Trust and the National Mental Health Development Unit, emphasizing the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health. The trust achieved their first 'star' for the 'triangle of care' in 2013, for work in their mental health inpatient wards, only the second trust in the country to achieve this. The trust was working towards a submission for their second 'star' during 2015.
- The Somerset Partnership NHS Foundation Trust carer's service supported families and carers of people with mental health issues in Somerset. The carers annual review report 2014 showed that, during 2014, 28 carers were supported by the befriending volunteers, a vital link for carers who were socially or geographically isolated. The nine 'carers assessment workers' were based in their locality community mental health team. The team was supported by seven volunteers who provide befriending to carers and assist with facilitating carers groups. The employment service provided a range of employment help and advice to carers to assist them with either general employment advice or looking and applying for work. Five new carers support groups were also established. During 2014 the team received 1,739 referrals and completed 1,348 formal assessments. As well as undertaking carers' assessments and supporting carers, the team held a number of workshops and training days, for carers and staff.
- We saw that emotional support was given to patients in all of the community health services provided. In the community inpatients service we saw staff, including therapy staff, supporting and encouraging patients' in maximising their independence. We observed staff providing emotional support to children, young people and their parents during their visit. Parents told us they felt supported emotionally by staff.
- The trust worked effectively in partnership with voluntary organisations. We were told about, and met, some of the volunteers who worked at the community hospitals we visited. They told us they sat with patients who had no visitors, if they wished them to. They talked with the patients, read to them or helped them with puzzles. We also saw volunteers, who had appropriate training, help patients with their drinks and meals. On the mental health rehabilitation ward we were informed about a project run by MIND volunteers where patients were offered alternative treatments such as Indian head massage or reflexology from trained volunteers.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

See above

Our findings

Planning and delivery of services

- Services varied in the responsiveness of meeting the needs of the local people. In the community adults service there were no systems in place to ensure that service delivery was planned to meet the specific needs of the local population. There was very limited involvement of patient groups in the planning of service delivery within the district nursing service or the independent rehabilitation teams. We found dental services were planned and delivered to meet the needs of patients. Staff had a clear understanding of who their population group were and understood their needs including, making appointments long enough to provide thorough investigations and treatment. However, the available resources were not meeting the demand for service delivery. There were excessive waiting lists for vulnerable adults and children who had been referred to the service and were waiting for their first assessment appointment. At the time of our inspection in Dorset there were over 450 children on the waiting list of which 15 children had been waiting 24 weeks and a large number had been waiting 22 weeks. The trust advised that this also reflected the `inherited waiting list from the services acquired by the trust earlier in the year.`
- The children and young people`s services, staff were committed to delivering care as close to home as possible, minimising disruption for children and their families. Staff visited children and young people in their own homes or in local children's centres, GP surgeries, schools and nurseries. Staff were creative in making the best use of their time and were mindful to plan and organise as many visits and appointments as possible in one local area.
- In community inpatients services we saw 'primary link' running a telephone service to help prevent admissions to the local acute hospitals. They had patients referred to them (usually from GP's) who needed some support at home or admission to a community hospital until they were fit for discharge. We saw the 'primary link' services were flexible in trying to place people who needed admission to a community hospital (CH). They negotiated with patients, where there was not a bed in their nearest CH, to be admitted to another one nearby with a plan they would be transferred to their nearest one when a bed became available. The service also arranged the relevant transport for the patient.
- The average bed occupancy across acute mental health and psychiatric intensive care wards between October 2014 and March 2015 was 90%. This was broken down as follows: Rowan ward 94%, Rydon wards one and two 91%, St Andrews ward 91%, Holford Ward 84%. Acute adult mental health beds were generally available and patients were actively reviewed to see whether they could be supported at home with the help of the home treatment team.
- The number of patients waiting allocation of a care coordinator across all specialities was 120. However, the trust had difficulty identifying exactly how many patients were waiting prior to and during our inspection visit. Information was subsequently provided.
- Additional pressure was put on the inpatient mental health services for older people as a result of delays to discharging patients'. According to figures supplied by the trust, in the six months from October 2014 to March 2015 there were delays in discharges from older person's mental health inpatient facilities totalling 449 days. Magnolia ward had the highest number of delayed discharges with 283 days and Pyrland wards had delayed discharges of 166 days. Staff at each of the wards inspected told us there were sometimes delays to discharge due to circumstances largely beyond their control, such as lack of suitable residential care places and delays in obtaining home care packages.
- Referrals to the learning disabilities teams came from GP, self-referral, paid carer and third sector, social care and other health care professionals. The teams had

capacity to respond to urgent referrals. However, referrals for occupational therapy and dysphagia assessments were only accepted if they met the urgent referral criteria. Capacity to respond to routine referrals for occupational therapy was limited. We were told this was due to shortage of staff. The trust did not operate a waiting list for the community learning disabilities services or the rapid intervention team; as a consequence there was no understanding of the number of patients requiring the service or their needs or risks.

Diversity of needs

- People could access an interpreter if needed and written information was available in different languages if required. There were recent examples of teams using an interpreter. All staff within the national deaf child and adolescent mental health service (NDCAMHS) received training in British sign language (BSL), including the administrative staff. This helped with communication to the families and also for those staff team members who were deaf.
- All the wards and community services provided access for disabled people and offered facilities such as disabled bedrooms and assisted bathrooms.
- The trust had identified a need to improve the environment of the wards in the community hospitals to meet the increasing numbers of people living with a dementia. The dementia friendly steps taken regarding the environments varied across different wards. For example, at Williton Community Hospital colour was used to help distinguish different rooms, and calendar clocks were on the walls to help patients be orientated.
- The mental health wards had occupational therapy teams and a full range of rooms and equipment to support treatment and care. There were therapy rooms where alternative therapies were delivered and wards were well equipped for art and music activities. All the wards had computer equipment and well equipped gymnasiums. Patients on Holford ward has access to online banking and shopping. All the wards had lounges where there were games, music and television. Patients could access gardens on all the wards. There was access to quiet areas, including a multi-faith quiet room, and female only areas.
- However, there were a number of issues related to the design and layout of the wards which impacted on staff's ability to promote recovery and maintain patient comfort, dignity and confidentiality at all times, on the older people`s mental health wards. For example, meeting rooms were inadequately sound proofed and not all bedrooms had en suite bathrooms.
- In the community hospitals, where there was a strong presence of League of Friends, we found a range of activities and support; however, where there was not this presence, we found very limited opportunities for patients. For eample, at West Mendip Community Hospital none of the patients we spoke with had been offered to take part in any activities and hobbies and patient interests had not been explored by staff. Patients said they were very bored.

Right care at the right time

- Patients who required urgent care received it in a timely way. In the urgent care service 61% of patients were seen within one hour and less than 0.5% of patients were seen outside of the 4 hour limit. District nurse teams were available 24 hours per day, seven days per week. In every community nursing hub, one member of staff was available to coordinate referrals between 8am and 6pm. There was a dedicated line for clinicians. There was no agreed triage pathway to determine when a patient should be visited, and waiting times for urgent patients were not routinely monitored. However, coordinators tried to ensure that urgent visits were prioritised and patients with urgent needs were seen within 24-48 hours.
- However, those needing non urgent care in the community adults service waited too long for treatment. Patients who required a review of their continuing healthcare or funded nursing care needs waited a long time for this to occur. Within the west of Somerset the average waiting time for a continuing healthcare review was eight months. Within the east of Somerset the average waiting time for a continuing healthcare review was six months. This meant that healthcare professionals did not have an up to date understanding of the clinical needs of frail patients living in nursing homes and, as such, those patients might not have been receiving adequate or appropriate care.
- Within the dental services there was an efficient appointment system in place to respond to patients' needs. There were vacant appointment slots for the dentist to accommodate urgent or emergency appointments. The patients' we spoke with told us they

Requires improvement

Are services responsive to people's needs?

were seen in a timely manner in the event of a dental emergency. Staff told us the appointment system gave them sufficient time to meet the requirements of high need patients'.

- Mental health beds were generally available within the trust. Community adult, older person and child and adolescent mental health teams (CMHTs) had capacity and systems to respond to routine and urgent referrals. There was a designated daily duty worker, with an additional single point of access worker, to manage incoming referrals. The trust had two health-based places of safety, one in the west and one in the east of the county. This meant the journey time for a detained person was minimised. Referrals to the crisis and home treatment teams were received via a single point of access. All referrals were screened and prioritised according to the presented risk. All assessments were arranged within 24 hours of contact.
- There had been no instances of people detained in police custody rather than a place of safety in Somerset as reported at September 2015. However, there were long waits for assessment in the health-based place of safety. For example, we found evidence that four people admitted out of hours had waited between seven and 15 hours for assessment. This practice was contrary to the trusts own joint health based place of safety protocol and the Mental Health Act code of practice. Some staff in the crisis and home treatment teams were unable to describe the protocol or pathway for people detained under section136 of the Mental Health Act, and displayed inconsistent knowledge of their own internal procedures or agreements for accessing Mental Health Act assessments out of hours.
- We found that the availability of medical cover was varied between services. Community hospitals had GP cover during the day. We saw GPs carrying out a weekly ward round at two of the hospitals we visited. Staff told us some GPs visited daily once they had finished their own surgery at which point they could assess patients and make any changes to medications or treatments as required. We reviewed the medical cover for the mental health wards and found that Rydon ward one and Holford ward had access to medical cover day and night, although night time was mainly by telephone. However, St Andrews did not have medical cover over night between 17.00 hours and 09.00 hours and there was no cover at weekends. Out of hours health advice was provided through the local general practitioner (GP) services, which had access to an on call psychiatrist. The physical health of patients' on the mental health wards, Holford, St Andrews and Rydon ward one were met by their GP. The local management informed us they had escalated concerns over poor access to Section 12 doctors, out of hours, to senior management in the trust.

Learning from concerns and complaints

- Prior to the inspection, concerns had been raised by people who had received services or cared for someone receiving services with the inspection team about how the trust responded to complaints. The trust had a small complaints and PALs team which report to the director of governance. We undertook a comprehensive review of the complaints process during our inspection.
- During the year 2014/15 there was 147 recorded complaints, which was an increase of 34 from 2013/14. There were a total of 1310 PALS enquiries registered, during 2014/15, which was a decrease of 19 from 2013/14. There were a total of 33 MPs enquiries registered during 2014/15, which was a decrease of 9 from 2013/14. Of the 147 complaints investigated, 57 were partially upheld, 34 were fully upheld and 56 were not upheld. There were six complaints referred to the Parliamentary Health Service Ombudsman, three were not upheld, one was upheld and two were still open at the time of inspection. Following our inspection visit the trust advised that both of these were subsequently not upheld. Based on the information available, the trust was in the lower quartile of mental health complaints per year per 100,000 occupied bed days, excluding and including leave and approximately 50% below the mean for comparable trusts. The number of complaints regarding community hospital services was also in the lower quartile compared to other trusts. Data was not available on all non-in-patient community health services. Senior staff were aware that the trust had a lower than average level of complaints.
- Complaints were reviewed monthly through the clinical governance group to identify any issues of clinical practice or concern and learning. Complaints, PALS and compliments were also reported monthly to the board, we confirmed this by reviewing a sample of the reports submitted. Complaints were also reviewed quarterly for trends and learning for the trust through the patient and

Requires improvement

Are services responsive to people's needs?

public involvement group. The trust completed and submitted an annual return of complaints figures to the Department of Health. This was submitted on 28 April 2015.

- The current complaints, concerns and compliments policy was ratified in May 2015. In an effort to ensure it was 'patient friendly' the trust had gathered feedback from patients and their families and in line with the national Patients Association Standards. However, senior clinical leadership in the complaints governance arrangements did not appear to be embedded. For example, the director of nursing, medical director and chief operating officer were not described or referred to in the complaints procedure although the trust advised that the director of nursing and patient safety and the head of operations would review all complaints. There was no clear definition of what a complaint or concern is and very little reference to learning.
- Managers from the service being complained about, always investigate and decide on outcomes from those complaints, the lead decision maker was always the divisional manager of the service being complained about. The complaints policy was supported by the complaints process handbook which would be given to staff who were involved in complaints. This explained the standards expected in investigating a complaint.
- The culture of managing complaints was one where staff work to get quick, local resolution, informally. However, we found that local issues were not consistently recorded. This meant that any patterns, trend, theme or learning across the trust was minimal and completely dependent on the proactivity of the local manager involved. There was no evidence that there was any organised governance to ensure low level, local complaints were recorded, learnt from or audited to ensure efficacy.
- However, the trust had recently encouraged the best practice groups to share learning from all incidents and it was too early to gauge their success in relation to complaints. A specific `best practice group for patient experience` had also recently been established to share learning specifically from complaints concerns and other patient feedback although it was too early to gauge their success in relation to complaints.
- New complaints and PALs posters and leaflets had recently been produced and were in place in the trusts buildings. The leaflets were also produced in Mandarin, Portuguese and Makaton. Mental health wards we inspected held 'have your say' meetings on the wards and the minutes were displayed on the ward, some of which were attended by PALS representatives. Most patients, across all the services, we spoke with felt able to raise concerns and knew how to make a complaint.

Requires improvement

Are services well-led?

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

Summary of findings

See above

Our findings

Vision, values and strategy

- The trust had a clear vision and set of values which we saw displayed on posters; staff were not always able to clearly explain these. However, they were able to explain principles such as working in partnership and providing high quality care. Some staff felt that they were not involved in development of the trust vision.
- The trust had been through a period of considerable change since 2011 when it had merged with Somerset Community Health, the community health service provider of NHS Somerset. The trust vision for the service was to provide a fully integrated service across the three counties where services were provided and had begun a process of transformation of services called 'Integration phase two' (IP2), which incorporated new ways of working for community teams focussed on integrated approaches to care. For example, in the community health services for adults, the main focus of this integration was centred on the integrated older peoples and long term conditions teams. This included mental health services and community health services.
- Staff were aware the implementation of IP2 was taking place and many were positive about the perceived benefits of further integration. Some staff felt they had been consulted and were participating in working groups. However, many of the staff we spoke with felt the process of change had not been effectively managed. Many mental health staff felt that the main emphasis was now on physical care and that they were losing the identity of being a mental health service. This was particularly evident in the services that were not remaining under the mental health directorate, for example older people`s mental health and child and adolescent mental health services. The executive team were aware of this difference between the mental health staff and community health staff.
- In July 2015, a series of consultation events were held and in August 2015 the project implementation group reviewed the proposed models of service delivery in light of the consultation. A new management structure was implemented in August 2015 to reflect the new integrated model of service. During our inspection, many of the appointees to posts, created in this restructure, had very recently taken up post, or had not commenced in their role. We found many senior managers were unable to explain how the success or impact of the implementation of IP2 would be measured.
- Staff in most services knew who the senior managers and executives on the board were and told us that they visited the ward regularly to complete 'patient safety walk rounds'. The chief executive undertook a regular programme of visits to all services and spoke with staff and patients. Staff valued this.

Good governance

- Performance was reported to the trust board through the performance exception report, and the corporate dashboard. The trust also maintained divisional level performance dashboards for each of its five operational divisions. Each divisional dashboard sets out the performance of the division, in relation to its commissioning for quality and innovation (CQUIN) objectives, as well as other local and national targets relating to the services managed within that division. These reports were intended to allow the board to monitor how effectively it was meeting local and national standards and identify any areas of performance which have been identified as an exception.
- The monthly quality report to the board set out the key issues and trends, in relation to services provided and patient experience. We reviewed the report for the

period ending 30 June 2015, and noted that it included updates about complaints, restraint, safer staffing, patient experience and mandatory training. There were a number of committees and meeting structures in place to implement and oversee the governance framework. For example, monthly divisional meetings which include governance as the main focus and the integrated governance committee which focused on statutory and regulatory compliance.

- However, we were concerned that there appeared to be inconsistency in how effective local governance processes were and how they linked in with the wider trust processes. For example, there was variation in management of complaints, medicines management, learning from incidents and use of risk registers. The patient safety lead, and members of the executive team, undertook regular walkarounds in the in-patient units but these did not link in with the local or divisional risk registers as part of this process, or have oversight of other significant patient safety areas such as ligature audits. We reviewed the report from an audit of the trust risk management system undertaken in July 2015, and noted that it identified a number of the concerns we had found. The trust board and senior team demonstrated commitment to understand and address these concerns. The trust's revised Risk Management Strategy, approved in July 2015, specifically targeted these aspects for improvement.
- Risks identified on the risk registers did not always reflect risks facing the trust. We found inconsistency across the trust in how local risk registers were used to record and escalate risks to the divisional and corporate risk register. Some of the senior management team told us that they felt there was a tendency for some staff to over rate risks, but also a tendency for under-reporting of risks. There was clear indications of an urgent training need in relation to assessing and managing risks, for frontline and managerial staff. The trust had no clear baseline from which to measure progress, or systematically identify areas (teams, wards, units, individuals) that were a priority for training in risk. Some training and ad-hoc question and answer sessions were being delivered; largely it appeared in response to specific staff requests. Whilst there was positive feedback about these sessions, it was not clear how this was being prioritised or evaluated.
- From an examination of the most recent corporate risk register presented to the trust board, at the time of inspection (in July 2015), there were no clear action plans in place to reduce risks back to target levels by a stated date. While some actions were recorded, and some of those actions were accompanied by dates when action was initiated. For example, the current trust medicines risk register identified the low level of clinical pharmacist support to the wards as a risk (dated 20 November 2014). There was no information in the register about the current controls or the action planned to reduce this risk. We noted that the trust risk management strategy had set a target date for actions plans to be in place for all risks on the corporate risk register. However, this improvement was not expected to be completed until January 2016.
- The trust governance systems had failed to identify the level of risk in the community learning disability services that we identified on inspection. We had serious concerns about the ability of the trust's specialist health services for adults with learning disabilities to provide care and treatment in a safe way that would prevent avoidable harm or risk of harm for service users. The community teams for adults with learning disabilities did not always respond appropriately to meet peoples' individual needs to ensure their welfare and safety. These concerns included the lack of risk assessments, person-centred care planning, and mitigation of risks, incident reporting and working with others where responsibility for care was shared or transferred. However, some senior managers told us that concerns had been raised about community learning disability services but the services did not seem to be a high priority for the trust.
- The trust had taken part in the countywide Patients Association peer review of complaints handling which was held in September 2013 and February 2014. The handling of three reports were audited; one was deemed good and two satisfactory. The Patients Association recognised that the trust had made improvements since the previous audit and appeared to have developed a 'strong complaints handling process. The director of governance identified that complaints would be audited as part of the 2016 audit programme.
- We were concerned that despite being a provider of mental health and learning disability services, the trust

did not view Mental Health Act or Mental Capacity Act training as a necessary part of the mandatory training programme. We were not assured that the current training offered, and numbers of staff who had undertaken it, would ensure staff had a good understanding of requirements or changes in legislation.

Leadership and culture

- We received five whistleblowing contacts prior to, and during, the inspection. These raised concerns about an authoritative management culture and issues of bullying within the trust. Information supplied by the trust relation to grievances raised through the human resources department showed that 16 complaints about bullying, or concerns about managers, had been logged between December 2014 and August 2015, across 11 different sites. Of these, three had been resolved informally, two had not been upheld, two had been upheld and nine had on-going investigations or awaiting final outcome. Some teams we visited had been negatively affected by allegations of bullying and the impact of on-going investigations.
- The trust had arranged a number of listening events for staff in August and September to improve communications, listen to staff and explore why staff felt as they did. However, these were cancelled when only three people out of 3860 staff signed up to participate. The 2014 staff survey was completed in October and November 2014 with a 30% response rate; this represented a return rate of 257 staff across the whole trust. This was a significantly lower response rate than for the 2013 survey (41%) and was in the lowest 20% of comparable trusts in the country. In the NHS Staff survey 2014 the trust scored worse than average for the percentage of staff suffering work-related stress and work pressure felt by staff.
- The trust recognised there was a significant need for improvement in staff engagement to ensure staff felt valued and fully supported. Most of the senior and executive team we spoke with did not identify an issue with bullying. However, they acknowledged that there was a need for the culture to change `from the top down`. They recognised that some staff may not have always felt empowered to challenge and contribute, including a number of senior managers.
- The board were aware of some staff concerns in relation to the service redesign and managerial changes. There was not a clear plan in place to support staff and monitor the impact of the service re-design, location and management changes, on staff health and wellbeing. There was a leadership programme being rolled out by the trust to address development needs of managers and senior clinicians who were key to the delivery of the changes. We reviewed the report of the findings of the 2014 national staff survey presented to the council of governors in May 2015; this stated that next steps would be for a staff engagement action plan to be developed. However, we found little evidence that there was clear strategy or action to engage staff. We were advised that the trust was waiting for the new human resources director to take up post and develop a workforce strategy.
- In July 2014, the trust executive team created the 'employee of the month' and the 'team of the month' staff awards. Their aim was to celebrate a team or individual who has "gone above and beyond their role to deliver great patient care". Quarterly "voicebox" meetings had been established in January 2015 this was a staff led engagement forum where key areas of concern could be raised by staff. We reviewed the August 2015 report, which reflected that there was poor attendance.
- However, local leadership in most services we inspected was good and staff felt well supported by their managers for operational support and career development. In many services, staff reported good morale. We were told that there was a good level of openness and honesty. However, in the sexual health service not all staff got the opportunity to talk with managers due to the disperse nature of the service. Within the older adults community mental health teams there was 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).

Fit and Proper Person Requirement

- We interviewed the trust's chair and members of the senior leadership team regarding the implementation of the fit and proper person's test and were assured that all

directors had received the appropriate clearance. We reviewed a random sample of executive members' personal files and found the appropriate documentation had been completed.

Engaging with the public and with people who use services

- The trust advised that the public and patient engagement aspect of IP2 was informed by the National Voices survey, the joint mental health strategy and Somerset's community services review. However, there had been little public or patient engagement following the development of the transformation plans and implementation, which was at an early stage at the time of our inspection.
- At the time of our inspection there was no formal user involvement within mental health teams and no opportunity to help recruit staff, other than within the child and adolescent mental health service. Staff and patients we spoke with in the mental health service 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. Patients we spoke with were not aware of any plans the trust may have had to increase user involvement in the future.
- The trust worked in partnership with local groups, the health and well-being board, local Healthwatch and voluntary organisations such as the league of friends and MIND. The trust patient and public involvement group comprised of trust managers, governors, voluntary sector representatives and representatives from Somerset Healthwatch. This group reported quarterly to the council of governors and the board received a quarterly patient experience report as part of its regular quality report.
- The trust launched a patient and public involvement best practice group in 2014, made up of staff from across operational divisions, with the aim to share learning and best practice in involvement and engagement. The NHS friends and family test (FFT) was introduced in 2013 to gauge patients' experience of their care and levels of satisfaction. The test asks patients how likely they would be to recommend our service to friends and family if they needed similar treatment. The trust annual report and accounts 2014/15, stated it received nearly 4,000 FFT responses each month, and more than 90% of respondents would recommend trust services to their friends and family members. The completion of FFT varied across the services, the board had noted there was a lower level of return within the mental health services.
- The level of engagement of the council of governors was clear and it was generally supportive of the changes the trust was making. The council of governors was well attended by a range of service users, carers, staff and executive members of the board, including the chief executive and chairman. We attended a council of governors meeting, and feedback we received was positive about the open engagement with the trust executive team. We observed that member's views were valued and that they contributed to the discussion and debate. However, the council of governors told us that they felt that some patients were not represented at all within the trust, for example, people with learning disabilities.

Quality improvement, innovation and sustainability

- The trust had progressed a number of innovative initiatives and several services had received nominations or recognition from national organisations. For example:
- A consultant physiotherapist in the orthopaedic assessment and musculoskeletal physiotherapy services had been awarded a National Institute for Health and Care Excellence (NICE) Fellowship 2015.
- Bridgwater's new community hospital was highly commended in the Innovations in ProCure21+ category at the 2014 Building Better Healthcare Awards which took place on 5 November 2014 in London.
- The deaf child and adolescent mental health team were nominated for the 1st Plymouth deaf children society (PDCS) hero's award for the excellent work that they do supporting deaf young people and their families.
- Innovation in practice award was presented on behalf of Burnham-on-Sea War Memorial Hospital. The award related to Burnham's implantation of the indwelling urinary catheter-free project.
- Ash Ward was a member was a member of the College Centre for Quality Improvement (CCQI) forensic network.

Requires improvement

Are services well-led?

- We saw numerous examples where staff and managers were involved in local quality improvement programmes such as the `triangle of care', in which a colour coded assessment tool used to monitor standards around involvement in care. Services were also involved in trust-led quality improvement programmes. We reviewed 'an evaluation of the Rowan ward professional nurse supervision group'. This was a report produced as part of the trust's 'new ways of working' initiative. Nurses introduced a monthly supervision group which was for professional nurses specifically. The group was started in recognition of the fact that nurses were being asked to work in a new autonomous way because of the 'new ways of working' initiative. Staff feedback was positive and they found the group good for seeking advice and support and developing their skills.
- The trust was committed to participation in research and development. It was currently recruiting to 15 research studies supported by the National Institute for Health Research, including one commercial study. Examples include the older people`s community teams involvement in dementia research, adult community mental health teams involved in a novel lifestyle intervention for patients with psychosis, and the stroke services involved in a number of stroke studies.

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 **Health and Social Care Act 2008 (regulated activities) Regulations 2014.** **Regulation 12 – Safe care and treatment** **Wards for older people with mental health problems** Risks associated with the physical ward environment, such as ligature points, had not been fully assessed and addressed. The provider had also not ensured that persons providing care or treatment to service users had the competence and skills to do so safely at all times, as staff had not received adequate training to be able to safely manage fit and able patients who were physically aggressive. **This was in breach of regulation 12 (2) (a)(b)(c)(d)** **Community mental health services for adults** 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).**

This section is primarily information for the provider

Requirement notices

Community and specialist dental services

The provider had failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

Not all staff providing care and treatment to children had undertaken training in paediatric life support.

This was in breach of regulation 12(2)(c)

Community and specialist dental services

The provider had not ensured that they were assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that a healthcare associated.

Legionella risk assessment recommendations had not been implemented; there was no system in place to monitor the responsibilities of cleaners; and the immunisation status of staff was not always checked and followed up for those who are required to have Hepatitis B immunity.

This was in breach of regulation 12(2)(h)

Community and specialist dental services

The provider had failed to ensure that where equipment and medicines are supplied, there were sufficient quantities of these to ensure the safety of the service users and to meet their needs.

This section is primarily information for the provider

Requirement notices

Relevant nationally recognised guidance had not been implemented to ensure safety standards were met for the availability and use of emergency equipment used for domiciliary visits.

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

Appropriate emergency medicines to reverse the effects of benzodiazepine medication were not being held on Holford ward.

This was in breach of regulation12(2)(f)

Crisis and health based places of safety

Out of hours Mental Health Act assessments did not take place in line with the timescales within the Mental Health Act or the trust joint protocol on Section 136.

Staff were not always confident and assured they could access support for Mental Health Act assessments out of hours on the health-based places of safety. They were also unclear of the hours section 12 doctors or Approved Mental Health Professionals would attend during these times.

This was in breach of regulation 12(2)(i)

Community mental health services for children and young people

The service did not have effective processes for reducing the risks to patients and staff. This included risks in the environment.

This section is primarily information for the provider

Requirement notices

We had concerns about the safety of the small staff galley kitchen in Mendip CAMHS.

This was a breach of Regulation 12(2)(d)

Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Community based mental health services for older adults

Memory services did not demonstrate that care and treatment was 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 had not done all that was reasonably practicable to mitigate such risks.

This was in breach of Regulation 12 (1) (2) (a)(b):

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 11 HSCA (RA) Regulations 2014 Need for consent **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Regulation 11 – Need for consent** **Wards for older people with mental health** **Problems** The registered person did not demonstrate that care and treatment were provided only with the consent of the

Requirement notices

service user or other relevant person. The registered person could not demonstrate that they had acted in accordance with the Mental Capacity Act 2005 in all instances where a service user lacked mental capacity to consent to their care and treatment.

This was in breach of regulation 11(1) & (3)

Mental health rehabilitation ward

The registered person did not demonstrate that care and treatment was provided only with the consent of the service user or other relevant person. The registered person could not demonstrate that they had acted in accordance with patients detained under the Mental Health Act 1983:

The provider must ensure that capacity to consent to medication is undertaken.

The provider must ensure that patient's capacity to consent is undertaken prior to a request for a second opinion appointed doctor.

Forensic/secure Wards

The registered person did not demonstrate that care and treatment was provided only with the consent of the service user or other relevant person. The registered person could not demonstrate that they had acted in accordance with patients detained under the Mental Health Act 1983:

The provider must ensure that capacity to consent to medication is undertaken.

This section is primarily information for the provider

Requirement notices

The provider must ensure that patient's capacity to consent is undertaken prior to a request for a second opinion appointed doctor (SOAD).

This was a breach in regulation 11(4).

Mental health services for children and young people

There was no recorded consent for any of the patients on Wessex ward. We found that admission check lists had missed out this area and that doctors were not routinely populating the required area of the notes with consent. We found no written parental consent for any of the patients on the ward or any reference to gillick competency for those under 16 and able to consent.

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

Care records showed staff were not always gaining consent to treat patients and they were not treating the consent process as an ongoing one.

This was in breach of Regulation 11(1).

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 9 HSCA (RA) Regulations 2014 Person-centred care **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Regulation 9 – Person-centred care**

This section is primarily information for the provider

Requirement notices

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 17 HSCA (RA) Regulations 2014 Good governance **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Regulation 17 – Good governance** **Community health services for adults** Protocols and practice in the community health services for adults did not adequately protect staff who were working alone in patients homes. The district nursing service did not use an appropriate staffing tool to calculate staffing requirements. This meant that safe staffing levels could not be reliably confirmed or audited.

Community health services for adults

The provider had failed to ensure that the care and treatment of people using the service was appropriate, met **their needs and reflected their preferences by carrying** out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

District nursing staff were not consistently completing essential risk assessments and basic observations to enable early detection of risk to patients health.

This was a breach in regulation 9(1)(a)(b)(c) and 9(3)(a);

This section is primarily information for the provider

Requirement notices

Community health services inpatients

Understanding of governance at a senior and local level in the community inpatients service, limited how risks were managed at the community hospitals. Risks were not assessed and continually monitored appropriately increasing the risk of harm to patients. The threshold of incident reporting was high, particularly around medication errors, resulting in a poor oversight of risks and scale of risk associated with this.

Community sexual health services

Within sexual health services where risks are identified the provider must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.

Community health services urgent care

Local risk registers in urgent care services were not complete or up to date and did not reflect current risks or contain clear action plans for addressing the risks.

Community dental health services

The trust must ensure operational systems and processes to assess monitor and improve the safety of the services provided are effectively implemented and used within dental services.

Community mental health services for people with learning disabilities or autism

This section is primarily information for the provider

Requirement notices

The trust did not have systems in place to mitigate the risks for people who were awaiting treatment or access to the services. The trust did not monitor did not attend appointments nor did they mitigate the risks for people who required services but could not access due to not meeting the eligibility referral criteria.

This is in breach of regulation 17(2)(b);

Community health services inpatients

The provider had failed to maintain securely an accurate complete set of records in respect of each service user including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Community health services for adults

Patient records in community adults services were not complete. Record keeping was not systematically to provide assurance of safety.

End of life services

Not all patients receiving end of life care had care plans for their assessed needs. Some patients' care plans did not contain actions for staff to follow in meeting their assessed needs.

Community mental health services for children and young people

Risk assessments did not always reflect changes in people`s circumstances, and were not always clearly

Requirement notices

linked to assessment of needs and identified risks. Capacity, consent and information sharing was not always recorded. This meant the information was not easily available or accessible to staff.

This was in breach of regulation 17(2)(c);

Community and specialist dental services

The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Systems and processes which were in place did not support the provision of an accessible and timely service.

The trust did not have adequate governance process in place to assess, monitor and improve the quality and safety of services provided.

Community mental health services for people with learning disabilities or autism

The trust did not have adequate governance process in place to assess, monitor and improve the quality and safety of services provided.

This was in breach of regulation 17(1)(2)(a)

Community and specialist dental services

The trust did not have systems in place to mitigate the risks for people who were awaiting treatment or access

Requirement notices

to the services. The trust did not monitor did not attend appointments nor did they mitigate the risks for people who required services but could not access due to not meeting the eligibility referral criteria.

This was in breach of Regulation 17(1)(2)(b)

Community and specialist dental services

The trust did not actively seek feedback from all people who used services. It was not clear that feedback was listened to, recorded or responded to when appropriate. It was not clear that improvements were made as a result of feedback being sought.

Community mental health services for people with learning disabilities or autism

The trust did not actively seek feedback from all people who used services. It was not clear that feedback was listened to, recorded or responded to when appropriate. It was not clear that improvements were made as a result of feedback being sought.

This was in breach of regulation 17(1)(2)(e)

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 15 HSCA (RA) Regulations 2014 Premises and equipment **Health and Social Care Act 2008 (Regulated Actives)**

Regulation 15 – Premises and equipment

Community health services inpatients

This section is primarily information for the provider

Requirement notices

At Chard Community Hospital a fire exit was blocked limiting escape routes in the event of a fire. Equipment was provided to get patients down the stairs. However, no staff at the community hospital was trained to use it increasing the risk of harm to patients during an evacuation.

This was in breach of regulations 15(1)(c).

Community sexual health services

The provide had failed to ensure that all premises and equipment used by the service provider were properly maintained,

People who use urgent care services were not protected against the risks associated with unsafe equipment because the trust were not able to produce evidence of adequate maintenance.

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

The trust must ensure resuscitation equipment and refrigerators are checked and maintained.

Community and specialist dental health services

Not all recommendations from fire risk assessments had been completed in dental services. Records for equipment in dental services did not demonstrate that they had been properly maintained and were safe for use.

This was a breach of regulations 15(1)(e)

This section is primarily information for the provider

Requirement notices

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Health and Social Care Act 2008 (regulated activities) Regulation 2014** **Regulation 19 – Fit and proper persons employed** How the regulation was not being met: The provider must ensure staff are recruited safely according to the trust recruitment policy and Schedule 3 of the Health and Social Care Act 2008. Particularly ensuring references and gaps in employment were evidenced during the recruitment process. **This was a breach of regulations (2)(3)(a)**

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 **Health and Social Care Act 2008 (regulated activities) Regulation 2014** **Regulation 18 – Staffing** The provider had failed to ensure that all staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

Not all staff were receiving appropriate ongoing or periodic supervision in their role to make sure competence is maintained. Not all staff were compliant with statutory mandatory training for moving and handling

This was in breach of regulations 18(2)(a)

Community health services for adults

People who use services were not protected against potential harm because there were insufficient members of staff to provide a safe district nursing service.

Community based mental health services for older adults

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 was a breach of regulation 18 (1)

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Health and Social Care Act 2008 (regulated activities) Regulation 2014** **Regulation 13 – Safeguarding service users from abuse and improper treatment**

This section is primarily information for the provider

Requirement notices

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

Staff at Holford were not always aware of the need to consider making safeguarding referrals in the event of incidents between patients or when patients assaulted one another.

This was a breach of Regulation 13 (2) (3)

This section is primarily information for the provider

Enforcement actions

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 HSCA 2008 (Regulated Activities) Regulations 2014** **Safe care and treatment** **Community mental health services for people with learning disabilities** The trust did not take measures to prevent avoidable harm or risk of harm for people who used services. Care and treatment was not always based on an assessment of people's needs and preferences. Staff did not always respond appropriately to meet people's individual needs to ensure their welfare and safety. Risk assessments and risk formulations were not always being completed or reviewed. There was no monitoring or mitigation of risks for people awaiting treatment. **This was in breach of Regulation** 12(1)(2)(a)(b)(I)