Somerset Partnership NHS Foundation Trust

RH5

Community health inpatient services

Quality Report

2nd Floor, Mallard Court,
Express Park,
Bristol Rd,
Bridgwater
TA6 4RN
Tel: 01278 432000
Website: www.sompar.nhs.uk

Date of inspection visit: 27, 28 February and 1, 2, 13 March 2017
Date of publication: 01/06/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5X1	Bridgwater Community Hospital		
RH5F8	West Mendip Community Hospital		
RH5X5	Dene Barton Community Hospital		
RH5X2	Burnham-on-Sea War Memorial Hospital		
RH5X3	Chard Community Hospital		
RH5X4	Crewkerne Community Hospital		
RH5F1	Williton Community Hospital		

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

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

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

During this inspection we found the service had addressed the Requirement Notices following our September 2015 inspection. However, we found some areas where further improvements were required.

The ratings for the community health inpatients service remain the same in safe (requires improvement), caring (good) and well-led (requires improvement). Effective has changed from good in 2015 to requires improvement, while responsive has changed from requires improvement in 2015 to good.

Overall, we rated the community inpatients service as requires improvement because:

- The procedure for the application of duty of candour was not followed according to the regulation and medicines were not managed or stored correctly across the community hospitals in line with the trust's medicine management policy.
- Staffing was considered a risk for the trust due to the high number of vacancies, staff sickness turnover and the lack of matrons to have oversight of the hospitals. Safe staffing levels at three of the hospitals had not been met in January 2017.
- There were inconsistencies between how the hospitals monitored and recorded pain. There were multiple pain scoring systems in use which had led to confusion and inaccurate recording of pain. This had remained an issue from the previous inspection in September 2015.
- Staff did not understand or feel confident with the relevant consent and decision making requirements and guidance, including the Mental Capacity Act 2005 and there were inconsistencies about the recording of consent across the community hospitals.
- The governance framework did not always support the delivery good quality care and there was a lack of leadership to ensure actions from audits to improve compliance with trust policies were implemented into practice.

However:

- The safety performance within the trust was good and demonstrated a commitment to patient safety. Staff understood and were aware of their responsibilities to report incidents and were knowledgeable about the systems and processes in place for safeguarding patients.
- There was effective multidisciplinary working both within the trust and with other external organisations and the organisation participated in delayed transfer of care calls with local NHS trusts to overcome barriers to patient discharge.
- Staff demonstrated compassion to all patients and respected their privacy and dignity and staff ensured patients understanding of their care and treatment. Those close to them were involved in the planning of their care.
- There was a positive patient centred culture across the community inpatient service and the trust worked to engage both staff and the public.

Summary of findings

Background to the service

Somerset Partnership NHS Foundation Trust provides community inpatient services across Somerset. It has 248 hospital beds in 13 community hospitals. At the time of our inspection, 10 community inpatient beds at Minehead Community Hospital were temporarily closed. The community hospitals sat under two divisions. The east division covered Chard, Crewkerne, Frome, Shepton Mallet South Petherton, West Mendip and Wincanton hospitals and the west division covered Bridgwater, Burnham-on-Sea, Dene Barton, Minehead, Wellington and Williton hospitals. The trust served a population of 560,000 people, with 10% of the population being over 75 years of age.

The hospitals were nurse-led and medical cover was provided by doctors directly employed by the Trust or local GP services. Each ward had allied healthcare professionals, such as physiotherapists, occupational therapists and speech and language therapists, to manage patient rehabilitation and end of life care.

During this inspection, we visited Chard, Dene Barton, Crewkerne, Williton, West Mendip and Burnham-on-sea. We also visited Bridgwater as part of the unannounced inspection. We visited these hospitals to follow-up on outcomes from our previous inspection in 2015. We spoke with 81 staff, and 40 patients and their relatives. We also looked at 29 sets of patient records and 55 sets of prescription charts across the seven hospitals.

When the CQC inspected the trust in September 2015, we found that the trust had breached regulations. We issued the trust with requirement notices for community health inpatient services. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Our inspection team

Our inspection team was led by:

Team Leader – Gary Risdale, Inspection Manager (Mental Health), Care Quality Commission

The team included CQC inspection managers, inspectors and an inspection planner.

There were also a variety of specialist advisors supporting the CQC team from a variety of community health service backgrounds, including a community nurse, an older people nurse and an occupational therapist.

Why we carried out this inspection

We undertook this inspection to find out whether Somerset Partnership NHS Foundation Trust had made improvements to their community health inpatient services since our last comprehensive inspection of the trust in September 2015.

When we last inspected the trust in September 2015, we rated wards for older people with mental health problems as requires improvement overall.

We rated the core service as requires improvement for safe, responsive and well-led and good for caring and effective.

Following the September 2015 inspection, we told the trust to make the following actions to improve community health inpatient services:

- The provider must ensure that there is suitable access to fire escapes and training for emergency equipment to all at Chard Community Hospital.
- The provider must ensure that risk is properly assessed at the community hospitals and that this is recorded and escalated Patient records should be consistently completed in full.

Summary of findings

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 15 Premises and equipment

Regulation 17 Good governance

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We carried out an announced visit on 27 and 28 February and 1 and 2 March 2017, and an unannounced visit on 13 March at Bridgwater Hospital.

During the visits we talked with a range of staff who worked within the service, including nurses and therapists. We spoke with 81 members of staff.

We talked with 40 people who use services, their carers and/or family members and observed how people were being cared for.

We reviewed 29 care and treatment records and 55 prescription charts, as well as a large amount of data from the trust. We also received one comment card.

What people who use the provider say

Patients we spoke with at all of the community hospitals consistently provided us with positive comments about the care provided by the staff.

At Dene Barton community hospital, patient's said:

"Everyone is so willing to assist you when required."

"Staff are always so cheerful when they first approach you."

'Excellent staff, swift response to problems'

"Plenty of encouragement and motivation to help you get well,' "There are serene and beautiful surroundings to help your mind heal and your body recover."

Patients at Chard described the care as "very good" and 'splendid'. They told us the "nurses are so kind they cannot do enough."

Patients at Williton hospital told us the care was "outstanding" and "exceptional."

Good practice

- The care provided to end of life patients in the community inpatient service was exceptionally good. In one example we were given at West Mendip community hospital, a patient had requested to die outdoors. Nurses at the hospital were able to accommodate this patients dying wish despite the challenging weather conditions. Nursing staff put canopies up to keep the patient dry and ensured they remained warm and comfortable. A harp was also playing to help the patient remain relaxed.
- Burnham-on-Sea hospital had adopted 'compassionate interviewing,' a recommendation from the Francis report. Compassionate interviewing was based on the 6C's, (values from the Nursing and Midwifery Council, which all nursing staff should aspire to). The interview incorporated various tasks which identified elements of the 6C's demonstrated by the interviewee. Only candidates who demonstrated awareness of the 6C's in their application were invited to interview. This approach ensured staff being recruited were caring and compassionate.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- Ensure the duty of candour regulation is fully complied with in the inpatient service.
- Ensure compliance with the Mental Capacity Act (2005), and in particular capacity assessments and consent recording.
- Ensure medicines are stored and managed correctly across the community inpatients service, and that refrigerator temperature checks are completed.

Action the provider SHOULD take to improve

- Ensure all staff required to complete level three adult safeguarding training have done so.
- Make sure the resuscitation policy stored on the resuscitation trolleys is in date.
- Ensure all equipment is serviced and in date.
- Make sure all clinical waste is put in designated clinical waste bins and not left on the floor.
- Make sure cupboards containing cleaning fluids and detergents remain closed and locked at all times.
- Ensure safe staffing levels are met at all times in the community inpatient services.
- Make sure staff complete patient fluid balance charts to enable accurate monitoring of patients.
- Ensure all staff are up-to-date with their appraisals.
- Establish one consistent method of monitoring pain between the community hospitals.
- Ensure the admission transfer and discharge policy is in date and reviewed according to set timeframes.
- Make sure leaflets available for patients contain the most up to date information from best practice guidelines.
- Ensure patients are receiving regular physiotherapy input to ensure the service provided is responsive to the needs of the patient.
- Make sure there is consistent use of the “This is Me” documentation throughout the community hospitals.
- Continue to strengthen the governance framework across the community inpatient service to ensure it fully supports the delivery of good quality care.
- Ensure there is good oversight and leadership of audits across the community inpatient service to ensure actions are put into practice.
- Ensure matrons have the capacity to lead effectively.

Somerset Partnership NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

During this inspection we found the service had addressed the Requirement Notices following our September 2015 inspection. However, further areas for improvement were identified, which is why the rating has not changed since 2015.

Overall, we rated the safety of the community inpatient service as requires improvement because:

- Matrons did not respond to duty of candour incidents with a written apology.
- Medicines were not managed or stored correctly across the community hospitals in line with the trust's medicine management policy. Refrigerator checks were not complete and there were unexplained omissions on patient medicines charts.
- A small amount of equipment was out of date for service.
- Cleaning fluids and detergents were not always stored securely.
- Staffing was a risk for the trust due to the high number of vacancies, staff sickness, turnover and the lack of matrons to have oversight of the hospitals.

However:

- The safety performance within the trust demonstrated good levels of harm free care.
- Staff understood and were aware of their responsibilities to report incidents. However, we found some examples from talking to staff about incidents which had not been reported. Feedback and learning from incidents was shared and staff could provide us with examples of wider shared learning and changes to practice as a result of an incident at a different community hospital.
- Systems for safeguarding patients were clear and staff were aware and knowledgeable about the process they were required to follow.
- Patient records were accurate, complete and stored securely.
- Compliance with infection prevention and control procedures was generally observed to be good.

Requires improvement

Are services safe?

- The inpatient service had systems and processes to assess and monitor patient risk and used the National Early Warning Score to recognise a deteriorating patient.
- There were improved systems and process with regards to fire safety and training at all of the community hospitals.

Detailed findings

Safety performance

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm-free care. There are four key measures as part of the safety thermometer, which include falls, pressure ulcers, venous thromboembolism and urinary tract infections in patients with catheters. Safety performance is recorded on a single day every month.
- The community inpatient service demonstrated a consistent safety performance over time, based on internal and external information. Between February 2016 and February 2017, the service achieved between 90.6% and 93.1% harm-free care.
- The trust participated in the Sign up to Safety campaign. The campaign is a national initiative to help NHS organisations achieve their patient safety aspirations and care for their patients in the safest way possible. The community inpatient service had developed initiatives around falls, pressure ulcers and medicines management in relation to the Sign up to Safety Campaign.
- The service worked closely with the local clinical commissioning group and other organisations to raise awareness and reduce the numbers of pressure ulcers. Work had been undertaken looking into themes and trends regarding pressure ulcers, with study days set up for this purpose. A best practice working group had been set up to continue the drive to improve the care and management of patients with pressure ulcers. This had a positive impact upon patient care with none of the hospitals we visited having had a patient develop a hospital-acquired pressure ulcer for over a year.

Incident reporting, learning and improvement

- Staff were aware of their responsibilities to raise concerns and understood the process of how to report and record safety incidents, however not all incidents were reported.
- There was a policy and system in place to report incidents and staff we spoke with were able to provide us with examples of incidents and near misses they would report. There was an electronic system to allow incidents to be reported and investigated appropriately. However, during the inspection we were provided with examples of incidents which had not been reported. Staff told us about incidents with GP's from the out of hours service which they had not reported and we observed a medicines incident which also had not been reported.
- The community inpatient service had reported 3,199 incidents between January 2016 to January 2017 inclusive. This accounted for 35% of all incidents reported to the trust in this reporting period. Five of the 13 community hospitals had reported over 300 incidents during this period. These were Bridgwater with 397, South Petherton with 377, West Mendip with 355, Burnham-on-Sea with 329 and Frome with 301. This was to be expected as Bridgwater, West Mendip and South Petherton were the largest community hospitals.
- There were recognised themes and trends amongst reported incidents. The top seven themes were accidents which may result in personal injury (975), treatment procedures (462), access, appointment, admission, transfer and discharge (332), medication (286), abusive, violent, disruptive or self-harming behaviour (278), infrastructure or resources relating to staffing, facilities, environment (254) and implementation of care or ongoing monitoring or review (212).
- There had been no never events within the community inpatient service between January 2016 and January 2017. Never events are serious patient safety incidents that have the potential to cause serious patient harm or death and should not happen if healthcare providers follow national guidance on how to prevent them.
- Staff did not receive individual feedback on incidents they had reported. However, feedback from learning was shared. All incidents were reviewed and investigated if required by the ward sister. Investigations carried out identified learning points and action plans to address the issues. Ward managers would provide feedback about incidents to staff at ward team meetings. We saw evidence of these discussions taking place at team meetings. Learning from incidents included the marking of patients' folders kept outside the room with a traffic light system to alert staff to the

risk of the patient falling. Another example was how staff breaks were allocated on the wards at hospitals which faced challenges, ensuring patient visibility at all times due to the layout of the ward. This change was made following a patient falling.

- Ward sisters were provided with feedback following any investigation into incidents reported about deteriorating patients or pressure ulcers. The clinical skills team investigated all unplanned transfers. Feedback was provided with regards to the investigation and any learning or action which could have been taken to improve the recognition and care of deteriorating patients. We also saw examples where the tissue viability team had provided feedback with regards to incidents about pressure ulcers and their management.
- Learning from incidents was cascaded across the inpatient service. Staff were able to provide us with examples where there had been changes to practice following incidents which had occurred at a different hospital. Staff provided us with an example of how each patient menu choice had to be signed by the nurse in charge. This was to ensure their meal choice was appropriate for the patient's diet. A new incident at Shepton Mallet hospital had also identified trust wide learning, with regards to all stroke patients being reviewed for prophylactic anticoagulation therapy (a method of using medicine as a primary prevention against developing a blood clot in a vein) and if appropriate, prescribed according to National Institute of Health and Care Excellence (NICE) guidelines. At the time of our inspection, this incident had just occurred and action plans were yet to be completed. The learning and actions were due to be shared trust wide to improve safety and practice for patients.

Duty of Candour

- Staff demonstrated an understanding of their Duty of Candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. We saw evidence where the Duty of Candour had been employed within the service.
- Staff demonstrated an awareness of this regulation and could explain their responsibilities in relation to it. Staff spoke of their practice being open and transparent with the families they worked with. Ward sisters and matrons provided us with examples of when they had been open and transparent with patients and their families, when a dementia patient sustained an injury to her leg from the bed pan. The patient's family were called in to discuss the incident and provided with an apology.
- Matrons, ward managers and sisters had received appropriate training for duty of candour.
- We looked into how incidents requiring the duty of candour application were being managed. The duty of candour regulation was not being met in full because a written apology, explanation and investigation was not being provided to the relevant person.

Safeguarding

- There were systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from abuse. All staff we spoke with understood their responsibility to report safeguarding incidents. Staff of all grades were able to tell us what they would do if they needed to report a safeguarding incident and provided us with examples. There was a clear safeguarding policy available for all staff on the intranet. The policy covered definitions of safeguarding and the responsibilities of staff to report any suspicions of abuse. We also saw posters in the different community hospitals providing staff with information and contact details of how to manage an incident of this sort.
- The Trust required staff to attend both safeguarding adults and children training on a three-yearly basis. For the community inpatient service, 96.8% of staff had completed safeguarding adults training level one and 95% had completed safeguarding adults training level two, against the trust's 95% compliance target. However, only 12 of the 29 senior staff (41%) had completed safeguarding adults level three training. This low compliance was due to staff being on long term sickness and vacancies within the team. Staff also undertook level one safeguarding children training, with a compliance rate of 98.2%. The majority of staff had completed safeguarding children level two training, with 91% having completed the training against a target of 95%.

Medicines

Requires improvement

Are services safe?

- The community inpatient service still faced challenges with regards to the storage and administration of medicines as observed at our previous inspection in 2015. The countersigning of controlled drugs was not in line with the trust's medicines management policy.
- Controlled drugs were kept in locked cupboards in locked rooms and the nurse in charge on shift held the keys. Regular weekly checks were carried out of the controlled drugs by nursing staff and the pharmacist. Nurses adhered to trust policy with regards to the signing out procedure for controlled drugs, with the exception of Exmoor ward. It was also evident that patient's own controlled drugs were booked in and out according to trust policy. We saw evidence of weekly checks of patient's own routine medicines. Staff were able to tell us the process they would follow if any medicines were missing.
- Staff on Exmoor ward were neither following the trust's policy or working in line with best practice with regards to the management of controlled drugs. Exmoor ward had been temporarily moved from Minehead hospital to Williton hospital in December 2016. Only one registered nurse covered each nursing shift on Exmoor ward, supported by two healthcare assistants. Controlled drugs were being countersigned by a healthcare assistant, rather than a registered nurse. No risk assessment had been completed despite the deviation from the trust's policy. This issue was discussed at the medicines incident group in October 2016. The outcome was that if wards do not have a second registered nurse, they should do 'a single independent check rather than use a healthcare assistant.' The hospital's medicine management policy stated controlled drugs should be signed by two registered nurses or a doctor and a nurse. However, in exceptional circumstances, where there is only one registered member of staff, another healthcare professional, student nurse or healthcare assistant may act as a witness. The situation on Exmoor ward was not exceptional as there were nurses on the ward next door who could support with the countersigning of controlled drugs. There seemed to be a lack of clarity and understanding about the correct procedure in this scenario. The Nursing and Midwifery Council best practice guidelines, standards for medicines management for controlled drugs states, 'all entries must be signed by two registrants, or one registrant and one student nurse or midwife (for administration only). Exceptionally, the second signature can be by another practitioner (for example, doctor or pharmacist) provided they have witnessed the administration of the drug.'
- A controlled drugs audit was carried out monthly at each community hospital. In January 2017, the community hospital with the lowest compliance was West Mendip at 88%, with the other community hospitals demonstrating between 94% and 100% compliance with the management of controlled drugs as set out in the trust's policy. For the wards which were less than 100% compliant, the pharmacy technicians provided feedback on the areas of the audit which fell short to enable improvement to be made. However, the results of this audit did not match our findings with regards to the countersigning of controlled drugs in line with trust policy on Exmoor ward.
- There was a service level agreement and a system for ordering medicines from a local acute hospital. Medicines could be ordered urgently for same day delivery, or a non-urgent order would see the delivery arrive the next day.
- Some of the hospitals we visited were not acting in accordance with the trust's policy regarding the safe storage of medicines. Staff generally recorded the opening dates for bottles of liquid medicines, although at Dene Barton and Bridgwater we found three medicine bottles which had been opened but no opening date recorded. This put patients at risk of taking medicines outside of manufacturers' guidelines, which may have harmful effects upon the patient. This issue had been identified at our previous inspection in 2015, however remained unresolved. The medicines' refrigerators at Bridgwater hospital contained insulin and were unlocked. However, there was a facility for the refrigerators to be locked. We also found the five cupboards which contained medicines were not locked and medicines had been left out on a trolley in the treatment room at Crewkerne hospital. The hospital's medicines management policy stated all medicines should be stored in a locked medicines cupboard.
- A medicines trolley remained unlocked and unsupervised on one occasion at Chard hospital during a drug round when a nurse was giving medicine to a patient. This posed a risk that medicines could be accessed by patients or others.
- The trust carried out an audit of the management and safe and secure handling of medicines in the

community inpatient hospitals in 2016. The outcome of the audit demonstrated some areas of variable compliance. These correlated to the areas where we found the hospitals to be in breach of their medicines management policy. There was an action plan detailing action required to improve compliance with the safe and secure handling of medicines. This was time phased and had a nominated individual who was leading various actions to ensure their completion. The issues picked up during our inspection demonstrated the actions had not been fully addressed and implemented into practice, despite the target date of 31 January 2017.

- We reviewed 55 prescription charts throughout the seven community hospitals we visited. All prescription charts were signed and dated. Twelve out of the 55 charts checked contained omissions where there was no record of the medicine being given and staff had not always recorded the reason why this had been omitted. We did not see evidence of any actions taken following missed doses; therefore, it was not clear whether these patients had received their prescribed medicines.
- Staff recorded medicines' refrigerator temperatures daily to check they were in a safe range to store medicines. However, we found several omissions across the community hospitals looking back at records from October 2016.
- NHS prescriptions were regularly checked and each one signed out on a named patient basis. This was important as it prevented fraudulent use. However, at Crewkerne hospital we found three prescriptions were missing. This was brought to the attention of the ward manager who notified pharmacy. We did not ask at the time whether this was reported as an incident.
- During the inspection, we picked up a medicines error on Exmoor ward. A patient had two prescription charts; one was an old chart and one a new chart. One medicine had been signed on both charts to demonstrate it had been given to the patient at 8.15am and 8.30am by the same nurse. The nurse who had undertaken the round was spoken to and confirmed the medicine dose had not been given twice, but they had signed both prescription charts. The nurse advised a note should be put on the electronic recording system under the patient's record and the old chart removed; however, this near-miss incident did not trigger an incident report.
- There were systems and processes for staff to report medicines incidents. Staff would report incidents on the electronic reporting system. Of the incidents reported between January and December 2016, 286 accounted for medicines incidents. Of these 286 incidents, there were eight themes, the biggest being the administration or supply of medicine, which accounted for 105 incidents. There were 56 medicines errors following the prescription process, 20 regarding the monitoring of or follow up of medicine use and 16 regarding the preparation or dispensary of medicines. There were 83 incidents which were categorised as 'other medication errors.'
- Of the 286 incidents reported, two of the community hospitals were the highest reporters of medicines errors. South Petherton had reported 61 incidents and Burnham-on-Sea had reported 37. The lowest reporting hospitals were Shepton Mallet, reporting five incidents, and Wellington, reporting seven. These reporting figures were to be expected as the hospitals reporting the larger number of medicines incidents were the larger hospitals within the inpatient service.
- The medicines' incident review group examined all medicine errors reported. Staff involved in medicines incidents completed reflective accounts which were attached to each incident report. These included actions to prevent recurrence.

Environment and equipment

- The design, maintenance and use of facilities and the community hospitals premises kept people safe. However, there was a contrast between the facilities in which patients were cared for. Some of the hospitals had been more recently refurbished and were more spacious, for example Bridgwater and West Mendip hospitals. Chard and Dene Barton hospitals were older buildings which lacked space. On Exmoor ward (which had been recently moved on a temporary basis to Williton hospital) the design of the ward did not make it easy to observe all patients at all times. The older hospitals were maintained to the best standard they could be with the facilities they had.
- At the previous inspection in 2015 in Chard hospital, we found an unsafe shower which required patients to step up and into. This posed a falls risk for patients due to

the bathrooms being small and not allowing sufficient access for staff to support patients. This shower had been decommissioned since the previous inspection in 2015.

- The environment at West Mendip and the ward at Williton hospital was designed in a way to reduce the risk to patients with poor mobility and dementia. There were handrails along each of the hospital corridors which were coloured differently to enable patient with dementia to differentiate between the rail and the wall and to enable people with visual impairments to see them more clearly.
- At West Mendip and Bridgwater hospitals there was a large amount of space around patients' beds. This made it easier for nurses when using large pieces of equipment such as hoists. However, due to the older facilities and building at Chard Hospital, the lack of space made the use of larger items of equipment more challenging.
- Staff on Exmoor ward were dissatisfied with the facilities at their temporary location. Staff told us they had temporarily left their modern hospital in Minehead where they had space and access to up-to-date equipment. Staff felt their new environment lacked space and the design of the building provided several single side rooms which meant there was less visibility of patients and less observation. This had been highlighted as a risk and an action put in place to reduce the risk posed to patients. Patients' risk assessed as a high falls risks were moved into bays by the nursing station to improve patient visibility. Staff also felt they did not have all the equipment required on the ward. We were told staff had been back to the hospital at Minehead to collect small items; however, they no longer had access to some of the larger items of equipment.
- Resuscitation equipment was fit for purpose and daily checks on equipment were carried out at most of the hospitals we visited, apart from Bridgwater hospital. Trolleys were checked on a daily basis and were clean, with all equipment and medicines on the trolleys in date and tamper-evident. The resuscitation trolley checklists from West Mendip and Chard hospitals and Exmoor ward for the last three months were complete. None of the records contained any omissions; however, we noted six days where checks of the resuscitation trolley at Bridgwater had been omitted. We found an out of date bag, valve and mask on the trolley at Chard hospital. We raised this with the ward sister and it was replaced immediately. We also found the resuscitation policy on the trolley was out of date. This was removed when raised with the ward manager. This put patients at risk of incorrect procedures being carried out which were not in line with current best practice guidelines. However, the policy on the staff intranet was in date.
- We observed a completed quality control log book for the capillary blood sugar (CBS) machine at West Mendip. However, the 'hypo box' (a box which is available on wards to promote access to prompt and effective treatment for all patients in the event of hypoglycaemia (low blood sugar)) did not contain Glucose liquid. This was flagged to the nurse and immediately replaced.
- At Dene Barton, West Mendip and Bridgwater hospitals the doors to the cleaners' storerooms were unlocked, enabling access for anyone. We found liquid detergents and toilet cleaner on the side, which could all be harmful if they were ingested. We raised this with the domestic staff members who immediately locked the cupboards.
- Most equipment was within its service date. However, some out of date equipment was found at one hospital we visited. Burnham-on-sea hospital had hoists which were overdue a service, with one last being serviced in 2014. We also found some hospital beds at Burnham-on-Sea which were overdue a service. We informed the nurse in charge who acted on this and provided us with a date that had been arranged to service the equipment.
- Staff could access more specialist equipment if required and had appropriate equipment for a bariatric patient on the ward at Chard hospital at the time of our inspection. Bariatric equipment could be accessed at the central store at South Petherton hospital. We were told if a piece of equipment was not available and was required urgently, it could be ordered via the online equipment store used by the trust, however this could be costly.
- Therapy staff had access to equipment which could be provided to patients on the ward and also for a patient's discharge home. Some of the hospitals kept a small stock of basic equipment such as walking frames and raised toilet seats. Therapists also had access to an online equipment store where they could order equipment for patients or have this sent to the patient's

home. Delivery usually took between three and five days, however, there was the facility to order urgent equipment as required for same day delivery, however this could be costly.

- Burnham-on-Sea had improved the garden area for patients. Staff at the community hospitals talked about their own League of Friends who raised money to make improvements at the hospital and provide new equipment. The league of friends had recently refurbished the garden to improve the safety of patients when walking through.

Quality of records

- Patient care records were written, managed and stored in a way which kept patients safe. There had been an electronic recording system introduced into the inpatient service six months ago. The electronic record enabled staff to complete patient care plans, monitor patient observations and maintain a multidisciplinary set of records for each patient. All of the care plans had been personalised for the individual patient.
- We reviewed 29 sets of electronic patient records. All patients had completed care plans and these were reviewed on a weekly basis, unless individual patient need required a more frequent review. We also saw evidence of updated actions in response to changing care plans to keep people safe. Each member of staff had a unique logon code to access the electronic system. Each hospital we visited had several mobile computers on trolleys, which were located in the office and in various locations on the ward and in day rooms. This enabled staff to complete patient records whilst still being present to look after patients on the ward.
- There was a working group to develop the electronic record. Despite most care plans being electronically recorded, patients across the community inpatient services had a paper document folder at the end of the bed. Blood sugar charts, fluid balance charts and intentional rounding forms were still completed on paper; however, the electronic record working group were working to develop these charts electronically. The divisional lead told us there were plans to be a paperless service by summer 2017; however, ward managers we spoke with were unaware of this. Current paper records were scanned onto the electronic record system once the patient was discharged.
- At Dene Barton community hospital, complete patient medical records (complete records transferred over with patients from local acute hospitals) were kept in a trolley stored in the ward office. The trolley was covered but not locked, however there was a ward clerk or someone in the office to observe the trolley. At Crewkerne community hospital, medical notes were kept in a locked trolley behind the nurses' station.

Cleanliness, infection control and hygiene

- The majority of staff adhered to infection, prevention and control policies and procedures. Most staff demonstrated good handwashing and application of hand gel following contact with patients. However, one doctor did not wash his hands between patients and healthcare assistants at West Mendip hospital were changing several patients' beds and handling clean linen without washing their hands when moving between beds.
- There was adequate personal protective equipment available for staff working on the wards. Staff wore gloves and other personal protective equipment when appropriate, particularly for isolated patients. There were sinks available for handwashing and hand gel available for use in clinical areas.
- There had been no reported cases of Clostridium difficile (C. diff) or Methicillin-resistant Staphylococcus aureus(MRSA) bacteraemia in the trust for the past year.
- There were plenty of general waste and clinical waste bins available to use in the community hospitals we visited. The bins we checked were used appropriately for the type of waste they were designed for.
- In the sluice at Dene Barton hospital the floor was visibly dirty and there were discarded items of general waste on the floor and not in the waste bins provided. This posed an infection control risk to patient and staff.
- At Chard and Bridgwater community hospitals we found 'I am clean' stickers on equipment, such as commodes. These stickers had been signed and dated to show the equipment had been cleaned and was ready for use.
- Patient-led assessments of the care environment (PLACE) results were collected by the trust. The average cleanliness score was 99.9%. This was higher than the national average of 97.9%

Mandatory training

- All of the 13 community hospitals were achieving the trust's compliance target of 90% for mandatory training. Compliance was between 95.2% and 99.2% within the community inpatient service.

Requires improvement

Are services safe?

- Mandatory training was completed either once yearly or three yearly, depending on the requirement of the topic. Annual training included basic life support, fire safety, infection prevention and control and information governance. Safeguarding adults and children was completed every three years, along with moving and handling training levels one and two, consent, conflict resolution and equality and diversity training. Staff also completed a one-off training session about dementia. Mandatory training was a combination of both face-to-face and e-learning.
- Staff had opportunities to complete e-learning training during night shifts when the ward was quieter. Staff told us it was difficult to complete e-learning during daytime shifts due to time constraints and being very busy with patients. Some ward managers, where possible, would encourage staff to complete e-learning during working hours; however, if they had to complete this in their own time, staff would get this time back. Staff confirmed this was the case.
- There was a system to remind staff when their mandatory training was due an update. Staff and their ward manager would receive an email three months in advance, providing information about what mandatory training required an update. This gave staff time to arrange a refresher course to ensure they remained complaint. Overall, the staff provided us with positive feedback about the quality of the mandatory training.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who used the service and were developed in line with national guidance. Of the 29 sets of records we viewed, all had completed, individualised risk assessments stored on the electronic record system. These included falls, skin integrity, malnutrition, venous thromboembolism, mobility and moving and handling. All patients were assessed on admission and reassessed at weekly intervals during their stay unless there was a requirement to complete risk assessments more frequently. This was dependent upon the individual patient and the associated risk. Risk assessments were completed and reviewed and demonstrated how staff responded to changing risk assessments.
- The community inpatient service had access to equipment to respond to patients who were at risk of falls. If a patient was identified at risk of falls following a risk assessment, pressure mats were introduced to alert staff when a patient stood up. This enabled the staff to respond to these patients and reduce the risk of them falling. At Bridgwater hospital the layout was challenging for staff managing patients at risk of falls, due to the high number of single side rooms away from the nursing station. This was on the hospital's risk register. Staff tried to relocate patients to the bays closer to the nurses' station but also used falls mats to provide an alert when patients attempted to stand up.
- The community inpatient service used a scoring system recommended for use by the National Institute for Health and Care Excellence (NICE) to recognise a deteriorating patient. The National Early Warning Score (NEWS) was recorded by nursing staff when patient observations were completed. The information was stored on the patient's electronic record so it could be seen by all staff involved with their care. Health care assistants informed the nurse looking after the patient if their NEWS was elevated and needed a review. There was a standard operating procedure detailing the level of escalation for specific NEWS scores, either to telephone the GP or 999 ambulance service. We saw evidence of this in practice. Nurses told us there had to be an element of discretion when interpreting some raised NEWS. We were given an example of how the NEWS score would flag up a score of one about a patient's temperature despite the temperature being recorded in a safe range. This was due to the sensitivity of the electronic recording device and the narrow parameter regarding a normal temperature, which had been programmed by the manufacturers on the system.
- Nursing staff regularly carried out checks on patients to review their care needs. The inpatient service carried out intentional rounding, a structured approach whereby nurses conduct checks on patients to assess and manage their fundamental care needs.This assessment was carried out at specific intervals throughout the day and recorded on the intentional round checklist, kept at the patient's bedside.
- The arrangements for handovers at nursing shift changes kept patients safe. A handover of all the patients on the ward was provided to the staff coming on duty. A nursing handover sheet was provided to each staff member. This contained detailed information about the patient's condition, history, status and actions to be taken which staff could refer to during their shift. An audit was carried out in May 2016 of each of the handovers in the 13 community hospitals. This

demonstrated the community inpatient service was complaint with the trust's handover policy. Each hospital also carried out a local audit of their handovers bi-monthly to continue to review the effectiveness of the handover process and the information provided.

Staffing levels and caseload

- The hospitals were under pressure because of a shortage of qualified nursing staff and a small number of healthcare assistants due to staff vacancies, sickness and turnover. There was also a high level of sickness and vacancies amongst the community matrons, leaving them understaffed. This meant they had to take on other hospitals within the patch to provide higher level management and oversight, which impacted upon their capacity and ability to manage the hospitals effectively. The increasing dependency and complexity of patients in the community hospitals was also creating further challenge to the staffing issues. Nursing staffing was on each of the community hospital's risk registers and had also been escalated to the divisional risk register.
- The community inpatient service had not met safe staffing levels at three of the community hospitals in January 2017. Bridgwater hospital only met 64.1% of their recommended nursing hours, whilst Wincanton only met 72.6% and West Mendip only met 73.8%. West Mendip hospital did not meet safer staffing levels during night shifts, only meeting 67.7% of their nursing hours. West Mendip had also not met 80% of its safe staffing levels in December 2016. Despite this, we saw no evidence that patients had experienced harm due to the staffing levels not being met. The trust was monitoring the situation closely to ensure patient safety was not compromised.
- Actual staffing levels were lower than the budgeted establishment. Information provided by the trust showed out of 125.9 whole time equivalent (WTE) qualified nursing staff, there were 26.5 WTE vacancies. The data also showed out of the 138 WTE health care assistant staff, there were just 3.6 WTE vacancies. The highest numbers of vacancies were reported to be at Crewkerne, South Petherton and Wellington hospitals, which ranged between 18.4% to 22.6% vacancies, mainly for qualified nursing staff. Wincanton hospital had the lowest vacancy rate of just 2.7%. In order to cover the gaps, substantive staff would take on extra shifts and ward managers would use their supervisory days to work clinically on the wards. This meant the ward manager would have less time to carry out their management commitments and manage the ward. Bank and agency staff were also used to cover shifts. This could be challenging as a new member of staff working on the ward would be unfamiliar with systems and processes on the ward, requiring other staff to provide support, detracting from patient care.
- The community inpatient service faced challenges with regards to the turnover of staff. Staff turnover rates for the last 12 months since January 2017 had seen four out of the 13 community hospitals rated as red, which indicated staff turnover had been above 15%. Chard, South Petherton, West Mendip and Williton all had staff turnover rates between 16.1% and 22.6%. At this time, Williton hospital also had a number of staff attaining retirement age following long term service to the hospital, which contributed to the turnover. Despite these high rates of staff turnover, both Chard and West Mendip had seen a reduction in the cumulative staff turnover over the period. Wellington community hospital had seen no turnover of staff and Shepton Mallet had only had a 7.4% turnover.
- Some of the community hospitals had high rates of staff sickness for the last 12 months. In January 2017, seven of the community hospitals had sickness absences which were over 5%. These were Bridgwater, Dene Barton, Burnham-on-Sea, South Petherton, Wellington, West Mendip and Wincanton. Shepton Mallet had the lowest rate of sickness at 3.2%.
- Data provided by the trust demonstrated a high number of bank staff and a small number of agency staff were used to cover unfilled shifts for both qualified nurses and healthcare assistants. Bridgwater, Shepton Mallet and South Petherton saw the highest use of bank staff between January and December 2016. Matrons told us that high use of agency and temporary staff could potentially affect quality of care. Some wards block booked bank and agency staff, whilst others would try to ensure the member of staff filling the shift was familiar with the ward and the way the hospital worked. Ward managers felt this was important to help reduce pressures on existing staff and to ensure continuity of safe care.
- Dene Barton community hospital had three registered nurses leaving in the next three months and at West Mendip, their band seven ward manager was leaving. At the time of our inspection, these positions had not yet been recruited to. Matrons told us it was challenging to

recruit qualified nurses; however, there were always plenty of applications for healthcare assistant posts. These upcoming vacancies meant there was a risk that Dene Barton hospital would not be able to meet safer staffing levels, and there would be a lack of senior oversight on the ward at West Mendip.

- Staffing levels and skill mix were planned and based on the National Institute for Health and Care Excellence 'Safer Staffing' standards, which was modified in line with the increasing dependency, complexity and acuity of patients on each ward. This had very recently been introduced in the community hospitals. The inpatient services had been using The Association of UK University Hospitals and Safer Nursing Care validated definitions to define the dependency of the community hospital patients. This enabled the service to monitor the dependency and acuity of the patients in the hospital at three points over a 24 hour period. This tool helped to identify the total number of hours of care required to cover each nursing shift. This then compared information with the availability of staff on the electronic rostering system, enabling ward managers to determine the level of staffing required to safely staff the wards. There were examples of where two beds had recently closed at Burnham-on-Sea to ensure safe staffing levels could be met. The tool had only recently been introduced at the time at the time of our inspection.
- There were deficits in the number of community matrons to oversee the hospitals. Vacancies and long term sickness meant the remaining few matrons had taken on other community hospitals to cover for the gap. One matron was overseeing four community hospitals. Staff at these hospitals no longer saw the matron on the wards due to them having commitments with other community hospitals and too little time. This meant there was less oversight and management at the individual hospitals and the geography and rurality of Somerset did not make it easy for the matrons to move from hospital to hospital.
- Recruitment of nursing staff was ongoing. However, this was challenging for the trust and inpatient service. The services faced challenges recruiting in key locations, specifically West Somerset and South Somerset. There had been a recent recruitment drive and open day to try and recruit new staff into vacant posts. There had been a successful international recruitment drive which had seen the majority of the nurses remain in their posts, even in the more rural areas of Somerset. The hospitals were also supporting healthcare assistants, who were internationally trained and qualified nurses, to upgrade their skills to enable them to work as qualified nurses in the UK.
- Decisions had been taken in conjunction with the local clinical commissioning group to temporarily close hospital beds to match the availability of staff in order to reduce any risks posed to patients. This included the temporary relocation of the ward at Minehead to Williton hospital, with the temporary closure of nine hospital beds, out of the 19 beds available. The local Clinical Commissioning Group had also recently decommissioned six community stroke beds.
- Medical cover was provided at the community hospitals five days a week with the out of hours GP service used outside of these times. Medical cover at the hospitals was provided by either local GP surgeries or by doctors employed directly by the trust. At Chard, three GP's covered the ward and tended to come onto the ward in the afternoon. However, there was one regular GP that covered the weekly multidisciplinary ward round to ensure continuity for the patients. At Williton hospital the medical cover was being provided by a locum GP who was covering annual leave. Cover had been arranged for a locum doctor to cover Bridgwater hospital for the next two weeks to cover for annual leave for the permanent doctor who worked on the ward. All of the staff we spoke with spoke highly of the locum doctors and their valuable input on the wards. Medical cover was an issue that had been raised on the divisional risk register.
- Medical cover at West Mendip hospital was on both the local hospital risk register and the divisional risk register. A local GP provider did not take up the option of a new contract and an alternative provider could not be identified, therefore locum cover had been arranged. The first locum appointed required significant levels of support and was replaced by a more experienced locum, who was well regarded by the nursing team. A long term solution for the provision of medical cover at West Mendip Community Hospital was being sought at the time of the inspection.

Managing anticipated risks

- Potential risks were accounted for when planning the community inpatient service. These included planning for seasonal fluctuations in demand, and disruption to

staffing. Comprehensive winter management plans and major incident plans were available on the trust's intranet. These documents identified potential risks and detailed mitigating actions to reduce the impact. Senior members of staff had their roles and responsibilities clearly set out and documented to ensure seamless management of major incidents.

- Potential risks were taken into account when planning for adverse weather conditions. The matrons knew which staff would be affected and the 'on call' 4x4 vehicle would go and collect staff and take them to their place of work.
- Following our previous inspection, the trust had improved systems and processes with regards to fire safety and training at Chard community hospital. The ward at Chard community hospital was on the first floor of the building, which was old in design. Both fire escapes were clear and free from equipment and the small room which patients had to go through to access one of the fire escapes on the ward had tape which marked the route. The tape also outlined the area which needed to remain clear and free of any equipment. All staff had received horizontal evacuation training and this had been added to the trust's annual fire safety training. Training records demonstrated only one member of staff was out-of-date with their fire training. All staff we spoke with at Chard hospital were able to tell us what they would do in the event of a fire, including how they would safely manage patients if this event occurred.
- There was a yearly fire evacuation practice in the community hospitals and local evacuation plans were evident on wards of the hospitals we visited. Fire exits at the community hospitals were all clear.

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

Overall we rated the effectiveness of the community inpatient service as requires improvement. This was a change from a good rating in 2015 because:

- Information leaflets available for patients did not provide information from the most recent best practice guidelines.
- There were multiple pain scoring systems available to staff causing confusion and inaccurate recording.
- Some staff had concerns about the lack of presence of the doctor on the ward at Williton hospital and on Exmoor ward.
- Staff were not effectively completing patient fluid balance charts.
- The trust's policy for admissions, transfer and discharge was out of date.
- Staff did not understand or feel confident with the relevant consent and decision making requirements and guidance, including the Mental Capacity Act 2005.
- There were inconsistencies and a lack of understanding and clarity about how and where mental capacity and consent should be recorded across the community hospitals.

However:

- Care and treatment was provided in line with guidance from the National Institute for Health and Care Excellence (NICE).
- We saw evidence of effective multidisciplinary working both within the trust and with other external organisations.
- Staff were encouraged to develop their knowledge and skills and were supported if they were new to the ward.
- Delayed transfer of care calls were being held twice-weekly to understand the cause of a delayed patient discharge and work to overcome this.
- Staff had timely and easy access to the information required to deliver effective care.

Detailed findings

Evidence-based care and treatment

- Evidence-based guidelines were used to develop how services, care and treatment was delivered. Care was provided in line with guidance from the National Institute for Health and Care Excellence (NICE). For example, care planning for patients was based on guidelines for the malnutrition screening tool, the management of pressure ulcers, stroke and falls. There was a reference at the end of each policy to show which guidance had been followed.
- Patients had their needs assessed, care goals identified and care planned and delivered in line with evidence-based practice, guidance and best practice. For example, the assessment provided following a fall and falls prevention work were audited against the National Institute for Health and Care Excellence guidelines (NICE) QS86. Faecal incontinence was also audited against NICE guidelines QS54. The faecal incontinence audit was completed in 2016 and included 136 sets of patient records across all of the community inpatient hospitals, to determine the management of faecal incontinence. The audit demonstrated only partial compliance in three out of the five standards. There was a comprehensive completed action plan following the outcome for these audits, with a re-audit taking place in April and June 2017.
- Best practice groups had been developed which incorporated a multi-disciplinary approach to improving the quality of care, by use of best practice guidelines. For example, each community hospital had a falls best practice group which was represented by different members of the multidisciplinary team. The group discussed any new guidance issued about falls against the current practice in the community inpatient service. This was then used to develop care and treatment, to help reduce the number of falls sustained by patients in the inpatient setting.
- The service provided evidence-based leaflets for patients regarding pressure ulcers; however, the evidence was out of date. The pressure ulcer prevention and management leaflet had been produced in conjunction with the clinical commissioning group. However, the contents were based on the National Institute for Health and Care Excellence (NICE)

guidelines published in 2005. NICE guideline CG179 Pressure Ulcers: prevention and management had been updated in 2014; however, the leaflet had not been updated to reflect the changes to the guidelines.

- There had been recent changes to the sepsis proforma. The changes had come about as a result of new guidelines for the recognition of sepsis from the Sepsis UK Trust.
- West Mendip community hospital was using an evidence-based memory activity to benefit patients living with dementia as part of their activity programme. Evidence demonstrated reading aloud; mental arithmetic and writing could activate brain activity in older people and could restore communication and independence in those living with dementia.

Pain relief

- Patients had their pain monitored regularly throughout the day. However, different hospitals demonstrated different ways of monitoring and measuring pain and there were multiple pain scoring systems being used. This was causing confusion. Some hospitals maintained a paper record, whilst some monitored pain electronically. There was confusion when pain was recorded, as some of the scales used recorded pain numerically between one and three but on the chart were scores of four and seven. There was further confusion because there was another numerical scale in use for recoding pain, between one and 10. At Chard hospital, the paper record used to record pain contained numerical scales, non-verbal pain monitoring systems and body maps. This had the potential to cause confusion about the patient's actual level of pain. This in turn could potentially lead to inaccurate prescribing of medicines. This issue was identified at our 2015 inspection but remained unresolved.
- Despite the confusing records, patients said their pain had been well managed and nurses regularly monitored their pain. Patients told us they never had to wait long to get pain relief once they had requested it.

Nutrition and hydration

- The trust used the malnutrition universal screening tool (MUST) to assess the nutritional and hydration needs of patients in line with National Institute for Health and Care Excellence guidance. Staff were required to complete the tool within two hours of a patient's admission to the ward. This was being completed within two hours in line with the trusts Commissioning for Quality and Innovation (CQUIN) (a payments framework which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare).This was reported monthly for each hospital to monitor compliance. The tool identified the nutritional and hydration risks for each patient and also identified actions taken to provide supplement drinks for patients who had an elevated MUST score.
- There was a widespread issue at all of the community hospitals with regards to completing the paper-based fluid balance charts. Several fluid balance charts had not been tallied up so patient's fluid balance for the day could not be effectively monitored. We also saw examples of fluid balance charts where the patients input and output had not been recorded for the whole day. We raised this with staff during the inspection who told us it was the role of the night staff to complete the charts and this was something they needed to address. Poor management and completion of these charts could lead to inaccuracies in patient care and treatment.
- Patients had access to jugs of water at all times. These were refreshed and replenished at various times throughout the day. Members of staff went around with drinks trolleys at various times offering patients a variety of hot drinks.
- Patients were satisfied and liked the food they received at the hospital. Patients also felt there was a good choice.

Patient outcomes

- The community inpatient service collected quality and outcome information to monitor care and treatment. Local audits, such as handover audits, discharge summary audits and physiological observations audits were carried out in all of the community inpatient hospitals to review compliance and performance. The results of the audits carried out in 2016 demonstrated improvements could be made. Action plans had been written following the audits' findings, which were time phased and assigned to specific members of staff to ensure they were overseen and completed.
- The increasing complexity of patients and the lack of capacity to accommodate the rising demand for community health and social care services was impacting upon patient's length of stay. The length of

patient stay varied between the hospitals in January 2017. South Petherton had the highest length of stay at 35.4 days; whilst at West Mendip the average length of stay was 18.4 days. The average length of patient stays across the community hospitals was 28 days in 2015/16. Six of the community hospitals saw patients staying longer on the wards than this average in 2015/16. South Petherton, Shepton Mallet and Dene Barton saw the highest length of stay for patients, with patients remaining on the ward at South Petherton for an average of 34 days, whilst Minehead hospital saw the lowest length of stay at just 14 days.

- The inpatient services worked within set Commissioning for Quality and Innovation (CQUINs) targets. These targets required the completion of specific care plans, such as dementia screening, hydration and nutrition, and venous thromboembolism, within two hours of a patient's admission to a community hospital. Completion of these CQUIN targets was monitored and a report was sent monthly to the ward manager to review and provide an explanation as to any anomalies or outliers to the target. This enabled the ward manager to look into the root cause of the missed target and share the learning with the inpatient team to improve the effectiveness of care for patients. Minutes of team meetings demonstrated CQUIN and targets were discussed with ward staff and what needed to happen to improve their outcomes.
- The service aimed to improve the outcomes for the small number of stroke patients they treated, by auditing the service against evidence-based standards and national and local benchmark. This ensured patients received high quality care and rehabilitation following a stroke. The action plan following the outcome of the April 2016 Sentinel Stroke National Audit Programme (SSNAP) audit identified three areas where improvements were required. These were: time taken for rehabilitation goals to be agreed, the percentage of days during admission that the patient receives occupational therapy, physiotherapy and speech and language therapy and the percentage of patients seen and assessed by therapy within 72 hours of admission. Action plans were time phased and each action assigned to a specific member of staff to ensure it was overseen and completed. At the time of our inspection there had been no further audit completed to see if improvements had been made.
- Performance and quality was monitored using the inpatient hospital dashboards. An individual dashboard containing information regarding the performance of the hospital was provided monthly. The dashboard contained an overview of service delivery and quality and safety information. It also provided a comparison against the outcome of how performance had improved or deteriorated since the previous month. The outcomes were also rated as red, amber or green. If outcomes were unusually poor or out of range they would be flagged up and highlighted red. Outcomes within range were highlighted green. This provided ward managers and more senior managers with better oversight of the performance and outcomes for each individual hospital. The information was used to make improvements to the areas of the community inpatient service which demonstrated a lack of compliance.
- Therapy staff used outcome measures, a test used to objectively determine the baseline function of a patient at the beginning and end of treatment. Several different outcome measures were used to monitor a patient's mobility and balance and review the progress patient outcomes at discharge following therapy input. There had been no audit carried out to demonstrate the effectiveness of treatment provided to patients.
- Therapy staff used patient-centred goals and care plans as their focus for rehabilitation. Staff worked with patients to come up with functional goals they needed to achieve before returning home. These goals would prepare a patient for discharge back into the community. We observed a conversation between an occupational therapist and a patient discussing what the patient wanted to achieve for going home and then coming up with a suitable related goal. We reviewed where the therapist documented the goals in the patient electronic care plan and the action taken to achieve these goals. These goals were reviewed following input with a therapist and progress against them updated.

Competent staff

- Staff had the knowledge and skills required to carry out their role and were proactive about learning and developing their skills.
- The majority of staff had received a performance appraisal within the last year where discussions had taken place about performance and career development. All of the community hospitals were

between 97% and 100% complaint with their appraisals, with the exception of Williton hospital where only 87% of staff had received their appraisal. Appraisals contained learning requirements and actions were clearly documented. Staff felt listened to during their appraisals and supported to achieve their learning objectives. It was noted that the 87% of staff who had a completed appraisal did not include the six overseas nurses who were in the process of undertaking a trust development programme on commencement of employment with the Trust. Due to this, an additional appraisal from Meadow Ward was not required as the nurses were receiving ongoing monitoring.

- There were arrangements for supporting and developing staff, with learning needs identified through group supervision sessions. At both Chard and West Mendip, a monthly group supervision session was held for registered nurses and healthcare assistants. The group was led by the staff and they brought any clinical issues to the group, including suggestions for training. There had recently been a session to provide extra training on mouth care as requested by the healthcare assistants. Ward managers felt it was sometimes challenging to run the group session every month due to pressures on the ward. However, they aimed to do this as regularly as possible, as patient dependency allowed.
- Staff were encouraged and given opportunities to develop. Staff provided us with examples of how they had been encouraged and supported to develop their knowledge and skills and some were undertaking NVQ training and assistant practitioner training. One healthcare assistant had recently moved to undertaking bank shifts at West Mendip hospital. They had been encouraged to undertake the full nursing qualification with a view to returning to work for the trust once qualified.
- New members of staff appointed to their first leadership role were provided with leadership training. Two nurses recently appointed into their first band six roles were provide with an internal 'coach to lead' course to provide them with essential leadership skills to ensure they were effective in their new role. They had support from their band seven ward manager and one had previous experience of carrying out elements of the role from a previous job. However, there were parts of the role they were still unfamiliar with and having to learn on the job, for example, the electronic staff rostering system. The band seven had been supportive and had provided these nurses with regular one-to-one sessions to support them in their new role and the matron had also allocated them a protected administration day whilst they became used to the requirements of the role.
- A ward manager told us that two of her registered nurses were completing university courses funded by the trust. The ward manager was studying a university module for leadership and an in-house course on 'coaching to lead'. The ward manager had also been awarded a leadership award from the trust last year, to recognise her development and contribution to the service.
- Nursing staff completed competencies to demonstrate competence in various areas of their role. This demonstrated staff had up-to-date skills and knowledge of specific areas of their practice. Staff held completed competency documentation demonstrating their competence, and sign-off for various procedures undertaken in their role.
- Staff had access to supplementary training to ensure they were competent in their role. The trust ran training sessions which staff could attend to upgrade or refresh their skills. For example, Chard hospital was due to run a glucose monitoring training session in March 2017.
- We spoke to a newly qualified band five staff nurse who was on the trust preceptorship programme. This included monthly study days for one year. The nurse had two preceptors and spoke highly of the support provided.
- Nurses coming to work for the trust were supported and given time to settle into the hospital environment. We spoke with nurses who were relatively new to the trust who had recently joined from neighbouring local acute trusts. On starting their new role, nurses were given two weeks of shifts where they were able to shadow a qualified nurse on the ward. This enabled the new nurses to become familiar with systems, process and ways of working before they stared to work independently. Nurses we spoke with had found this system very helpful.
- At Burnham-on-Sea, one healthcare assistant was working towards the national care certificate provided by the trust and the remaining 15 healthcare assistants held either the national care certificate or NVQ level two or three.

- Ad-hoc training sessions were arranged at the different community hospitals to develop the knowledge and skills of the staff. These included specialised training for wound management, end of life sessions conducted by the hospice nurse and electrocardiogram (ECG) competency training.
- There were arrangements to support bank and agency staff. The band six nurse at West Mendip hospital had put together a 'How to' file to support the high numbers of bank and agency staff working on the ward. The nurse was aware of the impact to the running of the ward when bank or agency staff who were less familiar with the ward were covering shifts. The file contained useful information, such as various protocols and a simple guide of how to navigate around the electronic patient record to make the experience working on the unfamiliar ward easier.
- Bank and agency staff were provided with an induction when they came to work on the wards. Induction checklists were completed and demonstrated staff had been shown around the ward and discussions had been held regarding working systems and processes to ease their integration into working on the ward. Any bank or agency staff who worked more than one day on the wards also completed the local induction and the trust induction.

Multi-disciplinary working and coordinated care pathways

- Different professions working on the ward, including those from different teams and services were involved in assessing, planning and delivering peoples care and treatment. The community hospitals we visited held weekly multidisciplinary team meetings where therapists, doctors and nurses attended to discuss plans for ongoing patient care and discharge, their ongoing progress with their rehabilitation goals and any other concerns.
- Each community hospital had an arrangement to work with a social worker from the local social care team to help plan, deliver care and support patients in a holistic way. A social worker attended weekly multidisciplinary meetings on the wards to support with discharge planning, arrange any paperwork and liaise with the patient and the family about discharge plans. Social workers rotated their role on a six monthly basis, in line with the role specification, at West Mendip hospital. Nurses found this challenging due to each social worker having a different approach to their way of working, which took time to adjust to.
- The trust worked closely with other local acute trusts. Daily calls with the local acute trusts provided a forum to identify and understand the status and pressures of each service. The call provided a platform to enable the different trusts to determine how they could work together to improve patient flow through the different organisations.
- Each community hospital held a falls local action group (FLAG) meeting with representation from the multidisciplinary team. On a monthly basis, members of the multidisciplinary team came together to review all of the falls on the ward over the past month. Each member of the team contributed to the meeting by discussing their thoughts on the falls and how ways of working and practice could be improved to reduce the number of falls. Each hospital had a local falls action plan and the actions were reviewed at each FLAG meeting. Outcomes from the FLAG meeting were then actioned on the ward to enable more effective management of falls patients and to reduce the risk of patient falls on the ward.
- The electronic patient record demonstrated multidisciplinary team working. Records contained entries from members of the multidisciplinary team who were involved with the patient's care. Each entry contained the name, role of the staff member and the time and date of the entry. The electronic record enabled information about the patients care and treatment to be maintained in chronological order, where all authorised professionals could review the outcome of treatment sessions or interventions for the individual patient.
- Physiotherapists and occupational therapists worked together to enable more efficient and effective working. The occupational therapist and physiotherapist carried out joint home visits with patients to review the patient's ability in their own home. This enabled the therapists to work together and with the patient to align their therapy goals and have a clear focus of what was required from the patient for discharge.
- A multidisciplinary ward round at the patient's bedside was carried out on a weekly basis, if not more often, on all but one of the wards we visited. Each hospital carried out their ward round slightly differently, but the doctor and the ward sister visited each patient's bedside. The

one exception was Exmoor ward, where a weekly review of each patient, who were all medically fit, took place in the ward office with a bedside review for any patient whose condition was causing concern. This did not give every patient the opportunity to be involved in their care and treatment.

- There was a lack of medical input at multidisciplinary team meetings from the doctor working on the ward at Williton hospital and covering Exmoor ward. Staff said this was challenging when they needed to clarify medical issues which may impact on patient discharge. Staff told us the doctor did not regularly attend the weekly multidisciplinary team meetings on Williton ward. We looked at the doctor's attendance at the multidisciplinary team meetings since October 2016 and saw the doctor had only attended six out of the 15 meetings. Staff on Exmoor ward held a multidisciplinary team meeting weekly, however the doctor never attended. Staff on both wards at Williton hospital were concerned about the lack of presence from the doctor. However, they did tell us the doctor could be contacted by mobile when not available onsite. There was no evidence at the time of the inspection that the medical needs of patients on the ward were not being met.
- A county-wide bed coordination and staffing centre worked closely with the community hospitals. The centre contacted the community hospitals three times a day to determine their bed state. They then supported the hospitals to make the necessary admission arrangements for patients into the hospitals.

Referral, transfer, discharge and transition

- The trust had a clear admissions, transfer and discharge policy. The policy outlined the trust's procedures for discharges, complex discharges and patients who were reluctant to be discharged. The policy also outlined the procedure for transferring a deteriorating patient back to a local acute trust. However, the admissions transfer and discharge policy was out of date and was due for a review in May 2016.
- New processes and forms for obtaining packages of social care were negatively impacting on patient discharge times. All requests for packages of care had to go through a panel, a process which could be slow and at times was delayed.
- Staff worked together to overcome challenges to patient discharges. Twice-weekly delayed transfer of care calls were held where members of the inpatient team, a social worker from the local social care team and the divisional leads discussed the patients ready to be discharged on the ward. The call ensured all staff were aware of any delayed discharges so plans to resolve issues could be made.
- A single point of access service for all patients referred by local GP's or from a local acute provider helped to facilitate community admissions where admission to an acute hospital was not required. The service spoke with the GP and discussed the patient's immediate needs. They located empty beds as locally as possible to the patient's home and discussed with the hospital whether they would be able to take the patient. The service then informed the GP, patient and their family where they were going to be admitted and arranged transport for them.
- There were arrangements for patients to continue to receive therapy input once they were discharged from the ward. The ward therapy staff also covered the community services. If a patient's home was within the local area, where possible, the therapist who had been involved with the patient on the ward continued to review the patient in the community. This provided better continuity for patients. If the patient was discharged to an area the therapists did not cover, they made a referral to the appropriate community team and provided copies of the patient's therapy records and goals to enable a continuation of therapy post-discharge.
- There was a standard operating procedure for the transfer of patients back to the acute trust if their condition deteriorated. Staff would send with the patient a copy of specific documentation, along with the last 10 recorded physiological observations and multidisciplinary case notes. The hospital's policy required for the patient's bed at the community hospital to remain open for 24 hours following the transfer in case the patient was able to return to the community hospital. Nurses would follow up the patient's status with the local acute trust. Between January and December 2016, there had been 91 transfers from the community hospitals back to local acute trusts.
- There were clear mechanisms for sharing patient information on discharge with their GP. Most of the community hospitals we visited were using an electronic discharge letter. The electronic system prepopulated information from the patient record into a template letter. Members of the multidisciplinary team

could each add extra information as required. Nursing staff also attached other copies of important documentation to the discharge letter and this was sent to the patient's GP on the day of their discharge. All the community hospitals aimed to be using the electronic discharge process within the few weeks following our inspection.

Access to information

- All of the information needed to deliver effective care and treatment was available to staff in a timely and accessible way. All the staff on the wards had access to the electronic patient record. Staff inputted patient notes into an electronic multidisciplinary record. This enabled the whole team to be aware of the input and outcome of care and treatment from the different professions in chronological order.
- Authorised staff had access to electronic medical systems where they could review pathology or diagnostic imaging results in a timely way. One locum doctor we spoke with at Williton hospital had been working for the trust for a short time but had not yet received his log on details to access the system. He explained the nurses were able to access the information required. When asked, the doctor had not yet escalated that he did not have a log on for the system. However, other information we were provided with stated all locum doctors were provided with this log on information when joining the trust and this was reactivated when locuming at different places within the trust. It was unclear whether the doctor did not have a log on for the system or whether he was unaware that the same log on was reactivated for subsequent locums within the trust.
- Patients were usually transferred to the community hospitals from the local acute trusts with a complete set of medical records. Ward clerks at West Mendip said there had been a few occasions when patients had been transferred without their full medical record however, they said this was easy to request from the trust who would send them over. The full medical records were not always used during the patient's admission, but were usually stored in locked cabinets, in locked rooms, to ensure confidentiality.
- The hospitals reviewed patients do not attempt resuscitation (DNAR) orders. DNAR orders usually came with the patient from the acute trusts. These were reassessed on admission to the community hospitals by the doctor. The trust used documentation provided by the resuscitation council and the information was also stored on the electronic recording system and nursing handover sheet.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Not all staff we spoke with understood or felt confident with the relevant consent and decision making requirements and guidance, including the Mental Capacity Act 2005. Mental Capacity Act training was only covered every three years during safeguarding training. There was no training on how to complete a mental capacity assessment. Although staff were able to recognise whether or not a patient had capacity, some told us they did not know how, or feel confident to, undertake a formal assessment and document this. Staff on Williton ward told us if there were concerns about a patient's capacity, either the doctor on the ward or the social worker that visited would undertake a capacity assessment. At Crewkerne, we found a patient who had very complex discharge issues due to problems with their mental capacity. There was no evidence of any care planning or documentation to reflect the complexities of this patient, which included deprivation of liberty, mental capacity and referral to the Court of Protection. However, at Williton hospital, we observed completed documentation, with the appropriate authorisation granted, for patients subject to a deprivation of liberty order.
- There were inconsistencies and a lack of understanding and clarity about how and where consent should be recorded across the community hospitals we visited. Some patients had paper documentation completed and some didn't. Some patients had their consent electronically recorded, however there were inconsistencies with how this was recorded. Some staff would get the patient's family to sign a consent form on the patient's behalf if the staff didn't believe the patient had capacity. This does not meet the requirements of the legislation. Some staff told us that a member of the senior management team had advised the paper consent forms were not fit for purpose and should not be in use, but no further advice or clarity around what staff should be doing was provided. This was causing confusion amongst the staff.
- However, we did see some examples where consent and capacity were being well-managed. For example, staff at

Requires improvement

Are services effective?

West Mendip had adopted a new system to record consent. Each member of staff had to get a patient's consent for each intervention carried out on the patient. This then had to be documented on the patient's electronic record.

- The ward sister at West Mendip hospital felt confident to undertake a capacity assessment and had encouraged some other nurses on the ward to observe her doing this, to improve their knowledge and confidence in this area.

Good

Are services caring?

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

Summary

Overall we rated the community inpatient service good for caring because:

- Feedback from patients and those close to them was consistently positive.
- There was a strong patient-centred culture with staff demonstrating compassion to all patients and respecting their privacy and dignity.
- Staff involved the patient and those close to them in the planning of their care.
- Staff ensured patients understood what they wanted to do and encouraged patients to ask questions.
- Staff recognised the need to support patients emotionally and were able to provide that support.
- Staff understood the impact of a patient's condition on those close to them and worked hard to support families in their time of need.

Detailed findings

Compassionate care

- We found staff treated patients with dignity, compassion and respect. For example, a hotel services worker was singing and chatting to patients as he worked and the patients all joined in. The same member of staff reacted immediately when a patient said they were cold, by providing her with a blanket. Patients felt staff treated them in a caring and compassionate way and nothing was too much trouble. Patients told us staff spoke to them in a way they understood. One patient told us "the nurses are all very patient."
- Staff demonstrated an encouraging and supportive attitude towards patients. For example, a healthcare assistant at Crewkerne hospital provided support throughout a transfer and gave verbal encouragement and praise to an elderly patient during and after transferring from chair to chair. We also observed a nurse taking the time to sit with a patient and provide encouragement to drink. The nurse held the patient's hand and provided support for the patient whilst she finished her drink.
- Patients we spoke with at all of the community hospitals consistently provided us with positive comments about the care provided by the staff. Patients at Chard described the care as "very good" and "splendid" and one patient said the "nurses are so kind they cannot do enough." Patients at Williton hospital said the care was "outstanding" and "exceptional."
- Staff ensured patients' privacy and dignity was maintained when physical or intimate care was carried out. Staff closed curtains and doors to respect a patient's privacy and dignity. If a door was shut, staff knocked prior to entering the room. Staff also made use of the signs on the doors, such as the engaged signs on the toilet doors to ensure patients privacy. Patients we spoke with felt nurses did everything they could to maintain their privacy and dignity. The trust scored 90.2% for the patient led assessment of the care environment, which was better than to the national average of 85.2%.
- Staff treated patients as individuals. Staff engaged patients in general topics of conversation with patients, for example the weather and also responded and engaged in conversation brought up by patients. Staff also had a laugh and a joke with patients, rather than just communicating about their care and treatment.
- Staff understood the importance of patient choice. A healthcare assistant at West Mendip hospital supported a patient to get ready for the day. The health care assistant took the time to explain the different options to the patient about what she could do and where she could spend time. A plan was also made with the patient with regards to the best time to get dressed, which was the least disruptive to the patient, but which fitted in with care and treatment that needed to be provided by the nurse.
- At Dene Barton community hospital, patient's told us "everyone is so willing to assist you when required" and "always so cheerful when they first approach you." "Excellent staff, swift response to problems, plenty of encouragement and motivation to help you get well," and patients told us there were "serene and beautiful surroundings to help your mind heal and your body recover."
- The trust used The Friends and Family Test, a feedback tool which supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Good

Are services caring?

Out of 113 responses in January 2017, 88 people said they would be extremely likely to recommend the community inpatient service; whilst 20 said they would be likely to recommend the service. There were four people who did not know whether they would recommend the service and just one person which stated they would be unlikely to recommend the service.

Understanding and involvement of patients and those close to them

- Staff understood the importance of involving family members and close relatives as partners in patients' care.
- Staff took the time to discuss ongoing care and treatment with the family and relatives of patients. Family members and relatives felt the nursing staff did their best to keep them informed or updated about any aspects of their relatives' care and treatment.
- One patient we spoke with at Williton hospital told us how the physiotherapist had involved his wife in a treatment session. The physio had invited the patient's wife to observe the session to see the progress the patient had made with regards to his mobility.
- The doctor at Crewkerne hospital took the time to explain the care and treatment required for the patient. The doctor explained the information in a simple way which the patient understood. The patient was given opportunities to ask further questions to gain further clarity and understanding about the ongoing treatment plans.
- Staff explained to patients what they were going to do and why they needed to do it before providing care and treatment.
- Patients and their families were involved in the ongoing care and support of patients. On Exmoor ward, a meeting had been arranged with a patient and family to discuss how they could work together to plan the patient's ongoing care arrangements and discharge plans.
- Staff understood the importance of patients understanding their care and treatment. One patient at West Mendip had spent a lot of time talking to the doctor and they understood the plan for their ongoing care and treatment and the reason for this. Another patient felt "very involved in their care and staff took the time to explain things to me."

Emotional support

- Staff recognised the broader emotional wellbeing of the patients under their care. We spoke with one patient at Williton hospital who told us they used to enjoy a bath, but had not been able to have one in years due to not being able to get in and out. Staff on the ward provided the patient with support to have a bath using equipment that ensured his safety. The patient described the experience as 'lovely.'
- At Williton hospital we observed a patient with dementia who was distressed and standing up at the bedside. The healthcare assistant went over to try and reassure them, however the patient remained distressed. The healthcare assistant then gave the patient the opportunity to move to a different part of the ward which was quieter. The healthcare assistant then sat and had a conversation with the patient. The patient at this point was no longer distressed and was engaging in conversation.
- Staff understood the impact on a patient's condition, care and treatment and how this affected their family and relatives. There were two end of life patients on the ward at Chard hospital and the staff told us how they worked hard to also provide support to the family and relatives of end of life patients throughout this challenging and emotional time.
- Nurses understood the importance of making a patient feel comfortable about the care and treatment they provided. There was a patient with memory problems who needed their physiological observations checked, however they were very anxious about this. The nurse spent time explaining to the patient what she needed to do and what would happen and provided a mini demonstration to put the patient at ease.
- Staff encouraged and supported patients to socialise to ensure their emotional wellbeing. Staff encouraged patients to spend time sitting in the day room at West Mendip hospital where they had access to activities, games, reading material and the television.
- Staff worked hard to ensure treatment was not disruptive or stressful for patients. One patient we spoke with told us the nurses had worked hard to have one of the patient's appointments rearranged for a different location to incorporate all this patient's treatment in one day at one place.
- Staff supported patients emotionally when they had worries or concerns about their care and treatment. A

nurse and a doctor took the time to discuss and explain to a patient about having a catheter. The staff took time to answer the patient's questions and provided them with support to make the decision. On leaving, the patient stated they were happy with the decision. When the staff left, the patient became tearful. When the healthcare assistant informed the nurse of this, the nurse went straight back to the patient and spent time providing reassurance and discussing things with the patient again until the patient felt comfortable.

Good

Are services responsive to people's needs?

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

Summary

We re-rated responsive as good because:

- The service had addressed the issues that had caused us to rate responsive as requires improvement following the September 2015 inspection.
- The needs of different people, regardless of culture or disability, were accounted for when planning and delivering services.
- The community inpatient service removed barriers to enable patient with complex needs such as patients with dementia, end of life patients and those close to them access the service.
- There were communication aids and information in other formats to support patient and relatives who came to the hospital.
- Activity co-ordinators had been employed to engage patients and improve patient wellbeing whist on the ward.
- Some wards had facilities for the family of end of life patients to remain on the ward to be close to their loved one.
- People we spoke with knew how to make a complaint and complaints were dealt with and responded to in a timely way.

However:

- There was inconsistent use of the 'This is Me' documentation on the wards.
- The out of hours cover was felt by staff across the community hospitals to be unresponsive to the needs of the service and had not been reported on the electronic reporting system.
- There was a lack of presence of physiotherapy staff on the wards and patients were not seen regularly.

Detailed findings

Planning and delivering services which meet people's needs

- Commissioners and other relevant stakeholders were involved with in planning services. Community hospital services were planned in conjunction with the local clinical commissioning group (CCG). There was an annualised contract with the local CCG where the number of community inpatient beds had increased over the winter months from 248 to 263 beds. At the time of the increase in the number of beds, all of the community hospitals were meeting 80% and over of their safe staffing requirement. This ensured the service could cope with the increasing demand for inpatient beds due to winter pressures.
- The services provided reflected the needs of the local population and worked to provide flexibility and ensure continuity of care for patients. The inpatient service worked with the local acute trusts to ensure the needs of the local population were met. There was a daily telephone call with two local acute NHS trusts, which enabled each service to discuss their bed status and the pressures they were under. Sharing this information enabled the inpatient service to have a clear understanding of the pressures faced by the acute trusts. This enabled the hospitals to work together to plan services to ensure a more effective flow of patients through the hospital system.
- The ambulatory care services provided at the community inpatient hospitals reflected the needs of the local population and enabled flexibility and continuity of care. Frome, Williton, Crewkerne and Shepton Mallet hospitals all provided ambulatory care services. This enabled patients to be referred to the hospital to receive intravenous antibiotics, blood transfusions and complex wound dressings. Ambulatory care allowed patients to access the hospital to receive the ongoing care they required without having to be an inpatient. This was in line with the local sustainability and transformation plan.
- Patients and those close to them had been engaged and involved in the planning, design and delivery of the community inpatient services. The trust had held feedback sessions and focus groups. Additional groups, such as the 'life after stroke' group for carers, had been set up to gain feedback and insight from patients and their relatives about the service, in order to help make improvements.
- There was a clear admission criteria for the community hospitals inpatient service. Patients admitted to a community hospital had to be over 18 years of age and had to meet one of the five criteria specified in the trusts

admission, transfers and discharge policy. There were also specific types of patients that required a 'prior acceptance discussion' with the nurse in charge of the ward. Patients who were MRSA positive and who required specialist equipment were in this category.

Equality and diversity

- The community inpatient services were planned to take into account the needs of people of different ages, religion or belief and disability and there were arrangements to meet the diverse needs of the local population. We were given an example of how the hotel services team had accommodated for a patient's specific Halal dietary requirements. Staff told us when the patient arrived on the ward, due to the meals having been delivered for the ward earlier in the day, there was nothing to suit this patient's needs. A member of the hotel services team went to a local supermarket to pick up food items for this patient. The following day, the patient was presented with a choice of Halal meals from the food supplier for the rest of their stay.
- Burnham-on-Sea hospital had taken into account the needs of people following different religions. The hospital had a room called the sanctuary. This was a multi-faith room where copies of different religious material could be found and all patients of any religion could use to pray.
- There were arrangements to access translation services for patients. Large posters were displayed in public areas on the wards we visited containing several languages. The poster was designed so if a patient could not speak English, they could point to their language so staff could determine the interpreter needed. Staff knew how to access the translation services, although none of the staff we spoke with had needed to use the service.
- There were arrangements available to meet the diverse needs of any patient or relative who may come to the hospital. Information on the back of leaflets for patients and relatives indicated information was available in other formats. These included easy reading summary versions, and other languages on request.
- Adjustments had been made to enable disabled patients and their relatives to access and use services. All of the hospitals we visited had disabled access. However, Chard hospital and Exmoor ward had older facilities, which lacked space and made it more challenging for wheelchair access. All of the hospitals we visited had disabled parking spaces near the entrance. Chard and Bridgwater hospitals also had lifts to enable disabled people to access the ward on the first floor.

Meeting the needs of people in vulnerable circumstances

- Services were delivered and co-ordinated to take account of people with complex needs, however the facilities differed between the hospitals we visited. All of the hospitals we visited had doorways painted different colours and different colour toilet seats and rails to help dementia patients to identify objects more easily. Some of the hospitals we visited, for example West Mendip, had simple picture signs on the toilet doors and boldly coloured walls to help orientate a patient living with dementia. Williton hospital had also made adjustments for dementia patients; however, there were no dementia facilities on Exmoor ward. At Dene Barton we did not see any dementia friendly colouring on the hospital ward. The older hospitals, for example Chard, had fewer facilities for dementia patients compared to the newer more modern buildings. All of the wards we visited had access to twiddle muffs (a decorative hand muff with items attached, such as buttons), which was designed to provide stimulation for a restless dementia patient.
- Activity co-ordinators had been employed at all of the wards we visited, apart from Exmoor ward. Daily activity programmes were carried out which engaged and helped to improve the mood of the patients on the ward. Patients could join in activities such as singing, craft, bingo, film day and flexicise (a stretching exercise class) on a daily basis. We spoke with staff from Chard and West Mendip hospitals who praised the activity co-ordinators for their work and efforts on the ward. The activity co-ordinator from Chard hospital often ran fundraising events to raise money to buy new equipment to develop the activity programmes. So far £700 had been raised. Some of the money had been put towards a new tea set for the breakfast club and other equipment. The passion and commitment to supporting patients' wellbeing was evident in the activity co-ordinators we spoke with.
- The activities co-ordinator at Chard hospital had developed a breakfast club to improve patient wellbeing and the confidence of patients on the ward who were due to be discharged home. Breakfast club enabled patients to sit around a table together to have

their breakfast. The aim of the club was to provide patients who were capable and close to returning home an environment where they could get their own breakfast, as they would be required to do at home, but in a controlled environment. The activities co-ordinator ran the club but also worked closely with the occupational therapist to monitor patient progress, which fed into the occupational therapy assessments. There were plans to provide the activity co-ordinators uniforms to enable them to be distinguished from other members of staff. This was to help patients living with dementia recognise them more easily. The activity co-ordinators wore white uniforms; however this was not a dementia friendly colour. They were moving towards wearing a green uniform because this was more dementia friendly.

- At Crewkerne, the activities coordinator worked Monday to Friday and their shifts were flexible to meet the demands of the patients. They generally worked from 9am until 5pm but could flex their shift if a patient needed 1:1 care from 10am till 6pm. This provided the ward with an extra member of staff to help manage the "sun downing" effect of dementia where patients become more agitated at late afternoon/early evening.
- Information was provided in picture format for patients with cognitive problems. Staff showed us menu folders in the dining room which illustrated the food on offer to support them to make an independent choice.
- There was inconsistent use of the "This is Me" forms, (documentation used for confused patients and patients with dementia) at the community hospitals. At Dene Barton community hospital the form was not routinely completed for dementia patients. However, at Crewkerne and Bridgwater community hospitals, the "This is Me" document was used for every dementia patient. This meant not all patients with dementia had their preferences, likes and dislikes identified at their admission unless they were admitted to the hospital with a completed form.
- Dene Barton community hospital provided information packs for patients on admission to provide them with important information about their stay at the hospital. The information included: the hospital handbook, resuscitation, discharge planning, confidentiality, pressure ulcers, falls prevention and round the clock care.
- The wards were supportive of anxious dementia patients. There were flexible arrangements which enabled families to come on the ward to support their loved one outside of allocated visiting hours. A family member of one patient on the ward at West Mendip hospital had come in to support and sit with them. Nursing staff told us the patient became very upset and agitated when his wife was not on the ward. Nursing staff encouraged the support of families and relatives of patients with dementia as they understood how an unfamiliar environment and routine could be upsetting and distressing for a dementia patient.
- Some of the community hospitals used alternative forms of therapy to support the wellbeing of patients. A therapy dog came to visit West Mendip ward every two weeks. The therapy dog went around to the ward to visit patients who wanted to stroke and interact with the dog. At Crewkerne, patients were visited by Lofty the pony. There were photos of Lofty on the walls, showing how patients had enjoyed his visit. Evidence has shown using animals as therapy can improve a patient's overall wellbeing and aid therapeutic recovery.
- The inpatient service removed barriers for, and met the needs of, vulnerable patients who required end of life care in the community inpatient setting. We were given an example at West Mendip community hospital where a patients request was to die outdoors. Nurses at the hospital were able to accommodate this wish, despite the challenging weather conditions. Nursing staff put canopies up to keep the patient dry and ensured they remained warm and comfortable. A harp was also playing to help the patient remain relaxed. West Mendip hospital won an award for its provision of its palliative care. Other staff we spoke with from the community hospitals we visited were most proud of the care they provided for end of life patients.
- End of life patients on the wards had unrestricted visiting times. At West Mendip and Williton hospitals, there were facilities to enable family and relatives to stay on the ward overnight to be close to their loved one. West Mendip hospital had brought in homely objects, such as lamps, to make the rooms feel less clinical for relatives. The ward manager also told us there were plans to refurbish the bathroom to make this more comfortable and less clinical, although there was no timeframe for this.
- At Crewkerne, West Mendip and Williton hospitals, patients were encouraged and given the opportunity to eat in the day room away from their bedside. This provided a more normal environment for patients which

helped to better prepare them for returning home. Patients who faced challenges eating were provided with support on the wards. Patients were provided with specialist cutlery and crockery to improve their independence with eating and drinking.

Access to the right care at the right time

- The community inpatient service faced challenges with regards to patients being able to access the right care at the right time. Delayed patient discharges from the community inpatient service disrupted the flow and admission of patients from local NHS trusts into community inpatient beds. In December 2016, Burnham-on-Sea hospital saw the highest number of delayed discharged amongst the community hospitals at 34, whilst Dene Barton saw the lowest at just eight delayed discharges. In January 2017 Burnham-on-Sea hospital had no delayed discharges. Delayed discharges can have an impact on a patient's mental wellbeing and can also lead to them being less likely to cope at home after discharge. Evidence has also shown that delayed discharges can lead to an increased risk of falls, pressure ulcers and muscle deterioration due to reduced mobility.
- The average waiting time for patients to access the community hospitals varied in 2015/16. The average waiting time for patients to access the community hospitals was 2.6 days. However, five of the inpatient hospitals saw patients waiting over the average. These were South Petherton, Dene Barton and Wellington Hospital. South Petherton patients waited the longest at 3.4 days, whilst patients only waited 1.7 days to access Wincanton hospital.
- Patients did not have timely access to physiotherapy assessment and treatment in all of the community hospitals, apart from Burnham-on-Sea hospital who had their own physiotherapy and occupational therapy arrangements. Therapy staff worked across the wards and for the integrated rehabilitation team in the community. Patients on the wards were seen on the basis of patient need, rather than the therapists having a structured amount of time to spend on the ward on a daily basis. There had also been recent challenges with regards to recruitment of physiotherapy staff which had been escalated to the divisional risk register. Dene Barton had just had its therapy cover reduced from seven days to five days per week due to being unable to staff the service, meaning less continuity of rehabilitation for patients. The lack of physiotherapy cover at West Mendip hospital had led to a small number of patient discharges being delayed for at least one week. Staff across the community hospitals told us of their frustration about the provision of therapy services at ward level and felt this had led to delays in initial assessment of patients and had affected the length of rehabilitation time. Patients we spoke with at the various community hospitals we visited did not receive much physiotherapy and would sometimes go for days without seeing the therapists. Patient's did receive some limited ongoing work with the rehabilitation assistant, which was dependent upon their capacity.
- Nursing staff tried to minimise the wait for patients receiving physiotherapy input, within the constraints of what they were safely capable to do. Patients were supposed to have a mobility assessment on admission to the hospital wards. However, due to the lack of physiotherapists and lack of capacity due to demanding community caseloads, not all patients were seen on admission. If a physiotherapist was not present on the ward to assess a new patient, the nursing staff would continue to mobilise or move the patients as documented in the handover plan and in the patient records from the local acute trusts, if safe to do so. Nursing staff would not attempt to progress a patient and would wait for the therapists to do this. Concerns were also raised over patient's expectations when they arrived from the local acute trusts when they have been told they will be provided with 'intensive physiotherapy,' which staff told us was not the case.
- Good medical provision was provided across the hospitals and timely arrangements were made to cover for sickness or annual leave to ensure wards always had access to a doctor. All hospitals had either a contracted doctor working on the ward employed by the trust, or each ward was managed by a local GP surgery. GP's from local practices visited the hospitals daily and if they were not available on the ward, were always contactable by telephone. A locum GP had been arranged to provide cover for the ward at Williton hospital and Exmoor ward based at Williton hospital, to cover for the contracted doctor's annual leave.
- A stroke consultant provided timely, ongoing, weekly assessments of stroke patients at Williton hospital. The presence of the consultant provided continuous

monitoring of the patient during their inpatient stay from a specialised individual to ensure any care and treatment provided was responsive to the needs of the patient and promoted optimal recovery.

- Patients did not have access to responsive care and treatment outside of working hours. Staff did not feel supported by the out of hours GP service and felt the level of support was variable, dependent upon the doctor on call, whilst some staff said it was unresponsive to their service. Staff at West Mendip and Williton waited a long time to receive a call back from the on call service and staff felt it was a challenge to get GP's to come out and review patients out of hours. This meant patients were having to wait to receive required care and treatment. We were provided with examples where an out of hours doctor would not come out and see a palliative patient who required a syringe driver meaning the patient was not provided with the pain relief responsive to their needs. Staff also told us the out of hours doctors would very rarely record any documentation regarding their visit to the patient. However, the trust had acted on the issues surrounding the out of hours GP service and had raised this with the local Clinical Commissioning Group.

Learning from complaints and concerns

- People's complaints and concerns were listened to and used to improve the quality of care.
- People using the service knew how to make a complaint and felt could raise any concerns with the clinical staff. Information on how to make a complaint was displayed in hospitals we visited and leaflets were available to patients and relatives, providing information about how to make a complaint, including the contact information and the complaints process.
- The community inpatient service had 13 complaints between the January 2016 and December 2016. One complaint was fully upheld and eight were partially upheld. We reviewed these complaints and saw two were regarding patient discharges, two around applications for continuing healthcare funding and nine regarding aspects of clinical care and treatment. Dene Barton had not received a formal complaint for the past 10 months, whilst Crewkerne hospital had not received a complaint in the last six months. There was an ongoing complaint at Shepton Mallet where a meeting had been arranged for the family to come in and discuss their concerns.
- Complaints were handled effectively and confidently, with regular updates for the complainant and a formal record maintained. Complainants received a timely response, explanation and apology where appropriate. Investigations also identified learning taken from the complaints and associated actions. Complaints were handled in line with the trust complaints policy and procedure.
- Complaints about the service were sent to the divisional lead and then onto the appropriate matron to deal with the complaint. Any response to the patient was review by the divisional lead and the complaints team prior to being sent out to a patient.
- Compliments and thank you cards were displayed on the walls in the wards we visited. All the cards we read were praising and thanking staff for the kind care they or their relative received whilst in the hospital. The community inpatient service received 1309 compliments between January and December 2016, with Wellington hospital receiving the most compliments.

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

During this inspection, we found the service had addressed the Requirement Notices following our September 2015 inspection. However, further areas for improvement were identified, which is why the rating has not changed since 2015.

Overall we rated well led as requires improvement because:

- Although the governance framework had been strengthened following our last inspection, further work was needed to ensure it consistently supported the delivery of good quality care.
- Staff were not clear about the values of the trust or the local vision and strategy.
- Staff felt uncertain about the future of the community hospitals and their job security.
- There was a lack of leadership to ensure actions from audits to improve compliance with trust policies were implemented into practice.
- Community matrons were not visible and this posed a challenge to the provision of effective leadership at the community hospitals.
- Staff on Exmoor ward felt there had been a lack of supportive leadership and communication regarding the temporary closure of beds at Minehead hospital.

However:

- There was a positive patient centred culture across the community inpatient service.
- The trust had provided training and support to managers to enable them to feel more confident to effectively manage risk.
- The majority of staff felt respected and valued and were proud of the team and the way they worked together.
- The trust worked to engage both staff and the public.

Detailed findings

Service vision and strategy

- There was a clear vision and strategy for the community inpatient service, aligned with the sustainability and transformation plans. The future provision of community hospital-based community services in Somerset was based on a service model with three components: step up, step down and health and wellbeing. However, staff we spoke with were not aware of the vision and strategy. Some staff expressed anxiety for the future of community hospitals and their job security. Staff did not know what the future held for the community hospitals.
- There were plans to provide 'step up' and 'step down' beds for patients. Patients would go into a 'step up' bed if they had come into hospital from home. The team managing a step up bed would be GP led, including a multidisciplinary team of nurses, therapists and a social worker. A 'step down' bed would be for patients coming out into the community from the local acute trusts. These units could be nurse led, along with a multidisciplinary team including therapists and a social worker. The plan was to use the smaller community hospitals as nurse led centres and the larger sites as GP led centres to make better use of the facilities and skill sets of the available staff. This would also bring more care closer to home in the community, in line with the sustainability and transformation plans.
- There were a clear set of trust values, however many of the staff we spoke with were not aware of the values. The values had recently changed when the new chief executive came into post. We were told by the senior management team that all staff had been consulted and given the opportunity to provide their thoughts about what the new values of the trust should be. However, the majority of staff we spoke with had not had any involvement with developing the values. We were told that band six staff and above had been given the opportunity, however they had not been asked to consult the rest of the staff for ideas or feedback. However, the February staff bulletin contained a whole page spread thanking staff for their involvement in various surveys and feedback groups. It was unclear whether staff in the community inpatient service had not been aware of the opportunity or whether they had chosen not to engage.

Requires improvement

Are services well-led?

Governance, risk management and quality measurement

- The governance framework did not always support the delivery of good quality care. The governance structure demonstrated how communication flowed up and down from ward level to the divisional managers and then onto the board, who had oversight of the whole service. Strategic meetings such as the medicines management and incident review groups fed into the divisional meeting. Similarly, best practice meetings, for example the pressure ulcer group and the community hospitals best practice group, also fed into the divisional meetings.
- Improvements to the governance arrangements had been made since the previous inspection in 2015; however, issues such as consent and mental capacity and a lack of leadership and oversight of the community hospitals had not been fully addressed.
- There were robust arrangements for identifying, recording and managing risks. Risks were monitored and mitigating actions put in place to reduce risk wherever possible. This was an improved position from our last inspection. Each community hospital had their own risk register. Any risks with a score of nine or above were escalated to a divisional risk register for closer monitoring and oversight by the senior management team. The top risks on the trust's risk register for the East and West division were staffing in relation to nursing cover, medical cover and lack of therapy staff. These issues were mirrored by the staff in the community hospitals and also against what had been recorded on the local hospital risk registers. All of these risks on both the local and organisational risk registers had appropriate mitigating actions, evidence they were regularly reviewed and the name of a lead individual who had oversight of each risk. There was evidence of regular review and updates being provided.
- Local risk registers reflected the ward managers' and matrons' concerns. For example, at Chard community hospital risks relating to the lift and the procedure if it broke down were recorded on the register, along with issues around delayed discharges. These mirrored the risks staff told us about at this hospital.
- An electronic copy of all risk assessments and mitigating actions were held at the community hospitals. Risk assessments contained clear information about the risk and the mitigating actions, which corresponded to risks on the risk register.
- The trust had developed training and support for staff regarding risk management since the last inspection. Staff managing risk had access to a risk management training course. A risk surgery was run every three months where staff could discuss local risks to ensure effective risk management. The matrons felt they were well supported with risk management and could discuss risk at their one to one sessions, with the divisional lead, or at the matrons meetings.
- There had been no management of the risks with regards to consent and mental capacity which were a cause for concern at each community hospital we visited. The senior management team were aware of the risks and work was ongoing to rectify this. However, despite this, there had been no actions taken to mitigate the risk. The community hospital's wider issues around consent and mental capacity did not feature on any of the local risk registers or on the divisional risk register.
- There was a systematic programme of clinical and internal audit; however, the quality of some of the audits were questionable. Audits were being used to monitor quality and to identify where action should be taken, however some of the audit results did not reflect our observations, particularly with regards to medicines management and controlled drugs. We saw examples of audits with ongoing action plans, which demonstrated learning and improvements to practice. All of the action plans had clear actions and a named person who had oversight of the action and its execution. However, the controlled drugs audit did not match our findings in relation to the countersigning of controlled drugs on Exmoor ward. This meant the actions from the audit had not fully addressed the ongoing issues, and although some actions had a target completion date of the end of January 2017, these had not been completed.
- The governance systems around medicines management had failed to recognise the risks around the management of controlled drugs on Exmoor ward. The administration of controlled drugs had not been followed in accordance with trust policy or best practice guidelines which posed risks to patients. Due to the challenges with the relocation, the lack of ward manager and matron oversight, this deviation from

policy had continued. There was also a lack of clarity from the senior management team with regards to the countersigning of controlled drugs and the trust's current policy regarding this, demonstrating a lack of risk management.

- The governance system had failed to address the effectiveness of tools used to monitor pain, despite this this issue having been highlighted during the previous inspection in 2015, however it remained unresolved. There was confusion across the community inpatient hospitals about how and where pain should be recorded and what tool should be used meaning that there was ineffective monitoring of patients, affecting the quality of care provided for patients.
- A monthly performance dashboard was produced for each community hospital to monitor quality and performance. The dashboard included details of compliance in mandatory training, staff sickness, staffing levels and patient related quality and safety performance indicators. The local clinical commissioning groups monitored the dashboards as part of their contract review.

Leadership of this service

- The Chief Executive had only been in post for one year, but was respected by staff. Staff spoke highly of the Chief Executive and told us he would take the time to communicate with them. Staff told us if they sent the chief executive an email, they would get a response. The Chief Executive had managed to visit two of the community hospitals, despite being in post only a short time and having lots of other areas of priority to focus on.
- Matrons did not have the capacity to provide effective leadership to their community hospitals and were not always visible. Due to long term sickness and vacancies, the community matrons had taken on additional hospitals to cover for the absences. One matron was overseeing four community hospitals across a relatively large, rural, geographical area. Staff told us they no longer saw the matron regularly due to the extra workload they were carrying. Staff felt the matrons did the best they could to make contact by telephone, but they missed the matron's presence on the ward and their hands-on approach to supporting the ward. At Dene Barton, the matron and the ward sister were both on long-term absences. Temporary leadership cover had been put in place, with a matron from a nearby hospital covering and the ward manager from Wellington working there one day a week. Staff felt supported by this arrangement and knew how to escalate issues when necessary.
- Despite their lack of capacity, the matrons and ward managers we spoke with had the skills, knowledge and experience to lead their inpatient hospital. They had an understanding of the challenges their hospitals faced with regards to providing good quality care and had actions in place to try and manage these. For example, the community inpatient service held regular internal calls to identify the pressures faced by each hospital and ways to overcome these issues were found to ensure good quality care. We were also told how the hospitals worked with closely external organisations to ensure good quality care.
- Nursing staff we spoke with on the majority of wards visited, felt their ward managers were visible, approachable and supportive. They felt confident to raise issues or concerns with them. There were positive interactions between the staff and the ward managers and we observed the hands-on approach to leadership from the ward managers.
- Staff felt the organisation had not responded the ongoing concerns and issues raised about the medical cover. Concerns had been raised by several members of staff, however the situation had remained unchanged leaving staff feeling unsettled. The community matron for Williton hospital was currently covering four other hospitals, impacting on her ability to be more visible in the hospitals and staff felt the matron had no oversight of this issue. We were unable to confirm this with the matron at the time of inspection as the matron was not available.
- Staff on Exmoor ward felt the senior management team had not communicated effectively regarding the temporary closure of Minehead hospital and felt the situation had been managed poorly. Staff were informed of the temporary closure and the move to Williton hospital less than one week before the move took place. Since the move, staff still felt there was a lack of communication and great uncertainty with regards to the future. However, the senior management team provided us with a timeline of staff engagement meetings which had taken place with the staff to discuss any concerns they had regarding the temporary move of

the hospital. It was unclear why the staff we spoke with did not mention any of these engagement meetings which had taken place. Staff were unsure if the inpatient beds at Minehead hospital would be re-opening.

Culture within this service

- Most of the staff we spoke with felt respected and valued and spoke of a positive working culture across the wards. Staff were proud of the patient-centred care they provided.
- Staff prided themselves on the end of life care they provided, and this had been recognised through the awards they had won for their excellence in this area.
- We found cheerful, relaxed environments within most of the community hospitals we visited, other than Exmoor ward. Staff felt the open culture was helped by the trust's 'See something, Say Something' campaign, where staff were encouraged to speak up about anything they saw which concerned them. Teams worked well together and staff felt supported by each other.
- There was a lack of integration between the staff at Williton hospital and on Exmoor ward, who had recently relocated to Williton hospital due to staff shortages. Staff we spoke with on both wards portrayed a very separate culture. Staff on Exmoor ward felt unsupported because they did not have a ward manager due to long-term sickness since the temporary move to Williton Hospital. The staff felt they did not often see the ward manager from Williton ward. The staff felt the ward sister was doing their best, but was still "finding their feet", and the lack of visibility of the matron left them somewhat unsupported.
- Staff we spoke with across most of the community hospitals felt they worked for a service with an open culture and could raise any issues concerning them with their ward managers. Staff also told us they would be happy to raise issues with their matron; however they no longer had the opportunity sue to the matrons not being visible around the wards. Staff felt comfortable to approach their ward managers to discuss any concerns or issues they had. Ward managers operated an open-door policy for all of their staff. Staff clarified on the whole, this was the case.
- All staff we spoke with were proud of their team and the way in which they worked together to support each other. Matrons were proud of their staff and how they worked as a team. One matron told us "each member of the team brings something different to the hospital."
- Staff felt the patient-centred culture within the community inpatient services was reflected by the number of thank you cards and compliments displayed on the walls on the wards. Staff were very proud of the good feedback from patients and relatives about the care they provided.
- Burnham-on-Sea hospital had adopted "compassionate interviewing," a recommendation from the 2013 Francis report. Compassionate interviewing was based on the 6C's, (values from the Nursing and Midwifery Council, which all nursing staff should aspire to). The interview incorporated various tasks which identified elements of the 6C's demonstrated by the interviewee. Only candidates who demonstrated awareness of the 6C's were invited to formal interview. This was in an attempt to recruit caring and compassionate staff.

Public engagement

- People's views and experiences were gathered and acted upon to improve the services the community hospitals had to offer.
- The inpatient service displayed "you said, we did" posters detailing how they had acted on feedback from patients and members of the public. For example, at Williton hospital one piece of feedback was about the lack of activities at the hospital. In order to improve, the hospital was looking to recruit an activities co-ordinator for 25 hours per week. Another stated it would be good to have music and songs playing. The league of friends responded to this and bought a range of music for the patients.
- The trust was using a variety of methods to connect with patients. Social media, drop-in sessions and focus groups were used to collect feedback about the service and this was used to improve services.
- Crewkerne hospital held drop-in sessions for patients or families to come and provide feedback about the ward. The session ran on a Wednesday for two hours. Patients, families and relatives or carers could drop in or make an appointment to provide feedback to the ward sister.
- The inpatient services also participated in the NHS Friends and Family Test to gather feedback from patients.

Requires improvement

Are services well-led?

Staff engagement

- Staff received a "What's on @ SOMPAR" news bulletin on a monthly basis. The bulletin included updates and information about what had happened in the trust over the last month. The bulletin also provided staff with information about policy updates and information about the outcomes and recommendations of clinical audits. The bulletin also highlighted the successes of individual teams and members of staff. Staff especially liked the "team player of the month" section.
- The inpatient service had sought feedback from staff about the new electronic patient record system. A group had been set up, along with a best practice working group, to gather staff feedback and suggestions about the new system in order to enhance and improve it.
- Staff were encouraged to take part in a yearly trust wide staff survey. However, at the time of our inspection, the results of the survey were not available.

Innovation, improvement and sustainability

- Improvements to quality were recognised and rewarded. The trust recognised and rewarded staff for their innovative work and the quality of their work. Staff were provided with awards, including for long service, employee of the month, and innovation. There was an annual award ceremony where successes were celebrated. Staff told us this made them feel valued.
- The community hospital inpatient service had received eight national and regional awards over the last two years. Awards had been given for early supported discharge for stroke and acquired brain injuries, the introduction of activity co-ordinators, the falls local action group (FLAG) looking at reducing falls, dementia co-ordinators and improving care of the deteriorating patient in community hospitals.
- Burnham-on-Sea hospital received a trust recognition award in 2016 and a commendation for patient safety. The ward manager had received a recognition award in 2015 for leadership.

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
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11(1) Care and treatment of the service users must only be provided with the consent of the relevant person. 11(3) If the service user is 16 or over and is unable to give consent because they lack the capacity to do so, the registered person must act in accordance with the 2005 Act. 11(1) There were inconsistencies and a lack of understanding and clarity about how and where consent should be recorded across the community hospitals we visited. Some patients had paper documentation completed and some did not. Some patients had their consent electronically recorded, however there were inconsistencies with how this was recorded. Some staff told us that if they felt the patient lacked capacity, they would get the patient's family to sign the consent form on their behalf. Confusion had arisen following advice that the paper consent forms were not fit for purpose and should not be in use, but no alternative solution had been provided. 11(3) Staff we spoke with did not understand or feel confident with the relevant consent and decision making requirements and guidance, including the Mental Capacity Act 2005. Staff told us they received minimal training around the Mental Capacity Act and were provided with no training on how to complete a mental capacity assessment. Staff told us they could recognise

This section is primarily information for the provider

Requirement notices

whether or not a patient had capacity but did not know how, or feel confident, to undertake appropriate actions to formalise and document a capacity assessment if required.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines 12 (2) (g) Staff on Exmoor ward were neither following the trust's policy or working in line with best practice with regards to the management of controlled drugs. Controlled drugs were being countersigned by a healthcare assistant, rather than a registered nurse. We saw no risk assessment completed, despite the deviation from the trust's policy. Medicines were not always being stored safely. Liquid medicines did not always have the date they were opened recorded. This issues had been identified at our previous inspection in 2015 but remained unresolved. Medicines refrigerators did not always have temperature checks completed and were not always locked. Twelve of the 55 prescription charts we checked contained omissions and reasons for these were not documented.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Requirement notices

20(4) the notification given under paragraph (2) (a) must be followed by a written notification given or sent to the relevant person containing –

20 (4) (a) the information provided under paragraph (3) (b)

20 (4) (b) details of any enquiries to be taken in accordance with paragraph (3) (c)

20 (2) (c) the results of any further enquiries into the incident, and

20 (4) (d) an apology

The community inpatients service did not provide written notifications, including an apology and details of the investigation findings and actions taken, in order to meet this regulation.