Requires improvement

Dorset Healthcare University NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDYEJ	Bridport Community Hospital	(CQC Team One) Bridport Community Mental Health Team	DT6 5DR
RDYFT	30 Maiden Castle Road	Dorchester Community Mental Health Team	DT1 2ER
RDYFT	30 Maiden Castle Road	Early Intervention Service West	DT1 2ER
RDYFX	49 Alumhurst Road	Early Intervention Service East	BH4 8EP
RDYY2	Westhaven Hospital	Weymouth and Portland Community Mental Health Team	DT4 0QE
RDYY2	Westhaven Hospital	Weymouth and Portland Assertive Outreach Team	DT4 0QE
RDYNM	Sentinel House	(CQC Team Two) Purbeck Community Mental Health Team	BH20 4DY

Summary of findings

RDY38	Fairmile House	Christchurch & Southbourne Community Mental Health Team	BH23 2JT
RDYY4	Yeatman Hospital	Sherborne Community Mental Health Team	DT9 3JU
RDY22	Alderney Hospital	Poole Community Mental Health Team	BH12 4NB
RDYNM	Sentinel House	Bournemouth West Community Mental Health Team	BH2 5JW
RDYNM	Sentinel House	Bournemouth & Poole Assertive Outreach Team	BH2 5JW

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.

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?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

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

- We found considerable variance in the quality and completeness of care plans and in how up-to-date they were. We identified safety concerns in relation to the standard of care planning and risk assessment and management at some teams. Allocation and management of caseloads varied between teams, and this meant that some staff held high caseloads.
- Some teams did not have the right numbers of staff or skill mix to safely meet all the requirements of the service. Variance in performance and quality across teams, and gaps in critical aspects of service provision, were issues which had been identified eighteen months previous to our inspection through the Trust's own internal investigations, following serious incidents. These issues had not been addressed at the time of our inspection.
- We saw some good examples of learning from incidents and actions to to improve safety at a local team level. However, we were concerned that there was limited evidence of wider learning for the community teams to improve safety following serious incidents.
- Staff demonstrated good understanding of safeguarding processes and were able to give examples of when they had acted effectively to protect people in their care.Teams had robust lone working procedures, which helped to ensure staff safety when out in the community. However, not all staff were up to date with their mandatory training. This training included areas of learning essential for safe practice such as safeguarding vulnerable adults, basic life support, moving and handling, and fire training.
- The availability of different professional disciplines varied across teams. In some teams gaps in staffing potentially impacted on the effective running of those services. We identified widespread delays from assessment to treatment and long waiting times for people requiring essential psychological therapies as part of their treatment.
- We identified a number of concerns in relation to the Trust meeting its legal obligations under the Mental Capacity Act 2005 (MCA). Mental capacity assessments and best interest decisions were not always recorded. Consent to sharing information was not always clearly documented. The majority of front line staff had not had training in MCA.
- People using services and their carers were treated with kindness, dignity and respect. Without exception, the staff we met were conscientious, professional and committed to doing the best they could for the people in their care. Staff also supported each other well and treated colleagues with kindness, dignity and respect. Staff in different roles told us they felt valued and appreciated by their colleagues, and all staff spoke positively of their immediate peers and line managers. Carers told us they were kept up to date and involved in assessments and decision making processes concerning their family members who used services.
- We observed people were actively involved in planning their own care, during home visits we undertook with staff. People were supported to access independent advocacy services if and as needed. Teams took a proactive approach to engage with people who found it difficult or were reluctant to engage with mental health services. People were able to provide feedback on the service they received. There was a comprehensive range of information provided for people who used services, and staff were able to obtain information in different formats and languages to support people's different communcation needs.
- Some of the staff we spoke to during our inspection could not tell us about the organisation's values. Lack of shared focus and direction meant some of the community teams seemed to operate in isolation from other community teams and the wider organisation. High caseloads, disconnect from the senior management team and the wider Trust, and the effect of serious incidents and the subsequent investigation processes, had all contributed to low morale in some of the teams we visited.

Summary of findings

- We identified examples of innovation in many teams and a commitment from all staff to deliver quality services, but saw insufficient evidence of best practice sharing across different community teams, which would have allowed for greater improvements in quality across those teams and the wider Trust. This was particularly evident in the response to and learning from serious incidents.
- We saw positive evidence of the integration of adult social care and health care in some teams, which were able to deliver a more effective, holistic service due to their shared knowledge and expertise. All non-management staff told us they got effective support and supervision from their team managers. Staff were well supported by their peers and spoke positively about ther immediate teams. We saw excellent examples of innovative projects and practice at many different teams, which demonstrated staff's willingness to improve the quality of service they delivered.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We identified issues in relation to the safety of the environment at a number of different locations. Although some of these issues had also been identified by the Trust's staff, they had not been effectively addressed at the time of inspection.
- Allocation and management of caseloads varied between teams, and this meant that some staff held high caseloads. Some teams did not have the right numbers of staff or skill mix to safely meet all the requirements of the service.
- Not all staff were up to date with their mandatory training. This training included areas of learning essential for safe practice such as safeguarding vulnerable adults, basic life support, moving and handling, and fire training.
- We identified safety concerns in relation to the standard of care planning and risk assessment and management at some teams. However, risk and safeguarding were discussed in detail as separate agenda items at each of the multi-disciplinary team (MDT) meetings we attended, and minutes to other meetings confirmed that similar discussions took place across community teams. We saw good examples of learning from incidents and actions to improve safety at local team level. However, we were concerned that there was limited evidence of wider learning for the community teams to improve safety following serious incidents. Staff demonstrated good understanding of safeguarding processes and were able to give examples of when they had acted effectively to protect people in their care. Teams had robust lone working procedures, which helped to ensure staff safety when out in the community.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Many of the care records we viewed were not person-centred.
- There was limited capacity to deliver and to access essential psychological therapies at some teams.
- The availability of different professional disciplines varied across teams and in some teams staffing shortfalls impacted on the effective running of those services.

Summary of findings

- We identified a number of concerns in relation to the Trust meeting its legal obligations under the Mental Capacity Act 2005 (MCA). Mental capacity assessments and best interest decisions were not always recorded. Consent to sharing information was not always clearly documented. The majority of front line staff had had not received training in this area and knowledge of this legislation was, in some instances, very poor.
- However, staff received specialist training specific for their roles and were able to access additional training if they needed it. Most staff received regular supervision, including peer supervision, safeguarding supervision and supervision by their manager. We saw many good examples of multi-disciplinary and inter-agency work.

Are services caring?

Good

We rated caring as good because:

- People using services and their carers were treated with kindness, dignity and respect. Without exception, the staff we met were conscientious, professional and committed to doing the best they could for the people in their care.
- Care plans and patient records did not reflect that people were always fully involved in the planning of their own care. However, we observed that people were actively involved in planning their own care, during the home visits we undertook with staff. People were supported to access independent advocacy services if and as needed.
- Carers told us they were kept up to date and involved in assessments and decision making processes.
- People were able to provide feedback on the service they received mainly through the quarterly annual national 'Friends and Family' feedback forms. Some teams had also devised their own questionnaires and service user satisfaction forms, which we saw were used to gather feedback to improve the service.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- We identified widespread delays from assessment to treatment and long waiting times for people requiring essential psychological therapies as part of their treatment.

Summary of findings

- Issues with soundproofing of interview rooms at most of the locations we visited meant service user confidentiality could not be effectively maintained when other people were in the communal areas and thoroughfares near to interview rooms.
- Several teams who met with people at their office were located in old buildings which did not have adequate access for disabled people.
- However, teams took a proactive approach to engage with people who found it difficult or were reluctant to engage with mental health services. There was a comprehensive range of information provided for people who used services. This included information on different conditions and treatments, service users' rights, local support projects including advocacy, and how to make a complaint. Staff were able to obtain information in different formats and languages if needed.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Some of the staff we spoke to during our inspection could not tell us about the wider organisation's core values. There was a lack of shared focus and direction, and some of the teams we visited seemed to operate in isolation from other community teams and the wider organisation.
- Variance in performance and quality across teams, and gaps in critical aspects of service provision, demonstrated to us that the governance of community-based mental health services for adults of working age was not sufficiently robust or effective.
- There was low staff morale in some of the teams we visited. High caseloads, disconnect from the senior management team and the wider Trust, and the effect of serious incidents and the subsequent investigation processes, were examples of concerns raised by staff who expressed issues with morale.
- There was insufficient evidence of best practice being shared across different community teams, which limited improvements in quality across those teams and the wider Trust. This was particularly evident in the response to and learning from serious incidents.
- However, we saw positive evidence of the integration of adult social care and health care in some of the teams we visited, which were able to deliver a more effective, holistic service due to their shared knowledge and expertise. Staff supported each other well and treated colleagues with kindness, dignity and

respect. Staff in different roles told us they felt valued and appreciated by their colleagues, and all staff spoke positively of their immediate peers and line managers. None of the staff we spoke with raised issues of bullying or harassment. We saw excellent examples of innovative projects and practice at different teams we visited, which demonstrated staff's willingness to improve the quality of service they delivered.

Summary of findings

Information about the service

The community-based mental health services for adults of working age are part of Dorset Healthcare University NHS Foundation Trust. The services work alongside other statutory health and social care providers, voluntary and private organisations, to provide support in the community to adults of working age who have mental health needs. There are nine main multi-disciplinary community mental health teams providing this service. In addition to the CMHTs there are two specialist teams in the east and west of the county that provide early intervention to people who develop psychosis, and two assertive outreach teams also in the east and west of the county that provide intensive support to people who are hard to reach or who find it difficult to engage with mainstream services.

Our inspection team

The team that inspected this core service was comprised of: two inspector team leaders, one psychologist, one psychiatrist, two nurse managers, an occupational therapist, three senior nurses and one expert by experience. An expert by experience is someone who has had either direct experience of receiving mental health services and / or caring for someone who does.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- Visited 12 of the community-based mental health services for adults of working age teams, based at nine separate locations
- Looked at the quality of the environment at each location, in particular at the seven locations where people who used the services were seen on the premises
- Spoke with 35 people who used these services and seven carers
- Spoke with the managers or acting managers for each of the teams
- Spoke with 63 other staff members made up of consultant psychiatrists, psychologists, social workers, support time recovery (STR) workers, team leaders, occupational therapists, locality managers, community mental health nurses and administrators
- Attended and observed seven multi-disciplinary meetings and a quality meeting
- Attended ten home visits, carried out seven clinical observations and attended a community based peer support group
- Looked at care records of 47 people who used community mental health services
- Looked at a range of policies, procedures and other documents relating to the running of the services.

Summary of findings

What people who use the provider's services say

People told us the support they had received through the community-based mental health services had helped their recovery. They told us they were treated with kindness, dignity and respect. They said they cannot fault the care and support they had received from staff and were grateful for the community mental health services. They told us staff listened to them and helped with their problems. They told us they thought all the staff were excellent and friendly, and that they couldn't fault them for anything. One told us the support they'd had from the team who supported them had been invaluable, and another said the support they had received had stopped them from going back to hospital.

Good practice

- An interactive white board in Bournemouth CMHT was used to capture people's thoughts and ideas about recovery. People were then able to take a photograph of the completed board to take home with them to remember their own coping strategies.
- At Dorchester and Poole, nurses ran a physical health clinic which allowed for greater support of people's physical health.
- Poole and Purbeck CMHTs had dedicated Carers Officers. These officers were able to provide one to one and on-going support to carers.
- We found some positive examples of how teams took a proactive approach to engage with people who found it difficult or were reluctant to engage with mental health services. At the east early intervention service we saw the positive impact of the 'Reach' peer support football project which brought staff and service users together in a relaxed, non-clinical setting.
- Poole CMHT had nominated a member of the team to act as crisis service link worker, following lessons learned from a serious incident. The team had identified that a high risk time for clients was during transfer between services, in particular from crisis service to CMHT. Staff in the team felt that transfer of care could be managed better, with discharge and follow up care plans developed between services. The aim of the link worker was to ensure the CMHT and Crisis Service linked effectively and kept up to date with each other's team developments, and that working relationships and communication between the two teams were further developed and improved.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure confidentiality at all times, particularly in regard to addressing the issues with sound-proofing of clinical and interview rooms, in order to protect the dignity and privacy of people using services.
- The provider must take appropriate steps to demonstrate that care and treatment are provided with the consent of each service user or other relevant person, and be able to demonstrate that they act in accordance with the Mental Capacity Act 2005 in all instances where a service user lacks mental capacity to consent to their care and treatment.
- The provider must ensure the risks to all service users are effectively assessed and that staff have done all that is reasonably practicable to mitigate such risks. Risk assessments relating to the health, safety and welfare of all people using services in the community must be completed and regularly reviewed.
- Following the investigation and review of serious incidents, the provider must ensure steps are taken to remedy the situation, prevent further occurrences and to make sure that necessary improvements are made.
- The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in each team in order to meet the needs of the people using the service at all times.

Summary of findings

Action the provider SHOULD take to improve

- The provider should review alarm systems and emergency processes to ensure all staff receive swift and effective response and support in the event of an emergency.
- Service locations that did not have adequate disabled access services should make appropriate adjustments to their environment in line with the Equality Act 2010.
- The provider should ensure mandatory training records are updated and any shortfalls in mandatory training addressed.
- The provider should ensure all front line staff have updated Mental Capacity Act training in order to help ensure teams work in line with statutory requirements.
- The provider should ensure supervision records are updated and complete in order to evidence more clearly the support, development and performance management of staff in every team.

Dorset Healthcare University NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bridport Community Mental Health Team	Bridport Community Hospital
Dorchester Community Mental Health Team	30 Maiden Castle Road
Early Intervention Service West	30 Maiden Castle Road
Early Intervention Service East	49 Alumhurst Road
Weymouth and Portland Community Mental Health Team	Westhaven Hospital
Weymouth and Portland Assertive Outreach Team	Westhaven Hospital
Purbeck Community Mental Health Team	Sentinel House
Christchurch & Southbourne Community Mental Health Team	Fairmile House
Sherborne Community Mental Health Team	Yeatman Hospital
Poole Community Mental Health Team	Alderney Hospital
Bournemouth West Community Mental Health Team	Sentinel House
Bournemouth & Poole Assertive Outreach Team	Sentinel House

Detailed findings

Mental Health Act responsibilities

We reviewed adherence to the MHA during our inspection and found the following:

- We saw evidence in records viewed that the services we inspected as part of this inspection adhered to the MHA and were in line with the Code of Practice. Some teams had staff who were approved mental health practitioners (AMHPs), whose role included overseeing the team's adherence to the MHA. Interviews with social workers across all services showed that most were qualified AMHPs and they were able to describe to us the underlying principles of the Code of Practice. One we spoke with told us they had regular AMHP hub meetings to discuss the new MHA Code of Practice.
- We were also told by staff in other teams that did not have an AMHP, that the Trust's central MHA team were very effective in supporting them. One team manager told us the central MHA team was very supportive if they ever had any MHA queries or questions. A member of staff from another team told us the central MHA team ensured process and protocols were being followed, for example in relation to section lapses for people on community treatment orders (CTOs).
- However, one team had created a date log so they were aware of when anybody's section was due to lapse. This helped to ensure they operated within the MHA at all times. Staff at Christchurch and Southborne CMHTs all had recent training on the use of CTOs and we saw in all the team meetings we attended that patients under a CTO were reviewed in each weekly meeting.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Some staff had received training in the the Mental Capacity Act 2005 (MCA), but other Staff from different teams told us they hadn't received any training. Staff from one CMHT, for example, told us they hadn't received much training in the MCA, although they did see and support people who lacked mental capacity to make decisions relating to their own care and treatment. We found that staff's knowledge of the MCA was, in some instances, very poor. We subsequently requested confirmation from the Trust as to how many CMHT staff had received MCA training. According to the Trust's own figures, of the 106 staff identified as working for CMHTs, only 10 had completed MCA training as of 29 July 2015, meaning that 96 staff still required MCA training. In ten of the teams, all of the staff were identified as requiring MCA training.
- We found that there was inconsistent practice in applying the MCA. We found some examples of good practice in applying the MCA. For example, we met with a qualified best interest assessor who was the assistant team manager in one team. They told us that they gave MCA advice to their team when required, and we saw they had attended formal 'best interest' meetings with people who used the service.
- Staff at several different teams told us they supported people who, through illness, disorder or substance misuse, lacked mental capacity to consent to or make decisions about their own treatment or medication. They told us some of those people had not had formal mental capacity assessments carried out and so best interests decision making processes had not been followed. This meant there was a significant risk that people were receiving care and treatment unlawfully, as they did not have mental capacity to consent and staff could not prove that the care and treatment they received was truly in their 'best interest'. In one team's care records for people who used the service we found multiple references to people lacking or potentially lacking mental capacity to consent to care and treatment, but found no evidence of formal mental capacity assessments or associated best interests decision making records. For example, one person's care record stated their 'capacity to consent to treatment is impaired by a lack of insight.' It was also recorded that '[they] lack capacity to make decisions about [their] treatment, because [they] appear unable to retain information given to [them].' Through their lack of insight and inability to retain information, the person would have met the criteria of a formal assessment that they did not have mental capacity to make decisions

about their treatment. However, the care record contained no formal assessment of mental capacity and no record of a best interests decision making process being followed in relation to either the person's care and treatment or their medication.

- We saw that evidence of consent to treatment was not recorded in some of the care plans we inspected. This varied across teams. For example, we reviewed 18 people's care records across 6 of the teams we visited and found consent to treatment was recorded in 11 of them. We looked in detail at 4 people's care records in another team, and none of them contained sufficient evidence of people's involvement in their own care planning or that they had consented to the treatment contained in their care plans. We we were unable to identify clearly from records whether this was because people hadn't given their consent to treatment or staff had not completed records fully.
- We identified concerns in relation to people's consent to the sharing of information in support of their care and treatment. Several different versions of a confidentiality and sharing information consent form were in use, and it was not clear on some of them what people were consenting to. The form stated that the person had read a service user information booklet, and 'acknowledge the section entitled confidentiality and sharing information and / or I have had the following information explained to me' (the form then listed what might happen in respect of patients' confidential information). People were required to sign the form, but it was not clear just what they were signing or giving their consent to, other than they had understood or had some information read to them.
- We checked records for six different people who used services provided by one team. The confidentiality and sharing information forms were not present for two of the six checked. One person's form had clearly recorded that they had refused to sign the form in July 2013, as they wanted more time to consider the implications. We checked with the team manager and confirmed this had not been formally revisited or checked since, meaning the person had never given their consent to the collection and sharing of their confidential information.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement because:

- We identified issues in relation to the safety of the environment at a number of different locations. Although some of these issues had also been identified by the Trust's staff, they had not been effectively addressed at the time of inspection.
- Allocation and management of caseloads varied between teams, and this meant that some staff held high caseloads. Some teams did not have the right numbers of staff or skill mix to safely meet all the requirements of the service.
- Not all staff were up to date with their mandatory training. This training included areas of learning essential for safe practice such as safeguarding vulnerable adults, basic life support, moving and handling, and fire training.
- We identified safety concerns in relation to the standard of care planning and risk assessment and management at some teams. However, risk and safeguarding were discussed in detail as separate agenda items at each of the multi-disciplinary team (MDT) meetings we attended, and minutes to other meetings confirmed that similar discussions took place across community teams. We saw good examples of learning from incidents and actions to improve safety at local team level. However, we were concerned that there was limited evidence of wider learning for the community teams to improve safety following serious incidents. Staff demonstrated good understanding of safeguarding processes and were able to give examples of when they had acted effectively to protect people in their care. Teams had robust lone working procedures, which helped to ensure staff safety when out in the community.

Our findings

Safe and clean environment

- All areas accessible by staff and patients were clean at the locations we visited. Although equipment was regularly maintained and appeared visibly clean, we found key items of emergency and clinical equipment did not have labels to formally identify when they had last been cleaned at several of the sites visited.
- We checked clinic rooms at each of the sites we visited where there was one present. At most locations we found the clinic rooms to be fit for purpose. They were also fully equipped with resuscitation equipment, appropriate emergency drugs and with the necessary equipment for carrying out physical examinations of patients. We identified a number of issues with the clinic room at Bridport. These included: lack of space for an examination table, no privacy curtain and no bins for clinical waste or rubbish. The building in which the Bridport CMHT was based had recently reopened after refurbishment and we were shown a 'snagging' list compiled by staff which identified some of the same issues we had found, however we were not shown a clear action plan for when those issues would be addressed.
- The design and layout of the reception areas at two of the sites we visited meant reception staff were not kept as safe as they should be. Staff told us that following separate incidents where staff's safety had been compromised, senior managers had been notified of the need to make improvements to the reception areas at these two sites. This work had not yet taken place when we visited, and there was no clear plan to manage these risks in the meantime. Most staff had personal alarms, but some of these were quite old. We saw that alarm systems and use of panic buttons varied between services. For example, we saw modern and discreet systems were in place at Poole CMHT. However, there was a lack of appropriate alarms for staff when they used treatment rooms other locations and within GP surgeries, as the Purbeck CMHT sometimes did. We looked at one incident report linked to this risk which

detailed aggression towards a staff member in an unsafe environment. Staff told us that this issue has been raised repeatedly, and the manager confirmed they had escalated the issue during the inspection.

Safe staffing

- Staffing levels varied across the different teams inspected. Staff at many of the teams we visited told us that their teams were adequately staffed to be able to safely meet the needs of people who used the service. However, at one CMHT we found some staff had considerably higher caseloads of patients per care coordinator. Staff from this team told us this was contributing to staff stress and associated sickness levels. Staff also told us they were regularly working additional hours beyond what they were contracted to work, but were unable to take back time owing as they had to continue to support the team's workload . Several team managers reported they still had their own substantial case loads, which affected their ability to carry out effectively their roles as team managers.
- Staff also acknowledged that caseload pressures were contributing to care records not being completed and updated. One member of staff at Bridport CMHT told it was difficult to keep up with records and paperwork due to the volume of cases they supported. Another member of staff of the same team told us they had acrued a large amount of time owing which they had not been able to take back, and also that RIO (the Trust's electronic records system) was not up to date due to their caseload. At Dorchester CMHT, a member of staff told us that their caseload was too heavy, which had resulted in the management of risk being "a bit of a scramble." Another member of the team told us staff were building up time owing and even coming in during their own annual leave to complete and update people's records, as they did not have time during their working day to complete all of the records they were required to complete.
- There were not consistent cover arrangements for staff sickness and vacancies. At Weymouth and Portland CMHT, for example, staff told us the Trust's bank staff were not suitable for cover as they did not come from a community mental health background. In addition, they had not been able to recruit to vacancies and were not able to use agency staff. We found that Purbeck and Bournemouth CMHTs were also experiencing staff absence issues. At another team, the manager told us that they were struggling with the number of referrals coming in and although we could see that the team did not have any staff vacancies, the number of staff who were long term sick or on leave at that time made it very difficult for the team to meet the demands of its caseload.
- Managers at Poole and Christchurch & Southborne and Bournemouth CMHT and Poole assertive outreach team reported no staff vacancies at the time of the inspection. Staff working at Bournemouth CMHT told us that they had been understaffed for 1 – 2 years; with two full time nurse posts down, one band 5 post cut during savings and 1.5 OT posts down. Staffing figures supplied to us by the Trust confirmed there was significant variance in staff sickness and vacancy rates across different CMHTs. Poole Central and West, Dorchester and Weymouth CMHTs, for example, had higher staff vacancy rates. Sickness rates over the previous year had also varied significantly between teams, from just over 1% sickness rate at the early intervention east team to almost 12% sickness rate at Bournemouth East CMHT.
- The Trust told us they followed NHS guidance that full time care co-ordinators should have a maximum caseload of 35 people and part time staff should have their caseload reduced pro rata. We subsequently requested team caseload figures from the Trust. The information available to the Trust and supplied to us did not show clearly the different caseloads according to job roles and weekly hours worked. This made it difficult to see clearly just how total caseloads varied across teams and between staff carrying out the same role in different teams. However, from the information provided we could see that some full time care co-ordinators had 35 – 60+ patients on their caseloads (considerably higher than the maximum caseload figures recommended by the NHS and other leading health bodies), while co-ordinators in other teams had between 25-30 patients. The figures provided also showed some teams had higher than average caseloads, with a greater proportion of those teams having high individual caseloads. In Weymouth and Portland CMHT, for example, half of the staff team (11 of 22 identified) had monthly caseloads which were between 35 – 80 on a

Requires improvement

Are services safe?

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

regular basis over the twelve months from June 2014 to May 2015. The figures were very similar for Central Dorset CMHT, which incorporated Bridport and Dorchester teams.

- There had been 6 serious incidents requiring investigation (SIRI) involving service users of one of the CMHTs in the previous 12 months. We requested the results of the Trust's own internal investigations following these incidents, and found that one of the reports from April 2015 into a serious incident had highlighted the staffing level at the particular CMHT as being an issue. The report included the recommendation that the Trust should review staffing at the CMHT 'as a priority'. The staffing level had not been increased since the investigations had concluded. During the inspection, staff at another CMHT told us about a serious incident to which the subsequent investigation had also recommended that they filled the team's staff vacancies to reduce the risk of this happening again. We were told that this still hadn't happened and as a result, there was only one person assessing new referrals, which at the time of inspection averaged 8 referrals a day.
- Not all staff were up to date with their mandatory training. This training included areas of learning essential for safe practice such as safeguarding vulnerable adults, basic life support, moving and handling, and fire training. The Trust's own training records showed that mandatory training completion rates varied considerably across different CMHTs. Weymouth and Portland, Purbeck, Bournemouth, Christchurch and Bridport CMHTs' rates were particularly low, which indicated many of those staff's mandatory training was either out of date or incomplete. For example,according to the Trust's records at Bournemouth East only a third of staff were up to date in Safeguarding Adults Level 1 training, and a third were up to date with Safeguarding Children training. At Christchurch & Southborne CMHT 63% of staff were up to date with Moving and Handling, and 68% of staff were up to date with Fire training. At Dorchester only a third of staff were up to date with their annual basic life support training. We were told by one manager that workload pressures impact on staff staying up to date with training.
- A senior representative of the Trust informed us that the staffing levels in community mental health services were currently under review, to ensure staffing levels were proportionate with each team's caseload. We were told that this work was due to be finalised imminently.
- Different team structures meant in some areas it was not always easy to access a psychiatrist quickly when required. Waiting times for access to a psychiatrist varied between services. At Poole CMHT they had a psychiatrist on duty every day. At Christchurch and Sherborne we were told that there were sometimes problems accessing a psychiatrist on the same day, which had a negative impact on people needing immediate psychiatric support. For example, staff told us that low numbers of clinical or psychiatric staff at the Weymouth and Portland and Bridport CMHTs made it stressful for the psychiatric staff in post. In other teams, such as the Bournemouth and Poole assertive outreach team (AOT), the lack of a psychiatrist within the team did potentially cause delays with access to psychiatric input.

Assessing and managing risk to patients and staff

- We looked at 47 people's care records across the different teams we inspected and found considerable variation in their quality and completeness and in how up-to-date they were.
- We looked at care records of five different people who accessed the Weymouth and Portland Assertive Outreach team. Risk assessments were present in each of the records inspected and were clear and up-to-date. They detailed the specific risks and outlined steps staff were to take to mitigate those risks and support people more safely. Similarly, we looked at the records of six people who accessed the Early Intervention Service East team and all of them contained detailed and up to date risk assessments.
- We looked at care records for five people who accessed Dorchester CMHT and found two had risk assessments that were incomplete and not up-to-date, and one person who had been with the service for five weeks did not yet have a risk assessment in their records.
- We found significant issues with care records for people who accessed Bridport CMHT. We looked at care records for four people and found each was incomplete and not up-to-date. For example, one person's initial assesment,

Requires improvement

Are services safe?

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

done in October 2014, identified they were at risk of suicide, self injury or harm and self neglect. There was no associated risk assessment and no care plan to address those clearly identified risks. Another person had been referred in November 2014, but their notes recorded they had not been contacted until March 2015 to arrange a formal assesment. The person had been identified as a potential suicide risk, but their records contained no risk assessment and there was no crisis plan to give staff guidance as to how they were to support the person in the event of a deterioration or crisis. Another person had an assessment which had been carried out in October 2014 which identified they had a drug misuse problem, had thoughts of harming themselves and others and also had suicidal thoughts. The patient's care plan had not been updated in response to the risks identified and contained no information about what staff were to do to support the person or to reduce those risks.

- We saw examples of good practice in relation to assessing and managing risk to patients and staff across the community teams we visited. For example, risk and safeguarding were discussed in detail as separate agenda items at each of the multi-disciplinary team meetings we attended, and minutes to other team's multi-disciplinary meetings confirmed that similar discussions took place across community teams. We observed during one multi-disciplinary team meeting that the team spent time highlighting all the individuals they saw as being at high risk and ensured that they had a care co-ordinator allocated to them. During the meeting we saw the team asked each other if they had missed anyone or anything out and shared experiences of how best to ensure people's safety. Particular attention was paid to people the team thought might be deteriorating or relapsing.
- Teams also had robust lone working procedures, which helped to ensure staff's safety when out in the community. However, staff from Bournemouth West CMHT raised a specific lone working risk that had come about due to a staff vacancy. They told us the vacancy had meant they would have to go out to a new referral by themselves, not knowing the levels of risk associated with the person and whether they required two people to carry out the assessment.
- The trust's records indicated not all staff were up-to-date with mandatory safeguarding training. However, staff spoken with demonstrated a good understanding of safeguarding processes and were able to give examples of when they had acted effectively to protect people in their care. Records contained evidence of appropriate contact with, and referrals made to, external agencies such as the police and local authority safeguarding teams.
- We identified issues in relation to the safe management of medicines at two of the locations visited. At Weymouth and Portland CMHT the clinic room's medication cabinet contained emergency drugs which had an expiry date of June 2014. The cabinet also contained appropriate and in-date emergency medication, but there was a risk that out of date and unsafe medication could be used by mistake in the event of an emergency. At Bridport CMHT we identified multiple concerns with the management of medicines. The clinic room and medication fridge temperatures had not been recorded and so were not being monitored. We also found a large quantity of unused medication for four different patients was being stored in the drugs cabinet. This included many loose and unidentifiable tablets and 'popped' blister packed medicines. There was no way of identifying exactly what medicines were present or who they belonged to, and some of the medicines had expiry dates in 2014. We brought these and other issues regarding the management of medicines to the attention of the appropriate manager during our visit, and they took action. A pharmacy inspector made a return visit to the location the following day and found the concerns raised had been addressed.

Track record on safety

- Information provided by the trust reflected that there had been 357 reported incidents over a 12 month period across the community-based mental health services for adults of working age. The majority of these incidents had resulted in no harm or minor, non-permanent harm to staff of patients. Of the 357 reported incidents, 51 of the incidents had been graded by the trust as having resulted in major harm, were catastrophic or ultimately had resulted in a death.

Requires improvement

Are services safe?

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

Reporting incidents and learning from when things go wrong

- We found good examples at a local level of how individual teams learned and made improvements when things went wrong. At Dorchester CMHT, for example, the manager was leading work to make improvements to the structure of the building following an incident where staff safety had been compromised. At the Bournemouth early intervention in psychosis team, we were told about an incident which had led to specific improvements in lone working practice which helped to ensure staff safety. Poole CMHT had based a team away day on a serious incident case study, so they could learn as a team how to reduce the likelihood of such an incident happening again. The manager at Poole CMHT explained how communication between community and crisis teams had been addressed during this day, and the intention was that being open and transparent would help to bridge any communication gap between these two teams, vital to ensuring more effectively the future well-being of people who used their services.
- Staff at each of the teams we visited told us that they were well supported by their immediate peers and line managers following any serious incidents. They told us that de-brief sessions took place at a local level after all serious incidents, where learning could be discussed and improvements made. Staff also told us they had been given emotional and psychological support if necessary from appropriately experienced colleagues in their respective teams.
- Of the 51 incidents which had been graded by the trust as having resulted in major harm, been catastrophic or which ultimately had resulted in a death, 31 had been considered as requiring formal internal investigation. This meant 20 significant incidents had not had any formal internal investigation. The NHS England serious incident framework guidance states that all incidents should be graded for severity and where indicated as serious, an investigation should be undertaken. A serious incident is defined as: “unexpected or avoidable death or severe harm to one or more patients, staff or members of the general public.”
- We identified significant concerns in relation to the community mental health teams we visited and the wider Trust not sharing effectively the essential learning from serious incidents. Of the teams we visited on this inspection, the Weymouth and Portland and Christchurch and Southborne CMHTs had reported signifcantly higher rates of serious incidents over a 12 month period. We subsequently requested to see reports from the trust’s internal investigations in to serious incidents at Weymouth CMHT for the last 18 months. In reports since March 2014, we saw a number of recommendations were made in relation to concerns about clinical documentation. For example, risk management, including assessing and recording changing risks to the person and having detailed care plans and crisis plans in place. We inspected community-based mental health services for adults of working age in June 2015, and found there were still significant issues in relation to the management of risk and planning of care at some of the CMHTs. We found that risks were still not clearly assessed and reviewed in some instances. We found some care plans were incomplete and missing key assessments, and many care plans were still not being regularly updated. This reflected the same issues which had been identified in the trust’s own investigation reports 18 months prior to our inspection, following serious incidents. Although the reports we asked for related to just one of the CMHTs, we identified the same issues at a number of different teams, which demonstrated learning was not being shared effectively across teams or across the wider trust.
- Several members of staff in different teams raised concerns regarding the effect of the trust’s internal investigation process following serious incidents. One referred to a blame culture, rather than a learning culture, in response to serious incidents, and felt the trust’s processes were more concerned with finding fault than making improvements. Another member of staff said that the investigation process had contributed to a shift of focus, so that staff were more focused on ensuring their notes were complete rather than focusing on the welfare of the person’s family or staff’s own well-being following incidents.

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.

Summary of findings

We rated effective as requires improvement because:

- Many of the care records we viewed were not person-centred.
- There was limited capacity to deliver and to access essential psychological therapies at some teams.
- The availability of different professional disciplines varied across teams and in some teams staffing shortfalls impacted on the effective running of those services.
- We identified a number of concerns in relation to the Trust meeting its legal obligations under the Mental Capacity Act 2005 (MCA). Mental capacity assessments and best interest decisions were not always recorded. Consent to sharing information was not always clearly documented. The majority of front line staff had had not received training in this area and knowledge of this legislation was, in some instances, very poor.
- However, staff received specialist training specific for their roles and were able to access additional training if they needed it. Most staff received regular supervision, including peer supervision, safeguarding supervision and supervision by their manager. We saw many good examples of multi-disciplinary and inter-agency work.

Our findings

Assessment of needs and planning of care

- Initial assessments of people's needs were completed in a timely manner in the majority of instances across the teams we visited. We found the initial assessments were more comprehensive in some teams, particularly when caseloads were 'capped' at a manageable level.
- We looked at 47 people's care records across the different teams we inspected. The majority of the care records we viewed were not person-centred, and very few of the records we viewed contained evidence of people's involvement in planning their own care. This was an issue across most of the teams we visited. We found considerable variance in the quality and completeness and in how up-to-date care records were in different teams. Care records viewed for people who accessed the Bridport and Weymouth & Portland CMHTs contained multiple gaps in key information and were not updated. At Bridport, one person's care records said only that staff met up with them every two weeks to support with their medication. The care records contained nothing about the person or to demonstrate their involvement, there was no care plan and no risk assessment. Progress notes for people accessing support through Weymouth CMHT were detailed and provided evidence of regular, ongoing contact in support of patients. However, one person's risk assessment identified significant risks but there was no further detail in their plan as to how staff were to help manage those risks. Another person's progress notes were again found to be very detailed, but their care records contained no risk assessment and no care plan. We reviewed the care records of six people who accessed the early intervention east team, and found them to be complete and regularly updated. Care records for people who accessed the the Weymouth and Portland assertive outreach team detailed people's involvement in planning their own care and support.
- We saw that all care plans and confidential records were stored securely, electronically, and only staff with security clearance were able to access the system. Some staff reported that the electronic notes system was over complicated and time consuming.

Best practice in treatment and care

- We saw some positive examples of good practice in treatment and care. In regard to the prescribing and management of people's medication, we observed a medication clinic at Dorchester where the clinical staff involved were professional and created a very positive atmosphere. Patients confirmed they valued this service and it helped them manage their medications. We saw evidence in care records that staff across the different teams we visited considered and monitored people's physical health on an ongoing basis as part of the care and support they delivered. Care records contained details of annual health checks being offered to patients and of physical monitoring taking place. At Dorchester and Poole, nurses ran a physical health clinic which allowed for greater support of people's physical health.

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There were machines for the analysis of blood on-site at a number of locations, including Alderney Hospital and Hahnemann House, which allowed staff to ascertain quickly whether there was any abnormality in a person's blood cell count. This helped to ensure that clozapine (an anti-psychotic medication) was safe to be given. This also reduced waiting times for access to a clozapine clinic.

- We saw evidence that teams' interventions included valuable support to people in other aspects of their life. For example, community team and local authority colleagues were available to give people support with employment, benefits and housing.
- We spoke to a clinical psychologist who told us that all staff in their team followed National Institute for Health and Care Excellence (NICE) guidelines and British Psychological Society guidance. We were shown records of an alcohol and substance misuse audit carried out by the team's consultant psychiatrist against NICE guidelines, and were told that lithium audits were also completed within the service.
- There were constraints on the variety and quantity of psychological therapies teams were able to deliver. Psychological therapies were made available to people, but in some teams the amount of such therapies they were able to provide was limited due to either caseload pressures or lack of appropriately trained staff in the team. At Weymouth and Portland CMHT and Bournemouth early intervention service, staff told us they were not able to provide valuable psychological interventions such as cognitive behavioural therapy (CBT) despite being trained to deliver such therapy, due to the teams' caseloads. However, staff were also not able to deliver family therapy in line with NICE guidelines due to not having sufficient skills or training. At a number of teams, including the Weymouth and Portland and Purbeck CMHTs, staff told us there was a long waiting list for psychological therapies. At the purbeck team, we were shown waiting times for some patients were between 6-12 months for CBT for example.

Skilled staff to deliver care

- A wide range of disciplines and workers provided input to each of the different teams we visited. Each team consisted of different staff, in both clinical and non-clinical roles, including occupational therapists, psychiatrists, psychologists and social workers, nursing staff and support workers. However, the availability of these different disciplines varied across teams and in some teams staffing shortfalls were identified which potentially impacted on the effective running of those services. For example, staff at Bridport CMHT told us that a lack of clinical staff was placing greater strain on the existing clinical staff. In other teams, a lack of dedicated psychologist or psychiatrist made it difficult for the service to provide consistently a full range of support and therapies in response to people's needs.
- Although we found that not all staff were up to date with their mandatory training, staff spoken with all told us they had received specialist training specific for their roles and were able to access additional training if they needed it. Most staff received regular supervision, and some staff received as much as three different forms of formal supervision every four to six weeks. This included peer supervision, safeguarding supervision and supervision by their manager. All staff spoken with told us they received adequate supervision and felt well supported.
- We found a lack of documented managerial supervisions in some teams, including Purbeck CMHT, Bournemouth CMHT and Bournemouth and Poole assertive outreach team. The records that were available were brief, handwritten and contained no dates to refer to. Two of the managers were not able to access the electronic system to show us supervision records, so this information was not made available to us at the time of inspection. We subsequently checked records supplied centrally by the trust and saw that some members of Bournemouth and Poole assertive outreach team had not had clinical supervision recently, with one person's last clinical supervision dating back to 2013, and another person's in 2014.
- We were told by psychology staff from the Purbeck CMHT that continuous professional development (CPD) was completed through the Trust and external training had been applied for. They were also able to attend monthly locality psychologists meeting. They confirmed that there was regular clinical supervision and all appraisals had been carried out by the manager. When we accessed their personnel records, we saw that all

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appraisals had been completed in the last year. Information provided centrally through the Trust showed that regular appraisals took place for staff in other teams.

Multi-disciplinary and inter-agency team work

- We saw good examples of multi-disciplinary and inter-agency work. Care records contained examples of staff working well with other teams in support of people who used services. For example, there was evidence of staff working with agencies such as the local authority and police when supporting people who needed safeguarding support. We saw evidence of effective liaison between the early intervention east and perinatal team staff, carrying out joint visits to people.
- We saw that staffing structures demonstrated that every service engaged in multi-disciplinary team (MDT) working. Every service we went to had regular MDT meetings, and we were able to attend and observe seven of these meetings at different teams. Each of these meetings was well attended by a range of different staff disciplines, effectively chaired and covered a spread of d ifferent agenda items essential for service operation. Discussions were open and transparent amongst team members, whilst remaining respectful to people under each service's care Topics discussed at each of the MDT meetings we attended included caseloads according to risk, safeguarding and learning from incidents and events. Staff spoken with confirmed they had regular team meetings and that they found those meetings to be a useful forum for team communication and update.
- At Purbeck, the CMHT shared their office space with voluntary sector mental health organisations and the local authority's adult safeguarding team. We observed these teams working in the open plan office and spoke to staff who told us how integrated working was beneficial to their holistic approach to care. Examples of the positive benefits to such close inter-agency working included more effective networking and referrals to other services, and being able to more quickly and effectively respond to safeguarding concerns.
- We cross referenced information regarding one person using a service that had been raised in a CMHT meeting in June 2015 with their electronic RIO records. We saw an outstanding action following the team meeting was then referenced on RIO. We saw that a multi-agency risk meeting had taken place, which was then also written up on RIO. The clinical psychologist we spoke to about this confirmed that information regarding patients was shared with care co-ordinators via RIO, while transfers of care were done face to face.

Adherence to the MHA and the MHA Code of Practice

- We saw evidence in records viewed that the services we inspected as part of this inspection adhered to the Mental Health Act (MHA) and the associated Code of Practice. Some teams had staff who were approved mental health practitioners (AMHPs), whose role included overseeing the team's adherence to the MHA. Interviews with social workers across all services showed that most were qualified AMHPs and they were able to describe to us the underlying principles of the Code of Practice. One we spoke with told us they had regular AMHP hub meetings to discuss the new Mental Health Code of Practice.
- We were also told by staff in other teams that did not have an AMHP, that the Trust's central Metal Health Act (MHA) team were very effective in supporting them. The central MHA team ensured process and protocols were being followed, for example in relation to section lapses for people on community treatment orders (CTOs).
- However, one team had also created a date log so they were aware of when anybody's section was due to lapse. This helped to ensure they operated within the MHA at all times. Staff at Christchurch and Southborne CMHTs had all had recent training on the use of Community Treatment Orders and we saw in all the team meetings we attended that patients under a CTO were reviewed in each weekly meeting.

Good practice in applying the MCA

- Some staff had received training in the the Mental Capacity Act 2005 (MCA), but other Staff from different teams told us they hadn't received any training. Staff from one CMHT, for example, told us they hadn't received much training in the MCA, although they did see and support people who lacked mental capacity to make decisions relating to their own care and treatment. We found that staff's knowledge of the MCA was, in some instances, very poor. We subsequently requested confirmation from the Trust as to how many

Are services effective?

Requires improvement

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CMHT staff had received MCA training. According to the trust's own figures, of the 106 staff identified as working for CMHTs, only 10 (9.6%) had completed MCA training as of 29 July 2015, meaning that 96 (90.6%) of staff still required MCA training. In ten of the teams, all of the staff were identified as requiring MCA training.

- We did find some examples of good practice in applying the MCA, but they were limited in number. For example, we met with one qualified Best Interest Assessor who was the assistant team manager in one team. They told us that they gave MCA advice to their team when required, and we saw they had attended formal 'best interest' meetings with people using the service.
- Staff at several different teams told us they supported people who, through illness, disorder or substance misuse, lacked mental capacity to consent to or make decisions about their own treatment or medication. However, formal mental capacity assessments were not consistently carried out and best interests decision making processes had not always been followed . For example, in one of the six care records we reviewed for people who used the East early intervention service, we found multiple references to the person lacking or potentially lacking mental capacity to consent to care and treatment, but found no evidence of formal mental capacity assessments or associated best interests decision making records. For example, one person's care record stated their 'capacity to consent to treatment is impaired by a lack of insight.' It was also recorded that '[they] lack capacity to make decisions about [their] treatment, because [they] appear unable to retain information given to [them].' Through their lack of insight and inability to retain information, the person would have met the criteria of a formal assessment that they did not have mental capacity to make decisions about their treatment. However, the care record contained no formal assessment of mental capacity and no record of a best interests decision making process being followed in relation to the person's care and treatment or medication.
- We saw that evidence of consent to treatment was not recorded in some of the care plans we inspected, and this varied across teams. For example, we reviewed 18 people's care records across 6 of the teams we visited and found consent to treatment was recorded in 11 of them. We looked in detail at 4 people's care records in another team, and none of them contained sufficient evidence of people's involvement in their own care planning or that they had consented to the treatment contained in their care plans. We we were unable to identify clearly from records whether this was because people hadn't given their consent to treatment or staff had not completed records fully.
- We identified concerns in relation to people's consent to the sharing of information in support of their care and treatment. Several different versions of a confidentiality and sharing information consent form were in use, and it was not clear on some of them what people were consenting to. The form stated that the person had read a service user information booklet, and 'acknowledge the section entitled confidentiality and sharing information and / or I have had the following information explained to me' (the form then listed what might happen in respect of patients' confidential information). People were required to sign the form, but it was not clear just what they were signing or giving their consent to, other than they had understood or had some information read to them. We checked records for six different people who used services provided by one team. The confidentiality and sharing information forms were not present for two of the six checked. One person's form was present, but it was recorded that they had refused to sign the form in July 2013, as they wanted more time to consider the implications. We spoke with the manager and confirmed this had not been checked since, meaning the person had never formally given their consent to the collection and sharing of their confidential information.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- People using services and their carers were treated with kindness, dignity and respect. Without exception, the staff we met were conscientious, professional and committed to doing the best they could for the people in their care.
- Care plans and patient records did not reflect that people were always fully involved in the planning of their own care. However, we observed that people were actively involved in planning their own care, during the home visits we undertook with staff. People were supported to access independent advocacy services if and as needed.
- Carers told us they were kept up to date and involved in assessments and decision making processes.
- People were able to provide feedback on the service they received mainly through the quarterly annual national 'Friends and Family' feedback forms. Some teams had also devised their own questionnaires and service user satisfaction forms, which we saw were used to gather feedback to improve the service.

Our findings

Kindness, dignity, respect and support

- People using services and their carers told us they were treated with kindness, dignity and respect. On visits to people in the community we observed staff treated people with compassion and were sincere and caring in the way they interacted and gave support. One person told us their care coordinator was easy to bond with and always very positive. A person who accessed support through Bridport CMHT told us staff listened to them and helped with their problems. Another person who accessed support through another team told us they thought all the staff were excellent and friendly, and that they couldn't fault them for anything. We were told by people who use services in Poole that they were impressed by the communication from staff and the quality of the interactions with workers. One person who accessed Weymouth CMHT told us the support they'd had from the team had been invaluable, and had saved their life. Another person told us the support they had received had stopped them from going back to hospital.
- Without exception, the staff we met were conscientious, professional and committed to doing the best they could for the people in their care. We attended seven multi-disciplinary team meetings at different teams. During these meetings we observed that patients were discussed in a respectful manner and that each patient was given due attention from a range of people supporting them.
- We saw positive examples of how staff took steps to maintain confidentiality. Purbeck CMHT was office based and located within a local council building that accommodated the offices for shared services, such as the Purbeck adult safeguarding team, and local voluntary sector bodies such as the Richmond Fellowship and Rethink who worked from hot desks in the same open plan office. Staff assured us that even though the office was open plan, confidentiality of information was not an issue as screens were locked when away from desks and a clear desk policy for records meant confidential documents were not left on display. We saw that they adhered to the clear desk policy at the time of our visit.

The involvement of people in the care they receive

- Care plans did not always reflect that people were fully involved in the planning of their own care. The majority of electronic care records we looked at did not state whether or not the patient had been involved in completing the care plan or had received a copy of their own care plan. However, we observed that people were actively involved in planning their own care during the visits we undertook with staff. On a visit to a person accessing the early intervention service (east) we saw they were given an updated copy of their own relapse prevention plan. On a visit to a person who accessed support through the Weymouth and Portland CMHT, we saw they were actively involved by staff in making changes to their own care plan. People we spoke with told us that they were involved in planning their own care. One person, for example, told us that staff worked with them in order to best meet their needs.

Good

Are services caring?

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

- People using services told us that they were shown ways in which to understand their mental health. We saw a good example of involvement in care during a home visit with a support time and recovery worker (STaR) for Sherborne CMHT. We observed that communication between the member of staff and the person supported was adapted to meet the person's needs. We observed the use of a visual traffic light system with pictorial coping strategies, and the person using the service was able to describe its effectiveness to our inspector. This system had had a positive impact on the person, who told us it had increased their independence. We observed a positive working relationship between the two which demonstrated respect, involvement and compassion. Another example of good care was seen when we observed a staff meeting in Sherborne, where the team were working across the board to support two people who were accessing their mental health services. The leading psychiatrist talked positively and openly during this discussion, looking at social inclusion and a referral to the STEPS to wellbeing programme (a free NHS service which offers a range of treatments for people experiencing mild to moderate depression and anxiety disorders).
- We observed that during a care programme approach review staff explained to the person using the service how they could be involved in their meetings, and they were encouraged to express and contribute to the discussion about their care and treatment. People who used service we spoke with told us that their medication and any side effects were explained to them by their team, and also why it was important they took their medication at regular times.
- Staff advised that people were supported to access independent advocacy services if and as needed. Team managers were able to tell us what services were available, including statutory independent mental health advocacy (IMHA), and we saw leaflets publicising local advocacy services were on display in CMHT reception areas. People who used services told us that they had been given information about advocacy and how to access the support of an independent advocate by their community team's workers.
- We spoke to seven carers of people who use the service and they told us they were kept up to date and involved in decision making processes concerning their family members who use services. Carers told us that they were involved in assessments of the people they support and that they were regularly updated by the team.
- Purbeck CMHT had access to carers support services, which was contracted to the local branch of the mental health charity Rethink, who offered talking therapies for mental health conditions. We were told that there was a named worker who linked with carers after an assessment was completed by CMHT staff. In complex cases the Rethink worker could be available to support the assessment. The carers support worker was able to carry out a number of direct support and advocacy roles with carers. This included hosting an annual carers' day in the locality as well as representing carers' views and feedback to the quarterly service review for the locality.
- We were told that the Poole CMHT had a dedicated carers officer who was a qualified mental health nurse. The officer was able to provide one to one and on-going support to carers. In addition, support was offered by CMHT staff who primarily provided care to the carer's relative or loved one. For example, care coordinators offered carers support and assessment, using a local authority assessment tool. This assessment identified carers' eligibility for additional non-means tested services and benefits, such as cinema vouchers.
- People were able to provide feedback on the service they received mainly through the quarterly annual national 'friends and family' feedback forms, details of which we saw were prominently displayed in reception and waiting areas at the different locations we visited. The early intervention service east had devised a bespoke annual service user satisfaction questionnaire, tailored to its own service users, which had been in use for several years and was getting a good response rate. We saw how this had been used to gather information on the quality of service people received, which had in turn resulted in improvements being made to the service. For example, the previous year's results had highlighted an issue of people not getting copies of their own care plan, but the results from the latest survey showed there had since been a sizeable increase in people saying they now had a copy of their own care plan.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

We rated responsive as requires improvement because:

- We identified widespread delays from assessment to treatment and long waiting times for people requiring essential psychological therapies as part of their treatment.
- Issues with soundproofing of interview rooms at most of the locations we visited meant service user confidentiality could not be effectively maintained when other people were in the communal areas and thoroughfares near to interview rooms.
- Several teams who met with people at their office were located in old buildings which did not have adequate access for disabled people.
- However, teams took a proactive approach to engage with people who found it difficult or were reluctant to engage with mental health services. There was a comprehensive range of information provided for people who used services. This included information on different conditions and treatments, service users' rights, local support projects including advocacy, and how to make a complaint. Staff were able to obtain information in different formats and languages if needed.

Our findings

Access and discharge

- Although most teams managed to carry out assessments of need within the Trust's four week target, we saw in the records of one person who had been referred to Bridport CMHT that they had not been contacted to arrange a formal assessment until four months after their initial referral. The person was identified as being at risk of suicide. Christchurch & Southbourne CMHT told us they did not consistently meet targets for carrying out assessments following initial referral to the service. Records showed the team was getting 25 new referrals per week, but only had 14 assessment appointments available. The impact of this was that it was difficult for them to meet the targets to see many of the people who were on their waiting list.
- Staff at most of the teams we visited told us that people were usually seen quickly for assessment following initial referral to the service. Teams aimed to meet with people for assessment within the Trust's own four week timescale after they received the referral, and those timescales were usually met. All services apart from Christchurch and Southbourne CMHT, told us they usually met their own targets for assessment following referral to the service. Christchurch and Southbourne CMHT was in frequent breach of the four week target, averaging five to six weeks. This potentially resulted in a negative impact on people who were waiting for an assessment of their care and treatment needs, as their conditions could worsen during this extended waiting time. None of the staff spoken to from other teams raised this particular issue.
- A significant number of staff at different teams did, however, raise concerns about the subsequent delay from when people were assessed to when they actually started the treatment they had been assessed as needing. This was particularly the case for psychological therapies such as cognitive behavioural therapy or family therapy. Staff told us this was due to lack of available time and resource to provide such therapies. At one CMHT, we were told it was not uncommon for people to have to wait six or more months for certain psychological interventions after their assessment. In order to confirm waiting times we had requested actual figures from the Trust, including for waiting times from assessment to treatment, but were told this information was not collected centrally by the Trust on its electronic records system. We were unable to verify formally from recorded figures, but staff also raised issues with delays in referral to other teams in the Trust, for example to the crisis intervention teams and children and adolescent mental health Service (CAMHS).
- We looked at duty systems and duty worker response times and capabilities. At Christchurch and Southbourne CMHT there were two people on duty who were responding to an average of 70-100 calls a day. One member described this set up as 'firefighting' and told us the duty worker regularly experienced stress as a result of the workload this created. However. the team at Poole CMHT had a different system consisting of two dedicated duty workers and a duty psychiatrist being available every day. In addition, staff from Poole CMHT had spent time with people using their services and

Are services responsive to people's needs?

Requires improvement

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provided them with accessible information about the duty call system, what would constitute an emergency and examples of what sorts of issues and questions could wait until their next appointment. We were told this system had resulted in both a decrease in non-emergency calls to the duty workers and an increase in the awareness and involvement of people who used the service.

- We found some positive examples of how teams took a proactive approach to engage with people who found it difficult or were reluctant to engage with mental health services. At Bridport, we were told all staff did home appointments if required in order to give people greater flexibility with their appointments. At Dorchester, we were told staff worked as flexibly as they could to meet with people at their GP surgery or other 'place of comfort', if they didn't wish to attend the CMHT. We went out with staff and saw how the east early intervention service had been doing some very effective work with hard to reach people through its 'Reach' football project.

The facilities promote recovery, comfort, dignity and confidentiality

- At most of the locations we visited where people who used services were seen on the premises, there were a range of different rooms and equipment to support treatment and care. This included rooms for interviews and therapy, clinic rooms for physical examinations, and larger communal rooms for group activities. There were a number of issues with the clinic room at Bridport CMHT. A snagging list compiled by staff contained some of the necessary improvements, but we were not provided with a timescale for when these improvements would be carried out.
- Staff at Purbeck CMHT told us that they didn't have enough access to rooms for treatment and assessment of patients. We were told that access to GP surgeries was difficult due to GPs charging the CMHT if the patient was not on their books, so rooms were booked in local hospitals. This system was described as unreliable and had also resulted in the team covering large distances to see patients. The rooms we saw were not always comfortable for providing psychiatric therapy, as we observed during one clinic there were trolleys and blood taking equipment in the room.
- We identified a widespread issue in relation to soundproofing of interview rooms at most of the locations we visited. At Bridport, Dorchester and Weymouth CMHTs, for example, it was possible to hear the conversations taking place between people in the closed interview rooms when passing in the corridor outside. This meant that patient confidentiality could not be effectively maintained when other people were in the communal areas and thoroughfares near to interview rooms.

Meeting the needs of all people who use the service

- At each of the locations we visited where people were seen on the premises, we saw there was a wide range of information provided for people who used services. This included information on different conditions and treatments, service users' rights, local support projects including advocacy, and how to make a complaint if they were not satisfied with the service they received. Team managers told us they were able to obtain information in different formats and languages if needed, so as to support people's different communication needs. Staff were also able to access the support of interpreters for people whose first language was one other than English.
- At most of the locations we visited where patients were seen on the premises, buildings had been adapted to ensure accessibility for disabled people. This included flat surfaces and ramps for wheelchair users and disabled adapted toilets. However, we found that services at Fairmile House (Christchurch & Southbourne CMHT), Hahnemann House (Bournemouth CMHT) and Ashley Elm House were in old buildings which did not have adequate access for disabled people.

Listening to and learning from concerns and complaints

- People who used services and carers we spoke to told us they felt able to complain. The majority of the people we saw said they knew how to make a complaint either via their team or through the patient advice and liaison service (PALS). We saw leaflets in all of the services we inspected about how to make a complaint, along with PALS leaflets.
- According to figures supplied to us by the Trust, the CMHTs, including the early intervention and assertive

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outreach teams, had received 53 separate formal complaints overall in the 14 months between April 2014 and June 2015. Of these complaints, approximately 40% had been upheld. One complaint had been referred on to the Ombudsman. However, this had not been upheld by them. A number of teams had received only one complaint or no complaints at all in this period, including Purbeck CMHT and the assertive outreach and early intervention teams. Of the complaints that had been upheld, the 'lessons learned' in the data supplied by the Trust contained examples of staff working with people to address issues raised and, in some instances, of formal apologies being given. We also saw examples of how improvements were made to services following complaints.

Are services well-led?

Requires improvement

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Summary of findings

We rated well-led as requires improvement because:

- Some of the staff we spoke to during our inspection could not tell us about the wider organisation's core values. There was a lack of shared focus and direction, and some of the teams we visited seemed to operate in isolation from other community teams and the wider organisation.
- Variance in performance and quality across teams, and gaps in critical aspects of service provision, demonstrated to us that the governance of community-based mental health services for adults of working age was not sufficiently robust or effective.
- There was low staff morale in some of the teams we visited. High caseloads, disconnect from the senior management team and the wider Trust, and the effect of serious incidents and the subsequent investigation processes, were examples of concerns raised by staff who expressed issues with morale.
- There was insufficient evidence of best practice being shared across different community teams, which limited improvements in quality across those teams and the wider Trust. This was particularly evident in the response to and learning from serious incidents.
- However, we saw positive evidence of the integration of adult social care and health care in some of the teams we visited, which were able to deliver a more effective, holistic service due to their shared knowledge and expertise. Staff supported each other well and treated colleagues with kindness, dignity and respect. Staff in different roles told us they felt valued and appreciated by their colleagues, and all staff spoke positively of their immediate peers and line managers. None of the staff we spoke with raised issues of bullying or harassment. We saw excellent examples of innovative projects and practice at different teams we visited, which demonstrated staff's willingness to improve the quality of service they delivered.

Our findings

Vision and values

- Some of the team managers we met were able to give examples of how they implemented the trust's vision and values into their team meetings and appraisals. However, other staff we spoke to during our inspection were not able to tell us about the wider organisation's core values. We found that there was a general lack of shared focus and direction, and the teams we visited seemed to operate in isolation from other community teams and the wider organisation. We found that staff were passionate about delivering high quality care, and did so with compassion and commitment. Staff at one CMHT spoke of feeling disconnected from the wider organisation, and that they as a team liked to plough their own furrow. A member of another team described being disempowered, because they felt innovative ideas tended to get stuck as they progressed up the hierarchy.
- Most of the staff we spoke to were aware of the trust's restructure in October 2014 and some staff could name members of the senior leadership team. Purbeck CMHT showed us an agenda for their team meeting in August which the Trust's chief executive was attending. Other staff told us they had met members of the senior management team once or twice. However, it was not the same experience at every team we visited. Many of the staff we spoke to said they had had little contact with the Trust's senior management team. One team manager told us there was a "distant, corporate feel to the Trust," while another thought it would be very beneficial for their team's morale if the senior team were more visible and had more direct contact with staff.

Good governance

- The Trust did not collect and collate centrally all key data in relation to waiting times, such as from assessment to treatment for each team. This meant it would not be able to monitor easily or effectively the performance and workloads of teams separately or in comparison with each other.
- Different aspects of individual teams' performance was managed centrally by the trust. Team managers explained to us how 'exception' reports were regularly emailed out to them, indicating where there were gaps in service provision or where there team was not

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performing as well as other teams. For example, exception reports showed managers how their team overall and individual members of the team were performing in terms of completion of mandatory training. They were then expected to manage people and address any shortcomings through supervision according to the information cascaded. Several of the managers we spoke to were quite negative about the effect of being managed centrally through these exemption reports. They told us the reports contributed to a sense of competition and separation between teams.

- We saw evidence of the effective integration of adult social care and health care in some of the teams we visited. This allowed teams to maximise the time spent with people and to deliver a more effective, holistic service due to shared knowledge and expertise. We found that Purbeck, Sherborne and Poole community mental health teams had strong management systems in place and stable team structures. This was also the case for Dorchester CMHT and the early intervention teams. We found these teams had a good mix of qualified staff from different disciplines who were utilised effectively to support, in the case of the CMHTs, large patient caseloads. Other teams had more recently undergone staffing and management changes, and we found evidence that these changes had impacted on the effective operation of those teams in some areas. For example, we found that incidents were being widely reported and risks effectively responded to in some teams. However, managers of other teams were unable to access records of their team's incidents, or to locate the Trust's risk register or demonstrate a knowledge of this document and how to submit items to the register.
- We identified considerable variance in completion rates for mandatory training across teams. There was significant variance in the quality of key records, including care plans and risk assessments, across the teams we inspected. We also found there were significant gaps in other important areas which were monitored and managed centrally by the trust, such as adherence to Mental Capacity Act procedures. Variance in performance and quality across teams, and gaps in critical aspects of service provision, demonstrated to us that the governance of community-based mental health services for adults of working age was not sufficiently robust or effective.

Leadership, morale and staff engagement

- We found issues relating to staff morale in some of the teams we visited. Different staff gave examples of feeling disempowered when their improvement initiatives were stifled. High caseloads, disconnect from the senior management team and the wider trust, and the effect of serious incidents and the subsequent investigation processes, were further examples of concerns raised by staff who expressed issues with morale in their team.
- In contrast, all staff spoken with were very positive about the leadership and support they received from managers at a local level. One member of staff told us their manager was interested in them as an individual and in the work they did. A member of staff in another team told us they were listened to by their manager and that their development had always been encouraged and promoted at a local level. All non-management staff spoken with said they got sufficient support and supervision from their managers. Similarly, all staff spoken with also told us they were well supported by their peers and enjoyed being part of their respective teams. During all interviews with staff we heard positive comments about their team managers and colleagues, and none of the staff we spoke with raised issues of bullying or harassment.
- Staff also supported each other well and treated colleagues with kindness, dignity and respect. One member of staff told us the support they received from their colleagues "exceeds my expectations." Another member of staff told us colleagues supported each other and allowed them time to recover themselves following serious incidents. Staff in different roles told us they felt valued and appreciated by their colleagues, and all staff spoke positively of their immediate peers and line managers.
- One team manager gave an example of how they regularly accessed support from their locality manager, who knew about all the 'hot spots' and issues the team were dealing with, for example the details of any serious incidents. They reflected how the team was able to work autonomously and with innovation because of the success of the integrated team model and because of the support they got from senior management in the locality. However, we spoke to two team managers who didn't have established relationships with their locality managers. They told us this had a negative impact on

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their workload and ability to manage their teams. We found it also impacted on their knowledge of systems and processes. One manager told us they hadn't been adequately supervised or supported. Several reported they still had their own substantial case loads, which affected their ability to carry out effectively their roles as team managers.

Commitment to quality improvement and innovation

- We saw examples of innovative projects and practice at different teams we visited, which demonstrated staff's willingness to improve the quality of service they delivered. At Bournemouth early intervention service we saw the positive impact of the 'Reach' peer support football project which brought staff and service users together in a relaxed, non-clinical setting. People involved in this project spoke enthusiastically about the positive impact the project had on their lives and metal health. At Dorchester CMHT, we were told about how the team were doing joint working with a local peer support group to bring about improvements in the service provided. Representatives from the support group had been involved in interviewing staff to the CMHT, and we were told there would be even closer working between the different parties in future.
- We saw evidence of audit reporting around 'did not attend' (DNA) rates following the merger of Southbourne CMHT with Christchurch and Bournemouth. At Bournemouth and Poole assertive outreach team we were shown a detailed action plan highlighting their areas for improvement and who in the team would take responsibility for different parts of the action plan being implemented. Poole CMHT had nominated a member of the team to act as crisis service link worker, following lessons learned from a serious incident. The team had identified that a high risk time for clients was during transfer between services, in particular from crisis service to CMHT. Staff in the team felt that transfer of care could be managed better, with discharge and follow up care plans developed between services. The aim of the link worker was to ensure the CMHT and crisis service linked effectively and kept up to date with each other's team developments, and that working relationships and communication between the two teams were further developed and improved.
- Poole and Dorchester CMHTs had each developed a physical health clinic. The aim of the clinics was to provide monitoring of people's physical health, especially those who were prescribed an anti-psychotic medication. We saw the clinic room in Poole's outpatients department had been refurbished and relevant equipment for performing basic physical health monitoring had been purchased. A nurse on each of the teams had been identified as the lead for the clinics.
- In spite of identifying examples of innovation in many teams and a commitment from all staff to deliver quality services, we saw insufficient evidence of best practice sharing across different community teams, which would allow for greater improvements in quality across those teams and the wider trust. This was particularly evident in the response to and learning from serious incidents.

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
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Not all people who used services were treated with dignity and respect, as the registered person did not ensure the privacy of users at all times. Poor sound-proofing of interview rooms had been identified as an issue by staff but not adequately addressed. This meant that not all reasonable efforts had been made to ensure that all discussions about care and treatment took place where they could not be overheard. This is a breach of regulation 10(1) & (2)(a)

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not demonstrate that care and treatment were provided only with the consent of the service user or other relevant person. The registered person could not demonstrate that they had acted in accordance with the Mental Capacity Act 2005 in all instances where a service user lacked mental capacity to consent to their care and treatment. This is a breach of regulation 11(1) & (3)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not demonstrate that care and treatment was provided in a safe way for service users. We saw evidence in care records that teams had not effectively assessed the risks to all service users and had

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Requirement notices

not done all that was reasonably practicable to mitigate such risks. Risk assessments relating to the health, safety and welfare of some people using services had not been completed and other risk assessments had not been regularly reviewed. Although serious incidents had been reviewed and thoroughly investigated, effective action had not been taken to remedy the situation, prevent further occurrences and make sure that improvements were made.

This is a breach of regulation 12(1) & (2)(a)&(b)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Appropriate systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided in the carrying on of the regulated activity. The systems and processes in place did not operate effectively to ensure improvements in practice were made following the investigation and evaluation of serious incidents. This is a breach of regulation 17(2)(a) & (f)

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in each team in order to meet the needs of the people using the service at all times. Staffing levels and skill mix had not been reviewed and adapted to respond effectively to the changing needs and circumstances of people using the service. This is a breach of regulation 18(1)