Requires improvement

Dorset Healthcare University NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/team)
RDY02	King's Park Hospital	Bournemouth East OPCMHT	BH7 6JE
RDYX9	Westminster Memorial Hospital	Shaftsbury OPCMHT	<Placeholder text>
RDYX4	Blandford Hospital	Blandford OPCMHT	DT11 7DD
RDY22	Alderney Hospital	Poole OPCMHT	BH12 4NB
RDYX8	Weymouth Community Hospital	Weymouth & Portland OPCMHT	DT4 7TB

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

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

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Good** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
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

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Summary of findings

Overall summary

We rated Community-based mental health services for older people as requires improvement because:

- The services had failed to make significant progress since our inspection in June 2015.
- The quality of care records and risk assessments was inconsistent.
- Understanding and application of the Mental Capacity Act (MCA) was not fully embedded in practice.
- There was a lack of consistency in practice across teams. Good practice was not shared and teams still worked in isolation.

However:

- A review of the service was being undertaken
- Case load sizes had been reviewed and reduced
- A review of psychology provision had been completed with the aim of improving access to psychological therapies.

Summary of findings

Requires improvement

Are services effective?

We rated effective as **requires improvement** because**:**

- The quality of recording in care records was of inconsistent quality. This included records that were incomplete, inaccurate and not contemporaneous. Most patients had risk assessments, but the quality of these varied, some were out of date and they did not always demonstrate a thorough understanding of risk or how it could be managed by linking them to care plans.
- Patients did not always have assessments of physical health.
- Understanding and application of Mental Capacity Act remained variable and was still not fully embedded in practice. The trust had developed a range of Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training. Across all older people community mental health teams, 40% of staff had undertaken the training. This was an improvement on the 13% of staff who had completed mandatory MCA and DoLS training at the time of the previous inspection.

However:

- The care notes that we looked at in Blandford and Shaftsbury were generally of a good standard
- A review of psychology services for older people had been completed which included recommendations for improved access**.**

Requires improvement

Are services well-led?

We rated well-led as **requires improvement** because**:**

- Care record auditing processes were confusing and had not achieved consistency.
- Morale had lowered in some teams and staff did not always feel engaged in the improvement process.
- There was still a lack of cohesion between the community mental health teams for older people across the whole county. This meant that good practice was not being shared and localities continued to work in isolation from each other.

However:

- Caseload sizes had been reviewed and reduced.
- Senior managers had reviewed services and were developing a strategy for community mental health teams for older people.

Summary of findings

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

Are services safe?
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 effective?
We rated effective as **requires improvement** because**:**

- The quality of recording in care records was of inconsistent quality. This included records that were incomplete, inaccurate and not contemporaneous. Most patients had risk assessments, but the quality of these varied, some were out of date and they did not always demonstrate a thorough understanding of risk or how it could be managed by linking them to care plans.
- Patients did not always have assessments of physical health.
- Understanding and application of Mental Capacity Act remained variable and was still not fully embedded in practice. The trust had developed a range of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Across all older people community mental health teams, 40% of staff had undertaken the training. This was an improvement on the 13% of staff who had completed mandatory MCA and DoLS training at the time of the previous inspection.

However:

- The care notes that we looked at in Blandford and Shaftsbury were generally of a good standard.
- A review of psychology services for older people had been completed which included recommendations for improved access**.**

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?
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 well-led?
We rated well-led as **requires improvement** because**:**

Requires improvement

Summary of findings

- Care record auditing processes were confusing and had not achieved consistency.
- Morale had lowered in some teams and staff did not always feel engaged in the improvement process.
- There was still a lack of cohesion between the community mental health teams for older people across the whole county. This meant that good practice was not being shared and localities continued to work in isolation from each other.

However:

- Caseload sizes had been reviewed and reduced.
- Senior managers had reviewed services and were developing a strategy for community mental health teams for older people.

Summary of findings

Information about the service

The community teams for older people in Dorset were based in a variety of different geographical areas. Each team provided services clustered around GP practices. Local authority staff, such as social workers, worked to these boundaries as far as possible while remaining responsible for residents of their employing local authority. The county was covered by three local authority areas.

The community teams for older people provided assessment, treatment and care for older people who required specialist mental health services, and provided support or signposting for carers. People with dementia who required specialist input, for example for behavioural or psychological issues, would be treated by the community mental health teams for older people (OPCMHT).

Shaftsbury and Blandford OPCMHTs were part of the north locality. The Shaftsbury team were based at Westminster Memorial Hospital and the Blandford team at Blandford Hospital. Bournemouth East team and Bournemouth North and West team were both based at Kings Park Hospital. The service at Weymouth & Portland was based at Weymouth Community Hospital. Poole OPCMHT for older people was based at Alderney Hospital.

Our inspection team

The inspection team was led by: Gary Risdale, Inspection Manager, CQC

The team that inspected community-based services for older people consisted of two CQC inspectors

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. During that inspection we rated two key questions for community based mental health services for older adults as requires improvement. We published the report from the comprehensive inspection in October 2015.

At the inspection in June 2015, community mental health services for older adults were found to be in breach of Regulation 17 HSCA (RA) Regulations 2014. This was because the care records were not always accurate, complete and contemporaneous in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided. Care records were not always complete, accessible and up to date including changes in living circumstances, personal circumstances and changes in presentation. This included patients care plans, risk assessments, physical health assessments, and on-going monitoring. It was not clear why decisions not to share information with patients had been made.

This inspection was to review 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 effective?
- Is it well led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information

Summary of findings

During the inspection visit the inspection team:

- visited five community teams
- spoke with service managers for the localities
- spoke with 34 other staff members; including team managers, doctors, nurses and social workers
- attended and observed six multidisciplinary team meetings
- looked at 39 care records of patients
- looked at the trust's improvement plan for community-based mental health services for older people
- looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

The provider must ensure that care records are accurate, complete and contemporaneous. This includes people's care plans, risk assessments, physical health assessments and ongoing monitoring.

The provider must ensure that staff fully understand their responsibilities under the Mental Capacity Act (MCA). This includes ensuring that staff record mental capacity assessments and best interest decisions clearly and that decisions are not made for people without adhering to the principles of the MCA.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

The provider should continue to work with commissioners and stakeholders to ensure equitable crisis support for people with dementia throughout the county.

The provider should continue working towards implementation of a strategy for older adults with mental health problems to ensure people receive person centred care appropriate to their needs wherever they live.

The provider should continue to work towards improving access to psychological interventions for older people.

Dorset Healthcare University NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
King's Park Hospital	Bournemouth East OPCMHT Bournemouth North & West OPCMHT
Westminster Memorial Hospital	Shaftsbury OPCMHT
Blandford Hospital	Blandford OPCMHT
Alderney Hospital	Poole OPCMHT
Weymouth Community Hospital	Weymouth & Portland OPCMHT

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had developed a range of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. This included face-to-face training within the trust, access to a Bournemouth University workbook and development of an online learning package that was due to be available from April 2016. Staff were also able to attend a mini-conference series that had been developed by Dorset County Council's DoLS team. There was an "assessment of mental capacity" course that was a practice-focused foundation course and could be accessed after the completion of other MCA and DoLS training.

The trust provided information about the percentage of staff that had completed MCA training, or were booked onto MCA training. There was a 40% completion rate for all staff within community mental health teams for older people. Inclusion of staff who were booked on to MCA training resulted in a notional completion rate of 81% by

the trust's target date of November 2016. Although still not good, this was a significant improvement on the 13% of staff who had completed mandatory MCA and Deprivation of Liberty Safeguards training during the period 1July 2012 to 30 June 2015.

All remaining staff were booked on training dates to ensure compliance with the trust's target date of November 2016.

However, understanding and application of MCA remained variable and was still not fully embedded in practice. We looked at 15 care records of people who appeared to have impaired capacity. Staff were not always demonstrating adherence to the principles of the Mental Capacity Act. For example, staff had indicated that two patients did not have capacity to make decisions or agree to the care and treatment being given to them. However, staff had not recorded mental capacity assessments to demonstrate how staff had reached these decisions about patients' lack of capacity. In one of these cases, the next of kin, who had been asked for consent on behalf of their relative, had also been deemed not to have capacity in the same progress notes.

The MCA makes it clear that other people, including relatives, cannot just make decisions on behalf of people who use services. The principles of the MCA have to be followed and MCA assessments, including best interest assessments, must be carried out in full where indicated as required.

Good

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

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

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

- The Trust had developed an action plan to ensure that patient records were accurate, complete and contemporaneous, including risk assessment and care plans. The action plan included issuing monthly reports to clinical staff whose clinical records were not complete. Quality of record keeping was to be monitored through supervision and use of a quarterly care plan audit tool. Arrangements for monitoring that these targets were met included use of performance reports and dashboards. Mental health managers oversaw this process. Care plan audits were to be monitored by the nursing and quality directorate.
- However, the quality of recording in the 39 sets of electronic care records that we reviewed was of inconsistent quality. This included records that were incomplete, inaccurate and not contemporaneous. Information tended to be recorded in progress notes, but was not always effectively recorded in care plans, risk assessments or other specialist assessment areas of the electronic care record. This meant that staff who were unfamiliar with the patient would not have easy access to information relating to care, treatment and risk relating to patients.
- The care notes that we looked at in Blandford and Shaftsbury were generally of a good standard. However, of the 39 care records looked at across the teams, nine did not have care plans, and some care plans were out of date. For example, one patient who was on enhanced care programme approach (CPA) had multiple entries that had been entered by the inpatient unit and were out of date by several months. This care plan had not been updated since May 2015. One care plan stated the need was to stop hallucinations and the activity was to support and educate the person in taking medication. There was no detail around what exactly the medication was or how taking it would help the patient with their hallucinations. There was no evidence of explanation or involvement of the patient in the care plan or in the progress notes.
- The majority of patients had risk assessments, but the quality of these varied. Four were out of date. Risk assessments did not always demonstrate a thorough understanding of risk or how it could be managed. For example, the documentation of a patient with dementia who was being treated with antipsychotic medication did not show consideration of the risk of increased confusion and falls in older adults with dementia when using this type of medication. A patient who had depression had a risk assessment that was ambiguous as to whether or not there was a risk of suicide. A patient with a diagnosis of schizophrenia had been rated as low risk with a significant long term risk, but there was insufficient detail to understand the nature of the long term risks. One standard sentence appeared to have been copied into each section of the risk assessment.

Best practice in treatment and care

- The trust had included increased psychological provision in its improvement action plan following our previous inspection. The plan included reviewing psychological provision, to ensure that psychological therapies could be accessed by those who might benefit from them. The review of the older people's clinical psychology service had confirmed a significant under provision of psychology for community mental health teams for older people and identified proposals for improvement. This was still in the stages of development but demonstrated that work had been undertaken to begin to address the issue.
- We looked at electronic records to see if physical healthcare needs were documented. Ten did not have an evaluation of physical health. The majority of the other physical health assessments were not detailed or complete. For example, one patient had diabetes and did not appear to have a record of assessment for their physical health since 2012.

Good practice in applying the MCA

- The trust had developed a range of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. This included face-to-face training within the trust, access to a Bournemouth University workbook and development of an online learning package that was due to be available from April 2016. Staff were also able to attend a mini-conference series that had been developed by Dorset County Councils' DoLS team. There

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.

was an "assessment of mental capacity" course that was a practice-focused foundation course and could be accessed after the completion of other MCA & DoLS training.

- The trust provided information about the percentage of staff that had completed MCA training, or where booked onto MCA training. There was a 40% completion rate for all staff within community mental health teams for older people. Inclusion of staff who were booked on to MCA training resulted in a notional completion rate of 81% by the trusts target date of November 2016. Although still not good, this was a significant improvement on the 13% of staff who had completed mandatory MCA and Deprivation of Liberty Safeguards training during the period 1July 2012 to 30 June 2015.
- All remaining staff were booked on training dates to ensure compliance with trust's target date of November 2016.
- However, understanding and application of MCA remained variable and was still not fully embedded in practice. We looked at 15 care records of patients who appeared to have impaired capacity. Staff were not always demonstrating adherence to the principles of the Mental Capacity Act. For example, two patients had been indicated as not having capacity to make decisions or agree to the care and treatment being given to them but there were no recorded MCA assessments to demonstrate how staff had reached these decisions about patient's lack of capacity. In one of these cases the next of kin, who had been asked for consent on behalf of their relative, had also been deemed not to have capacity in the same progress notes.
- In two other cases the staff documented that patients had tacitly consented to care and treatment. This meant that patients, while not actively agreeing to treatment, had allowed staff to treat them without protesting. This practice does not follow the principles set out in section one of the Mental Capacity Act.
- One patient did not have an MCA assessment and her husband had giving consent for her care plan. However, it was documented elsewhere in the notes that there were safeguarding issues. It was impossible to determine if the decisions were being made in the patient's best interest because the notes did not clearly show that a formal MCA process had taken place and this potentially left the patient vulnerable to abuse.
- Managers told us that that a section on capacity had been added to "editable letters". This meant that, for example, letters sent to GPs should contain a statement about capacity but this was not routinely being used when we looked at outpatient letters under the documents section of RIO.
- The trust had attempted to recruit a dedicated MCA/DoLS facilitator for two days per week but we were told that they were planning to advertise for a full time older person's trainer/facilitator who will also support clinical practice with facilitation of MCA/DoLS in practice.

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?

Good

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

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 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

Good governance

- The trust used key performance indicators and other tools, such as dashboards and performance reports to gauge the performance of the teams. The trust had undertaken a review to understand the reasons for performance against quality indicators. This had recognised that there had not been a mechanism for assurance of quality of interventions and had resulted in a draft framework for monitoring team performance.
- A team-led system of monitoring care records had been introduced. This meant that quantitative data could be accessed by clinicians to act as a reminder to record essential items on the care record, such as risk assessments and care plans. Teams were using the "business objectives" tool to audit cases. A seperate "care plan audit tool" was being used to monitor quality of recording. Quality of recording was also meant to be monitored in supervision. A work stream had been identified to standardise clinical audit, and a recommendation had been made in the "mental health framework of care for healthcare professionals" to audit two cases per month using an agreed record keeping audit tool and to take this to supervision. However, there was confusion amongst staff, including managers, about the auditing process and some teams had not started to audit.The measures had not demonstrably affected the quality of recording as it remained variable.
- Plans to improve training opportunities for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards were in place and showed increased numbers of staff were undertaking training. However, there continued to be a lack of understanding of the principles of the MCA in practice which demonstrated that oversight and monitoring of MCA procedures was insufficient to ensure good practice in applying the MCA was imbedded in everyday practice.
- An "out of hospital vision plan" for implementing equitable crisis support for patients with dementia across the county had been completed. It was planned that recommendations from the plan could be made to commissioners so that a strategy could be developed. This was ongoing and demonstrated a commitment to ensuring access to specialist crisis provision across the geographical patch. A vision for community mental health teams for older people had been produced and the trust was working with commissioners to develop a strategy for community mental health teams for older people.
- Psychology services for community mental health teams for older people had been reviewed and identified an under provision of psychological therapies compared with national expectations and when compared with provision for adults of working age within Dorset. This review included recommendations for improvement of access to psychological therapies for older adults with mental health problems.
- There was improved information sharing across localities but there continued to be a lack of cohesion between the community mental health teams for older people across the whole county. This meant that good practice was still not being shared and localities continued to work in isolation from each other.

Leadership, morale and staff engagement

- Morale and job satisfaction varied. Morale in some teams had improved and staff felt that improvements had been made. Staff told us that caseloads had been reduced and that this had made their workloads more manageable. However, morale in some teams had deteriorated and staff told us that there had been numerous reviews of the service but that implementing positive change was too slow. Some staff felt that their concerns were not listened to by senior managers, and did not feel engaged in the process of improving the service.
- Staff spoke positively about improved access to training.
- Staff had been issued laptops to enable mobile working and told us that this had enabled them to update care records in a more timely way.

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 Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that care records are accurate, complete and contemporaneous. This includes people's care plans, risk assessments, physical health assessments and ongoing monitoring. **This is a breach of Regulation 17 (2) (c) HSCA (RA) Regulations 2014**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider must ensure that care and treatment of patients are only provided with the consent of the relevant person; where a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005. **This is a breach of Regulation 11(1)(2)(3) HSCA (RA) Regulations 2014**

This section is primarily information for the provider

Enforcement actions

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.