Requires improvement

Dorset Healthcare University NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Date of inspection visit: 15th -17th March 2016
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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	Bridport Community Mental Health Team	DT6 5DR
RDY38	Fairmile House	Christchurch & Southbourne Community Mental Health Team	BH23 2JT
RDYY2	Westhaven Hospital	Weymouth and Portland Community Mental Health Team	DT4 0QE
RDYNM	Sentinel House	Bournemouth West Community Mental Health Team	BH2 5JW

Summary of findings

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:

- When we returned to the trust on 16 and 17 March 2016 we found that, although the trust had an action plan dated March 2016, few improvements had been made since our previous inspection in June 2015.
- There had been little demonstrable improvement in the quality of care plans and risk assessments in four teams. While we saw examples of good auditing of care records and assessments at one of the teams we visited, this was not replicated across other teams.
- Staffing levels had not improved and we found that teams did not always have enough psychiatrist time for patients to be assessed and reviewed. There were still long waits for psychology support and some talking therapies. The trust had carried out a review of staffing and caseloads across all community mental health teams and found that staffing levels were not sufficient in some teams. The trust was in the process of developing an action plan to address shortfalls in individual teams.
- We identified a number of concerns in relation to the safe management of medicines at Weymouth CMHT.
- The trust had changed the way it investigated serious incidents. Staff told us the investigation process was now less punitive and they were able to learn from incidents. However, we found there was limited evidence of learning across teams.
- Records viewed contained evidence of patients' mental capacity in relation to consent to treatment. However, recording of consent to share information was poor. The majority of records viewed did not contain this information.
- Staff morale varied across the teams, and some teams were positive whilst others felt over-stretched and stressed.

Requires improvement

Are services safe?

We rated safe as requires improvement because:

When we returned on 16 and 17 March 2016 we found that only minimal improvements had been made:

- there had been no changes to caseloads or skill mix
- there was still not enough psychiatrist time available for assessments and reviews of patients
- no improvements had been made to the quality of care plans and risk assessments in four of the five teams visited.

However

- some of the soundproofing issues had been addressed and alarms placed in interview rooms
- there had been improvements in staff mandatory training completion rates, which was now at 98% across the community teams.

Are services effective?

We rated effective as requires improvement because:

When we returned on 16 and 17 March 2016 we found that improvements had not yet been made:

- care records were still not sufficiently person centred
- access to psychological therapies had not improved
- staffing shortfalls continued to affect the effective running of services, for example with a patient not being able to see a psychiatrist within the agreed time frame or having to wait long periods to have psychological therapies

Are services caring?

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

Are services responsive to people's needs?

We rated responsive as requires improvement because:

When we returned on 16 and 17 March 2016 we found that improvements had not yet been made:

Summary of findings

- Bournemouth East did not meet the trust's referral to assessment four-week target for an average of 55% of patients. In Christchurch and Southbourne, only 56% of patients were seen within four weeks. The average across all teams was 80% of patients seen within four weeks
- steps had been taken to improve soundproofing but this had not always been effective. There had been improvement at Weymouth with the addition of door seals but in Bridport, the addition of carpets in interview rooms had not reduced noise.

However:

- the trust had carried out an audit of buildings to identify potential improvements to disabled access.

Are services well-led?

We rated well-led as requires improvement because:

When we returned on 16 and 17 March 2016 we found that improvements had not yet been made:

- teams continued to operate in isolation from each other.
- the trust did not have any governance systems in place to ensure consistency in practice across the community mental health teams
- staff in some teams continued to feel under pressure and experience low morale.
- best practice was not shared across teams. There was little evidence of service-wide learning from incidents.

However:

- staff told us that there had been an improvement in the way serious incidents were investigated.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

When we returned on 16 and 17 March 2016 we found that only minimal improvements had been made:

- there had been no changes to caseloads or skill mix
- there was still not enough psychiatrist time available for assessments and reviews of patients
- no improvements had been made to the quality of care plans and risk assessments in four of the five teams visited.

However

- some of the soundproofing issues had been addressed and alarms placed in interview rooms
- there had been improvements in staff mandatory training completion rates, which was now at 98% across the community teams.

Requires improvement

Are services effective?

We rated effective as requires improvement because:

When we returned on 16 and 17 March 2016 we found that improvements had not yet been made:

- care records were still not sufficiently person centred
- access to psychological therapies had not improved
- staffing shortfalls continued to affect the effective running of services, for example with a patient not being able to see a psychiatrist within the agreed time frame or having to wait long periods to have psychological therapies
- recording of consent had not improved.

Requires improvement

Are services caring?

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

Good

Are services responsive to people's needs?

We rated responsive as requires improvement because:

When we returned on 16 and 17 March 2016 we found that improvements had not yet been made:

Requires improvement

Summary of findings

- Bournemouth East did not meet the trust's referral to assessment four-week target for an average of 55% of patients. In Christchurch and Southbourne, only 56% of patients were seen within four weeks. The average across all teams was 80% of patients seen within four weeks
- steps had been taken to improve soundproofing but this had not always been effective. There had been improvement at Weymouth with the addition of door seals but in Bridport, the addition of carpets in interview rooms had not reduced noise.

However:

- the trust had carried out an audit of buildings to identify potential improvements to disabled access.

Are services well-led?

Requires improvement

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- teams continued to operate in isolation from each other.
- the trust did not have any governance systems in place to ensure consistency in practice across the community mental health teams
- staff in some teams continued to feel under pressure and experience low morale.
- best practice was not shared across teams. There was little evidence of service-wide learning from incidents.

However:

- staff told us that there had been an improvement in the way serious incidents were investigated.

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 patients who develop psychosis, and two assertive outreach teams also in the East and West of the county that provide intensive support to patients who are hard to reach or who find it difficult to engage with mainstream services.

Our inspection team

Team leader: Gary Risdale, Inspection Manager, CQC

The team that inspected community-based mental health services for adults of working age and comprised three CQC inspectors, a consultant psychiatrist and a specialist community psychiatric nurse.

Why we carried out this inspection

We carried out this focussed short notice announced inspection to review the progress the trust had made following our comprehensive inspection in June 2015. In that report we rated four key questions for community-based mental health services for adults of working age as requires improvement. We published the report from the comprehensive inspection in October 2015.

We also issued four requirement notices for consent, safe care and treatment, dignity and respect and governance.

We identified the following areas which required improvement:

• Care plans and risk assessments varied in quality and completeness.

• Some teams had gaps in staffing which had an impact on the safe delivery of treatment. The trust had identified these problems over a year previously from investigations into serious incidents.

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

• 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 found limited learning from serious incidents and limited sharing of innovative practice across community teams.

• 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.

• Some of the community teams seemed to operate in isolation from other community teams and the wider organisation. 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.

We told the trust that it must take the following actions to improve:

Summary of findings

• The provider must ensure confidentiality at all times, particularly in regard to addressing the issues with soundproofing 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.

This inspection reviewed the progress the trust had made

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Looked at 38 patient records
- Spoke with 26 staff
- Looked at caseload numbers in four teams
- Spoke with senior managers for community services on the day before the inspection
- Looked at records of training and supervision

Looked at records of a recent serious incident

What people who use the provider's services say

We did not speak with patients or carers at this follow up inspection.

Good practice

We saw good practice in the Weymouth south team where care records were audited within supervision.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure confidentiality at all times, particularly in regard to addressing the remaining issues with soundproofing 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.
- 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.

Action the provider SHOULD take to improve

- 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 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
Weymouth and Portland Community Mental Health Team	Westhaven Hospital
Christchurch & Southbourne Community Mental Health Team	Fairmile House
Bournemouth & Poole Assertive Outreach Team	Sentinel House
Bournemouth West Community Mental Health Team	Sentinel House

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.

We did not look at adherence to the Mental Health Act during this focused inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

When we inspected in June 2015 we identified a number of concerns in relation to the trust meeting its legal obligations under the Mental Capacity Act 2005 (MCA).

Detailed findings

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.

When we returned on 16 and 17 March 2016, we found that some improvements had been made. We saw staff had clearly recorded one capacity assessment. Consent to treatment and sharing information was not completed in the majority of care records we viewed across the five teams.

A number of staff had not yet received training in the MCA. The average completion rate for each team was 28% but in the Bournemouth east and Poole north teams 100% of staff had completed this training. The trust had a target date of November 2016 for 75% of staff to be trained.

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

Our findings

Safe and clean environment

At our inspection of June 2015, we found that not all interview rooms had alarms in place.

When we returned on 16 and 17 March, we found at the premises in Weymouth alarms had been placed in each interview room. These were not fitted to the walls but consisted of a personal alarm unit hung from a hook. This meant that it would be possible for the alarm unit to removed, which could prevent an alarm being raised in the event of an emergency.

We looked at the clinic rooms at Weymouth, Bridport and Bournemouth and found that they were clean and tidy. The Bournemouth clinic room did not have an examination couch but staff told us the room was not used for physical examinations.

Safe staffing

At our inspection in June 2015, we found some teams did not have the right numbers of staff or skill mix to meet safely all the requirements of the service.

At our inspection on 16 and 17 March 2016, we found that improvements had not yet been made and that in Weymouth and Bournemouth staffing had reduced due to re-allocation of local authority social workers and maternity leave. The trust's action plan had a date of 31 May 2016 to have carried out a review to establish a benchmark for safe staffing levels at each service. The trust then planned to work with commissioners on implementing these.

Managers told us that minimum staffing levels had not yet been agreed by the trust. Staff told us that a review of the trust community mental health teams had been undertaken. The review had found that Weymouth did not have enough staff as patients had higher levels of deprivation and homelessness. The team manager at Bridport told us there were enough staff as long as the Local Authority did not remove their staff from the team. The trust had filled vacancies at Christchurch and Southbourne and staff had been recruited to fill vacancies at Bournemouth although not to cover maternity leave.

Staff told us that there was not enough psychiatrist time available. This meant patients were not always assessed within four weeks of referral and not always reviewed quickly. One speciality doctor had left the Weymouth team and had not been replaced. In the Weymouth north team there was no junior doctor available and doctor input consisted of one consultant four days a week. The team also had a nurse prescriber.

The local authority employed the social workers in the teams and had recently changed the workload of these staff, so they were spending more time carrying out community care assessments. Nursing staff told us there had been a negative impact on the team as previously social workers had undertaken an allocated worker role for patients which involved monitoring their treatment, meeting regularly and providing support. This meant that nurses now had to pick up additional patients to cover the work social workers had previously done within the team.

At our inspection in June 2015, we found the allocation and management of caseloads varied between teams, and this meant that some staff held high caseloads.

We returned to four community mental health services on 16 and 17 March 2016 and found that caseloads remained at the same levels. Team leaders had high caseloads, for example, one team leader had 42 patients on their caseload. However, another team leader explained that new referrals were allocated to them until these could be allocated to a nurse or health care assistant. This was part of the referral tracking system, as it was the team leaders' role to ensure patients who were referred were assessed and allocated.

Staff at all five teams visited told us that there had been recent increases in the number of referrals to the team, which had an impact on caseload, and availability of doctors to undertake assessments. Staff explained that there had been an increase in inappropriate referrals to the team, which was placing additional stress on staff and on the duty workers.

Caseloads varied between the north and south teams in Weymouth. Staff in the north team had higher caseloads than the south team. The team leader of the north team told us that the team faced additional pressures in respect

Requires improvement

Are services safe?

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

of the complexity of patients that they cared for due to a high number of homeless patients, patients with drug and alcohol problems and general deprivation in the area. The highest caseload we saw was 42, which was held by the independent nurse prescriber who runs an outpatient clinic. Caseloads of other members of staff varied from 15 to 30 for registered staff.

Staff caseloads at Bridport were in the range of 20 up to 40 for full time members of staff. The team leader assured us that staff who had the higher caseloads were not allocated any new patients. New patients would be allocated to staff with lower caseloads or who were working with less complex patients. Nurses we spoke with at Bridport did not raise any concerns about the size of their caseload or staffing numbers.

Staff in Bournemouth had lower caseloads, in general, than other teams. Staff told us that their workload was manageable, despite current sickness and vacancies. Some members of staff had specialist knowledge, for example dual diagnosis, which determined the type of patient they had on their caseload. Staff in the assertive outreach team had lower caseloads, as appropriate for the type of intensive work they carry out.

Staff in Christchurch and Southbourne had higher caseloads than other services we visited. Two part time members of staff shared a caseload of 36 patients and another member of staff who worked three days a week had 29 patients. Staff at this service reported feeling stretched. Staff reported lower morale at this service.

Staff were able to discuss their caseloads in management supervision. We looked at minutes of team meetings which showed discussion of new referrals and allocations.

At our inspection in June 2015, we found inconsistent cover arrangements for staff sickness and vacancies. When we returned on 16 and 17 March 2016, we found there were still minimal arrangements in place for sickness, leave and vacant posts.

There was no budget available at Weymouth to pay for locum and bank cover. Managers told us that there was only one member of the staff on the bank with community experience and they were already employed on contract with the team. There were no other staff on the bank who had community experience.

At Weymouth, staff sickness over the last seven months was an average of 5%. No members of staff employed by the trust had left. However, social worker input had been reduced.

At the Bournemouth team, three staff were on maternity leave and cover could not be found for these posts. The team manager told us, and staff confirmed, that the team had absorbed the additional workload. Staff told us that it was a mature and robust team who worked well together to provide cover as needed. We identified that staff were not receiving clinical supervision and the new quality audit of records was not taking place, as staff focused on absorbing the extra workload.

At our inspection of June 2015, we found 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, the lack of a psychiatrist within the team had the potential to cause delays in access to psychiatric input.

When we returned on 16 and 17 March 2016, we found appointments for patients to see psychiatrists were not always available when needed. The trust had a four-week waiting time for patients to be seen. However, there was not always doctor time available to see patients within this time frame. Staff across all services we visited told us that often psychiatrist outpatient appointments were fully booked and this meant it was difficult to access a psychiatrist in an emergency.

At our inspection in June 2015, we found 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 returned on 16 and17 March 2016 and figures supplied by the trust showed that staff had now received mandatory training and the rate of completion was 98%.

Assessing and managing risk to patients and staff

We looked at 38 electronic care records across the four services we visited.

At our inspection in June 2015, we identified safety concerns in relation to the standard of care planning and risk assessment and management at some teams.

Requires improvement

Are services safe?

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

At our inspection of 16 and 17 March 2016, we found that the trust had not yet taken steps to improve and monitor the quality of risk assessments and management plans.

Team leaders had begun to carry out audits of electronic records and risk assessments. In Bridport, audits had found widespread failings in the quality of risk assessments and care plans. Staff had not always updated care plans or risk assessments and many were out of date.

In Bournemouth West at the time of our visit, audits of electronic records and risk assessments had not been carried out. We were advised that the quality of risk assessments and care plans were reviewed in management supervision but the records we reviewed did not evidence that the quality of records had improved.

In the Weymouth team, staff had not always updated patients' risk assessments regularly. We saw one example where an episode of potentially risky behaviour had been recorded in the patient's care notes but the risk assessment had not been updated with this information. A second set of notes contained information about a patient's behaviour that was a potential risk to staff, which had not been entered into the risk assessment.

At Bridport we saw a recent audit of records carried out by the team leader which had highlighted a number of patients who did not have appropriate risk assessments in their care plans. At Christchurch and Southbourne team, one patient's risk assessment had not been updated since July 2013 and another patient's risk assessment had not been updated to reflect an attempted suicide.

Our findings were similar across all four teams.

Staff explained and showed us that there was a problem with recording risk in the electronic records system. Due to a cap on the number of words in the risk summary, older information had to be moved to an accessible archive to allow the input of information that was was more recent. We saw that in one case this had led to risk information being deleted incorrectly.

We did not see any evidence of advance decisions being documented.

Of the records we looked at in Weymouth, four people had crisis plans in place. However, one of these had been written in November 2014. We looked at the records of one patient who had been assessed as high risk of accidental death from risk behaviour. This patient did not have a crisis plan.

Staff discussed risks at the multidisciplinary meeting. Records demonstrated that individual risk was discussed by the team and appropriate actions decided. We saw evidence of good practice in the Weymouth team of risk discussion and management planning.

In the Weymouth clinic room, four sharps boxes had been assembled; one of the four did not have the details recorded on it of who had assembled the box or when. Staff disposed of spoilt (dropped) medicine in the sharps box; they then completed a form to advise what had been placed in the box. Staff returned out of date medicine that was no longer needed to the pharmacy in a sealed box. We checked six of the medicines in the Weymouth medicines cupboard and found that one had gone out of date at end of January 2016. There were also out of date needles for injection in the clinic room.

The stock level of medicines in the medicines cupboard did not always tally with the amount recorded in the record book. Nurses took more medicines than they needed on visits to administer medicines and then recorded what they used when they returned it., This could lead to discrepancies between what was recorded as being in the medicines cupboard and what was physically there.

None of the medicines checked in Bournemouth were out of date.

In Weymouth, we found that the emergency medicines for the management of anaphylactic shock were out of date. In Bournemouth, we saw that emergency medicines were in tagged boxes, which indicated the date the first item went out of date. Staff told us that the pharmacy were aware of these dates and automatically sent through replacements.

The temperature of the fridge in which medicines were stored at Weymouth, had not always been recorded in line with the trust's policy. For example, during December 2015 the temperature had been recorded on 12 out of 23 days. The temperature recording for March 2016 was up to date on the day of our inspection. It was the responsibility of the first member of staff who used the clinic room to record the fridge temperature. None of the recordings were outside the required maximum or minimum temperature. All the medicine stored in the fridge was in date.

Requires improvement

Are services safe?

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

We could only review March 2016 fridge temperature recordings, in Bournemouth West. The team only recorded the actual temperature not the maximum or minimum. Staff told us previous records had been damaged by water.

Reporting incidents and learning from when things go wrong

At our inspection in June 2015, we found there was limited evidence of wider learning for the community teams to improve safety following serious incidents.

When we returned on 16 and 17 March 2016, we found some improvements had been made. Staff told us they knew what to report and how to do this.

Staff from outside the team now investigated serious incidents. The team manager completed the initial 72 hr report and then an external investigator carried out a detailed investigation.

Staff told us that learning from incidents would be shared at team meetings and the team would discuss how they would use this information. Staff at the Weymouth team told us about an education group which allowed the staff team to discuss learning, share good practice and reflect on incidents. However, we did not see any records of this.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

At our inspection in June 2015, we found many of the care records we looked at were not person centred.

At our inspection on 16 and 17 March 2016, we found that the quality of care records had not improved.

Trust policy was that for patients who were not treated under the Care Plan Approach (CPA), care plans would be contained in a letter, usually sent to the GP. This meant that in order to identify a patient's care plan it was necessary to search through a number of uploaded documents, rather than finding it quickly and clearly identified in the relevant area of care records. Staff who were unfamiliar with the system could potentially find it time consuming to access care plans in this way. Care plans contained in letters were brief and not person-centred.

We looked at 38 electronic care records across the four community mental health teams we visited. Twelve of the care plans had gaps, errors or were out of date.

Eight care plans reviewed at Weymouth had gaps or were out of date. We found three care plans that had not been updated. A member of staff had updated one patient's care plan the day before their review meeting. The member of staff had not met with the patient to discuss updates to their care plan but had updated it without their involvement.

We saw that a patient with anorexia had an inadequate care plan. The plan lacked detail and there was no record of contact with their community psychiatric nurse between August 2015 and January 2016. The care plan did not contain any information about how to identify if the patient's health was deteriorating (anorexia is a relapsing and life-threatening illness). The lack of information about relapse warning signs could potentially delay the recognition of relapse and delay treatment.

Another patient had a care plan left over from an inpatient admission but did not have a care plan about current care being delivered. A fourth patient had a care plan with very broad goals for example, 'for X to find a reason not to kill herself". There was no detail of how their caseworker would support them with this.

We found that only four of the care plans were up to date and of good quality. There was notable good practice in one care plan, which had been written by the patient.

At Christchurch and Southbourne team out of five records we looked at, four had gaps or errors. One patient had attempted suicide but their risk assessment had not been updated. Another patient's care plan was dated 2012.

Managers told us about work that was being undertaken to improve patients' involvement developing their care plans. Peer workers, from the Dorset Mental Health Forum, had been recently employed. These peer workers were currently on induction but their role was intended to help patients develop care and crisis plans in their own words. They were also to be involved in providing workshops for patients.

Skilled staff to deliver care

At our inspection in June 2015, we found some teams did not have the right numbers of staff or skill mix to meet safely all the requirements of the service. Variance in performance and quality across teams, and gaps in critical aspects of service provision, were issues that had been identified eighteen months before that inspection through the trust's own internal investigations, following serious incidents.

At our inspection on 16 and 17 March 2016 we found that, whilst a review of the whole community mental health service had taken place, action had not yet been taken to address the required changes the review had identified. Staff told us they were aware of the findings of the review but no changes had yet been implemented.

At our inspection in June 2015, we found the availability of different professional disciplines varied across teams. In some teams, gaps in staffing potentially affected the effective running of those services. We identified widespread delays from assessment to treatment and long waiting times for patients requiring essential psychological therapies as part of their treatment at Bridport, Purbeck and Weymouth.

At our inspection of 16 and 17 March 2016, we found this had not improved. There were particular shortfalls in access to psychiatrists. Staff told us that patients could also wait up to eight months for psychology input, which meant they did not receive psychological therapies in a timely fashion.

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.

Staff received regular supervision. We saw records of supervision and evidence that, in the Weymouth South team, staff discussed their caseload in supervision. Care plans, risk assessments, crisis plans and any safeguarding concerns were discussed in Weymouth South and the team leader recorded any actions to be taken.

In the Weymouth North team, supervision notes were less detailed. There was no evidence of the team leader checking that care plans, risk assessments and crisis plans were in place and in date. Records showed staff discussed patients on their caseload and actions to be taken during supervision.

Team meetings were held frequently. Staff were able to discuss their caseload and any risk.

We looked at records for Bournemouth teams and the assertive outreach team. Staff we spoke with in these teams were unanimous in praising the supervision and support they received.

Teams operated a zoning system as a way of monitoring risk – patients were zoned as red for high risk, amber for moderate risk and green for low risk. Each team managed this system differently, with one team using a board whilst another team discussed zoning in the multidisciplinary meeting.

Good practice in applying the Mental Capacity Act (MCA)

At our inspection of June 2015, we found 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.

When we returned on 16 and 17 March 2016 to check on improvements we found that, although the trust had action plans in place, this had not improved.

The majority of care plans did not have patients' consent to treatment clearly recorded. We noted that nurses in the clozapine clinic recorded consent to medication each time a patient attended. It was evident from some notes within electronic records that patients had given implied consent to the sharing of information, but we saw little evidence of formally recorded or signed consent to share information.

Managers told us the trust had introduced a standard form, used at the first appointment for recording a patient's consent to share information. However, we found minimal use of this form.

In the majority of care records, it was evident that staff had assumed a patient's mental capacity and those patients had been able to participate in decisions about their care. However, there was not always appropriate recorded evidence that staff had considered mental capacity when a patient's mental health had deteriorated.

One patient's record demonstrated staff had carried out a mental capacity assessment when the patient became unwell. The assessment was carried out correctly and the reason for the decision (that the person had capacity to consent to medication) was clearly documented.

A number of staff had not yet received training in the MCA. The average completion rate for each team was 28%, but in the Bournemouth east and Poole north teams 100% of staff had completed this training. The trust had a target date of November 2016 for 77% of staff to be trained.

Good

Are services caring?

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

Our findings

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

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

At our inspection in June 2015, we identified widespread delays from assessment to treatment and long waiting times for patients requiring essential psychological therapies as part of their treatment.

When we returned on 16 and 17 March 2016, we found longer delays in some teams than in others. Staff told us the target time to see referrals was within 20 days. However, this wait could be longer for patients who needed to see a psychiatrist. Staff told us there had been no improvement in the waiting times for psychology input.

In Weymouth, routine referrals were seen within in 20 days, urgent referrals were seen within five days. Breaches to these timeframes occurred due to there not being enough clinic time to see patients. Staff advised that the majority (80 – 85%) of breaches occurred due to patients needing to see a psychiatrist, and there not being enough psychiatry time available.

The trust provided figures, which showed that in four teams less than 70% of patients were seen within four weeks. The team at Bournemouth's Turbary Park site only saw 50% of referrals within four weeks. In Weymouth South, 96% of referrals were seen within four weeks whilst 80% of patients were seen within four weeks in Weymouth North.

The team manager at Christchurch and Southbourne told us that waiting time from referral to assessment was currently eight weeks, down from 11 weeks. Figures from the trust showed that 56% of patients were seen within four weeks of referral.

At our inspection of June 2015, we found that poor soundproofing of interview rooms at most of the locations we visited meant service user confidentiality could not be effectively maintained when other patients were in the communal areas and thoroughfares near to interview rooms.

When we returned on 16 and 17 March, we found the trust had taken some measures to improve soundproofing at the Weymouth offices. Door seals had been replaced which meant that conversations could no longer be heard in the corridor. However, staff told us that conversations could still be heard through the walls of the interview rooms.

The manager in Bournemouth told us that the concerns had been around a staff using a drinks station outside a consulting room being able to overhear conversations and that staff no longer used this. At Bridport, carpets had been put into interview rooms to improve soundproofing, but this measure had not been wholly effective and there was a risk that confidential conversations could still be heard from outside interview rooms.

At our inspection in June 2015, we found several teams who met with patients at their office were located in old buildings that did not have adequate access for disabled patients.

When we returned on 16 and 17 March 2016 we found improvements had not yet been made. The trust's action plan was for team managers to review premises and complete capital bids for work by November 2016.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

When we inspected the trust in June 2015, we found 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.

We returned on 16 and 17 March 2016 and found mixed views from staff about the wider organisation. Some staff were able to tell us about the wider organisation and others could not.

Good governance

When we inspected the trust in June 2015 we found the 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.

We returned on 16 and 17 March 2016 and found no change. There was a lack of an integrated and consistent governance model across different teams. Some teams had identified gaps in care records but not yet addressed quality. Other teams did not have an effective system in place to audit the quality of care records. Understanding of the trust policy regarding records audits varied across teams. Each team had their own local system for managing the quality of the service.

Leadership, morale and staff engagement

When we inspected the trust in June 2015, we found 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.

We returned on 16 and 17 March 2016 and found that there had been no improvement in staff morale in two teams. Staff told us that morale remained poor in Weymouth north as the team were stretched. There had been a reduction in social workers and an increase in referrals.

Staff in Southbourne and Christchurch told us they were under pressure and had insufficient resources.

Staff in Bridport and Bournemouth reported good morale and supportive teams.

Commitment to quality improvement and innovation

Staff told us that there had been changes made in the way serious incidents were investigated; someone outside the team now investigated them. One member of staff told us they felt the investigations were more transparent and less blaming.

When we inspected the trust in June 2015, we found 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.

We returned on 16 and 17 March 2016 and whilst staff told us learning occurred within teams, we found there was still little evidence of learning being shared across the wider trust's teams.

Since our previous inspection, the trust had carried out a review of the whole community mental health care pathway. We were told about a new initiative to recruit and train peer support workers who would have the role of supporting patients to take more ownership of their recovery. Some of these workers had been recruited and were preparing to deliver workshops about mental health and begin working with patients to develop their own care plans and risk assessments.

The provider had identified which areas had the highest acuity and incidence of mental illness across Dorset,

The report identified that there was variance across the region and that some teams did not have sufficient resources. An action plan had been developed to start to address the variances in staffing and quality.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 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 soundproofing 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
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not always demonstrate that care and treatment were provided only with the consent of the service user or other relevant person. The registered person did not ensure patients had provided consent for information to be shared with third parties.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 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 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. The registered person had not ensured that there was proper and safe management of medicines at each of the locations inspected. This is a breach of regulation 12(1) & (2)(a),(b) & (g)

The registered person had not ensured that all staff understood the principles and codes of conduct of the Mental Capacity Act 2005.

This is a breach of regulation 11(1) & (3)