Requires improvement

Dorset Healthcare University NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

Sentinel House,
4 - 6 Nuffield Road,
Nuffield Industrial Estate,
Poole,
Dorset,
BH17 0RB
Tel: 01202 277000
Website: **http://www.dorsethealthcare.nhs.uk**

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDY10	St Ann's Hospital	East Dorset Crisis and Home Treatment Team	BH13 7LN
RDY10	St Ann's Hospital	Health-Based Place of Safety	BH13 7LN

This report describes our judgement of the quality of care provided within this core service by Dorset Healthcare University 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.

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement
Are services safe?	**Not sufficient evidence to rate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Good**

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated East Dorset Crisis and Home Treatment Team and Health Based Place of Safety (HBPoS) as requires improvement because:

- During this inspection (March 2016), although some progress had been made, this was not sufficient to amend the ratings that were awarded at the time of the comprehensive inspection in June 2015.
- The trust had recruited two dedicated mental health support workers to operate the phone lines and there was a clear process describing its usage. However, at the time of our inspection, they did not have dedicated staff on duty due to staff sickness and two Bank support workers operated the phones lines. These staff members had not received any telephone specific training and one member of staff was observed not following the call escalation protocol correctly. At the time of the inspection, four registered practitioner posts remained vacant. Staff sickness rates for the year to February 2016 remained high at 8%. Only 88% of all staff had completed mandatory training – compared with the trust target of 95%. Not all staff received regular supervision- supervision compliance was at 85% in the east crisis team. The trust had not trained the bank support workers for telephone support but did provide an induction for one of them. As a result, one of the staff did not follow the escalation algorithm correctly. This meant the provider had not met the requirement notice to have sufficient appropriately trained staff available to provide care to people receiving services from the east Dorset crisis team.
- We found the provider did not fully follow policies and procedures in managing medicines. This meant staff did not manage medicines in line with current legislation and guidance, including those related to storage and transportation. This meant the provider had not met the requirement notice to provide safe care and treatment to people receiving services from the East Dorset Crisis Team.

However:

• The trust had installed a new phone system with wall screens that captured data. Team leaders had access to call data that allowed them to monitor all calls. The trust had recruited two dedicated mental health support workers to operate the phone lines and there was a clear process describing its usage.

Summary of findings

We did not collect sufficient evidence to make a rating on the key question of Safe.

Inspected not Rated

Are services safe?

We inspected but did not rate safe:

- Staff working on the crisis line had not been trained specifically to do so
- we observed staff who were not following the telephone support line process to ensure it was meeting the needs of patients using the service
- staff were not following the trust's policy and procedures on medicines management.

However:

- The telephone call management system had been updated

We did not collect sufficient evidence to make a rating on the key question of Safe.

Are services effective?

We rated effective as requires improvement because:

- The section 136 multi agency policy failed to reflect the requirements of the Mental Health Act 1983 Code of Practice
- internal, multidisciplinary team relationships between the East Dorset Crisis Team and the community mental health teams had not improved.

However:

- Mental health support workers who worked in the HBPoS had received appropriate training.

Are services caring?

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- Staff that did not maintain contact with a patient and did not record notes correctly
- the issue of one HBPoS is currently under review as part of a new trust wide acute care pathway, the pathway has been created in consultation with staff, external agencies, patients and carers, however, this was not discussed at the time of the inspection.

Are services well-led?

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Summary of findings

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

Are services safe?

Not sufficient evidence to rate

We inspected but did not rate safe:

- Staff working on the crisis line had not been trained specifically to do so
- we observed staff who were not following the telephone support line process to ensure it was meeting the needs of patients using the service
- staff were not following the trust's policy and procedures on medicines management.

However:

- The telephone call management system had been updated

We did not collect sufficient evidence to make a rating on the key question of Safe.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The section 136 multi agency policy failed to reflect the requirements of the Mental Health Act 1983 Code of Practice
- internal, multidisciplinary team relationships between the East Dorset Crisis Team and the community mental health teams had not improved

However:

- Mental health support workers who worked in the HBPoS had received appropriate training.

Are services caring?

Good

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Staff that did not maintain contact with a patient and did not record notes correctly

Summary of findings

• the issue of one HBPoS is currently under review as part of a new Trust wide acute care pathway, the pathway has been created in consultation with staff, external agencies, patients and carers, however, this was not discussed at the time of the inspection.	
Are services well-led? Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.	**Good** 

Summary of findings

Information about the service

Dorset HealthCare University NHS Foundation Trust has one Health Based Place of Safety (HBPoS), at St. Ann's hospital in Poole. The HBPoS is for patients detained under section 136 of the Mental Health Act. Section 136 is an emergency power, which allows for the removal of a person who is in a place to which the public have access, to a place of safety, if the person appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control. The HBPoS serves the whole of the county of Dorset.

There were crisis teams based at St. Ann's hospital and the Forston clinic Dorchester covering both east and west Dorset respectively.

The East Dorset Crisis Team provided short term enhanced support to patients who are experiencing crisis due to acute mental illness. The service also acted as a 'gate keeper' for all acute inpatient beds within Dorset. Patients that required admission to an acute inpatient mental health bed are referred to the respective crisis team who assess to determine if an admission is required or whether an alternative to admission is available as a less restrictive option.

The trust had a countywide street triage service based in east Dorset. The aim of this team is to ensure that patients receive mental health professional input in a timely manner whilst also diverting patients from inappropriate police custody or detention under section 136 of the Mental Health Act.

Our inspection team

Team leader: Gary Risdale, Inspection Manager CQC

The team that inspected East Dorset Crisis and Home Treatment Team comprised:

- a Care Quality Commission Inspector
- a Mental Health Act Reviewer

The team that inspected Health-based Place of Safety comprised:

- a Care Quality Commission Inspector
- a Mental Health Act Reviewer

Why we carried out this inspection

We carried out this focussed short notice announced inspection to review the progress the trust had made following our comprehensive inspection in June 2015. We published the report from the comprehensive inspection in October 2015.

In this service, we only looked at the two existing requirement notices (Regulations 12 and 18) to see if the trust had made the required improvements. We did not inspect any other areas of care on this occasion.

Regulation 18(1)(2a) Health and Social Care Act (HSCA) 2008 (Regulated Activities)Regulations 2014. Staffing.

Regulation 12(2)(i) Health and Social Care Act (HSCA) 2008 (Regulated Activities)Regulations 2014. Safe care and treatment.

This inspection reviewed the progress the trust had made.

Summary of findings

How we carried out this inspection

We undertook a focussed inspection of the areas where we had identified the need for improvement. We only reinspected the key questions that we had rated as requires improvement and this report details our findings related to;

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

Before the focused inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- Inspected the East Dorset Crisis Team and the Health-Based Place of Safety (HBPoS).
- spoke with two patients who were using the service, in their own homes
- spoke with the three team leaders of the East Dorset Crisis Team
- spoke with nine East Dorset Crisis Team staff members; including doctors, nurses, a social worker mental health support workers and nurse practitioners
- spoke with two bank mental health support workers
- spoke with nine mental health support workers who worked in the 136 HBPoS
- interviewed the senior management team with responsibility for these services, including the acute services manager and the executive director
- attended a staff peer group
- observed two handover meetings and a multi - disciplinary meeting
- looked at four treatment records of people using services
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

At the time of the inspection, we received positive feedback from patients who were currently using the crisis service. They told us that they felt supported and respected by staff that were polite and caring. However, they also felt that they saw too many different people from the team.

At the time of the inspection, we did not speak with any patients who had used the HBPoS /136

Good practice

At our inspection on 22-26 June 2015:

- The trust had a street triage service based in east Dorset. This service provided advice to police officers which ensured that patients got mental health professional input in a timely manner whilst also diverting patients from inappropriate police custody or detention under section 136 of the Mental Health Act assessments. The trust had established good relationships with the police. This was conducive to positive outcomes for patients using the services and staff from both organisations. The police mental health coordinator received a detailed and thorough induction to mental health services, which included working shifts on the acute inpatient wards.

When we returned to the Trust on 15, 16 and 17 March 2016:

- Staff informed us this service remained in place. We looked at detailed information that confirmed it was consistent in its delivery.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve following our inspection on 15 to 17 March 2016;

- The provider must ensure that there is sufficient appropriately trained staff which are available to provide care to patients receiving services from the East Dorset Crisis Team.
- The provider must ensure cooperative and good working relations between the East Dorset Crisis Team and locality CMHTs to ensure that patients requiring services can access the most appropriate service to have their need met in a timely manner.
- The provider must ensure staff follow the medicine management protocol.
- The provider must ensure they adhere to the code of practice with regards to HBPoS assessment times.
- The provider must ensure their internal policies meet the requirements of the mental health act code of practice.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve following our inspection on 15 to 17 March 2016;

- The provider should address the inequitable relationships between members of the multi-disciplinary team.
- The provider should ensure that staff operating the telephone lines receive suitable training and that they are following the protocol.
- The provider should ensure risk assessments are reviewed in a timely manner.
- The provider should ensure that all staff receive an appraisal.
- The provider should ensure managers encourage and support staff in their roles.
- The provider should access feedback data and analyse results.
- The provider should review their 136-assessment policy and make the appropriate changes in line with the code of practice.

Dorset Healthcare University NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
East Dorset Crisis and Home Treatment team	St.Ann's Hospital
Health-Based Place of Safety/section 136 suite	St.Ann's Hospital

Mental Health Act responsibilities

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

- Training in the use of the Mental Health Act was not mandatory. However, we found that staff had a good understanding of it and its guiding principles. We were assured, by talking to staff, that they understood how patients should be assessed, treated and cared for under the statutory requirements of the Mental Health Act
- Staff in the health-based places of safety understood their roles in relation to section 136 of the mental health act and had a good overall understanding of the legislation. When patients were admitted via section 136 they had their rights read to them upon arrival. If staff felt that patients did not fully understand, they would read their rights continuously over the duration of their stay
- There were regular inter-agency meetings in relation to crisis care and section 136 admissions. This was as part of the trust's involvement with the crisis concordat and involved external agencies such as the police and ambulance service. There were systems in place whereby police understood their roles and procedures in adhering to detaining patients under section 136; these were outlined in the trust's policy.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Health Act and Mental Capacity Act training is a role specific mandatory training requirement for all registered staff working in mental health services. This forms part of the Mental Health Learning Foundation pathway. Staff we spoke with demonstrated a good understanding about obtaining a person's consent, or if required, relatives and/or their representatives. However, we did not see any advanced decisions in the crisis plans or care plans that we looked at.

Not sufficient evidence to rate

Are services safe?

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

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

Our findings

Safe and clean environment

- Staff carried out the majority of the crisis teams' work in patients own homes, GP surgeries or clinic rooms. The environment where staff did see patients was clean and well maintained. Staff adhered to infection control principles.

Safe Staffing

- The trust had allocated finance for additional staff within the Crisis team. Two band six nurses started in February 2016, one band six social worker was appointed in March 2016. There was a plan in place to withdraw use of agency staff. However, four registered practitioner posts remained vacant. Two mental health support workers in post were dedicated to the telephone support line.
- Staff worked regular day shifts. The crisis team provided a service 24 hours a day, seven days a week. Two members of staff were on duty during the night. One was a registered nurse and one was a mental health support worker. The team had consultant psychiatrist input. During weekends and evenings, the crisis team could call on a duty doctor.
- The trust had installed a new phone system with wall screens that captured data. Team leaders had access to call data that allowed them to monitor all calls. The trust had recruited two dedicated mental health support workers to operate the phone lines and there was a clear process describing its usage. However, at the time of our inspection they did not have dedicated staff on duty due to sickness. Bank support workers operated the phones lines, these staff members had not received any telephone specific training and one of these staff did not follow the escalation process appropriately.
- Staff told us that they could arrange appointments within 24 hours of having an assessment. Staff did not have individual caseloads; instead, they managed the caseload as a team. Patients told us this created inconsistent care. Staffing numbers had increased and as a result, staff told us that home visits were taking place more regularly.
- Staff sickness rates for the year to February 2016 remained high at 8.7%.
- We were initially informed that that 67% of all staff had completed safeguarding mandatory training at the time of the inspection. We were concerned about this figure and asked the team leader why it was so low. Following the discussion a manager verified staff training records and encouraged staff to complete training on line during the inspection process. The figures that were verified increased the overall percentage of compliance to 83%. However, this was not compliant with the trusts overall target of 95%. This concern was fed back to the acute services manager. Mandatory training compliance in the East Dorset Crisis Team was 84% at the time of the inspection. The overall compliance for the crisis service was 88%

Assessing and managing risk to people using services and staff

- Patients had a risk assessment carried out by the crisis team at the initial assessment or triage stage. Staff carried out a further assessment when the crisis team saw patients. However, information was limited and was not reflected in the subsequent care plans.
- The crisis team did not have a qualified nurse prescriber. The team maintained a small supply of stock medicines that staff could use in emergencies. The service dealt with FP10 prescriptions only which patients had to take to a pharmacy and pay to have dispensed. Staff transported medication to the patient in unsecure containers; this was not in line with the trust's medicines policy when transporting medicines to the patient's home.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents. Staff told us that once the manager had reviewed incidents they forwarded them to senior

Not sufficient evidence to rate

Are services safe?

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

managers and the trust's patient safety team for further review. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these. Staff also recorded the action taken on the electronic system.

- Staff discussed significant incidents in staff meetings and handovers. However, not all staff attended these meetings. All staff were provided with copies of minutes from all staff meetings and hard copies of minutes were filed in the staff office for all to access.
- Managers offered staff debriefing sessions following serious incidents within a solution focused reflective peer group. We observed a session during the inspection, nine staff attended and one staff member presented a case to the group. The session ended before any other staff member was able to present a case and staff told us that the sessions were not held regularly.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- We looked at four patient care plans. Some of the information in all four of the care plans was out of date. We had observed a conversation between a staff member and a patient on the phone, when we reviewed that patient's progress notes it was clear the staff member had recorded incorrect information. All care plans reviewed had limited patient involvement.
- The trust stores records on the electronic recording system. The system was password protected.
- Staff told us they managed caseloads as a team and not individually. Staff confirmed this meant that different staff might see the same patient throughout the week. We found the information staff recorded within the assessments was not detailed enough for a new member of staff to begin work with that patient.

Best practice in treatment and care

- Staff conducted a local audit of the electronic care notes. However, there was limited information and no action plans for improvement. Staff did not have access to any other clinical audits for us to view and the trust did not submit information prior to the inspection taking place..

Skilled staff to deliver care

- The team had limited and variable access to the range of mental health disciplines required for patients using the service. There was input from a psychiatrist, nursing and supportstaff, but no occupational therapist, psychologist or approved mental health professional (AMHPs). The crisis team had to request an AMHPs services from the local authority when required.
- Staff in the crisis team received supervision and professional development. Staff we spoke with said they received individual and group supervision on a regular basis as well as an annual appraisal. However, records showed this was not consistent across the team.

Multi-disciplinary and inter-agency team work

- Staff held handover meetings twice a day. During the inspection, we attended two of these. We observed the lead nurse handing over information from the day, there was limited input from other team members, staff entered and left the meeting throughout, staff prepared medication for transportation during the meeting and there was a lack of focus on patient progress.
- We noted that the relationship between the East Dorset Crisis Team and the local community mental health teams remained poor. Staff told us that the community mental health team had put a message on their answerphone during working hours to contact the crisis team whilst they were in a meeting; this was not in line with the Crisis team's operational policy. Staff said this affected their service as they were dealing with inappropriate calls that were not from patients in crisis; Staff told us managers had not addressed this with the community mental health team.

Adherence to the MHA and the MHA Code of Practice

- We found that the multi–agency section 136 policy did not reflect the requirements of the Mental Health Act Code of Practice. The Code requires that within a local section 136 policy target times should be set for the start of the assessment. Whilst the trust's policy statesthe assessment must take place within three hours, it also goes on to say "or as soon as is reasonably possible". This negates the three-hour standard time limit identified in the policy, which is in breach of paragraph 16.65 of the Code of Practice. This states the Trust must set the expected time limits within which the assessment must take place in an HBPoS. We saw evidence that the trust had not met the three-hour target when admitting a patient, one detained patient in the HBPoS had been waiting over six hours before staff assessed them. The trust agreed they would review their policy and make the appropriate changes.

Good practice in applying the MCA

- Mental Capacity Act training and Deprivation of Liberty Safeguard training was not mandatory. Staff we spoke with demonstrated a good understanding about obtaining a person's consent, or if required, relatives and/or their representatives. However, we did not see any advanced decisions in the crisis plans or care plans that we looked at.

Good

Are services caring?

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

Our findings

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Meeting the needs of all people who use the service

- The trust only had one Health Based Place of Safety (HBPoS). Staff did not routinely ask patients who had used the HBPoS about their experience of the service. However, the HBPoS was under review as part of the trusts work to develop a new trust wide acute care pathway.
- We observed two bank mental health support workers operating the phone lines at night. The trust had appointed them in September 2015. They told us that they had not received any specific training to operate phone lines. This was a concern, as the patients using these resources were often very distressed and emotionally charged at the point of contact. At the time of the inspection, these staff members were not directly supervised but had access to support via the senior nurse in the team, the senior band 7 on site and the manager on call if required.

Listening to and learning from concerns and complaints

- We saw evidence that staff had listened and learnt from complaints. We noted a new phone system and additional staff in place to operate telephones at times of peak activity. The trust had installed wall screens that capture data. The service manager provided examples of complaints and identified learning. A specific example relating to a service users experience of S136 included a number of changes that the trust had implemented as a direct result of the services users concerns. This included transport arrangements and the provision of bedding. The service user had since supported the service to provide a patient experience account as part of a training DVD the service had produced.

Are services well-led?

Good

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

Our findings

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities)Regulations 2014: Staffing We found the provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced staff available to provide care to people receiving services from the East Dorset Crisis Team. This is a breach of regulation 18 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities)Regulations 2014: Safe care and treatment We found the provider did not ensure cooperative and good working relations between the East Dorset Crisis Team and locality CMHTs to ensure that people requiring services can access the most appropriate service to have their need met in a timely manner. This is a breach of regulation 12 (2) (I)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated activities) Regulations 2014: Safe care and treatment

This section is primarily information for the provider

Requirement notices

We found that the provider did not follow policies and procedures about managing medicines in line with current legislation and guidance, including those related to storage and transportation of medicines to patients homes..

This is a breach of regulation 12 (1) (2) (g)