Requires improvement

Dorset Healthcare University NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Date of inspection visit: 22 - 26th June 2015
Date of publication: 16/10/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDY10	St Ann's Hospital	East Dorset crisis and home treatment team	BH13 7LN
RDY10	St Ann's Hospital	Health-based place of safety	BH13 7LN
	Forston clinic	West Dorset crisis and home treatment team	DT2 9TB

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

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

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

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

Summary of findings

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Overall summary

We rated mental health crisis services and the health-based place of safety as requires improvement because:

- We found conflicting and contradictory evidence about staffing and sickness levels in the east Dorset crisis team. However, we found evidence to indicate that this had a marked adverse effect on the team's ability to provide a robust home treatment service.
- The telephone call management systems, set up specifically to deal with calls at night, did not function effectively and patients experienced difficulties accessing the east Dorset crisis team if experiencing a crisis, posing a potential significant risk.
- There were poor relationships between the east Dorset crisis team and the community mental health teams. Communication was ineffective and as a result people using services could experience delays in receiving support from the most appropriate team.
- In the east Dorset crisis team not all contributions from the multidisciplinary teams' members were considered equally valuable.
- There were several areas of concern related to poor morale, staff shortages and confusion about the crisis team model in the east Dorset crisis team. We found areas of good practice with clinicians delivering services in east Dorset but this was inconsistent. There was consistent examples of good and outstanding practice in the west Dorset crisis team.
- Both crisis teams fell well below the trusts target for completion of mandatory training in basic life support, breakaway techniques and the Mental Capacity Act.
- We had some concerns that the training needs of staff expected to work in the health based place of safety were not adequately met in relation to the application of section 136 of the Mental Health Act.
- Journey times to St. Ann's hospital, for people living in west Dorset ranged from one hour through to over two hours, traffic dependant. Reports we looked at showed that 90% of transport was provided by the police, in either a car or van and not an ambulance. This meant comparatively long journeys, often in the back of a police van, for people from the West of Dorset.

However,

- It is important to state that we found areas of very good practice. The layout and furniture of the health based place of safety was designed to promote people's safety, and privacy and dignity as far as possible. There was equipment available to deal with medical and psychiatric emergencies. All people had a risk assessment carried out when they were seen by the crisis teams, or were seen in the health based place of safety. People working with the crisis teams had their level of risk reviewed regularly. Staff knew how to identify and report safeguarding concerns. Staff knew how to report incidents. Staff were offered debriefing when serious incidents occurred.
- Peoples' needs were assessed and care was delivered in line with their individual care plans. The street triage initiative had been effective in reducing the number of people detained under Section 136 of the Mental Health Act, and the number of people referred to the crisis response team. Within the first six months, peoples' presentation at the health based place of safety reduced by 20% and in the following six months by 32%. There were strong and firmly established relationships between the provider and the police which were conducive to positive outcomes for people using services and the staff.
- Staff were caring, compassionate and motivated and there was good, professional and respectful interactions between staff and people using the crisis services, when we shadowed staff, during our inspection. Patients commented positively about how kind the staff were towards them.
- We noted all groups of people, including young people under 16 years of age are able to use the health based place of safety. We saw evidence that in all but one occurrence in May 2015, the police did not use police custody cells for people, once detained under section 136 of the Mental Health Act.
- In addition, people using the crisis services across Dorset had access to the recovery education centre which offered many courses to enable people to understand their experiences, manage their recovery and also how to support others with their journey. The west Dorset crisis service had a peer led carer's project. There was availability of crisis house beds across Dorset which provided as an alternate to an inpatient admission.

Summary of findings

- The senior management team was fully committed to making positive changes. We saw that the management team had put a robust plan in place to address deficiencies identified in order to develop and implement improvements to the service.

We did not provide a rating for 'safe' for mental health crisis and health based places of safety due to conflicting and contradictory evidence which meant a definitive, robust judgement could not be made.

Summary of findings

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

Are services safe?

We did not provide a rating for 'safe' for mental health crisis and health based places of safety due to conflicting and contradictory evidence which meant a definitive, robust judgement could not be made.

We found some evidence that indicated that:

- The telephone call management systems, set up specifically to deal with calls at night, did not function effectively and patients experienced difficulties accessing the east Dorset crisis team if experiencing a crisis, posing a potential significant risk.
- The east Dorset crisis team mainly delivered an assessment service. Home treatment visits had frequently been cancelled as staffing levels often fell below those on planned rotas due to high sickness levels and staff shortages.
- Both crisis teams fell below the trusts target for completing training in basic life support and breakaway techniques.

However,

- We found that the layout and furniture of the health based place of safety was designed to promote people's safety, and privacy and dignity as far as possible.
- There was equipment available to deal with medical and psychiatric emergencies.
- All people had a risk assessment carried out when they were seen by the crisis teams, or were seen in the health based place of safety.
- People working with the crisis teams had their level of risk reviewed regularly. Staff knew how to identify and report safeguarding concerns.
- Staff knew how to report incidents and staff were offered debriefing when serious incidents occurred.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There was poor, internal, multidisciplinary team relationships between the east Dorset crisis team and the community mental health teams. We noted that the relationship between the teams was damaged, communication was, at times, poor and as a result people using services could experience delays in receiving support from the most appropriate team.
- We saw from the 2013 health based place of safety survey that AMHPs and medical staff received training before working in the

Summary of findings

facility. Since the findings of the survey were published the trust had implemented the mental health foundation training pathway (November 2014), which provided specific training outlined the MHA CoP, for all new staff joining the trust before they commenced in their role. It made this mandatory in May 2015. However, several of the nursing and support staff told us they only received detailed training when they worked in the area and felt this did not prepare them adequately.

- In the east Dorset crisis team not all contributions from the multidisciplinary teams' members were considered equally valuable.

However,

Elsewhere peoples' needs were assessed and care was delivered in line with their individual care plans. The street triage initiative had been effective in reducing the number of people detained under Section 136 of the Mental Health Act, and the number of people referred to the crisis response team. Within the first six months presentation at the health based place of safety reduced by 20% and in the following six months by 32%. Relationships between the provider and the police were strong, well-established and conducive to positive outcomes for people using services and the staff.

Are services caring?

Good

We rated caring as good because:

- Staff were caring, compassionate and motivated. There was good, professional and respectful interactions between staff and people using the crisis services when we shadowed staff during our inspection. Patients commented positively about how kind the staff were towards them.

Are services responsive to people's needs?

Requires improvement

We rated responsive as inadequate because:

- There were several complaints, from patients, carers and staff from other teams about the east Dorset telephone crisis line, operated overnight by the crisis team, from staff in other teams, people trying to use services and staff from the health based place of safety. We noted the telephone system had been set up to operate a call waiting system. However, at the time of our inspection if the telephone was not answered the line was cut off. This often meant no one from the crisis team could be spoken to and that there was no voicemail availability to leave a message. We saw that the senior management team had put an action plan in place to address the deficiencies with the telephone system.

Summary of findings

- Journey times for patients requiring a health based place of safety ranged from an hour to two hours for patients in west Dorset could be up to. Ninety per cent of journeys were in a police car or van rather than an ambulance.

However,

The trust had one health based place of safety across the county. The MHA multiagency group (consisting of Dorset, Poole & Bournemouth police, out of hours social services, Dorset, Poole & Bournemouth local authorities, the CCG (commissioners), the south west Ambulance Service and the trust) agreed provided an adequate provision.

All groups of people, including young people under 16 years of age, were able to use the health based place of safety.

People in crisis could access a crisis house, based in the community in west Dorset.

Each crisis team offered extended hours (outside office hours, including weekends), but not a 24 hour service. However, people could access an emergency service 24 hours a day, which included the telephone helpline (not working effectively in east Dorset at the time of inspection) or A&E mental health liaison services.

Are services well-led?

Good

We rated well-led as good because:

- There was good staff morale in the west Dorset crisis team and that they felt well supported and engaged with a visible and strong leadership team which included both clinicians and managers. We found consistent examples of good and outstanding practice in the west Dorset crisis team. Governance structures were clear, well documented, adhered to by the teams and reported accurately.
- In the east Dorset team there was poor morale, staff shortages and confusion about the crisis team model. We found areas of good practice with clinicians delivering services in east Dorset but this was inconsistent.
- The senior management team was fully committed to making positive changes. The management team had put a detailed plan in place to address deficiencies identified in order to develop and implement improvements to the service. The action plan was robust and would address the deficiencies in the east Dorset crisis team in time.

Summary of findings

Information about the service

Dorset Healthcare University NHS Foundation Trust has one health-based place of safety, or section 136 suite, on one site at St. Ann's hospital in east Dorset, which covers the county. The place of safety is for people who are detained under section 136 of the Mental Health Act. This is the power that police officers have to detain people, believed to have a mental disorder, in a public place and to take them to a place of safety for assessment.

There are crisis and home treatment teams based at St. Ann's hospital and the Forston clinic, covering both east and west Dorset respectively. The crisis and home treatment teams provided short term work to help support people at home when in mental health crisis and support with earlier discharge from hospital. The teams aim to facilitate the early discharge of patients from hospital or prevent patients being admitted to hospital by providing treatment at home. In addition the East Dorset crisis team had access to a day hospital which also provided mental health support.

The trust had a street triage service in east Dorset to advise police officers when the police believed people needed immediate mental health support. The aim of this team is to ensure that people get mental health professional input in a timely manner whilst also diverting people from inappropriate police custody or section 136 of the Mental Health Act assessments.

We have inspected the services provided by Dorset Healthcare University NHS Foundation Trust 35 times between 2012 and 2015, across 18 locations. The health-based place of safety/section 136 suite and crisis response teams have not been inspected.

Our inspection team

The inspection team was led by:

Chair: Neil Carr OBE, Chief Executive of South Staffordshire and Shropshire Healthcare NHS Foundation Trust

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

The team that inspected the mental health crisis services and health-based places of safety consisted of 14 people, divided into two smaller teams;

- Two experts by experience and one supporter;
- Two inspectors;
- Two Mental Health Act reviewers;
- Four nurses;
- One social worker;
- One occupational therapist; and
- One psychiatrist.

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?

Summary of findings

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people using the services at focus groups.

During the inspection visit, the inspection team:

- Visited both crisis teams and the health-based place of safety. We looked at the quality of the environments and observed how staff were caring for people;
- Spoke with eight people who were using the service, six in their own homes;
- Spoke with two carers of people using the service; · Spoke with the team leaders;
- Spoke with 12 staff members; including doctors, nurses, occupational therapists, support workers and student nurses;
- Interviewed the senior management team with responsibility for these services, including the service manager;
- Attended one group for people using services; and
- Attended and observed three multi-disciplinary clinical meetings.

We also:

- Looked at 15 treatment records of people using services; · Looked at 18 records from the place of safety;
- Looked at 12 medication administration charts;
- Looked at a range of policies, procedures and other documents relating to the running of the service;
- Collected feedback from four people using services and three carers; and
- Attended a meeting with the chairperson of the mental health carer's project.

What people who use the provider's services say

We received positive feedback from people who were currently using the crisis services and their families. We did, however, receive several negative feedback and adverse comments from relatives, whose relatives, had received services from the crisis teams, exclusively about the east Dorset crisis team. In particular, about the telephone crisis helpline and about the cancellation of appointments.

We were unable to speak with any patients who had used the health-based place of safety/136 suite.

Good practice

- People using the crisis services across Dorset had access to the recovery education centre which offered many courses to enable people to understand their experiences, manage their recovery and also how to support others with their journey.
- The west Dorset crisis service peer led carer's project which provided flexible and individualised support for carers.
- The availability of crisis house beds across Dorset as an alternative to an inpatient admission.
- The trust had a street triage service in east Dorset to advise police officers, where the police believed people needed immediate mental health support. The aim of this team is to ensure that people get mental health professional input in a timely manner whilst also diverting people from inappropriate police custody or section 136 of the Mental Health Act assessments.
- There was strong and firmly established relationships between the provider and the police which were conducive to positive outcomes for people using services and staff from both organisations. The police mental health coordinator received a detailed and thorough induction to mental health services which included working shifts on the acute inpatient wards.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are sufficient, appropriately trained staff are available to provide care to people receiving services from the east Dorset crisis team.
- The provider must ensure that staff working in the crisis team have up to date mandatory training and that staff working in the health based place of safety have training on section 136 of the Mental Health Act.
- The provider must ensure that patients in east Dorset can contact the crisis team at night through the provision of an accessible telephone call management system.
- The provider must ensure cooperative and good working relations between the east Dorset crisis team and locality CMHTs to ensure that people requiring services can access the most appropriate service to have their need met in a timely manner.

Action the provider SHOULD take to improve

- The provider should address the inequitable relationships and at times inappropriate behaviour between members of the east Dorset multidisciplinary team.
- The provider should develop a crisis care pathway audit programme.
- The provider should ensure that staff working in the crisis team have up to date mandatory training and that staff working in the health based place of safety have training on section 136 of the Mental Health Act.
- The provider should review processes for receiving regular feedback from people using crisis services and the health based place of safety
- The provider should review, with its partners, the availability of a health based place of safety for residents of west Dorset and ensure transportation is provided in accordance with the MHA CoP.

Dorset Healthcare University NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
East Dorset crisis and home treatment team	St. Ann's Hospital
West Dorset crisis and home treatment team	The Forston Clinic
Health-based place of safety/section 136 suite	St. Ann's Hospital

Mental Health Act responsibilities

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

- Staff in both crisis teams and the staff managing the health based place of safety could refer people for Mental Health Act assessments as required. Neither crisis team had their own approved mental health professionals (AMHPs) which at times had caused delays in accessing the AMHP. The AMHP was responsible for locating and arranging section 12 doctors to undertake assessments.
- Information was recorded about how long people spent in the health based place of safety suite, and what the outcome of their assessment was.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We noted that many clinical staff had not received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and that only 19% of eligible staff were up to date with refresher courses.
- There were no current Dols applications and this was appropriate.

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 did not provide a rating for 'safe' for mental health crisis and health based places of safety due to conflicting and contradictory evidence which meant a definitive, robust judgement could not be made.

We found some evidence that indicated that:

- The telephone call management systems, set up specifically to deal with calls at night, did not function effectively and patients experienced difficulties accessing the east Dorset crisis team if experiencing a crisis, posing a potential significant risk.
- The east Dorset crisis team mainly delivered an assessment service. Home treatment visits had frequently been cancelled as staffing levels often fell below those on planned rotas due to high sickness levels and staff shortages.
- Both crisis teams fell below the trusts target for completing training in basic life support and breakaway techniques.

However,

- We found that the layout and furniture of the health based place of safety was designed to promote people's safety, and privacy and dignity as far as possible.
- There was equipment available to deal with medical and psychiatric emergencies.
- All people had a risk assessment carried out when they were seen by the crisis teams, or were seen in the health based place of safety.
- People working with the crisis teams had their level of risk reviewed regularly. Staff knew how to identify and report safeguarding concerns.
- Staff knew how to report incidents and staff were offered debriefing when serious incidents occurred.

Our findings

Safe and clean environment

- The layout of the health-based place of safety (health based place of safety) allowed staff to observe patients to ensure their safety whilst they were in the suite. The furniture was comfortable and designed so that it did not present a risk to patients or staff.
- Access to the health based place of safety suite was via a communal corridor and did not have a separate entrance. The health based place of safety was on the first floor. This meant that patients had no private access to the health based place of safety and needed to access the facility via the hospital main entrance, communal stairwell and a communal corridor which could compromise their privacy and dignity. This could also present a risk, if for example, a person may require restraint on a stairwell.
- There was a main patient room with a bathroom and toilet facilities specifically for the suite. There was no shower facility available. The suite could comfortably house three staff and one patient at most. There was no adjoining office space for staff although we were told that there was available office space within the vicinity.
- If the health based place of safety was in use, there was additional available, office and interview space within St. Ann's Hospital which could be used to avoid turning any one away for assessment.
- The health based place of safety had a ligature risk assessment. Specific action to be taken to mitigate the risks identified were detailed and that when in use the room was never unsupervised by staff.
- The health based place of safety was based in St. Ann's hospital and was the only one place of safety available across the county of Dorset. It had been agreed by the
- We noted there was an area for making hot and cold beverages which could be closed off with shutters if this represented any risk to patient safety.
- The health based place of safety had an attached, secure outside courtyard area, albeit small.
- There was emergency resuscitation and medical equipment available in the suite.
- Staff had emergency alarms, so they could call for support if necessary.

Are services safe?

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

- The health based place of safety and the areas where patients were seen in the crisis teams were clean and well maintained.
- Most of the crisis teams' work was done through visiting people in their own homes to provide an assessment and ongoing care and treatment to support people in mental health crisis.
- Where there were concerns about risks to staff, staff would visit in pairs or arrange to see people in safer alternative venues. For example, the east Dorset crisis team had access to a day hospital facility. Staff from the crisis teams also had access to interview rooms on site at St. Ann's hospital and the Forston clinic.

Safe staffing

- Both of the crisis teams were staffed by nurses, doctors and support workers. We noted that occupational therapy staff were available in the west Dorset crisis team but not in the east Dorset team. Staff in the east Dorset crisis team told us that high vacancy and sickness levels were having a marked adverse effect on the ability to provide a robust service to patients, even though some vacancies were covered by temporary staff. The trust provided evidence that in February 2015 the east Dorset crisis team had 28.8 whole time equivalent staff (WTE) from a budgeted establishment of 35.6 WTEs. However, in April 2015 a review of the staffing establishment was undertaken and the WTE reduced to 30.11.By June 2015 there were 6 WTE vacancies although the trust identified that 4.3 of these were always covered by temporary staff. In addition, between April 2014 and May 2015 the sickness levels varied between 7.5% to 8.6%. The team told us that they frequently had to cancel home treatment visits due to staff shortages, with people using the service being asked to attend a day hospital facility for treatment and support and primarily delivered assessments. Staff also told us that there were frequent periods where the actual staffing numbers on shift fell below the expected staff numbers planned on the rota. Examination of rotas confirmed this.
- Staff were not confident in describing the crisis and home treatment model in east Dorset.
- Most staff in crisis teams had received and were up to date with some mandatory training. Prior to the inspection both teams fell below the compliance target of 85% for basic life support training at 50%. However, at the time of the inspection this had improved for both teams to 61%. Both teams fell below the trusts training compliance target for breakaway training with the east team achieving 71.4% and the west team achieving 81% compliance and for Mental Capacity Act (MCA) training although MCA training had only been mandatory since May 2015.
- The health based place of safety had staff allocated from the inpatient wards at St. Ann's hospital. The health based place of safety was overseen by the bed manager. Each ward would provide staff for an hour at a time. This meant that people using the service could have several different staff supporting them during their assessment period, leading to marked inconsistency. We were also told by staff that their inpatient ward could suffer adversely by losing a staff member for hourly slots, often for a sizeable part of one shift. By using staff who were already part of the safe staffing compliment in another area the provider was putting the safety of that service at risk.
- As the health based place of safety was very near to inpatient wards, additional staff were called for assistance when necessary.

Assessing and managing risk to people using services and staff

- There were several complaints from patients, carers and staff in other teams about the east Dorset telephone crisis line, operated overnight by the east Dorset crisis team. The telephone system had been set up to operate a call waiting system. However, at the time of our inspection if the telephone was not answered the line was cut off. This often meant no one could speak to the crisis team. Therefore, the team was unable to respond appropriately to patients who had emergency care needs at night. In addition, there was no voicemail availability to leave a message. This meant that the team were potentially unaware of, and therefore not able to understand the level of risk or manage the risk to people who may be in crisis at night. We saw that there was an action plan in place to address the deficiencies with the telephone system but no action had been taken at the time of the inspection.
- People using services had a risk assessment carried out at the initial assessment or triage stage. When people were seen by the crisis teams, staff carried out a further risk assessment. This took account of people's previous risk history as well as their current mental state.

Are services safe?

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

- In the crisis teams, comprehensive risk assessments were completed and reviewed regularly which included at multidisciplinary team meetings. The assessments used a recognised tool, and followed a zoning or "RAG (red, amber, green) rating" system to make the level of risk clearly identifiable. The level of risk was then reviewed regularly, and adjusted as necessary. Each person was discussed at the daily staff handover, and their level of risk and care plan reviewed.
- We noted in the health based place of safety that the bed manager would receive the detained person and contact the approved mental health professional (AMHP) to co-ordinate a Mental Health Act assessment. All people entering the health based place of safety received a brief mental health handover form between the police and receiving staff, documented on the health based place of safety template form.
- Throughout the detention period effective systems were in place to assess and monitor risks to individual people using the suite to determine whether the police officer would be required to remain in the health based place of safety to provide support.
- The trust had a safeguarding policy, which followed the county-wide multi-agency policies. Over 85% of crisis team staff had completed safeguarding training, and those we spoke with demonstrated that they could identify safeguarding concerns, and knew what action to take in response. There were safeguarding leads within or accessible by the teams, and staff knew who they were and how to contact them for advice.
- The trust had a lone working policy. The staff we spoke with were familiar with this, and confidently gave examples of what they did to keep one another safe. For example, if they had particular concerns about a patient they may visit in pairs or arrange for the patient to be seen at the office or day hospital in the east of Dorset.
- We noted that the west Dorset crisis team had developed maps of telephone network black spots, due to the rural nature of the area. This enabled staff to stay in contact with one another, through the use of three different mobiles phones, covering three different networks.
- We also saw that the west Dorset crisis team had undertaken specific training on risks associated with working in a rural community which included visiting farms and the availability of farmers' shotguns on site.
- We were told that neither crisis team had a qualified nurse prescriber and that medicines management had posed difficulties previously with both teams. Patients complained that they had to take their prescriptions to the pharmacy and this was costly. However, both teams maintained a small supply of stock medicines which could be used in emergencies. The trust told us that patients in the east of the county could take their prescription to the pharmacy at St. Ann's Hospital and no longer had to pay. The west Dorset crisis team had been offered the same service but did not want to adopt this so there was no similar facility in the west of the county.

Track record on safety

- We noted three serious incidents involving people using the east Dorset crisis team within the previous three months, all were unexpected deaths. Where serious incidents had occurred within the teams, serious incident investigations had been completed and dated action plans implemented. For example, following incidents in the crisis teams the process for assessment of patients had been reviewed.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system (Ulysses). All incidents were reviewed by the manager, and forwarded to senior managers and the trust's patient safety team for further review. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these. The action taken was also recorded on the electronic system.
- Staff we spoke with told us that they did not always receive feedback after they had reported an incident. Significant incidents were discussed in staff meetings and handovers, but as not all staff were at every meeting, this could prove problematic. Staff were offered debriefing sessions following serious 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:

- There was poor, internal, multidisciplinary team relationships between the east Dorset crisis team and the community mental health teams. We noted that the relationship between the teams was damaged, communication was, at times, poor and as a result people using services could experience delays in receiving support from the most appropriate team.
- We saw from the 2013 health based place of safety survey that AMHPs and medical staff received training before working in the facility. Since the findings of the survey were published the trust had implemented the mental health foundation training pathway (November 2014), which provided specific training outlined the MHA CoP, for all new staff joining the trust before they commenced in their role. It made this mandatory in May 2015. However, several of the nursing and support staff told us they only received detailed training when they worked in the area and felt this did not prepare them adequately.
- In the east Dorset crisis team not all contributions from the multidisciplinary teams' members were considered equally valuable.

However,

Elsewhere peoples' needs were assessed and care was delivered in line with their individual care plans. The street triage initiative had been effective in reducing the number of people detained under Section 136 of the Mental Health Act, and the number of people referred to the crisis response team. Within the first six months presentation at the health based place of safety reduced by 20% and in the following six months by 32%. Relationships between the provider and the police were strong, well-established and conducive to positive outcomes for people using services and the staff.

Our findings

Assessment of needs and planning of care

- Peoples' needs were assessed and care was delivered in line with their individual care plans. We did note however that there was a variable standard of care records. The care plans at the east Dorset crisis team were basic and not always personalised or recovery focussed. The west Dorset teams care plans were more detailed and the entries into the daily records were completed to a high standard.
- Both crisis teams held daily meetings, which we attended, where the team discussed people's care and the support they required. Staff were aware of the needs of people and were putting plans in place to address these needs.
- Records showed that all people received a physical health assessment by their general practitioner, where they had agreed to, on being taken on by the crisis teams. We noted that risks to physical health were identified and managed effectively. We noted care plans were available for those patients with an identified risk associated with their physical health. As the east Dorset crisis team had moved into St. Ann's Hospital within the previous six months, we saw they had access to the physical health care team for advice or consultation.
- We noted that the west Dorset crisis team operated a nurse led model and we were told the east Dorset crisis team was medically led. We were told by staff from the east Dorset crisis team that they did not always feel an equal member of the team and that their views during multi-disciplinary meetings were not always heard. Staff from the east Dorset crisis team told us that they were not always sure what the service model was, or what the service objectives were and there was some confusion as to the role of the day hospital.
- The assessment information was fed into people's care plans, and influenced the care they received. For example, how frequently they were visited, and whether this was face to face or by telephone.
- We noted that approved mental health professionals (AMHPs) were not part of the crisis teams, or based with the teams and we were told that this caused delays to Mental Health Act assessments for both the people using the crisis service and the health based place of safety.

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.

Best practice in treatment and care

- NICE guidance were used to support the prescribing of medication.
- We noted there was no psychology led interventions available in either of the crisis teams.
- All people using the crisis services were assessed using the Health of the Nation Outcome Scales (HoNOS). These covered twelve health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.
- We could find no evidence of clinical audit activity by the crisis teams.
- From January 2014 a joint initiative was funded collectively between the NHS and the police for a mental health practitioner to be available in a police custody suite. The practitioner was available, via phone, to the police on patrol, to offer advice and support if they found someone who appeared to be suffering from mental health problems. This was called the 'street triage' initiative, and had been effective in reducing the number of people detained under section 136 of the Mental Health Act, and the number of people referred to the crisis response team. Within the first six months presentation at the health based place of safety reduced by 20% and in the following six months by 32%.
- We received a compliment from the police about the 'streamlined risk assessment process' used by staff in the health based place of safety. The person was assessed promptly and the police released quickly.

Skilled staff to deliver care

- The teams had some limited and varied access to the range of mental health disciplines required to care for the people using the service. Each team had access to a psychiatrist, nursing and support staff. The west Dorset crisis team had access to an OT but not the east Dorset crisis team. Neither team had access to psychology or AMHPs. AMHPs were attached to community mental health teams and a duty system out of hours which the crisis teams had to request.
- As staff in the health based place of safety were released hourly from their wards to assist in supervising the facility and assessment of the person using the service it was not possible to carry out detailed training to this unspecified group of staff.
- We saw from the 2013 health based place of safety survey that AMHPs and medical staff received training before working in the facility. Since the findings of the survey were published the trust had implemented the mental health foundation training pathway (November 2014), which provided specific training outlined the MHA CoP, for all new staff joining the trust before they commenced in their role. It made this mandatory in May 2015. However, several of the nursing and support staff told us they only received detailed training when they worked in the area and felt this did not prepare them adequately.
- Staff in the crisis teams received in the main appropriate supervision and professional development.
- We noted that support staff in the east Dorset crisis team had received training on how to triage any incoming calls.
- All staff we spoke to said they received individual and group supervision on a regular basis as well as an annual appraisal. We saw that 84% of staff in the east Dorset team and 96% of staff in the west Dorset team had received an appraisal and had a professional development plan.
- Both crisis teams had a regular team meeting and staff in the west Dorset team described morale as very good with their team leaders being highly visible, approachable and supportive. The east Dorset crisis team described quite poor and unsettled morale, linked to having a high staff vacancy factor and high usage of temporary staff. Nursing staff in the east Dorset crisis team also commented on some frustration and confusion as to the model of the service implemention and the role of the day hospital.

Multi-disciplinary and inter-agency team work

- Both crisis teams had weekly multi-disciplinary clinical review meetings. Handovers between staff took place twice a day. Staff in the east Dorset crisis commented that they did not always feel their contributions in these meetings were considered of equal value. We attended a meeting and observed this to be the case. We witnessed some non-verbal communication between staff members which we felt could be perceived as demeaning and leave staff members feeling undervalued.
- The crisis teams visited the wards regularly and worked closely with the ward teams to assess which patients may be suitable for early discharge. We attended one of the twice weekly bed management meetings which was led by the east Dorset crisis team. We noted that the bed

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.

manager was not a member of this meeting and we judged that this could create inconsistencies in overarching bed management principles. We saw that challenges were made to the inpatient representatives about their bed usage and possible discharges that could be made. We did not find the meeting conducive to good joint working as we found some of the challenges unjustifiable. We also found inequitable relationships between the teams at the meeting. We drew our experience of this meeting to the attention of a senior manager.

- We noted that the relationship between the east Dorset crisis team and the local community mental health teams (CMHTs) was poor. During our inspection we received several complaints by the CMHTs about examples of where they and the people using services had received a poor quality of service from the east Dorset crisis team. We also received a number of complaints from the east Dorset crisis team about poor responsiveness by the CMHTs. We noted that the relationship between the teams was damaged. Communication was, at times poor and as a result people using services could experience delays in receiving support from the most appropriate team. We noted an attempt to improve relationships between the teams by the east Dorset crisis team which had identified two link workers from the team to work with the CMHTs more closely.
- Staff we spoke to in the east Dorset crisis team said they felt under continued pressure to discharge patients too early, from hospital into the care and treatment of the crisis team. The team also described difficulties accessing acute admission beds when they had assessed this as being required. The staff did accept and acknowledge that they undertook assessments of people but were poorly resourced to offer home treatment on an ongoing basis, in keeping with the home treatment model.
- The telephone crisis line operated by the east Dorset crisis team had no clear boundaries about its usage.
- The bed manager, who managed the health based place of safety, was in contact with the police prior to accepting a person into the suite. We saw that a monthly liaison meeting was held with the police looking primarily at use of the place of safety however also all incidents involving the police and any general security issues at any site. We observed inter-agency working taking place. We attended one of the services' regular police liaison meetings, attended by the hospital manager, the head of patient safety and risk, the patient safety manager and the police neighbourhood liaison officer. We noted strong and firmly established relationships between the provider and the police which were conducive to positive outcomes. For example, we saw a sizable reduction in inappropriate telephone calls made to the police by hospital staff following the introduction of clear guidance on the criteria. We also heard that all police received mental health training, provided by the trust and that the police mental health co-ordinator spent time on the acute wards as part of their induction to the role.
- We also noted the regular strategic mental health legislation multi-agency group which was held with the trust, police and ambulance service. We looked at a series of minutes from the meeting which addressed issues arising across the organisations relating to mental health included all detentions under section 136 of the Mental Health Act and usage of the health based place of safety. The trust worked with the local authorities, NHS trusts, police and ambulance services to monitor and review the use of the health based place of safety.
- General Practitioners received timely discharge summaries from the crisis teams.

Adherence to the MHA and the MHA Code of Practice

- Staff in both crisis teams and the staff managing the health based place of safety could refer people for Mental Health Act assessments as required. Neither crisis team had their own AMHPs. The AMHP was responsible for locating and arranging section 12 doctors to undertake assessments.
- Information was recorded about how long people spent in the health based place of safety suite, and what the outcome of their assessment was.

Good practice in applying the MCA

- We noted that not all clinical staff had received refresher training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and that only 19% of eligible staff were up to date with refresher courses.
- There were no current Dols applications and this was appropriate.

Good

Are services caring?

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

Summary of findings

Staff were caring, compassionate and motivated. There was good, professional and respectful interactions between staff and people using the crisis services when we shadowed staff during our inspection. Patients commented positively about how kind the staff were towards them.

Our findings

Kindness, dignity, respect and support

- In both of the crisis teams we observed the staff to be kind, caring and compassionate. This was demonstrated by all the staff we shadowed. When we spoke with people receiving support they were generally positive about the support they had been receiving.
- We observed one staff member describing a patient in a disrespectful manner which was discourteous and unprofessional. We drew this observation to the attention of a senior manager.
- We could not locate a regular feedback mechanism available for people to feedback their views on the crisis teams.
- Staff demonstrated a good knowledge and understanding of people using the services. In the shadow visits we undertook, it was clear that staff had a good understanding of people's needs.
- People's confidentiality was maintained by all the staff teams. When we accompanied staff on home visits the staff members asked if the person was content for a CQC team member to be present prior to the visit. All staff spoken with were aware of the need to ensure a person's confidential information was kept securely. Staff access to electronic case notes was protected.

The involvement of people in the care they receive

- The west Dorset crisis team was running a carer led, peer, support programme which was organised by two carers. They attended the team meeting regularly, held coffee mornings, offered one to one support for relatives of people using the service, organised regular social events and linked in with all of the acute wards in West Dorset.
- Staff involved people's carers and families where appropriate. The crisis teams carried out or referred people for carer's assessments. Families and carers were also given information about carers' support groups.
- Information was available about services provided by the trust and other organisations. For example, information booklets and leaflets were on display, and provided to people, about the trust's out of hours helpline and the availability of the crisis house in west Dorset. There was also information about support groups and independent advocacy services.
- However, we did note that the east Dorset crisis team referred to care plans as treatment plans which meant that the plans were more prescribed, than developed jointly between staff and the people using the service.

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:

- There were several complaints from patients, carers and staff in other teams about the east Dorset telephone crisis line, operated overnight by the east Dorset crisis team. The telephone system had been set up to operate a call waiting system. However, at the time of our inspection if the telephone was not answered the line was cut off. This often meant no one could speak to the crisis team meaning that the team was unable to respond appropriately to patients who had emergency care needs. In addition, there was no voicemail availability to leave a message. We saw that the senior management team had put an action plan in place to address the deficiencies with the telephone system but no action had been taken at the time of the inspection.
- Journey times for patients requiring a health based place of safety ranged from an hour to two hours for patients in west Dorset. Ninety per cent of journeys were in a police car or van rather than an ambulance. The Mental Health Act Code of practice states that police transport should only be used exceptionally.

However,

- The trust had one health based place of safety across the county. The Mental Health Act (MHA) multiagency group (consisting of Dorset, Poole & Bournemouth police, out of hours social services, Dorset, Poole & Bournemouth local authorities, the CCG (commissioners), the south west Ambulance Service and the trust) agreed provided an adequate provision.
- All groups of people, including young people under 16 years of age, were able to use the health based place of safety. There was evidence that in all but one occurrence in May 2015, the police did not use police custody cells for people, once detained under section 136 of the Mental Health Act. Patients were able to access the health based place of safety when required. Both crisis teams could access a crisis house based in west Dorset as an alternative to hospital admission.
- People in crisis could access a crisis house, based in the community in west Dorset.
- Each crisis team offered extended hours (outside office hours, including weekends), but not a 24 hour service. However, people could access an emergency service 24 hours a day, which included the telephone helpline (not working effectively in east Dorset at the time of inspection) or A&E mental health liaison services).

Our findings

Access and discharge

- The trust had one health based place of safety which provided a service to the whole of Dorset and was based in east Dorset at St. Ann's Hospital. The MHA multiagency group (consisting of Dorset, Poole & Bournemouth police, out of hours social services, Dorset, Poole & Bournemouth local authorities, the CCG (commissioners), the south west Ambulance Service and the trust) agreed provided an adequate provision based on an analysis of where most patients requiring a health based place of safety came from. Journey times to St. Ann's Hospital, for people living in west Dorset ranged from one hour through to over two hours, traffic dependant. Reports we looked at showed that 90% of transport was provided by the police, in either a car or van and not an ambulance (the police are responsible for making the decision how to transport patients). This meant comparatively long journeys, often in the back of a police van, for people from the west of Dorset.
- All groups of people, including young people under 16 years of age were able to use the health based place of safety. We viewed one set of care records for a young person who had been assessed in the suite and we found them to be detailed and appropriate. People were not excluded from the health based place of safety as a result of taking alcohol or unprescribed drugs.
- We saw evidence that in all but one occurrence in May 2015, the police did not use police custody cells for people once detained under section 136 of the Mental Health Act. The police liaison officer we spoke to said this practice was unacceptable and would not occur other than in an exceptional circumstance. Any such incident would be investigated in detail and reported to all agencies.

Are services responsive to people's needs?

Requires improvement

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

- Information was recorded about how long people spent in the health based place of safety, and what the outcome of their assessment was. This was recorded consistently on a template which included information on what time the AMHP and section 12 doctor were contacted and their time of arrival. The form noted at what time the police were able to leave the health based place of safety, usually within 30 minutes and all records we viewed were completed fully. The trust's target for starting assessments was one hour and completing assessments was six hours. Where there were delays in people being assessed in the health based place of safety this was mainly due to lack of availability of AMHPs and Section 12 doctors. We were told this occurred on average about once each week. Crisis teams were notified of all admissions to the health based place of safety, however we were told this was often leaving a voicemail message or making repeated telephone calls to the East Dorset crisis team.
- The 2013 health based place of safety survey showed us that there were 272 assessments carried out in the health based place of safety. No one was unable to access the facility due to it already being in use or not being adequately staffed.
- We found 21 referrals for March 2015 of which all 21 were assessed in the health based place of safety. Following these March assessments six people were admitted into hospital. During April 2015, 36 referrals were assessed, all in the health based place of safety. Of these assessments 16 people were admitted in to hospital. During May 2015, 22 referrals were assessed, one in police custody. Of these assessments 9 people were admitted into hospital. The average admission to hospital following assessment over this three month period was 37% of all people seen.
- We noted that people who had used the health based place of safety were not routinely asked about their experience of the service.
- We were told that people in crisis could access a crisis house, based in the community in west Dorset. The service, run by the non-statutory sector, had eight beds available, six for residents of west Dorset and two for those residing in east Dorset. The crisis teams had a good working relationship with the crisis house and regular dialogue took place.
- At the time of our inspection the west Dorset crisis team were providing care and treatment for 10 people and the east Dorset team for 32 people. 5,013 referrals were made to the crisis teams from April 2014- February 2015, 450 of these were re-referrals.
- The crisis teams were the gatekeepers for admissions to acute beds on the inpatient wards. They assessed patients to determine if admission was necessary, or if alternative care and support could be provided. They worked with the wards to determine if they could provide support for current inpatients, so that they could be discharged safely as soon as possible. Gatekeeping admissions to acute wards by the crisis teams fell below the England average in quarter 1 and 2 in 2014/15. This figure rose in quarter 3 to above the England average and was at 98.83% for quarter 4.
- Each crisis team offered extended hours (outside office hours, including weekends), but not a 24 hour service. However, people could access an emergency service 24 hours a day, which included the telephone helpline or A&E mental health liaison services.
- There were several complaints from patients, carers and staff in other teams about the east Dorset telephone crisis line, operated overnight by the east Dorset crisis team. The telephone system had been set up to operate a call waiting system. However, at the time of our inspection if the telephone was not answered the line was cut off. This often meant no one could speak to the crisis team meaning that the team was unable to respond appropriately to patients who had emergency care needs. In addition, there was no voicemail availability to leave a message. We saw that the senior management team had put an action plan in place to address the deficiencies with the telephone system but no action had been taken at the time of the inspection.
- People stayed, on average, under the care of the crisis teams for up to six weeks, with discharge planning initiated within the first week.

The facilities promote recovery, comfort, dignity and confidentiality

- The furniture was comfortable and designed so that it did not present a risk to patients or staff and maintained the dignity of patients. We saw that the health based place of safety had a ligature risk assessment. Specific

Are services responsive to people's needs?

Requires improvement

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

action to be taken to mitigate the risks identified were detailed and that when in use the room was never unsupervised by staff. People were given food and drink whilst they were in the health based place of safety.

- The crisis teams worked flexibly with patients to promote their privacy and dignity. For example, male staff would not routinely visit female patients on their own. There was flexibility as to where staff visited people. For example, if a person found it difficult to meet with staff at home, they may arrange meetings in cafes or at the day hospital base instead.

Meeting the needs of all people who use the service

- Some information leaflets were readily available in different languages. Staff told us that if they needed information in a different language they would find it on the intranet, provided by the trust. Interpreters could be accessed if necessary.
- Services in the crisis teams were accessible by people in wheelchairs. The health based place of safety was accessible via lift to the first floor and had accessible toilet facilities.

Listening to and learning from concerns and complaints

- Information about how to complain was on display in patient areas and on the trust's website. The trust's website also had information about the Patient Advice and Liaison Service (PALS) which supported patients in raising concerns. Patients using the crisis services were given information about how to make a complaint as part of their introductory information leaflets.
- Staff were able to describe the complaints process and how they would process any complaints.
- We noted in the trust's annual complaints board report from April 2014 that 14 complaints had been specifically made about the East Dorset crisis team. This was the highest occurrence of complaints in comparison to other services provided across the Bournemouth and Christchurch areas. We noted that these accounted for 3% of all of the trust's complaints. We noted that nine of these complaints related to the crisis teams and that five were about the attitude of staff. As a response to complaints about access to the crisis teams a telephone helpline and call waiting system had been developed. At the time of our inspection the system was not working effectively and calls were being cut off.

Are services well-led?

Good

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

Summary of findings

We rated well-led as good because:

- There was good staff morale in the west Dorset crisis team and that they felt well supported and engaged with a visible and strong leadership team which included both clinicians and managers. We found consistent examples of good and outstanding practice in the west Dorset crisis team. Governance structures were clear, well documented, adhered to by the teams and reported accurately.
- In the east Dorset team there was poor morale, staff shortages and confusion about the crisis team model. We found areas of good practice with clinicians delivering services in east Dorset but this was inconsistent.
- The senior management team was fully committed to making positive changes. The management team had put a detailed plan in place to address deficiencies identified in order to develop and implement improvements to the service. The action plan was robust and would address the deficiencies in the east Dorset crisis team in time.

Our findings

Vision and values

- The trust's vision and strategies for the service were on display in many of the clinical and office areas. Not all the staff we spoke with were familiar with the trust's vision and strategy, but they told us they were committed to providing high quality care for people using their services.
- Staff knew who their local managers were, such as the service manager. The east Dorset crisis team commented on the support the team had received from the new service manager and hospital manager, since the team had recently moved into St. Ann's hospital. The team managers had regular contact with the hospital manager and service manager.
- We found that the senior management team was fully committed to making positive changes. We saw that the management team had put a detailed plan in place to address deficiencies identified in order to develop and implement improvements to the service. We saw that the action plan was robust and would address the deficiencies in the east Dorset crisis team. Managers were aware of the concerns we raised and we were confident that the service was well-led and addressing the issues in a timely manner.

Good governance

- We noted that the crisis teams had access to governance systems that enabled them to monitor and manage the teams and provide information to senior staff in the trust and in a timely manner.
- We looked at the crisis team's performance management framework and saw that data was collected regularly. Where performance did not meet the expected standard action plans were put in place. Managers could compare their performance with that of other teams and this provided a further incentive for improvement.

Leadership, morale and staff engagement

- We found that the crisis teams were well-led and had team managers in position. The managers were visible within the service during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support.
- Most of the staff we spoke to, and particularly in the west Dorset crisis team, were enthusiastic and engaged with developments within the service. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers. Some staff gave us examples of when they had spoken out with concerns about the care of people and said this had been received positively as a constructive challenge to practice. We did hear some feedback, particularly from the east Dorset crisis team, that the service was so busy it was difficult to create time to reflect on practice or carry out any clinical audits to ensure that the quality of the service delivered was good. We fed this back to senior managers at the time of our inspection. We noted that the senior management team had an action plan in place to address this and increase the staffing resource in the east Dorset crisis team.
- Staff in the west Dorset crisis team told us that staff morale was, 'very good'. We noted there were concerns in the east Dorset crisis team about poor staff morale.
- We spoke to managers about work underway to analyse this and develop strategies to reduce levels of absence.

Are services well-led?

Good

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

- Staff were aware of the whistleblowing process if they needed to use it.
- We were reassured that the new local leadership within the service was aware of the issues and concerns that we found in relation to the east Dorset crisis team. We saw a robust action plan had been developed prior to our visit which set out a credible plan to address those concerns.

Commitment to quality improvement and innovation

- People using the crisis services across Dorset had access to the recovery education centre which offered many courses to enable people to understand their experiences, manage their recovery and also how to support others with their journey.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust must have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. Staff employed must receive appropriate mandatory training. • The provider must ensure that there are sufficient appropriately trained staff available to provide care to people receiving services from the east Dorset crisis team. • The provider must ensure that staff working in the crisis teams have up to date mandatory training and that staff working in the health based place of safety have training on section 136 of the Mental Health Act.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(i) HSCA 2008 (Regulated Activities)Regulations 2014 safe care and treatment • The provider must actively work with others to make sure that care and treatment remain safe. • The provider must ensure cooperative and good working relations between the East Dorset crisis team and locality CMHTs to ensure that people requiring services can access the most appropriate service to have their need met in a timely manner and that people can access the service through appropriate channels at all times