Dorset Healthcare University NHS Foundation Trust

Quality Report

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Website: www.dorsethealthcare.nhs.uk

Date of inspection visit: 23 -26 June 2015
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Core services inspected	CQC registered location	CQC location ID
Wards for older people with mental health problems	Herm Ward, St Brelade's Ward, Alderney Hospital	RDY22
	Alumhurst Ward, St Ann's hospital	RDY10
	Chalbury Unit, Weymouth Community Hospital	RDYX8
	Melstock House, Forston Clinic	RDYEW
Community health services for children, young people and families	Sentinel House	RDYNM
	The Junction Sexual Health Clinic	RDYGE
	Blandford Community Hospital	RDYX4
	St Leonard's Community Hospital	RDYFG
	Weymouth Community Hospital	RDYX8
	Wareham Hospital	RDYFD
	Bridport Community Hospital	RDYX5
	Poole Community Health Clinic	RDY62
Community health services for adults	Sentinel House	RDYNM
	Blandford Community Hospital	RDYX4
	Bridport Community Hospital	RDYX5
	St Leonard's Community Hospital	RDYFG
	Alderney Hospital	RDY22
	King's Park Hospital	RDY02
	Westhaven Hospital	RDYY2
	Westminster Memorial Hospital, Shaftesbury	RDYX9
	Wareham Hospital	RDYFD
Community health inpatient services	Westhaven Hospital	RDYY2
	Portland Hospital	RDYY6

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	Westminster Memorial Hospital Yeatman Hospital Bridport Community Hospital Swanage Community Hospital Blandford Community Hospital Victoria Hospital, Wimborne Alderney Hospital St Leonard's Community Hospital Wareham Hospital	RDYX9 RDYY4 RDYX5 RDYFF RDYX4 RDYFE RDY22 RDYFG RDYFD
Community mental health services for people with learning disabilities or autism	Hillcrest, Bournemouth Community team for People with Learning Disability and Intensive Support team main office Delphwood, Borough of Poole Learning Disability Team	RDY25 RD99
Urgent Care Services	Weymouth Community Hospital Portland Hospital Westminster Memorial Hospital, Shaftesbury Yeatman Hospital, Sherborne Bridport Community Hospital Swanage Community Hospital Blandford Community Hospital Victoria Hospital, Wimborne	RDYX8 RDYY6 RDYX9 RDYY4 RDYX5 RDYFF RDYX4 RDYFE
Community-based mental health services for adults of working age	Sentinel House	RDYNM
Wards for older people with mental health problems	Herm Ward, St Brelade's Ward, Alderney Hospital Alumhurst Ward, St Ann's hospital Chalbury Unit, Weymouth Community Hospital Melstock House, Forston Clinic	RDY22 RDY10 RDYX8 RDYEW
Specialist community mental health services for children and young people	Sentinel House	RDYNM
Child and adolescent mental health wards	Pebble Lodge, 49 Alumhurst Road	RDYFX
Mental health crisis services and health based places of safety	St Ann's Hospital: east Dorset crisis and home treatment team and health based place of safety Forston clinic: West Dorset crisis and home treatment teams	RDY10 RDYEW

Summary of findings

Acute wards for adults of working age and psychiatric intensive care units	St Ann's Hospital Linden Unit Waterstone assessment unit, Forston clinic	RDYEW
Community end of life care	Sentinel House Wareham Community Hospital Swanage community Hospital Yeatman Hospital Alderney Hospital	RDYNM RDYFD RDYFF RDYY4 RDY22
Long stay/rehabilitation mental health wards for adults of working age	Nightingale House Nightingale Court 30 Maiden Castle Road	RDYFX RDYFX RDYFT
Forensic community services	Sentinel House	RDYNM
Forensic inpatient/secure wards	St. Ann's Hospital	RDY10

This report describes our judgement of the quality of care at this provider. It 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.

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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 services at this Provider	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.

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Overall, we rated the trust as requires improvement because:

- The services that the trust provided varied in their quality. We had particular concerns about the child and adolescent mental health services, minor injuries units, and mental health crisis and rehabilitation services. We found some significant variance in the quality of care delivered between teams and across the trust.
- The child and adolescent mental health services (CAMHS) in Weymouth and Portland and in Bournemouth and Christchurch did not assess risks to young people waiting for assessment or treatment effectively. Also, the teams were unable to meet the waiting time targets because of the number of vacant posts and staff who were on sick leave.
- At Weymouth, Portland and Bridport minor injuries units there was a lack of clinical leadership. There was no clearly defined system for triage and clinical assessment of patients arriving at the units. This meant that the service was not assessing and responding to potential risks, and patients could be waiting for some time without clinical assessment, when possibly needing urgent or more acute care and treatment. This was not in line with the trust's service operational policy or national guidance. In addition, there were staff shortages and a lack of an appropriate skill mix across the service, and on occasions agency staff were working alone without adequate support or induction.
- We found conflicting and contradictory evidence about staffing and sickness levels in the east Dorset crisis team. However, we found evidence to indicate that staffing issues 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.
- At Nightingale House and Nightingale Court patients were not able access comprehensive rehabilitation programmes in the community; they were unable to do their weekly shopping and cooking. During the inspection we saw that some patients on these rehabilitation wards spent much of their time smoking rather than engaging in meaningful activities. There were high levels of detention under the Mental Health Act on all rehabilitation wards and some patients had been detained on the wards for a considerable length of time which is unusual on rehabilitation wards.
- We found inconsistencies in the planning and delivery of a number of services across the trust.
- There were deficiencies in monitoring and checking safety and emergency equipment across older people's mental health services and in inpatient wards in community hospitals
- The quality of patient records in community health services was variable. A combination of electronic and paper patient records were in use where care was delivered in patients' homes. In community health care inpatient services, records were stored securely on SystmOne. However, there were inconsistencies within SystmOne due to how it had been set up, which meant that staff had limited access to some parts of the system as patients moved across services and not all agency staff had access it.
- The governance frameworks did not always operate effectively for minor injuries units. There were insufficient processes for proactively identifying, assessing and managing risks and seeking staff views. There was insufficient auditing of quality or learning across the service.

However:

- The trust responded very quickly and positively when we raised concerns about the risk assessment process for children and young people on waiting lists in the Weymouth and Portland and Bournemouth and Christchurch child and adolescent mental health

services and took prompt action to review and reduce the highest risks. The trust drew up an action plan to review all waiting lists, caseloads and the risk assessment process, and has kept us updated on the positive progress with this.

- The trust responded quickly and positively when we raised concerns about the safety of services delivered in Weymouth and Portland minor injuries units. It assured us that only experienced clinicians would work at these units and that if safe cover could not be found the units would close. All units would have a band six nurse at all times as a minimum. The trust also told us that it is considering how it could provide band 7 shift leaders in each unit. The opening hours at Portland would be changed, with no weekend working, and there would be receptionist cover during opening hours.
- There was visible and positive clinical leadership at Blandford and Swanage minor injuries units, which resulted in a locally well led and well organised service.

In addition:

- We observed outstanding care and treatment in both inpatient mental health services and the forensic community services.
- In inpatient mental health services we found that the model of care and acute care pathway optimised patients' recovery and that there was a strong emphasis on recovery-orientated therapeutic programmes, many of which were instigated by patients.
- The forensic community Pathfinder service worked with patients with a personality disorder who were at risk of offending to improve their outcomes and at significantly lower cost than being in hospital. The service was psychology led and worked with patients around their risk behaviour. The staff within the community forensic services went out of their way maintain contact with patients placed on wards out of the area and worked hard to bring patients back into the area as soon as they could, including supporting the maintenance of relationships with relatives.
- The trust had a relatively new board (executives and non-executives), with the majority having been appointed only since the arrival of the chief executive in 2013. The director of nursing had been in post for ten months before our inspection and a new medical director was due to take up post immediately after our inspection. The leadership team was positive, passionate, energetic and open and transparent. We concluded that they were a cohesive team who respected one another and shared a common purpose.
- The executive team, along with the senior managers, were aware that the trust needed to improve and we found that, despite many of them only recently coming into post, they had been very active in working quickly to address and identify issues. They had engaged well with staff, developing a new vision, 'to lead and inspire through excellence, compassion and expertise in all we do', which was underpinned by the principle of doing 'better every day'. In addition, they had engaged positively with stakeholders, an aspect for which the chief executive had taken specific responsibility. This included creating active relationships with the clinical commissioning groups (CCGs), NHS England, local authorities, and visiting groups of GP's. They had been successful in changing attitudes and fostering positive relationships – so much so that commissioners and other stakeholders now held the trust in high regard and were positive about the future, whereas previously they had held a very different view. It was clear that there was a cohesive strategy based around driving improvements in clinical practice and working in partnership with patients, staff and stakeholders; we saw clear evidence of this in several areas across the trust.
- We found that the trust had developed an impressive, high quality and detailed governance system to support it to achieve its vision and this was in the process of being rolled out, although it was not yet fully embedded across all services. We found those systems were robust and we were confident that, given time, areas of concern could be identified speedily and managed well.
- In addition, the trust had recently moved to a locality-based delivery model to promote integration of both physical health and mental health services. This model was in the early stages and was developing well for some services but not so well for others, resulting in some variation in the quality of services and some services feeling fragmented as a result. For example, staff felt there was now a lack of strategic focus for people with functional illness across older people's community services. Staff questioned whether the

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child and adolescent mental health service was too small to be split across localities and they felt that there was insufficient leadership of urgent care services.

- We found good practice across the services that we inspected, with a caring, enthusiastic and committed workforce that in the main treated patients in their care with dignity and respect.
- Although we found some care that gave us cause for concern, as identified above, throughout the inspection the trust was very receptive to any comments that we made and we saw immediate and appropriate action taken when we raised a concern.
- We have not taken any enforcement action and are confident that the trust will quickly address all areas of concern identified in the requirement notices detailed in this report.

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

Dorset HealthCare University NHS Foundation Trust requires improvement. However, we saw that it was well led by its new leadership team and was in the process of deploying effective systems that we were confident would result in the delivery of improved, high quality services for the patients it serves in the future.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated 'safe' as requires improvement because:

- The child and adolescent mental health services (CAMHS) in Weymouth and Portland and in Bournemouth and Christchurch did not assess risks to young people waiting for assessment or treatment effectively.
- There was no clearly defined system for triage and clinical assessment of patients arriving at the minor injuries units.
- 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 and crisis telephone helpline at night.
- A number of the trust services were provided from Victorian/ Georgian buildings, some of which were listed buildings so posed some difficulties for the trust in making appropriate alterations when modernising the facilities. However, we found that where buildings and wards needed refurbishment or services needed relocation plans were in place. Some major refurbishments were taking place at the time of the inspection. A key priority of the trust's strategy was to rationalise its buildings in order to meet the needs of its clinical service delivery.
- Although staff followed infection control policies and procedures in most services, these were not followed in a small number of the community hospitals and put patients at risk of infection.
- There were deficiencies in monitoring and checking safety and emergency equipment.
- Alumhurst and Chalbury wards were small and cramped and unfit for the purpose for which they were being used.
- Staffing levels were not always appropriate in community hospitals, children and young peoples' health, urgent care and mental health crisis services. There was concern over the cover provided by junior doctors out of hours on mental health older peoples inpatient service, including some lack of confidence about junior doctors ability to manage complex patients during this time; particularly on Chalbury ward due the isolation of the service.The trust was working hard to address staffing issues.

Summary of findings

- Although the trust was making progress in developing safe medicines management practices and policies and practice relating to legal high in the rehabilitation service and the safe storage of medicines in some community hospitals needed attention.
- Some minor injuries unit staff were using out of date patient group directions to administer medicines to patients and there was a lack of pharmacy support outside normal working hours, including at weekends and bank holidays. (A patient group direction allows a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription).

However:

- Staff across the trust were open and transparent
- We found that the majority of wards and facilities were visibly clean and well maintained.
- Patient risk assessments were being carried out on admission and reviewed regularly across the trust, with mental health services using a variety of nationally-recognised tools to assess risk.
- Staff actively promoted de-escalation techniques to avoid restraint and seclusion of patients of mental health services where possible. We saw evidence that all staff in acute inpatient mental health wards and forensic inpatients were trained in promoting safer and therapeutic services.
- Staff knew how to recognise and report incidents on the trust's electronic recording system (Ulysses). Most staff followed reporting procedures, although this was not consistent and not all staff understood or used the system. There was evidence that some learning from risks, incidents and near misses was shared with staff.

Are services effective?

Requires improvement

We rated 'effective' as requires improvement because:

- The quality of patient records varied in detail and quality from ward to ward, team to team and service to service, and in some areas did not always reflect the current needs of patients, were not always up to date and the timeliness of discharge information was inconsistent.
- We found that the planning and delivery of care was inconsistent across the trust in end of life care and was based

on historical commissioning arrangements, meaning that the services received was very much dependent on where a patient lived. However, the quality of services delivered by the trust were inconsistent across the trust.

- The trust used electronic record systems. Records were securely stored on an electronic patients' record system but not all agency staff had access. The implementation of the SystmOne electronic patient record system used in community health services had not been wholly successful and staff told us they were experiencing difficulties. Access to the system was variable across services and some services could not access records completed in other services when patients moved between them because of the different configurations used in the different services which could pose a potential risk. The trust acknowledged the difficulties with the implementation and we saw that they were working to address this.
- Care and treatment across the trust was generally delivered in line with relevant national guidelines but there was a lack of evidence of sharing best practice across some teams and services.
- We had some concerns about practices relating to 'legal highs' as practice often differed from the trust policy. This was of particular concern on the mental health rehabilitation wards where legal highs were stored in the controlled drugs cabinet, with no system to manage them.
- Although recently updated on electronic systems, some minor injuries unit staff were using out of date patient group directions to administer medicines to patients.
- We found that staff in many areas lacked a comprehensive understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

However:

- In most areas records were patient centred and staff described how they put patients' needs at the centre of care and support. This was particularly evident in the forensic community services, where patients had recorded their views about what they wanted to achieve from their care.
- Staff were generally committed to providing holistic care and we saw evidence of staff supporting the emotional needs of patients and their carers.
- The majority of patients using mental health services had physical health checks completed and risks to their physical health were identified and managed effectively. Patients at St Ann's hospital had access to a dedicated physical healthcare team.

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- Care and treatment across the trust was generally delivered in line with relevant national guidelines, such as those produced by the National Institute for Health and Care Excellence (NICE).
- Across all areas of the trust, care and treatment was provided by multidisciplinary teams of competent staff who were qualified and trained for their roles. A number of the mental health services, including rehabilitation and older people's community mental health services, had limited access to psychologists.
- In both community health services and mental health services we found a strong ethos of multidisciplinary working.
- Patients were given information about their rights and how to contact independent advocates on admission and at regular intervals during their detention under the Mental Health Act (MHA).
- We rated community forensic services as outstanding for being effective due to the innovative approaches to patient care.

Are services caring?

Good

We rated 'caring' as good because:

- The majority of staff we met with were caring, compassionate and kind. Patient feedback was consistently positive about the way they were treated and involved in their care.
- Acute inpatient mental health wards/psychiatric intensive care units and community forensic services were rated outstanding because of the manner in which they cared for patients and for the passion that they clearly demonstrated for their work.
- We found many examples of patients being involved in their care and some services demonstrating innovative ways of involving people – for example, through a mutual expectations charter and the development of short films involving young people with lived experience to demonstrate good practice in involving young people in their care.
- The trust had developed a carers strategy to ensure that carers were treated appropriately and involved in the care and treatment of their relatives/friends as appropriate.
- Most services had written information in different languages and access to interpreter services if needed.

However:

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- In some mental health wards for older people the dignity of patients was, at times, compromised; we saw patients receiving personal care with bedroom doors open in view of people passing.

Are services responsive to people's needs?

Requires improvement

We rated 'responsive' as requires improvement because;

- We found planning and delivery of health services was inconsistent across the geography of the trust, based upon historical commissioning arrangements. For example, the generalist palliative care service in Bournemouth and Poole was more responsive than the community nursing service in west and north Dorset, as they could support both health and social care needs of patients. If personal care services were not available to support a discharge in rural Dorset these patients did not have timely access to end of life care in their preferred place of care.
- For older people with mental health problems there was a very good intermediate care service for dementia which provided specialist crisis support. However, this was not available in west Dorset.
- A telephone call management system had been set up in east Dorset to respond to patients in crisis at night. However, at the time of our inspection, if nobody answered the phone, it simply rang off. There was no answer phone. This meant that a patient in crisis had no way to contact the team night and the team had no means of understanding and managing the potential risks for patients.

However:

- There was only one health based place of safety for the whole of Dorset, situated at St Ann's Hospital, the trust and its partners believed this was sufficient provision. Patients in west Dorset requiring care in the health based place of safety were generally transported in police vehicles which is not in line with the Mental Health Act code of Practice, which states that this should be the exception. But, the trust had not had to turn anyone away in 2014/2015 to date and the relationships between the trust and the police in working together to address the needs of those in crisis was excellent.
- The trust was making a considerable investment and had a development programme to improve the hospitals/buildings it delivered services from.
- Complaints were well managed and the trust apologised when things had gone wrong.

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- There was a clinical services review being undertaken across Dorset by the clinical commissioning group to look at how services were configured. This could have a significant impact on the way the trust delivers services in the future
- We rated 'responsive' as outstanding for acute wards for adults of working age and psychiatric intensive care units (PICU) because there was very good bed management and how they met the needs of the people who used there services.

Are services well-led?

Requires improvement

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

- The services that the trust provided varied in their quality. We had particular concerns about some of the child and adolescent mental health services, some minor injuries units, the east Dorset mental health crisis and the rehabilitation services. We found some significant variance in the quality of care delivered between teams and across the trust.
- The locality-based delivery model was in the early stages of implementation and was developing well for some services but not so well for others, resulting in some variation in the quality of services, with services feeling fragmented and some staff feeling that they had not been engaged enough in the process of change.

However:

- We found that the trust had identified some significant areas of concern, had acted to change them and that there were now significant improvements in those services (for example, acute mental health inpatient wards, which we rated as outstanding).
- The trust had a relatively new board (executives and non-executives). The leadership team was positive, passionate, energetic and open and transparent. We concluded that they were a cohesive team who respected one another and shared a common purpose.
- The trust had engaged positively with stakeholders and had been successful in changing attitudes and fostering positive relationships – so much so that commissioners and other stakeholders now held the trust in high regard and were positive about the future, whereas previously they had held a very different view.
- There was a cohesive strategy based around driving improvements in clinical practice and working in partnership with patients, staff and stakeholders.

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- The governance framework was in the process of being rolled out and in time this should ensure that the trust is able to identify and act on issues quickly.

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Our inspection team

Our inspection team was led by:

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

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

The team included CQC inspection managers, inspectors, Mental Health Act reviewers, pharmacists an analyst and two inspection planners.

There were also specialist advisors from a variety of mental health and community health service backgrounds, including consultant psychiatrists, psychologists, consultants in community health services, junior doctors, senior nurses, student nurses, social workers and a GP.

In addition, the team included experts by experience who had personal experience of using either mental health or community health services or caring for someone who had used these services.

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 get to the heart of people who use services' experience of care, 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?

Before the visit, the inspection team:

- Reviewed information that we hold on the trust.
- Requested information from the trust and reviewed that information.
- Asked a range of other organisations that the trust works in partnership with for feedback. These included NHS England, Dorset Clinical Commissioning Group, Monitor, Healthwatch, overview and scrutiny committees, Health Education England, and other professional bodies and user and carer groups.
- Sought feedback from patients and carers through attending focus groups and meetings.
- Reviewed information from patients, carers and other groups received through our website.

During the announced inspection visit from 23 to 25 June 2015, the inspection team:

- Observed how people were being cared for in wards and clinics and accompanied community teams on visits to people's homes, seeing 91 episodes of care in the community.
- Spoke with 429 people who used the services and their carers or family members and received 182 comment cards that we had left in patient areas before our inspection.
- Spoke with 624 staff who worked within the trust, such as nurses, doctors, therapists and support staff.
- Interviewed the chief executive and all the members of the trust board, including all but one of the non-executive directors.
- Attended a meeting of the trust board.
- Interviewed other senior managers in the trust, including 67 managers of services, such as ward managers and team leaders.
- Reviewed 539 care or treatment records of people who use services.
- Visited all the wards in community hospitals and the mental health inpatient units as well as 52 locations where community services were delivered.

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Following the announced inspection, the inspection team:

- Visited the trust headquarters and spent a day reviewing electronic care records.
- Completed unannounced visits to three minor injuries units.
- Completed unannounced visits to three community inpatient locations.

Information about the provider

Dorset Healthcare University NHS Foundation Trust (DHUFT) provides a range of services to the population of Dorset, including integrated community health and mental health, specialist learning disability services, community brain injury services, community hospitals and prison healthcare. We did not inspect prison healthcare services at the time of this inspection.

Most of the trust's services are provided in the local communities, in people's homes, community hospitals or in local centres. Several services are delivered by locally-based integrated health and social care teams. The trust also provides specialist assessment and treatment inpatient centres.

Whilst the trust headquarters is in Poole, the trust provides local services across a range of locations throughout Dorset.

The trust serves a population of almost 700,000 people across the county of Dorset.

The trust achieved foundation trust status on 1 April 2007.

The trust has a total of 533 inpatient beds across 18 locations. These include mental health inpatient beds and beds in community hospitals.

The trust has a workforce of 5,436 . It had an income in 2013/14 of £242.5 million and an expenditure of £240.1 million.

In 2010, the trust gained University status, having already established a collaborative university department of mental health with Bournemouth University. The trust also has relationships with Southampton University and St Loyes Foundation (a charity working to transform the lives of disabled and disadvantaged people).

In 2012, following the introduction of clinical commissioning groups, the trust took over services previously provided by Dorset Primary Care Trust and Bournemouth and Poole Community Care Trust, which included community health services and community hospitals.

There have been 35 inspections between 2012 and 2015 across 18 locations registered to the trust.

There have been a number of changes in senior leadership at the trust since 2012. The current chief executive came into post in autumn 2103. Following this, a new executive team has been appointed. A new medical director was due to take up post immediately following our inspection.

There were four locations that were non-compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 at the time of our visit.

- St Leonard's Community Hospital (19/06/2013): Non-compliant against regulations 21 (Staffing), 10 (Assessing & monitoring the quality of service provision) and 20 (Records).
- Weymouth Community Hospital (20/09/2013): Non-compliant against regulation 20 (Records).
- Westhaven Hospital (11/06/2013): Non-compliant against regulations 21 (Staffing) and 20 (Records).
- Linden Community Support Unit (30/05/2013): Non-compliant against regulation 21 (Staffing), and 10 (Assessing & monitoring the quality of service provision).

What people who use the provider's services say

We received 182 comment cards that were left in patient areas before our inspection, of which 91.2% (166) were

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positive and only 1.6% (3) negative. Positive comments included that staff had a positive attitude and that they were helpful and caring. Patients in the main felt listened to and treated with dignity and respect.

Healthwatch Dorset had received 152 comments between January 2015 and March 2015, made up of 99 negative comments, 36 positive and 17 comments of mixed/neutral/unclear sentiment.

The main negative themes related to concerns about community mental health services, in particular complaints around mental health crisis services being slow to respond and complaints about access to speech and language therapy for children.

For more detail of what patients told us, please see the core service reports for each area, which give patients' views on the individual services that we inspected.

Good practice

Community health services for children, young people and families

- The Dorset working women project in Bournemouth, supported by the sexual health services, provided an outstanding level of care and support. The staff were dedicated and helped a very vulnerable group of women, going beyond their contracted duties. For example, they provided emotional support to women attending court cases regarding care for their children and they ensured that drop-ins sessions were enjoyable as well as practical. The staff also produced newsletters and coordinated charity work for the women.
- The enuresis service (which dealt with involuntary urination, including bed-wetting) provided support to children and young people in a particularly caring and sensitive way. Feedback was used to develop the service and new equipment that would improve outcomes and experiences for children had been introduced.
- The breast feeding service in Bournemouth had received UNICEF baby friendly accreditation and people using the service were particularly complimentary about it. They liked the way health visitors contacted them and reminded them of clinics by text, and also that staff offered to visit them at home if that was preferred. One person said "I wouldn't have had the energy to go out; it was great they came to my house".

Community health services for adults

- The pain service had undertaken research on a specialist pain management programme conducted for patients living with fibromyalgia to help them deal with their condition from a position of confidence and empowerment. The team had been invited to present the research at various local and international events, including information on development of Royal College of GPs' commissioning guidelines and development of the early pre-screening tool, which was to be adopted by the faculty of pain at the Royal College of Anaesthetists.
- Staff were going an extra mile to support patients who could not access the services readily. Community nursing staff had provided services to patients in traveller sites, caravans and prison and on one occasion to a patient who lived in a tent in a geographically difficult location.
- The brain injury vocational service provided a range of rehabilitation activities for patients to practice and regain their confidence and essential skills. It held different workshops, such as job clubs, health for work, IT workshop, and community outreach services. We observed a workshop where patients were participating in glass painting and sanding furniture/woodwork.

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Community health inpatient services

- In Bridport, inpatient beds were part of a locality-wide service providing multi-agency support to meet the needs of individual patients. The Bridport inpatient team took part in a weekly multidisciplinary virtual ward meeting to discuss vulnerable patients and the most appropriate services and care pathway to meet their needs. This model was being rolled out to Weymouth in September with co-location of primary medical care and social services with community services and community inpatient beds.
- There was a nurse practitioner who was trained in an extended role and undertook certain surgical procedures at the day surgery unit at Bridport hospital.

Urgent Care Services

- The medicines refrigerator temperature records were displayed visually as a graph so it could be clearly identified if a reading was outside normal limits (area coloured red). There were clear instructions for staff to follow in the case of temperature variation. Fridge temperatures are important because some medicines deteriorate if not kept cold enough.

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Forensic inpatient/secure wards

- The ligature management plan included a description, photograph and barcode so that potential ligature points were easily identified. The plan rated the level of risk each ligature point presented, and any action that was to be taken. (Ligature points are places to which patients intent on self-harm might tie something to strangle themselves.)
- Patients had their physical healthcare reviewed every three months by a dedicated physical healthcare team in the hospital.
- A patient on the ward was a peer representative and attended ward and forensic service meetings, and was able to raise patients' concerns.

Forensic community services

- The Pathfinder service was a satellite of the forensic community team, with many staff working across both services. It was provided as an alternative to hospital treatment (typically in medium or high secure services) for offenders with a personality disorder.
- The service had set up a small olanzapine depot injection clinic, so that community patients could receive their medication and have the necessary three-hour monitoring period afterwards. (Depot is a special preparation of medication given by injection that is slowly released into the body over a number of weeks.)

Summary of findings

Acute mental health wards for adults of working age and psychiatric intensive care units

- Each ward had either a sensory room or the availability of a calm box, or both. Staff and patients spoke positively about this initiative, which provided a coping skills toolbox full of aids to assist in calming distress, anxiety and agitation. Examples included something to touch, such as stress balls, some music to listen to, happy pictures to look at, herbal teas to taste and aromatherapy products to smell. The initiative was part of the nationally-recognised good practice example of safe wards. Charitable funds had been raised to ensure the sensory rooms were furnished and equipped to a very high standard.
- There was a particularly positive and successful initiative called, getting to know us', part of the safe wards interventions. The aim of the intervention was to enhance therapeutic relationships between staff and patients through the sharing of personal information. All wards advertised posters, with pictures of all staff and described their likes, dislikes, preferences for music, hobbies, food, travel, aspirations and hopes for themselves. The information shared personal information about staff and showed an openness and trust to allow patients access to such information.
- We observed inter-agency working taking place. We attended one of the services' regular police liaison meetings, which was also attended by the hospital manager, the head of patient safety and risk, the patient safety advisor and the police neighbourhood liaison officer. There were 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 ward staff following the introduction of clear guidance on the criteria. We also heard that all police received mental health training and that the police mental health co-ordinator spent time on the acute wards as part of their induction to the role.
- A joint project, the wellbeing and recovery partnership (WaRP), between the trust and the Dorset mental health forum across all of the acute wards, had been developed. Peer specialists, people with lived experience of a mental health condition, provided a varied and rich programme of educational and recovery-focussed sessions on the wards. In addition, patients had access to the recovery education centre, which offered many courses to enable patients to understand their experiences, manage their recovery and also how to support others with their journey. Peer specialists provided recovery coaching to patients and staff on the wards and provided patients with personal support plans.
- Each of the acute wards had a carers lead staff member and that the leads meeting was proactive in engaging carers through a variety of initiatives. Peer carer specialists were employed by the Dorset mental health forum to work within the trust. These were people who had lived experience of being a carer for someone experiencing mental health problems. Examples were given of carer drop-in sessions and carers' 'high tea' events, picnics and peer specialists working with the staff carers leads to improve engagement with carers. A carers' resource pack was available electronically.
- We spoke to staff about an initiative set up to support staff, called 'hidden talents'. This was an additional forum for staff who have had or have mental health issues. The support forum was an action group working within national guidelines promoting people in the workplace with lived experience of a mental health need.

Summary of findings

Mental health crisis and health based places of safety

- 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 a carers' project, which provided flexible and individualised support for carers.
- 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 was to ensure that people got mental health professional input in a timely manner while also diverting people from inappropriate police custody or section 136 of the Mental Health Act assessments. (Section 136 gives power to the police to take someone from a public place to a place of safety if they have a mental illness and are in need of care.)
- We noted strong and firmly established relationships between the provider and the police, which were conducive to positive outcomes for people using services and for staff from both organisations. We saw that the police mental health coordinator received a detailed and thorough induction to mental health services, which included working shifts on the acute inpatient wards.

Community mental health services for people with learning disabilities or autism

- Work around needle phobias helped people who use the service who had a phobia of needles to have injections in a more comfortable setting.
- A dialectical behavioural therapy group helped meet the needs of some of the people who used the service and gave them skills to manage their emotions productively.
- Life skills groups (which staff have trained staff outside the trust to deliver) helped the people who use the service in their daily lives.
- A transition project helped people using the service to manage the transition from school to adult life by spending time in a bungalow learning skills on how to live more independently in the community.
- The Bournemouth community learning disability team ran a memory clinic to provide support to people who used the service who might also have dementia and the team had written an article about it for a peer reviewed journal.

Summary of findings

Long stay/rehabilitation mental health wards for working age adults

- Staff used the quality, effectiveness and safety trigger tool (QUESTT) to improve their service delivery. This was completed monthly.
- Staff used the Liverpool University neuroleptic side effects rating scale (Lunsers), a tool designed to monitor medication, including side effects related to neuroleptic (anti- psychotic) medications.

Community-based mental health services for adults of working age

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

Summary of findings

Wards for older people with mental health problems

- There was a high level of innovation and dedication to patient comfort on Chalbury Ward. We found the staff went above and beyond what could reasonably be expected to provide a good environment for the patients. The ward décor was worn and in need of improvement, so staff had used their own time and resources to decorate parts of the ward and create reminiscence areas.

Specialist community mental health services for children and young people

- The children's learning disability service won an innovation award from the Royal College of Psychiatry in 2014 for 'developing parenting groups as an initial intervention'.
- The north Dorset community child and adolescent mental health service team had set up an advisory telephone service for professionals in North Dorset. The telephone service offered support in identifying whether a referral to the service was appropriate. Information on the telephone service had been sent to all schools, children's centres and GP practices in the North Dorset area.

Summary of findings

Child and adolescent mental health wards

- The child and adolescent mental health service ran the wave project, which provided free surfing to young people with mental health problems. The wave project aimed to improve young people's wellbeing, social skills and mental health while teaching them to surf off the Dorset coast. Young people from Pebble Lodge were referred to the project (where appropriate) as part of their therapeutic activities. The ward transition nurse was also the wave project lead. The project was part of the national wave project, which used the Stirling child wellbeing scales to measure outcomes for young people participating in the project.
- The patients were able to attend regular education at the on-site school, which had recently been rated as outstanding by Ofsted.

Areas for improvement

Action the provider MUST take to improve

The trust MUST do the following:

Community health services for children, young people and families

- Provide enough staff to deliver the health and wellbeing programmes for children, young people and families.
- Use robust infection control procedures and monitor them.
- Manage medicines consistently and safely.
- Provide robust governance arrangements, including management of the risk register.
- Ensure that business continuity plans provide clear guidance for staff.
- Improve mandatory training compliance.
- Enable an open and transparent culture where staff feedback and involvement is encouraged.

Summary of findings

Community health services for adults

- Ensure that there are sufficient numbers of suitably qualified staff in all community teams and that staff have safe caseload levels, especially the night nursing team.
- Protect patients against the risks of unsafe or inappropriate care and treatment arising from incomplete patient records or the inability to access electronic patient records when required.
- Ensure that staff receive appropriate training and that there is a formal process for staff to follow to meet requirements of the duty of candour.

Community health inpatient services

- Store medicines in accordance with its policies and standard operating procedures.
- Ensure that appropriate dates are placed on medicines once opened or stored at an appropriate temperature.
- Implement infection prevention and control policies and procedures and thorough environmental infection control audits on all inpatient wards.
- Provide enough adequately experienced and trained staff to meet the assessed needs of patients at all times.
- Ensure that equipment servicing and checks are carried out regularly and that records are kept showing that equipment is safe for use.
- Ensure that emergency equipment is fit for purpose and available in all areas at all times.
- Train all staff in basic life support to deal with emergency situations.
- Provide robust monitoring of the safety and quality of the service, identify risks and take timely actions to manage them.

Summary of findings

Urgent Care Services

- Ensure that operational policy and service specification for minor injuries units are clear, meet the needs of patients and are communicated to staff.
- Strengthen the leadership of the service at both individual minor injuries unit level and trust wide.
- Implement a formal system that ensures all patients attending a minor injuries unit receive a timely clinical assessment in line with the 15 minute timescale .
- Provide robust monitoring of the safety and quality of services, identify risks and take timely actions to manage them.
- Provide robust governance arrangements, including management of the risk register.
- Protect patients' confidentiality and privacy when booking into minor injuries units receptions and disclosing their reasons for attendance.
- Provide enough adequately experienced and skilled staff to ensure safe, effective and responsive care and treatment at all times.
- Ensure that emergency equipment is fit for purpose and available in all areas at all times.
- Train all staff in basic life support to deal with emergency situations.
- Ensure that all staff are up to date with safeguarding training, know how to identify and report concerns, and know how to respond appropriately to child protection flags.
- Ensure that all staff working in minor injuries units have access to and follow clinical guidelines and treatment protocols in line with National Institute for Care and Health Excellence guidelines and the latest evidence-based guidance.
- Ensure that the patient group directions used in minor injuries units to enable staff to administer prescription-only medications are signed by staff and are current..
- Ensure that equipment servicing and checks, including portable appliance testing, equipment maintenance and calibration are carried out regularly and that records are kept showing that equipment is safe for use.

Summary of findings

End of life care

- Strengthen strategic leadership and governance arrangements and ensure that there is regular reporting to the trust board on the quality of end of life services.
- Undertake a needs assessment and review of end of life services and develop plans to improve responsiveness across the area covered by the trust.
- Ensure that an end of life strategy is developed, consulted upon and communicated effectively to staff, patients, relatives and the wider community.

Long stay/rehabilitation mental health wards for working age adults

- Protect patients against the risks associated with the unsafe use and management of medicines on Glendinning ward by ensuring that the record of the administration of medication is accurate.

Summary of findings

Community-based mental health services for adults of working age

- Ensure confidentiality at all times, particularly by improving the sound-proofing of clinical and interview rooms in order to protect the dignity and privacy of people using services.
- 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.
- Ensure that the risks to all service users are assessed effectively 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, ensure that steps are taken to remedy the situation, prevent further occurrences and to make sure that necessary improvements are made.
- Provide enough suitably qualified, competent, skilled and experienced staff in each team to meet the needs of the people using the service at all times.

Wards for older people with mental health problems

- Ensure that all care plans reflect the risks identified in the risk assessment process.
- Ensure that privacy and dignity are protected on Alumhurst ward and at Melstock House, with robust systems to check and monitor compliance and to ensure that staff understand their responsibilities.
- Ensure that staff check that all safety and emergency equipment is safe and that there are robust systems to enforce compliance.
- Provide patients with enough access to outside areas and ensure that staff are competent in fire evacuation procedures.
- Provide appropriate wheelchair access to disabled people's bedrooms in Melstock House.
- Ensure that environmental risks escalated to a corporate level are responded to in a timely way and that actions to mitigate risk are communicated clearly to staff.

Summary of findings

Specialist community mental health services for children and young people

- Implement a consistent risk assessment process for all cases of children and young people waiting for assessment or treatment.
- Provide enough suitably skilled staff in the specialist community mental health services for children and young people.
- Keep staff up to date with their mandatory training.

Forensic inpatient/secure wards

- Identify environmental risks on the ward and take action to mitigate them.
- Provide clear written policies on procedural security on the ward, which should include management of barred items, use of emergency alarms and security of keys.
- Ensure that sharps bins are used appropriately and that lids are secured when in use.

Summary of findings

Crisis and health-based paces of safety

- 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.

Community-based mental health services for older people

- Ensure that care records are accurate, complete and contemporaneous.

Action the provider SHOULD take to improve

The trust SHOULD do the following:

Summary of findings

Urgent Care Services

- Develop service strategies through consultation with staff, patients and the public and ensure that they are clear and communicated effectively.
- Ensure that equipment and medicines required in an emergency are tamper-evident and standardised
- Support and encourage all staff to report and learn from incidents and complaints consistently to support continuous improvement in service quality.
- Ensure appropriate lone working arrangements for nurses, and the availability of healthcare assistants and receptionists for MIUs when they are open.
- Provide all staff working in minor injuries units with access to protocols, trust policies and procedures and all other trust information on the intranet.
- Ensure that staff receive clinical supervision and appraisals by a senior nurse who understands their job role.
- Provide nurses with access to specialist clinical advice and training to support them to deliver latest evidence-based practice in minor injuries units.
- Ensure that there is a clinical lead nurse on duty and available for all MIUs on every shift.
- Ensure that minor injuries units and adjacent departments, such as X-ray departments, are easily accessible.
- Provide clearer signposting to minor injuries units in towns so that patients know where to go with minor Injuries and clearer signage to the units at hospital main entrances or in car parks, including opening times.

End of life care

- Ensure that the palliative care medicines administration chart is used consistently across all services where end of life care is provided.
- Ensure that all staff are trained in the Mental Capacity Act 2005 and in the documentation of all decision-making processes in relation to the Act.
- Ensure that patient and relative involvement, or the reason why they were not involved, is recorded on forms relating to the resuscitation of patients.
- Ensure that there is consistent record-keeping across services for all aspects of end of life care.
- Make mortuaries and viewing rooms fit for purpose, if they continue to be used.
- Ensure that end of life care plans reflect the needs and wishes of individuals.

Summary of findings

Community health services for children, young people and families

- Support and encourage all staff to report incidents and complaints consistently to support continuous improvement in service quality.
- Provide Mental Capacity Act 2005 training to all staff where this is needed.
- Produce service strategies that are clear and communicate them effectively.

Community health services for adults

- Clarify and promote information about criteria for referral to community services.
- Engage community staff in developing policies and procedures and in service planning with commissioners, and ensure that they are fully consulted about changes that affect them.

Summary of findings

Community health inpatient services

- Ensure that discharge planning processes are proactive and well-coordinated with social services to reduce delayed transfers out of hospital.
- Review and improve referral and admission processes to reduce the risk of inappropriate admissions.
- Review medicines ordering and supply processes to minimise delays in treatment initiation and ensure that patients have access to their medicines as prescribed in a timely way.
- Prove staff with access to appraisal, clinical supervision and training to meet the needs of patients in a sub-acute inpatient setting.
- Audit the environment of all inpatient sites to ensure that patient privacy and dignity is not compromised.
- Ensure that service strategies are clear and that they are communicated effectively.
- Encourage and support staff at all levels to raise concerns, promote improvement and contribute to innovation.

Long stay/rehabilitation mental health wards for working age adults

- Ensure that patients who use the male bathroom in Nightingale House can alert staff in an emergency.
- Ensure that there is a record of all staff and patients on each ward in case of emergency.
- Enable all patients to have their planned escorted leave.
- Review the storage, use of and audit arrangements for legal highs to ensure patient safety.
- Ensure emergency equipment is maintained safely.
- Ensure that staff who witness the administration of controlled drugs have satisfactorily completed the trust's competencies training to do so safely.
- Ensure that the frequency of audits of controlled drugs is in line with the trust's policy.
- Ensure that any cigarette remains are cleared promptly to ensure patient safety.
- Ensure patients' privacy is maintained at all times.
- Ensure that staff follow the Mental Health Act (MHA) and Code of Practice.
- Ensure that patients return from their overnight stays with family in line with their plan.
- Ensure that the principles of the Code of Practice, including least restriction, are further developed in the rehabilitation wards.
- Ensure that Mental Capacity Act training is completed by all staff on the wards.
- Review the current system of smoking breaks in the very small yard in Nightingale House as this might be considered to be a blanket restriction under the Code of Practice.

Summary of findings

Community mental health services for people with learning disabilities or autism

- Ensure greater consistency in the quality of its care plans.
- Ensure timely uploading of care information to the electronic record system.
- Ensure that staff pass on information about how to access advocates in an accessible way.
- Ensure that mental capacity assessments are conducted and documented and ensure that consent to treatment is always sought.

Community-based mental health services for adults of working age

- Review alarm systems and emergency processes to ensure that all staff receive a swift and effective response and support in t an emergency.
- Ensure that service locations that did not have adequate disabled access to services make appropriate adjustments to their environment in line with the Equality Act 2010.
- Ensure that mandatory training records are updated and any shortfalls in mandatory training addressed.
- Ensure that all frontline staff have updated Mental Capacity Act training to comply with statutory requirements.
- Update and complete supervision records in order to show more clearly the support, development and performance management of staff in every team.

Summary of findings

Wards for older people with mental health problems

- Provide a clear corporate strategy on older people with mental health problems and communicated it to all staff teams.
- Improve communication between senior management and ward staff regarding planning for services for older people with mental health problems to provide good support and reassurance to the teams.

Specialist community mental health services for children and young people

- Review caseloads regularly to ensure that they are manageable and that young people receive appropriate treatment.
- Ensure that the action plans it produced following our visit to the community child and adolescent mental health service teams are implemented without delay.
- Ensure that all care plans are up to date.
- Ensure that correspondence to carers and young people relating to their treatment plans is sent to them promptly.
- Ensure that correspondence referring children and young people to other services is sent promptly without delaying their treatment.
- Provide systems to ensure greater consistency in the standards and working practices across the different community child and adolescent mental health service teams.

Summary of findings

Child and adolescent mental health wards

- Ensure that a full pharmacy history and medicines reconciliation is recorded for each patient.
- Ensure that all therapy and interview rooms are sufficiently soundproofed to maintain the confidentiality of the patients and staff using them.
- Ensure that outcome measures are used consistently.
- Ensure that detained patients are informed of their rights in accordance with the Mental Health Act Code of Practice.
- Ensure that the ward environment and bedrooms are age-appropriate.

Forensic inpatients/secure wards

- Ensure that resuscitation equipment is routinely checked.
- Review the seclusion room in accordance with the Mental Health Act Code of Practice.
- Consider the specific training needs of staff working in a low secure service.
- Review its blanket policy of locking all patients' bedrooms during the day, and perceived lack of choice by patients when attending groups.
- Review access to occupational therapy and psychology on the wards.
- Review access to secure services for women and consider, with commissioners whether this service should be offered .

Summary of findings

Forensic community services

- Review its lone working arrangements.
- Review access to secure services for women.

Acute wards for adults of working age and psychiatric intensive care units

- Review the definition of the word seclusion while describing de-escalation on the RiO electronic patient record system in order that the intervention is accurately described.
- Maximise use of the physical health teams.
- Provide training for all staff groups on the new Mental Health Act Code of Practice.
- Review input from psychology in order to offer patients a good selection of psychological therapies.
- Review procedures for acquiring advance directives from patients.
- Review the availability of outside space on Seaview ward for non-smokers.
- Review the bed manager's roles and responsibilities as the post has multi-functions and is extremely busy.

Crisis and health based places of safety

- 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.

Summary of findings

Community-based mental health services for older people

- Complete the planned review of caseload sizes across the county and identify ways to reduce them as caseloads varied between teams and in several teams they were very high.
- Work with commissioners and stakeholders to ensure equitable crisis support for people with dementia throughout the county. The intermediate care service for dementia provided very good crisis care for people with dementia but was available only in the east of the county.
- Develop and implement a clear strategy for older adults with mental health problems to ensure that all people who use the services received person-centred care and treatment appropriate to their needs and to remove inequalities of service across the county.
- Review psychological provision for older people to ensure that psychological therapies can be accessed by all patients who may benefit from them.
- Ensure that staff are trained in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and fully understand their responsibilities under the Act.

Dorset Healthcare University NHS Foundation Trust

Detailed findings

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.

- Appropriate arrangements were in place for the safe management and administration of the Mental Health Act and the Code of Practice. Administrative and legal support was provided by the acting mental health legislation manager and his team, some of whom were based in St. Ann's Hospital, Poole, and some at the Forston Clinic, Dorchester.
- In addition to dealing with issues relating to the Mental Health Act, the team were also responsible for work relating to the Mental Capacity Act.
- The trust had a mental health legislation dashboard (a document providing summary information about the performance of services), which was presented to the mental health legislation assurance committee, chaired by a non-executive director of the trust. Medical recommendations were scrutinised by a designated consultant psychiatrist.
- The trust was conducting a number of audits to ensure it was applying the Act correctly. These included audits on consent to treatment, the use of section 5 (2), section 132 rights and section 17 leave.
- The trust was part of a strategic mental health legislation multi-agency group, which included the three local authorities covering Dorset, the police, the ambulance service and other agencies involved in mental health services.
- There were a number of lay individuals who acted as Mental Health Act managers. We met with some of the managers, who told us about their work.
- During our inspection we examined a significant number of legal detention records and found them in good order. There was an effective scrutiny process, which had identified some mistakes in the legal documentation, which had been corrected. Adherence to the consent to treatment requirements was to some extent limited and further work was required to improve practices. Patients' rights were explained in accordance with section 132 but in a number of situations this had not been done in a timely manner. Patients were regularly accessing leave. However, we noted that leave forms were not always fully completed so it was not possible to see if patients had been given a copy of the leave form.
- We found that a patient, who was subject to a section 37/41(ordered to be detained for treatment by a court), had been given ground leave but this has not been authorised by the Ministry of Justice.
- We had contact with the independent mental health advocacy service, who commented positively on its links with the trust. Details of the service were available throughout the trust.
- Training was available on the new Code of Practice. However, some staff that we spoke with had not received this training and so did not fully understand the

changes. The trust recognised it had improvements to make to ensure compliance with to the new Code of Practice. This was detailed on the trust risk register and action was being taken.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The CQC has made a public commitment to reviewing provider adherence to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We found that staff in many areas lacked a comprehensive understanding of the MCA and DoLS, particularly in the older people's mental health community teams and the mental health rehabilitation wards.
- Training in this area was not consistent across the trust and although most areas met the trust mandatory training target, some areas had very poor compliance with it. For example, in the community mental health teams only 10% of staff had completed the training.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated 'safe' as requires improvement because:

- The child and adolescent mental health services (CAMHS) in Weymouth and Portland and in Bournemouth and Christchurch did not assess risks to young people waiting for assessment or treatment effectively.
- There was no clearly defined system for triage and clinical assessment of patients arriving at the minor injuries units.
- 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 and crisis telephone helpline at night.
- A number of the trust services were provided from Victorian/Georgian buildings, some of which were listed buildings so posed some difficulties for the trust in making appropriate alterations when modernising the facilities. However, we found that where buildings and wards needed refurbishment or services needed relocation plans were in place. Some major refurbishments were taking place at the time of the inspection. A key priority of the trust's strategy was to rationalise its buildings in order to meet the needs of its clinical service delivery.
- Although staff followed infection control policies and procedures in most services, these were not followed in a small number of the community hospitals and put patients at risk of infection.
- There were deficiencies in monitoring and checking safety and emergency equipment.
- Alumhurst and Chalbury wards were small and cramped and unfit for the purpose for which they were being used.
- Staffing levels were not always appropriate in community hospitals, children and young peoples'

Detailed findings

health, urgent care and mental health crisis services. There was concern over the cover provided by junior doctors out of hours on mental health older peoples inpatient service, including some lack of confidence about junior doctors ability to manage complex patients during this time; particularly on Chalbury ward due the isolation of the service.The trust was working hard to address staffing issues.

- Although the trust was making progress in developing safe medicines management practices and policies and practice relating to legal high in the rehabilitation service and the safe storage of medicines in some community hospitals needed attention.
- Some minor injuries unit staff were using out of date patient group directions to administer medicines to patients and there was a lack of pharmacy support outside normal working hours, including at weekends and bank holidays. (A patient group direction allows a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription).

However:

- Staff across the trust were open and transparent
- We found that the majority of wards and facilities were visibly clean and well maintained.
- Patient risk assessments were being carried out on admission and reviewed regularly across the trust, with mental health services using a variety of nationally-recognised tools to assess risk.
- Staff actively promoted de-escalation techniques to avoid restraint and seclusion of patients of mental health services where possible. We saw evidence that all staff in acute inpatient mental health wards and forensic inpatients were trained in promoting safer and therapeutic services.
- Staff knew how to recognise and report incidents on the trust's electronic recording system (Ulysses). Most staff followed reporting procedures, although this was not consistent and not all staff understood or used the system. There was evidence that some learning from risks, incidents and near misses was shared with staff.

Our findings

Safe environment

- We found that the majority of wards and facilities were visibly clean and well maintained. The average PLACE score for cleanliness was in line with the national average of 97% and for condition, appearance and maintenance it was above the national average. (PLACE stands for patient-led assessments of the care environment. This is a system involving local people going into hospitals each year to assess how the environment supports patients' privacy and dignity, also covering food, cleanliness and general building maintenance.)
- A number of the trust services were provided from Victorian/Georgian buildings, some of which were listed buildings so posed some difficulties for the trust in making appropriate alterations when modernising the facilities. However, we found that where buildings and wards needed refurbishment or relocation, such as St Ann's Hospital and Chalbury ward, there were plans in place. Some major refurbishments were taking place at the time of the inspection – for example, on Dudsbury and Twynam wards. A key priority of the trust's strategy was to rationalise its buildings in order to meet the needs of its clinical service delivery.
- We observed staff following infection control policies and procedures in most services but there was little evidence of auditing of the environment and staff practice to ensure this was implemented consistently. The infection control processes and practices at a small number of the community hospitals were not robust and put patients at risk of infection.
- There were deficiencies in monitoring and checking safety and emergency equipment, including resuscitation equipment, across older people's mental health services and in inpatient wards in community hospitals. Maintenance and testing of some pieces of electrical equipment was out of date.
- There were 50 incidents of use of seclusion across six locations at the trust in the six months to the end of March 2015 (lower than similar type trusts). Haven Ward had the highest number, with 22. There were no incidents of long-term segregation. In both forensic inpatient and acute mental health inpatient services, including psychiatric intensive care wards, we observed nationally recognised guidance in early intervention

techniques used to reduce the need to seclude patients. None of the mental health acute inpatient services had seclusion rooms. A seclusion room had been available at St Ann's hospital, attached to the psychiatric intensive care unit, but was closed for refurbishment at the time of our inspection. All wards had de-escalation rooms and there was a procedure for the use of the rooms. On two occasions staff had described the process of de-escalation inappropriately as seclusion in the electronic care records and we brought this to the attention of senior managers. The seclusion room in Twynam ward (forensic inpatients) did not meet the recommendations of the Mental Health Act Code of Practice in some areas, even though the ward had just gone through a major refurbishment. The trust assured us it was aware of this and was taking action to rectify it. (Seclusion is the supervised confinement of a patient in a room, which may be locked, to contain severely disturbed behaviour likely to cause harm to others.)

- There was one health-based place of safety covering the whole of the county of Dorset based at St Ann's Hospital. The layout of the health-based place of safety allowed staff to observe patients to ensure their safety. 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. It did not have a separate entrance and was on the first floor. This could also present a risk if, for example, a person needed to be restrained in a stairwell.
- The trust had a ligature risk reduction policy and we heard from staff that they were committed to reducing ligature risks to provide a safe environment. (ligature points are places to which patients intent on self-harm might tie something to strangle themselves. Ligature risks are the risks of such harm.) In the majority of areas, ligature risks had been identified and were being managed. We noted that where the trust had planned refurbishment work on wards that included avoiding creating ligature risks. In the newly refurbished Twynam ward there were ligature points in some areas. These had been clearly identified with a description, photograph and barcode and we were assured that they would be removed.
- Lone working arrangements for staff working in the community and for nurses, healthcare assistants and receptionists in minor injuries units were used inconsistently and placed staff and patients at risk.
- The majority of the wards that were mixed gender had separate facilities for men and women. However, on Alumhurst and Chalbury wards there were difficulties meeting the Department of Health gender separation requirements due to the restricted nature of the environment. Bathroom and toilet facilities were accessible to both males and females at both ends of the ward communal areas. In Alumhurst ward bedrooms were arranged in four-bedded bays separated by doors. Females had to pass through a closed male area to access their bedrooms. Both environments were unfit for the purpose for which they were being used.

Safer staffing

- The overall percentage of vacancies for the trust was 9.2% (excluding seconded staff) at 31 May 2015. The main issue with staffing was the shortage of registered nurses, particularly in older people's mental health inpatient wards. There were 31 mental health or 'other' services (which included some community health services) with five or more substantive staff and a reported vacancy rate of 20% or greater, including older people's inpatient mental health services and community health services for adults.
- There were 6,528 shifts filled by bank or agency staff in mental health or other services between 1 January and 31 March 2015. The core services with the highest usage of bank or agency staff were acute mental health wards (1,063), mental health rehabilitation and forensic/secure services (944) and older people's mental health non-acute inpatient admissions (876). There were 4,089 shifts not filled in these services over the same period.
- Sickness rates at the trust were consistently higher than the England average between October 2013 and Nov 2014, varying between 4.3% and 5.3% during this time period.
- Staffing levels were having a negative impact in a number of areas. For example, in community hospitals, staffing levels were not always appropriate to meet the needs of patients and in some hospitals they were consistently below accepted safe levels. In adult community services some teams were stretched and

there was a high vacancy rate for night nursing team staff. This team felt they were overworked, with not enough capacity with one team to cover a very large geographical area.

- There were shortages of staff in some areas of services for children, young people and families' school nursing, children in care, sexual health and health visiting services. This was due to unfilled vacancies and, in some cases, high sickness levels. There were staff shortages across urgent care services and on occasions agency staff were lone working without adequate support or induction.
- We found conflicting and contradictory evidence about staffing and sickness levels in the east Dorset crisis team. This had a marked adverse effect on the team's ability to provide robust home treatment services and crisis telephone helpline at night.
- We noted that medical cover was safe throughout daytime hours in older people's mental health wards. However some concern was raised over junior doctor cover out of hours, including confidence of junior doctors in managing highly complex patients during this time. On Chalbury Ward the risks were higher due to the location and isolation of the service. We were shown examples of admissions out of hours where medical staff were not locally based and could take a long time to attend the ward. The trust assured us however following our inspection that appropriate medical cover had been increased.
- The trust was working hard to address staffing shortages and had been making progress in this. Opportunities were available for support workers to be seconded to undertake pre-registration undergraduate programmes in a range of professions, including adult and mental health nursing, occupational therapy, physiotherapy, learning disabilities nursing. Staff could also undertake accredited return-to-practice programmes to re-join the nursing workforce. This included practical help on these programmes – for example, grants for the return-to-practice programmes.
- The trust had recently increased its target of completion of mandatory training to 95% and so had not achieved its target rate for mandatory training as of 31 March 2015, with a 91.1% compliance. There was low compliance with mandatory training in some services, including children and young people's services. The low levels of training in basic life support were a particular concern on the community health inpatient wards. Not all staff in some minor injuries units had updated intermediate life support training so might not be able to respond appropriately to patient emergencies.
- In the NHS Staff survey 2014 the trust scored worse than the national average for the percentage of staff feeling satisfied with the quality of work/patient care they are able to deliver and the percentage of staff feeling pressure to attend work when feeling unwell in the last three months. The trust scored better than the national average for the percentage of staff suffering work related stress in the last 12 months.

Assessing and managing risks to patients

- The child and adolescent mental health services (CAMHS) in Weymouth and Portland and in Bournemouth and Christchurch did not assess risks to young people waiting for assessment or treatment effectively. However we found excellent leadership and multidisciplinary team working in the North Dorset community child and adolescent mental health service and the children's learning disability services, which enabled these teams to deliver high quality services to children and young people and managed their risks effectively.
- In the main, patients' risks assessments were being carried out on admission and reviewed regularly. However, there was no clearly defined system for triage and clinical assessment of patients arriving at the minor injuries units. This meant the service was not assessing and responding to potential risks and that patients could be waiting for some time without clinical assessment when possibly needing urgent or more acute care and treatment. This was not in line with the trust's service operational policy or national guidance.
- 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.

- Across mental health services, we saw evidence of good practice in the use of tools such as the HCR-20, a tool to assess the risk of violence and aggression, the modified early warning score (MEWS), the structural assessment of protective factors (SOFAR), the malnutrition universal screening tool (MUST), the psychiatric rating scale (BPRS) and the Liverpool University neuroleptic side effects rating scale (Lunsers). Across mental health services, there was evidence of patients' risk assessments being discussed at multidisciplinary team meetings, in care programme approach (CPA) meetings and on ward rounds.
- Staff across all community services for adults described anticipated risks and how these were dealt with.
- Staff followed processes for assessing risks such as pressure ulcers, falls and malnutrition and developed care plans to manage the risks effectively in both community and inpatient settings. However, the trust had not achieved its target to 'reduce the number of avoidable hospital-acquired pressure ulcers'.
- Surgical procedures were undertaken safely and effectively.
- There were effective systems for supporting prompt referrals and working collaboratively to deliver the care required when a child or young person needed additional health or welfare support.
- All community hospital wards used an early warning score to determine if patients were at risk of deteriorating. Records showed that the early warning scoring system had been used appropriately and advice from doctors sought if the patient required a medical review.
- We found that any blanket restrictions on mental health wards (such as banning contraband items and locking doors to access and exit the ward) were justified. Clear notices explained to patients why these restrictions were being used. Informal patients were advised through signage that they were free to leave at will, and this information was also detailed in the ward information leaflets.
- There were 316 incidents of restraint recorded in the six months to 31 March 2015 across 20 wards/teams. There were 63 occasions when patients were restrained in the prone position and 39 restraints resulted in rapid tranquilisation being given. Seaview Ward had the highest number (54) of restraints. Dudsbury and Waterston units had the highest number of restraints in the prone position (12), nine of which resulted in rapid tranquilisation. Staff actively promoted de-escalation techniques to avoid restraints and seclusion where possible. We saw evidence that all staff in acute inpatient mental health wards and forensic inpatients were trained in promoting safer and therapeutic services. We saw that staff were trained in two evidence-based systems; stress incident management and trauma incident management. The trust was committed to eradicating the use of prone restraint in line with national recommendations this was implemented with commitment from the trust board.
- The majority of staff were able to describe what constituted a safeguarding incident and how and where it should be reported. Staff we spoke with told us they understood their safeguarding training. However, not all staff were up to date with safeguarding training. Safeguarding was discussed at ward team meetings and staff supervision to ensure that staff had sufficient awareness and understanding of safeguarding procedures. There were safe systems and practices to safeguard adults and children and young people from abuse. However, some MIU staff did not know about, or respond appropriately to, the child protection flags on the electronic patient records system.
- The trust had previously identified issues with medicines management across the trust and had commissioned an independent review, which had presented a large number of recommendations that the trust had accepted and was working to implement. The trust had been innovative in some of its medicines management practice; our pharmacy inspectors found that the trust's method of monitoring fridge temperatures was extremely effective. The fridge monitoring charts were the best recording tool they had seen.
- The palliative care drug chart was another good innovation, which was judged by pharmacist to be very effective. However, we had concerns that this was not in

place in all community settings and was only being used in some teams and community hospitals, presenting a potential risk if patients moved between settings and services.

- All staff providing end of life care were trained in the use of one model of syringe driver and there was a palliative care drug administration chart available but this was not used across all services.
- The trust had a system of checking medication for patients to take out of the hospital when they were discharged. This involved two nurses signing the record and also included a check on the medication supplied from the pharmacy and a final check of medication on the day of discharge cross-checked with the patient's medication chart. This was a system that we had not observed elsewhere and was an effective safeguard against errors.
- We had some concerns that there were no opening dates on eye drops, liquid medicines and that there were unclear dates written on the sides of bottles. This was further complicated because some liquid medicines had 'once-opened expiry dates' and were specific to the supplier. For example, on the Linden unit different methadone bottles had different once-opened expiry dates of one month and two months.
- We found a number of overstocked 'just in case' cupboards. Two cupboards on the wards at Bridport hospital were full and items fell out on opening one cupboard.
- We had some concerns about practices relating to 'legal highs'; practice differed from the trust policy. This was of particular concern on the mental health rehabilitation wards where legal highs were stored in the controlled drugs cabinet, with no safe system to manage them.
- Medicines management in some services, including hospitals and children, young people and families services, was not safe and some storage facilities did not meet current guidelines.
- Although recently updated on electronic systems, some minor injuries unit staff were using out of date patient group directions to administer medicines to patients. (Patient group directions allow a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription.)
- There was a lack of pharmacy support on call, at weekends and during bank holidays.
- Business continuity and major incident plans were in place across most services but in children and young people's services they were not robust with clear guidance to help staff know when to implement escalation procedures.

Track record on safety

- The trust reported a total of 5,485 incidents to the National Reporting and Learning System (NRLS) between 1 April 2014 and 31 March 2015. Incident analysis showed a high proportion of no harm or low harm incidents, which indicated a safe reporting and effective management culture. There was evidence of high incident reporting rates in mental health services, paediatric speech and language therapy, dentistry and sexual health services. Serious incidents were investigated to deliver improvements in practice.
- .Trust staff reported 144 incidents to the strategic executive information system (STEIS) between 1 April 2014 and 30 April 2015, 42 of which involved the death of a patient. There were no 'never events'. The trust monitored safety thermometer data in relation to care provided to patients at home and in community hospital wards. The NHS safety thermometer provided a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls. Between April 2014 and April 2015 grade three and four pressure ulcers accounted for the highest number of serious incidents reported through the NRLS for community services. Falls with harm saw an increase in April 2014, although the number of reported incidents went down after that.
- Some 128 serious incidents requiring investigation (SIRI) were reported by the trust between 1 January and 31 December 2014, 42 of which concerned deaths of patients. The top three incident types reported were 'pressure ulcers' (47), 'suicide/suspected suicide' (33) and 'falls with harm' (19).
- Between 25% and 50% of the alerts being generated by the Medicines and Healthcare products Regulatory Agency (MHRA) were being closed late (outside of the required timeframe) by the trust . This had flagged as a risk in the CQC's intelligence monitoring system. The trust had plans to address this as part of the actions coming out of the independent medicines management review.

- In the NHS staff survey 2014 the trust scored better than the national average for the percentage of staff witnessing potentially harmful errors, incidents or near misses in the last month (witnessed fewer). However, the trust scored worse than the national average for the percentage of staff reporting errors, incidents or near misses witnessed in the last month and for the fairness and effectiveness of incident reporting procedures.

Reporting of incidents and learning when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system (Ulysses). Most staff followed the process and procedures to report incidents and monitor risks. However, this was not consistent and not all staff understood or used the system. All incidents were reviewed by a manager and forwarded to senior managers and the trust's patient safety team for further review. The system ensured that senior managers in the trust were alerted to incidents in a timely manner and could monitor the investigation and response to them.
- There was evidence that some learning from risks, incidents and near misses was shared with staff. Staff in children, young people and families services and some working in minor injuries units did not demonstrate a consistent understanding of the value of incident reporting. Some were not clear what should be reported and six staff from different professions across children, young people and families services said they were discouraged from using the incident reporting system. Staff in mental health services told us that they did not always receive feedback after they had reported an incident. We were told that significant incidents were discussed in staff meetings and handovers but because not all staff were at every meeting this could prove problematic. Staff were offered debriefing sessions following serious incidents and could access external debriefing experts if they wished.
- There was evidence of root cause analysis and action plans to reduce the risk of a similar incident reoccurring in community adults' teams. For example, in response to a high number of incidents related to pressure ulcers, the trust had conducted pressure ulcer awareness training across various disciplines. Pressure ulcer care bundle and risk assessments were developed and access to a tissue viability nurse was made easier. (A bundle is a selected set of elements of care that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.)Community nurses were given a laminated pocket card that outlined the management and suggested action plan for pressure ulcers.
- When planning refurbishment of buildings, trust managers had taken account of lessons learnt from incidents. For example, in acute mental health inpatient wards particular attention had been paid to creating the feeling of space, as more incidents had been noted in more confined spaces. Ceiling heights and corridor widths had been maximised to ensure a feeling of space and to increase light into the ward areas.

Duty of Candour

- Staff across the trust were open and transparent but many were unfamiliar with the requirements of the duty of candour legislation. Staff were aware of the importance of investigating incidents and potential mistakes and we saw that they did meet the patient/ family and shared the findings of investigations and offered an apology if things had gone wrong. However, they were unaware this was now a legal requirement. Staff were unaware of whether the trust had a formal process that should be followed despite one being in place with commitment from the trust board.

Requires improvement

Are services effective?

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:

- The quality of patient records varied in detail and quality from ward to ward, team to team and service to service, and in some areas did not always reflect the current needs of patients, were not always up to date and the timeliness of discharge information was inconsistent.
- We found that the planning and delivery of care was inconsistent across the trust in end of life care and was based on historical commissioning arrangements, meaning that the services received was very much dependent on where a patient lived. However, the quality of services delivered by the trust were inconsistent across the trust.
- The trust used electronic record systems. Records were securely stored on an electronic patients' record system but not all agency staff had access. The implementation of the SystmOne electronic patient record system used in community health services had not been wholly successful and staff told us they were experiencing difficulties. Access to the system was variable across services and some services could not access records completed in other services when patients moved between them because of the different configurations used in the different services which could pose a potential risk. The trust acknowledged the difficulties with the implementation and we saw that they were working to address this.
- Care and treatment across the trust was generally delivered in line with relevant national guidelines but there was a lack of evidence of sharing best practice across some teams and services.
- We had some concerns about practices relating to 'legal highs' as practice often differed from the trust policy. This was of particular concern on the mental health rehabilitation wards where legal highs were stored in the controlled drugs cabinet, with no system to manage them.
- Although recently updated on electronic systems, some minor injuries unit staff were using out of date patient group directions to administer medicines to patients.
- We found that staff in many areas lacked a comprehensive understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

However:

- In most areas records were patient centred and staff described how they put patients' needs at the centre of care and support. This was particularly evident in the forensic community services, where patients had recorded their views about what they wanted to achieve from their care.
- Staff were generally committed to providing holistic care and we saw evidence of staff supporting the emotional needs of patients and their carers.
- The majority of patients using mental health services had physical health checks completed and risks to their physical health were identified and managed effectively. Patients at St Ann's hospital had access to a dedicated physical healthcare team.
- Care and treatment across the trust was generally delivered in line with relevant national guidelines, such as those produced by the National Institute for Health and Care Excellence (NICE).
- Across all areas of the trust, care and treatment was provided by multidisciplinary teams of competent staff who were qualified and trained for their roles. A number of the mental health services, including rehabilitation and older people's community mental health services, had limited access to psychologists.
- In both community health services and mental health services we found a strong ethos of multidisciplinary working.
- Patients were given information about their rights and how to contact independent advocates on admission and at regular intervals during their detention under the Mental Health Act (MHA).

Requires improvement

Are services effective?

- We rated community forensic services as outstanding for being effective due to the innovative approaches to patient care.

Our findings

Assessment of needs and planning of care and treatment

- The quality of patient records varied in detail and quality from ward to ward, team to team and service to service.In some areas records did not always reflect the current needs of patients, were not always up to date and the timeliness of discharge information was inconsistent. However, in most areas records were patient-centred and staff described how they put patients' needs at the centre of the care and support. This was particularly evident in the forensic community services were patients had recorded their views about what they wanted to achieve from their care, in acute mental health inpatient services where care planning had a strong focus on strengths and goals, and in community health services for children and young people where care planning was comprehensive, clear and informative. People using community learning disability services had a 'yellow health book', which contained a record of all their care and could be used to facilitate assessment of needs and care planning whatever service they accessed.
- Staff were generally committed to providing holistic care and we saw evidence of staff supporting the emotional needs of patients and their carers. For example, in community health, children and young people's services and in child and adolescent mental health services, staff were committed to supporting the emotional, social and welfare needs of patients as they recognised the pressures of a child or young person experiencing a physical or mental health problem or living with a child or young person with these issues.
- All patients in mental health services were assessed and monitored using the health of the nation outcome scales (HoNOS), which covered twelve health and social care domains and enabled clinicians to build up a picture over time of the patient's responses to interventions.
- The majority of patients using mental health services had physical health checks completed and risks to physical health were identified and managed effectively. Patients at St Ann's hospital had access to a dedicated physical healthcare team; all patients were assessed on admission and regularly thereafter in line with any risks and care needs identified.
- Staff across the trust staff demonstrated a good understanding of the need to obtain consent to treatment, although this was not always documented in line with best practice.
- The trust used electronic records systems. Records were securely stored on an electronic patients' record system but not all agency staff had access. Mental health services used the RiO system, which was well established and understood by the staff using it. Community health services had moved from paper records to SystmOne, an electronic system that had a more physical health component, in 2014. We saw that the implementation had not been wholly successful and staff told us they were experiencing difficulties. Access to information on electronic records systems was variable across services and some services could not access records completed in other services when patients moved between them because of the different configurations used in the different services. This meant that care plans were not always updated and the timeliness of discharge information was inconsistent. Where patient care was delivered in people's homes, a combination of electronic patient records and paper records was used; there were some inconsistencies in the information recorded. For example, in end of life services the preferred place of death was not always recorded, which could result in patients' wishes not being followed. The trust had recognised the problems with the community health electronic records and work was starting to review how SystmOne was used and to give staff additional training.

Best practice in treatment and care

- Care and treatment across the trust was generally delivered in line with relevant national guidelines, such as those produced by the National Institute for Health and Care Excellence (NICE) but there was a lack of evidence of sharing best practice across some teams and services. For example, in community mental health teams, community child and adolescent mental health

services teams, older people's community mental health teams and minor injuries units we saw little interaction between teams. We found some out of date NICE guidance and treatment protocols in use in the minor injuries units. Staff knew that up to date guidelines were available electronically but could not always accessed them.

- However, despite this we saw many examples of good and innovative practice. We found that end of life care was planned and delivered in line with best practice. The trust had introduced a new communication plan to tell patients and the public about how it planned and delivered end of life care following the withdrawal of the Liverpool care pathway. In community health services for children and young people, care pathways were based on recommended best practice and new guidelines were incorporated into practice to ensure it was up to date. Arrangements were in place to deliver care to children moving between services and parents told us this was helpful. Acute inpatient mental health services delivered services in line with a recovery-based model and each ward had a sensory room and a calm box available, which was nationally recognised to support a reduction in aggressive and challenging behaviour. The Pathfinder community forensic service was part of a national initiative that provided an alternative to hospital treatment for offenders with a personality disorder. Although the service was still developing, detailed audits had shown positive results.
- NICE guidelines were followed for prescribing medication in most areas but in some services, including community hospitals and community health services for children, young people and families, some practices and storage facilities did not meet with current guidelines. Although recently updated on electronic systems, some minor injuries unit staff were using out of date patient group directions to administer medicines to patients. (Patient group directions enable nurses to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription.)
- We had some concerns about practices relating to legal highs as practice often differed from the trust policy. This was of particular concern on the mental health rehabilitation wards where legal highs were stored in the controlled drugs cabinet, with no system to manage them.
- Staff were using a number of different tools and measures to monitor the outcomes of implementing best practice in the care of patients. Examples include the use of the mood, interest and pleasure questionnaire in community learning disability services and the use of the model of human occupation screening tool and social problem-solving inventory in forensic services. Patient outcomes in community health children and young people's services and community health services for adults was primarily based on contact measures and patient satisfaction surveys.
- Staff participated in a range of clinical audits, including national clinical audits of schizophrenia, the Sentinel stroke audit, physical health checks and the NICE patient experience audit. Local audits included those of care plans, falls and pressure ulcers. However, we found that there was little auditing of adherence to guidelines or monitoring of patient outcomes in minor injuries units.
- The trust had undertaken an audit of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) assessments and found that they were well completed. (Patients or their families or clinicians may opt not to have cardiopulmonary resuscitation (CPR). Their health records are marked with DNACPR meaning 'do not attempt CPR. However, we found that almost half of the assessments reviewed in the end of life service did not include a clear explanation as to why patient or relative was not involved in the decision. There was no regular reporting of the quality of end of life care to the trust board.
- The trust partially achieved a Quality Account (2013/2014) priority of 'clinical effectiveness - to implement the dementia care pathway across all services' but had plans in place to ensure it would meet this priority across the trust in 2014/2015.
- The trust used the malnutrition universal screening tool to assess and record patients' nutrition and hydration on admission. Food and fluid balance charts were used to monitor patients' fluid and food intake. The patient-led assessments of the care environment (PLACE) showed that 86% of patients were satisfied with food and hydration, including choice, taste, temperature and availability over 24 hours. The result was lower than the national average of 89%.
- A number of the mental health services, including rehabilitation and older people's community mental

health services, had limited access to psychologists, who tended to provide a consultative service to wards rather than specific input. In good quality rehabilitation services a psychologist should be available as needed. However, the trust had been innovative in developing other staff groups to deliver psychological therapies to patients. For example, nursing staff were being trained to deliver dialectical behavioural therapy.

Skilled staff

- Across all areas of the trust, care and treatment was provided by multidisciplinary teams of competent staff who were qualified and trained for their roles.
- A number of the mental health services, including rehabilitation and older people's community mental health services had limited access to psychologists who tended to provide a consultative service to wards rather than specific input. This meant that teams were not always able to offer holistic multidisciplinary assessments and care to support recovery. In good quality rehabilitation services a psychologist should be available as needed. The national audit of schizophrenia identified ' that patients receiving psychological therapies was below that which should ideally be provided. However, the trust had been innovative in developing other staff groups to deliver psychological therapies to patients. For example, nursing staff were being trained to deliver dialectical behavioural therapy.
- As identified previously, the trust achieved its mandatory training target of 85% across the trust and achieved an overall compliance rate of 91.1% for all training.
- Staff we spoke with told us that access to specialist training and support for continuing professional development was good across the trust and that new staff were supported in their roles. However, staff from crisis teams used to staff the health-based place of safety did not all have specific training in working in this service, which could potentially compromise care for patients and put staff at risk. The NHS staff survey for 2014 identified that 79% of respondents from the trust said they had received job-relevant training, learning or development in the last 12 months (compared with the national average of 82%).
- The majority of staff in mental health services told us they received appraisals and supervision, although the NHS staff survey for 2014 identified that the trust performed worse than the national average for mental health trust for staff receiving appraisals. There were inconsistencies across community health services. The trust data identified that 94% of staff across the trust received an appraisal as of May 2015. There were clear systems for the revalidation and appraisal of doctors and all consultants that we spoke with described a clear system of appraisal.
- The General Medical Council national training scheme survey 2014 highlighted that doctors in training were satisfied overall with the clinical supervision provided by the trust. Junior doctors said they had an adequate experience at the trust and adequate access to educational resources but a worse experience than expected in old age psychiatry.
- Medical staff told us that there were enough doctors available over a 24-hour period, seven days each week. However, medical cover was of concern on all older people's mental health wards at night; the trust acknowledged that there was insufficient medical staff to cover all the units and wards.

Multidisciplinary and inter-agency working

- In both community health services and mental health services, we found a strong ethos of multidisciplinary working. We attended multidisciplinary team meetings in most of the wards and services that we visited. We found that they took place regularly, usually weekly, had clear agendas that demonstrated effective sharing of information and knowledge, and provided a safe environment for staff to raise constructive challenge about care and treatment. Some professionals, such as psychologists and occupational therapists, did not always attend every meeting in some services. For example, this happened in community-based services for older people, community mental health services, rehabilitation services and mental health inpatient services for older people.
- However, whilst links between inpatient and community services in both community health and mental health services was generally good, links between community-based mental health services and inpatient mental health services for older people varied. Some teams were geographically distant from the inpatient wards where patients were admitted and there were not always clear procedures to communicate information about discharge. In addition, the relationships between

the east Dorset crisis team and the local community mental health team was poor and communication did not support effective service delivery, resulting in delays in receiving appropriate care for patients using these services.

- A number of interagency effective working practices had developed. For example, staff at Swanage minor injuries unit accessed a virtual fracture clinic, where they were able to discuss patients with an orthopaedic specialist. However, there were no other telemedicine links to acute hospitals or specialist services. All community health services had developed good relationships and effective working with local GPs. Community child and adolescent mental health services and children's learning disability teams had built good working relationships with local schools. In community learning disability services we found evidence of staff helping to create resources such as easy read leaflets for other health care providers to enable positive outcomes for people with learning disabilities who used their services. There was regular liaison with the police in acute mental health inpatient, crisis and health-based place of safety and forensic services. This had resulted in a marked reduction in inappropriate calls to the police from patients suffering a mental health problem, and had enabled effective working to ensure public protection arrangements and the development of joint research projects.
- Local partner organisations, including local authorities, nursing and care homes, the acute NHS trusts, police and ambulance services, were positive about the working relationships with the trust and staff delivering its services.

Assessment and treatment in line with Mental Health Act

- Staff across mental health services reported that patients were given information about their rights and how to contact independent advocates on admission and at regular intervals during their detention under the Mental Health Act (MHA). Staff were confident in discussing the Act although some were not as familiar with the new code of practice as they should have been.
- We reviewed care records of people detained under the Act and found that in older people's inpatient mental health services records were mostly completed correctly. There were occasions when patients had been referred to a tribunal on the wrong date and on Alumhurst ward a section 62 (section of the MHA under which emergency treatment can be given) had been completed retrospectively. In acute inpatient services one patient on a section three of the MHA (detention for treatment) had a delay of five days before their rights were explained. In Nightingale House (rehabilitation service) some certificates completed by second opinion appointed doctors (SOADs) where not kept with the medication chart and on Glendinning ward staff did not recognise that a breach of leave conditions had occurred when a patient did not return from overnight leave. On all three rehabilitation wards there were high levels of detention and one patient had been continuously detained for 14 years, which is not normal practice.
- Good signage was observed throughout all wards where patients were detained, providing informative information for patients and carers. Notices on exit doors explained that informal patients could come and go as they wished and explained why doors were locked.
- There was a county-wide approved mental health professional (AMHP) rota that covered Mental Health Act assessments and applications for patients. Theapproved mental health professionals provided high quality reports to the Ministry of Justice for patients subject to restrictions imposed by the Ministry.
- Training was available on the new Mental Health Act code of practice. However, some staff that we spoke with had not received training in relation to the new code and so did not fully understand the changes. The trust recognised it had improvements to make to ensure adherence with the new code of practice; this was detailed on the trust risk register and an action plan was being implemented.
- There was access to independent mental health advocacy (IMHA) services and mental health solicitors. Details of IMHA services were available throughout the trust.

Good practice in applying the Mental Capacity Act

- Staff that we spoke with in community learning disability services were able to demonstrate a detailed understanding of how to assess patients' capacity to make decisions about their care and made referrals to the psychologists in the teams if they were in doubt about a person's capacity.

Requires improvement

Are services effective?

- We found that staff in many areas lacked a comprehensive understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLSs), particularly in the older people's mental health community teams and the mental health rehabilitation wards. However, we did note that capacity was discussed in most multidisciplinary team meetings and that there was a trust-wide protocol that identified that capacity and consent to treatment issues should be included routinely in outpatient letters.
- It was not always clear that capacity to consent had been assessed and consent to treatment and information-sharing was not consistently recorded.
- Training in this area was not consistent across the trust and although most areas met the trust mandatory training target some areas had very poor compliance, for example, in the community mental health teams where only 10% of staff had completed the training and in community mental health teams for older people where only 13% had completed training. Some staff were unsure whether training was mandatory.

Good

Are services caring?

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

Summary of findings

We rated 'caring' as good because:

- The majority of staff we met with were caring, compassionate and kind. Patient feedback was consistently positive about the way they were treated and involved in their care.
- Acute inpatient mental health wards/psychiatric intensive care units and community forensic services were rated outstanding because of the manner in which they cared for patients and for the passion that they clearly demonstrated for their work.
- We found many examples of patients being involved in their care and some services demonstrating innovative ways of involving people – for example, through a mutual expectations charter and the development of short films involving young people with lived experience to demonstrate good practice in involving young people in their care.
- The trust had developed a carers strategy to ensure that carers were treated appropriately and involved in the care and treatment of their relatives/friends as appropriate.
- Most services had written information in different languages and access to interpreter services if needed.

However:

- In some mental health wards for older people the dignity of patients was, at times, compromised; we saw patients receiving personal care with bedroom doors open in view of people passing.

Our findings

Dignity, respect and compassion

- Across the majority of the wards and services we found that staff were kind, caring and compassionate. In acute mental health wards for adults, psychiatric intensive care units and in community forensic services, we found that staff were outstanding in their care and the passion they clearly demonstrated for their work. However, in some mental health wards for older people the dignity of patients was, at times, compromised; we saw patients receiving personal care with bedroom doors open in view of people passing.
- We observed many instances were staff treated patients with dignity, respect and kindness. Even in services where staff were working with increased levels of stress due to high caseloads and staff shortages, we saw that staff were able to give time for one-to-one interactions with patients.
- Relatives we spoke with told us that staff delivered compassionate care and that staff were very attentive to their needs and those of their relatives. Relatives were very complimentary about how patients were cared for at the end stage in their lives. Children, young people and their families receiving both community health services and child and adolescent mental health services told us about the way staff treated the whole family with care, compassion, patience and understanding and that staff recognised the difficulties faced by families, as well as children and young people when faced with the ill health of a child.
- Without exception, patients receiving adult community health service praised staff for their empathy, kindness and caring and in inpatient services in community hospitals we found staff were willing to go the 'extra mile' in supporting patients with emotional needs.
- Observations of dental care showed that people were treated in a courteous way and with kindness. Dentists ensured people were put at ease before and during treatment.
- In the acute mental health patient wards, we saw staff who were fully engaged with patients and carers and who had introduced an initiative called 'getting to know us'. The wards had boards that introduced each staff member with details about themselves, such as their likes and dislikes, hobbies and interests. This served to brea kdown barriers and demonstrated respect to patients. In addition, staff and patients had worked

together to develop a 'mutual expectations charter' that comprised a set of statements that set out how all would treat each other. We observed extremely positive attitudes from staff that was responded to by patients. An example of how this permeated to all levels of staff was demonstrated when we saw a consultant psychiatrist walking past nursing staff and patients having a game of football and spontaneously joining in.

- The majority of staff we spoke with across the services were passionate about their work, spoke with compassion and respect for the people they cared for and demonstrated a high level of understanding of patient needs.
- The trust's overall PLACE score for dignity, privacy and respect was 85.80% in 2014, which was in line with the England average of 85.74%. (PLACE stands for Patient-Led Assessments of the Care Environment. This is a system involving local people going into hospitals each year to assess how the environment supports patients' privacy and dignity, also covering food, cleanliness and general building maintenance.)
- The friends and family test showed that 76% of respondents were 'likely' or 'extremely likely 'to recommend the trust as a place to receive care and 59% as a place to work (England averages 77% and 61% respectively).

Involvement of people using services

- Patients generally spoke highly about how staff involved them in decisions about their care and treatment. Staff generally took time to explain about treatment and involve patients in developing care plans.
- People spoke highly of the way staff listened to them and involved them in their care in children, young people and families community health services. They said they were involved in decisions about their care, given time to consider options and put at ease if they were anxious.
- Patients told us they felt involved in decision-making about their care in community services for adults.
- The multidisciplinary teams on the community hospital wards shared information with patients and their relatives and involved them in decision-making.
- Young people who used community child and adolescent mental health services had participated in the children and young people improving access to psychological therapies project. The young people using the services and community child and adolescent mental health services teams had worked with Healthwatch and Birmingham University to develop short films with young people with lived experience of mental health services that could help demonstrate how young people could and should be involved in their care.
- People using community learning disability services were involved in the recruitment of staff and were represented on the trust's partnership board.
- We saw several variations on mental health inpatient wards of the 'you said and we did' initiative. Each ward had developed its own template and brand for this initiative. For example, one ward used 'a bucket list' to put ideas on a post-it note into a bucket for patients and staff to use. Another ward had an 'ideas tree' where ideas could be posted onto the tree. Improvements made as a result of suggests included more hairdryers, more information on patients' medication, access to bikes to ride locally, information on legal highs and drugs, individual appointment times for ward rounds, and access to mobile phones and laptops.
- Patients in community forensic services provided extremely positive feedback about involvement in their care and how the treatment, therapy and support they had received had benefitted them. Examples included improving their relationships with their families, supporting them with practicalities such as finances, and improving their quality of life by giving them structure within their lives and pursuing their interests. Patients told us they felt listened to and supported.
- The majority of wards and services gave patients information about the service, what to expect and their rights and an explanation of how they would be involved in their care. The majority of mental health wards had regular community meetings. There was information available throughout the majority of wards and clinical areas and there was access to interpreting services if needed.
- Both the NHS Choices and Patient Opinion websites received several positive comments about patients and carers' involvement in care and treatment and several comments about the support received from staff. In the

Good

Are services caring?

CQC community mental health patient experience survey the trust scored better than most other trusts for patients knowing who to contact if they had a concern about their care (9/10) and patients knowing who to contact outside normal working hours in a crisis (8/10).

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated 'responsive' as requires improvement because;

- We found planning and delivery of health services was inconsistent across the geography of the trust, based upon historical commissioning arrangements. For example, the generalist palliative care service in Bournemouth and Poole was more responsive than the community nursing service in west and north Dorset, as they could support both health and social care needs of patients. If personal care services were not available to support a discharge in rural Dorset these patients did not have timely access to end of life care in their preferred place of care.
- For older people with mental health problems there was a very good intermediate care service for dementia which provided specialist crisis support. However, this was not available in west Dorset.
- A telephone call management system had been set up in east Dorset to respond to patients in crisis at night. However, at the time of our inspection, if nobody answered the phone, it simply rang off. There was no answer phone. This meant that a patient in crisis had no way to contact the team night and the team had no means of understanding and managing the potential risks for patients.

However:

- There was only one health based place of safety for the whole of Dorset, situated at St Ann's Hospital, the trust and its partners believed this was sufficient provision. Patients in west Dorset requiring care in the health based place of safety were generally transported in police vehicles which is not in line with the Mental Health Act code of Practice, which states that this should be the exception. But, the trust had not had to turn anyone away in 2014/2015 to date and the relationships between the trust and the police in working together to address the needs of those in crisis was excellent.
- The trust was making a considerable investment and had a development programme to improve the hospitals/buildings it delivered services from.
- Complaints were well managed and the trust apologised when things had gone wrong.
- There was a clinical services review being undertaken across Dorset by the clinical commissioning group to look at how services were configured. This could have a significant impact on the way the trust delivers services in the future
- We rated 'responsive' as outstanding for acute wards for adults of working age and psychiatric intensive care units (PICU) because there was very good bed management and how they met the needs of the people who used there services.

Our findings

Access, discharge and bed management

- Community hospital inpatient services were largely based on historical commissioning arrangements. For example, there were a lot more 'step down' beds (beds used for patients who were nearing discharge but still not well enough to go home) in the east part of an intermediate care pathway. There was more 'step up' provision from GPs in the community in north and west Dorset. The trust had responded to increasing needs of patients by creating additional intermediate care beds to meet the needs of patients and the local community. Bed occupancy levels and delayed discharges were high and the lack of available beds impacted on access to treatment and care for patients.
- The trust was developing more integrated locality models in west Dorset. In Bridport, inpatient beds were part of a locality wide service providing multi-agency services to meet the needs of individual patients.
- Between March 2014 February 2015 the number of patients delayed had been consistently above the England average and peaked in January 2015 at 67. The majority of these were due to patients having to wait for nursing home placement or to the availability of care packages to support patients in their own homes, some

of which was dependant on other providers of services. The ratio of the number of patients whose transfer of care was delayed to average daily number of occupied beds open overnight, where the delay was attributable to NHS and both NHS and social care was 7.3% of cases compared to an expected value nationally of 2.6%.

- At the time of our inspection the psychiatric intensive care unit (PICU) was closed for refurbishment however we saw good evidence of plans in place to manage access to beds whilst the work was completed.
- We found bed management processes for mental health beds were very effective. Patients were able to access an acute and PICU bed when required. Although average bed occupancy was at 85% (it is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital), some wards had considerably higher bed occupancy rates, for example, PICU 100.4%, and in some older people's wards (e.g. Alumhurst) there was a bed occupancy of 99.6% and 97.6%. However, there were no access issues when somebody in crisis required a bed. There was no access to beds in the area for women requiring PICU or forensic services.
- Stakeholders told us that the adolescent mental health unit, Pebble Lodge, was very responsive to the needs of young people. Commissioner were also complimentary about how the service responded to requests to vary services to meet the needs of young people.
- We were concerned that there were several complaints about the east Dorset telephone crisis line, operated overnight by the crisis team. We noted that telephone system had been set up to manage call coming into the service but at the time of our inspection if the telephone was not answered the line was cut off and there was no voicemail service available. This often meant that patients could not contact the crisis team . We did note that action had been planned to improve the telephone line functionality and effectiveness.
- 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. We were told that the police were responsible for making the decision how to transport patients. However, the MHA CoP identifies that police vehicles should only be used exceptionally. This meant comparatively long journeys, often in the back of a police van, for people from the west of Dorset.

  However, the trust had not had to turn anyone away in 2014/2015 to date. The relationships between the trust and the police in working together to address the needs of those in crisis was excellent. In west Dorset there was a crisis house that could be used by people with a mental health crisis as an alternative to admission. The trust proportion of admissions to acute wards gate kept by the CRHT Team fell below the England average between April and September 2014. Rates had risen again between October to December 2014 to above England average levels.

- Although between April 2014 and February 2015 community mental health teams achieved between 81% and 87% against their 100% target for referrals seen within four weeks we were concerned that there were widespread delays from assessment to treatment for people accessing community mental health teams in particular the long waiting teams for people requiring essential psychological therapies as part of their treatment.
- The trust had submitted data showing that between April 2014 and February 2015 child and adolescent mental health services have achieved 78.5%-98.8% (Tier 3 - specialist multidisciplinary outpatient CAMHS) and 74.3%-95.2% (Tier 2 - a combination of specialist CAMHS and community based services such as GPs) for referrals seen within four weeks staff in some community teams could not provide us with detailed information about the number of young people waiting for assessment or treatment or how long they had waited. Local stakeholders were concerned at the wait for treatment.

The facilities promote recovery, dignity and confidentiality

- The trust was making a considerable investment and development programme to improve the hospitals it

delivered services from. Where the building work had been completed, such as the Waterston Unit, we found environments that were well designed and fit for purpose.

- The trust had been innovative in some of the ways that it had competed the refurbishments including the development of a tablet application that helped in the assessment of ligature risks. We saw that ligature risks were either removed or well managed across the trust.
- However, in other areas we found that patients' dignity and privacy were compromised when receiving care in some hospitals, due to a lack of facilities and environment issues. These included the environments of some minor injuries units which were cramped and had reception areas that compromised privacy and dignity.
- We were concerned at the environments in the wards for older people with mental health problems as two of the wards were on the first floor resulting in patients having poor access to outside space and fresh air. We also saw that although one ward had bedrooms designated for disabled access, the door frames were too narrow for wheelchair access.
- Several community mental health teams were located in old buildings which did not have adequate access for disabled people.
- At Westminster community hospital we identified and issue with a communal toilet where passers by could see in. This was immediately rectified by the trust when we raised it with them.
- In Nightingale Court the treatment room was also used as the activity room; the room was divided by a curtain. On the day of inspection, patients involved in an activity could hear a staff member taking medical observations of a patient behind the curtained area.
- Glendinning ward was on the ground floor of a building shared with other teams in the trust. There was a dividing door between the ward and the corridor of one team's workplace. The door was glass panelled so patients in any state of undress could be easily seen by staff or visiting members of the public.
- The trust had created age appropriate material for young people accessing services. Within Pebble Lodge adolescent unit there were concerns regarding soundproofing of some therapy rooms meaning that patients confidentiality could not always be assured. This was also an issue in some of interview rooms the community mental health teams at various locations.
- In the national PLACE survey in 2014 the trust was 1.5% above the England average for other MH/CHS trusts for the appearance, condition & maintenance of its facilities.

Meeting the needs of all people who use services

- The trust's strategy document for 2014-2019 reflected the increasing demand for services for children and young people, which had resulted from a steady increase in population of 0-19 year olds and an estimated growth in the numbers of children living in vulnerable circumstances. The strategic direction for community services has been to transform services to deliver personalised, integrated care. To this end, community services, including those for children, young people and families, were reorganised in October 2014 into the current locality structure, to promote integration of physical and mental health services.
- The service leads had liaised with the extensive range of commissioners involved in services for children, young people and families. Information about the demographics had been used to inform recent and current tendering processes.
- There were some inconsistencies in service provision, often as a result of historical factors. For example, in Wareham, where there were no breast feeding counsellors, staff said they encouraged mothers to access services in Poole. Plans were in place to address this however, by training nursery nurses and creating breastfeeding champions.
- The trust had developed the Wave project which provided surfing lessons for young people with mental health problems to help promote their well being.
- The Dorset working women project provided a range of services to support peoples emotional wellbeing as well as providing sexual health services. These included a weekly drop in session where women could receive support from trained project workers.
- The health visiting teams had addressed the specific needs of the travelling community and had focussed on delivering a comprehensive immunisation programme for them.
- Staff across the trust recognised the equality and diversity of patients when providing care and had completed training.
- Appropriate information for people using services was available in the majority of community settings and for child and adolescent mental health services work had

Requires improvement

Are services responsive to people's needs?

been put in to develop age specific material. However, the community inpatient services only had written material available in English and this needed development to meet the diverse needs of patients.
- Staff were able to access interpreter services when required.
- Inpatient services provided a range of menus to meet peoples dietary and cultural needs.
- People with lived experience of mental health conditions delivered a series of educational and skills based workshops and programmes, directly on mental health wards for patients in partnership with staff.

Learning from concerns and complaints

- There was a process which staff followed in dealing with the effective management of concerns and complaints, and there was some evidence of learning and changes in response.
- We found that in most areas complaints were a standard item on multidisciplinary team meeting agendas and when complaints had been investigated, recommendations were made and an apology was issued.
- We reviewed a random sample of 10 complaints and found that documentation was in order, investigations had been completed on time and that responses were appropriate and timely. The chief executive reviewed all final responses.
- 482 formal complaints were made in the 12 months to 31st March 2015. 205 (42.5%) of these were upheld.

Requires improvement

Are services well-led?

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 requires improvement because:

- The services that the trust provided varied in their quality. We had particular concerns about some of the child and adolescent mental health services, some minor injuries units, the east Dorset mental health crisis and the rehabilitation services. We found some significant variance in the quality of care delivered between teams and across the trust.
- The locality-based delivery model was in the early stages of implementation and was developing well for some services but not so well for others, resulting in some variation in the quality of services, with services feeling fragmented and some staff feeling that they had not been engaged enough in the process of change.

However:

- We found that the trust had identified some significant areas of concern, had acted to change them and that there were now significant improvements in those services (for example, acute mental health inpatient wards, which we rated as outstanding).
- The trust had a relatively new board (executives and non-executives). The leadership team was positive, passionate, energetic and open and transparent. We concluded that they were a cohesive team who respected one another and shared a common purpose.
- The trust had engaged positively with stakeholders and had been successful in changing attitudes and fostering positive relationships – so much so that commissioners and other stakeholders now held the trust in high regard and were positive about the future, whereas previously they had held a very different view.
- There was a cohesive strategy based around driving improvements in clinical practice and working in partnership with patients, staff and stakeholders.
- The governance framework was in the process of being rolled out and in time this should ensure that the trust is able to identify and act on issues quickly.

Our findings

Vision, values and strategy

- The trust had a clear vision and a credible strategy to deliver good clinical quality care in partnership with patients, carers and stakeholders. The trust aspired to deliver healthcare services that empowered people to make the most of their lives and to care for people when they were unwell, support their recovery and give them the knowledge and confidence to stay as healthy as possible. The trust had a clear vision, developed with the involvement of staff, which was to 'lead and inspire through excellence, compassion and expertise in all we do'. This was underpinned by the principle of 'better every day'. The leadership team and senior managers were clearly focussed on improvement of the services and care delivered. Posters displaying the vision, values and goals were visible in many of the clinical settings that we visited and the majority of staff that we spoke with knew of the vision, values and strategy
- Although the trust had set out a clear strategy some of it relied on the outcome of a health-economy-wide clinical services review, which was being undertaken by the clinical commissioning group (CCG). The review will produce a single plan for all health services in Dorset (excluding dentistry) that will set out how services need to change to cope with increasing demand and limited budgets. The objective is to ensure that the NHS in Dorset provides quality, safe and clinically and financially sustainable services for the future. A major public consultation programme will be undertaken by Dorset CCG..
- Under the leadership of the chief executive, the trust had undertaken a robust engagement process with stakeholders and partners to ensure the trust's vision

fitted with local demand for services. The trust was already leading the delivery of integrated services in Dorset, having transformed its service management arrangements so that physical and mental health services were integrated and operated across 13 localities with the same boundaries as primary care and GP services. In Bridport, the trust had worked hard to break down the boundaries between family doctors and community services, bringing real improvements to patients and being recognised by consultants from McKinsey (leading the review) as a beacon of good practice and an example for others to follow. The trust was working with GPs to develop similar models in the Weymouth and Portland and Purbeck localities, in Poole and Bournemouth, sharing learning and good practice. However, the reorganisation into localities was resulting in some variation in the quality of services and some services feeling fragmented as a result. For example, staff felt that there was now a lack of strategic focus for people with functional illness across older people's community services, staff questioned whether the child and adolescent mental health service was too small to be split across localities, and staff felt that there was insufficient leadership of urgent care services.

- There was a good financial plan underpinning the strategy, with income in 2013/14 of £242.5 million and expenditure of £240.1 million. For 2015/16, the trust was working towards a financial surplus of £2.3 million. It planned to invest an additional £4.5million strategically into initiatives including governance, organisational development, human resources, communications, the pump-priming of new service models, mental health clinical systems, and information management and technology developments, resulting in a planned deficit of £2.2million.
- The overarching strategy set out seven strategic goals and was underpinned by a quality strategy, which was equally clear. The quality strategy was particularly robust on the safety components. This was demonstrated through the trust's monitoring metric dashboard, which had more robust measures for safety than for clinical efficacy.
- Both the overarching strategy and the quality strategy had recently been developed and had been approved by the trust board only in April 2015. We saw evidence of a good plan to inform and engage the workforce and stakeholders about them. However, despite there being clear evidence of actions taken (and to be taken) to address concerns, it was less clear how the trust would measure the outcomes of the changes or the impact of the strategy. The trust was in the process of developing its approach.

Good governance

- In 2013/14 Monitor found that the trust was in breach of its licence conditions and it was therefore subject to enforcement undertakings to address a number of failings identified by the Care Quality Commission (CQC). By June 2014 Monitor was satisfied that the trust's new leadership had dealt with the issues that caused the breach of its licence conditions, that it had a clear plan, 'the blueprint', to take it forward and it deemed that the trust was no longer in breach of its licence.
- The trust had successfully concentrated on addressing key areas that had previously been highlighted as needing improvement by patients, staff, stakeholders and the CQC and it had plans to address other issues of concern. This was particularly evident across mental health inpatient services, where we saw that the trust had made sustained improvements. The trust had invested in capital improvements and in health visiting services, where new staff had been employed and caseloads had been reduced. There were plans to review all community staff caseloads.
- Major concerns had been identified related to the management of medicines across the trust. It had commissioned an external review to look at its systems. We saw that this review had produced a comprehensive report with recommendations, which was presented to the trust board at a meeting during our inspection. We were assured that the trust had fully accepted all the recommendations and was taking action to implement them. We saw a number of positive initiatives that had been implemented, including innovative use of drug charts in palliative care and new checking systems for 'take home' medication.
- The trust had worked hard to improve the relationships with local stakeholders. Dorset CCG had noted a significant improvement in how the trust worked in partnership with local stakeholders. We were told that the trust was now very good at responding to concerns

raised locally and was proactive in informing the CCG when the trust itself identified issues. NHS England, who commissioned the child and adolescent mental health service inpatient services and the forensic services, said that it considered the services were performing well, that they had improved since the new leadership team had been in post and that there was now a very good focus on delivering patient-centred care.

- We saw that the chief executive had focussed his leadership on building successful relationships externally. This had involved going out to meet local stakeholders to understand their concerns fully and to engage them in the trust's programme of change. This included meeting all locality GPs, which was well received and valued. The availability of district nurses had been a key concern raised and we were given an example by the CCG of where some localities had concerns about district nursing services. With the leadership of the director of nursing, the trust was able to gain support of GPs for the blueprint to develop this service.
- There was a clear and coherent governance framework, which had been developed as a whole system approach. We found that this had been coordinated by the trust board in conjunction with the non-executive directors. The non-executive directors had an excellent understanding of governance and their roles. There was a clear demarcation between the non-executive directors and the executive members of the board, which ensured effective accountability. Within the senior leadership and management team there was an excellent understanding that good governance was a critical foundation for the sustained delivery of high quality care and performance as a trust.
- The governance framework had all the key components to ensure good functional governance. The trust had a high quality performance monitoring dashboard, which included a 'confidence in data' indicator. This was important as the board understood the need to monitor the quality of its data and interrogated this rather than just accepting data returns. The dashboard also pulled together risk and financial information in a comprehensive and useable format. Both the chair for the inspection and our specialist advisor for governance said that it was the best they had seen.
- In the roll-out of the governance framework, the trust was starting to identify areas of concern and agree metrics to measure performance against standards. However, the roll-out was still at an early stage and in a number of services we did not see that key performance indicators or data were used to inform clinical leaders at team level how well they were performing. Data was being collected but was seen as something that only senior managers would have an interest in. The trust was working in its roll-out programme to address this alongside its development of leadership.
- We saw that the trust had adopted the 'three lines of defence' risk assurance model to ensure clear accountability at all levels for managing risk whilst preventing a blame culture from developing.
- The trust was actively engaged in a number of national clinical audits and other clinically relevant quality initiatives. Several services had received accreditation from Royal Colleges. There was an impressive and well-coordinated programme of local management and clinical audits, which were designed to complement each other to ensure comprehensive assurance. We saw examples of clinical audits being undertaken, including trust-wide audits such as the medicines management audit, the audit of the use of opioids in palliative care and the audit of physical health checks in mental health services. There had been a clear decision to reduce the number of audits within the trust to be able to focus on the quality of the activity that produced meaningful data that could be acted on.
- All the key components of the governance framework were present and had been recently reviewed and improved, including the dashboard, assurance framework, risk management systems, complaints analysis, management of serious untoward incidents and internal and clinical audit. These had been designed to allow analysis of weaknesses or failings to promote improvement. We were impressed with the systematic and thorough approach to meaningful audit that could inform change.
- The clinical commissioning group felt that following these changes the appropriate structures were now in place to monitor and improve services.
- However, although these systems will provide the trust with good, safe governance systems in the future, the

majority were relatively new and still in the process of implementation and were not yet embedded in many wards and service delivery units. We saw that in some areas governance processes were not robust, as risks were not managed effectively and there were ad hoc arrangements for improving quality. Although staff had reported the continued practice of inappropriate transfers, there was no evidence that actions had been taken to minimise the risks. Other risks, such as environmental and infection control risks, were not managed safely and effectively and audits were not fully developed. The governance frameworks did not always operate effectively for minor injuries units. The trust had not proactively identified risks such as lone working resulting in patients waiting some time in minor injuries units without being seen whilst staff dealt with other patients, and a lack of triage and clinical assessments. The trust had failed to identify that risk assessments of children and young people referred to some community child and adolescent mental health service units were not being done, that waiting lists were not being effectively managed, and that the inappropriateness of fire evacuation and other environmental risks had either not been picked up or had not been acted upon in a timely manner.

- We saw that there was clear learning from incidents. The trust had also created a serious and untoward incident panel, which used presentations and discussion to identify the main learning points to share with staff. We saw innovative use of technology to share that learning. On the NHS staff survey for 2014 the trust score for the fairness and effectiveness of incident reporting procedures was 3.45 out of 5 (compared to the national average of 3.52).
- Staffing levels were, in the main, safe and staff told us they had enough time to deliver good quality care. However, staffing levels were not always appropriate in community hospitals, children and young people's health and urgent care services. Medical cover was insufficient in mental health older people's wards. The east Dorset crisis team had a 50% vacancy rate, which had a marked adverse effect on the team's ability to provide robust home treatment services. The trust highlighted that the main issue with staffing was the lack of registered nurses. Generally, wards achieved an overall coverage of staff even if it was not at the trust's agreed qualified/unqualified ratio. The trust monitored its safe staffing levels as part of the national safe staffing agenda and was working hard to address staffing level issues.
- As of April 2015, the trust had completed mandatory training for 91% of eligible staff, compared with a target of 85% (the trust had recently moved its target to 95% meaning it was no longer meeting its target).
- The trust had taken steps to rationalise and reform its training programme from 2013, including the way that e-learning was delivered. This included a series of e-learning modules that were not just mandatory training modules but also professional development learning. This had led to an increase from 979 e-learning modules completed in 2013/14 to 5,604 in 2014/15. The trust had also changed the way it delivered its practical training, moving from a classroom delivery model to a more flexible approach that met the workforce's needs. This included delivering training in teams' bases (for example, manual handling training on the wards) meaning that it was more specific to the needs of the workforce. The NHS staff survey for 2014 identified that 79% of respondents from the trust said they had received job-relevant training, learning or development in the last 12 months (compared to the national average of 82%).
- The majority of staff in mental health services told us they had received appraisals and supervision, although the NHS staff survey identified that the trust performed worse than the national average for mental health trusts for staff receiving appraisals. There were inconsistencies across community health services. The trust data identified that 94% of staff across the trust received an appraisal as of May 2015.
- The trust made 120 Deprivation of Liberty Safeguards (DoLS) applications in the six months to 31 March 2015 but there had been challenges for the local authority responding with decisions. The trust was working with local authorities and providing training to staff to mitigate risks posed by this.
- The trust had conducted a number of audits of its use of the Mental Health Act (MHA) and Mental Capacity Act (MCA) to ensure that it was applying them correctly. However, we found that Mental Health Act documentation was not always completed properly and that staff had not been trained in the new code of

practice so they did not understand what was required of them. Staff in many areas lacked a comprehensive understanding of the Mental Capacity Act and completion of training was inconsistent across the trust.

Leadership and culture

- The trust had a relatively new board (executives and non-executives), with the majority having been appointed only since the arrival of the chief executive in 2013. The director of nursing had been in post for ten months before our inspection and a new medical director was due to take up post immediately after our inspection. The leadership team was positive, passionate, energetic, and open and transparent. They demonstrated that they understood the importance of a positive culture as a key component of patients' safety and experience. They were committed to ensuring that the trust's vision and values were embedded at all levels, and we saw that they had this work underway. We concluded that they were a cohesive team who respected one another and shared a common purpose.
- The board was very aware of the importance of leadership in ensuring that change was driven positively and embedded and they had identified 'ineffective clinical leadership across all services' as a key risk (on the corporate risk register) to delivering the change. The trust had moved to a locality management model to promote integration of physical health and mental services and to build local leadership capacity. The model had generally been well received by staff. The trust had developed leadership training programmes for managers and clinical leads, and in February 2015 had introduced forums for senior staff to share learning. Senior nurse managers from mental health and matrons from community hospitals had started meeting in these forums and described how they now shared learning and how the support was helping to develop their leadership skills and practice.
- We saw particularly strong nursing leadership from the director of nursing that was responsive to situations and set clear standards of care the trust should provide.
- The trust had engaged positively with stakeholders, an aspect for which the chief executive had taken specific responsibility, and it had been successful in changing attitudes and fostering positive relationships, so much so that commissioners and other stakeholders now held the trust in high regard and were positive about the future, whereas previously they had held a very different view. It was clear that there was a cohesive strategy based on driving improvements in clinical practice and working in partnership with patients, staff and stakeholders; we saw clear evidence of this in several areas across the trust. Staff side representatives overwhelmingly expressed confidence in the senior management team and spoke positively about the changes that were occurring and how the new board was much more open than any they had seen previously. However, they did have some concerns that changes were often brought in quickly with little consultation or due process.
- We noted that the chief executive had not formally identified a deputy chief executive, which could pose a potential risk given the key external focus that the chief executive needed to take to consolidate and build on external relationships through a significant period of rapid change.
- When speaking to managers and leaders within the trust, we found a very open culture. All of the executives and senior managers we spoke with were transparent about areas of concern we might find. They were also aware that their governance systems were still not fully embedded and that they did not yet have a full understanding of potential areas of concern. They welcomed our inspection to help them identify areas that needed to be looked at until their governance systems were fully operational.
- All of the governance documents and strategic plans we viewed displayed a strong awareness of the need for openness and transparency to support the sustained delivery of high quality care and to achieve continuous improvement. However, a number of consultants and senior doctors expressed frustration about a lack of engagement and involvement with them in the changes being made – for example, the move to the locality model.
- We saw that the trust had invested in a leadership programme to address the risk and development needs of managers and senior clinicians who were key to the delivery of the changes. This programme had been accredited through Bournemouth University.
- The NHS staff survey results from 2014 showed that the trust's performance was rated better than or the same as the national average for staff believing the trust provided equal opportunities for promotion or career progression, staff suffering work-related stress, staff

experiencing discrimination at work, and staff experiencing physical violence, bullying, harassment or abuse from patients or relatives. Areas in which staff did not feel the trust performed well were related to raising concerns about getting support from immediate managers, job satisfaction and staff recommendation of the trust as a place to work or receive treatment.

- The trust was working hard to address previous concerns among the workforce regarding management and leadership. In particular, there were concerns among staff about how complaints and investigations were handled. Staff side representatives told us they had confidence in the way the new leadership team had addressed this. This included bringing in external people to conduct and review investigations. This had helped to restore transparency and confidence in the investigation system.
- Information was sent to staff regularly by email and newsletter.

Engagement with the public and with people who use services

- The trust's senior managers expressed a commitment to engaging those using services and their carers in developing services and they had developed a patient and public engagement strategy. Patient experience information was reported quarterly to the patient and public engagement and experience (PPEE) committee, patient and carer group and the quality assurance committee. Patient stories were presented regularly to trust board meetings.
- The level of engagement of the trust governors was clear and they were supportive of the changes the trust was making. We observed, at a trust board meeting, that their views were valued and that they contributed to the discussion and debate, asking pertinent questions that held the board meaningfully to account.
- We saw that the trust was working hard to develop and ensure engagement with people who use services. This included running annual participation surveys by services. The trust had also asked for volunteers to take part in feedback sessions to teams.
- The trust worked in partnership with local groups, particularly Dorset mental health forum, the health and well-being board, local Healthwatch and voluntary organisation such as the league of friends. This had led to initiatives that greatly improved patients' experiences. For example, peer specialists – people with lived experience of a mental health condition –provided a varied and rich programme of educational and recovery-focussed sessions on the wards and coordinated support for carers. The west Dorset crisis team was running carer-led peer support programmes. In community health services, events had been held to help patients and their carers understand how the trust would carry out end of life care planning following the adverse publicity associated with the Liverpool care pathway. A wellbeing centre had been developed at Blanford hospital and at Swanage hospital calendars had been produced, depicting staff in the areas of their work to help patients and the community understand about the services of the hospital.
- The trust had a patient experience team, who monitored local patient surveys and helped facilitate change to improve the patient experience.

Quality improvement, innovation and sustainability

- There was clear recognition at board level of the need for a sustainable financial plan that underpinned sustainable quality of service and continuous improvement. This was demonstrated by the sound financial plan for both the previous and present year. For 2013/2014 the trust had an operating surplus, which was used to progress an extensive investment programme. The trust had made substantial improvements to the mental health inpatient units. We saw that environments had been refurbished to a high standard that would benefit the patients' experience. In addition, Twynam ward (secure inpatient services) had been refurbished to a high standard, although there were still some faults to put right. The psychiatric intensive care unit, Haven ward, was closed for refurbishment at the time of our inspection. We saw numerous other plans to improve the environment. In 2014/2015 the trust planned to invest strategically into initiatives including governance, organisational development, human resources, communications, the pump-priming of new service models, and mental health clinical systems and information management and technology developments.
- The trust board required the finance director to provide a model of financial reporting that allowed it to manage the trust's budget in as near to real time as possible. We saw in the board meeting a shared ownership of the financial decisions and risks.

Requires improvement

Are services well-led?

- We saw active development to aid quality improvement in clinically innovative ways. This was demonstrated by the development with the local university of a new professor post. The trust and Bournemouth University planned to appoint a professor of integrated care as a joint appointment across the two organisations. The role was designed to help the trust in developing new models of care through academic research and evaluation, which would not only improve clinical outcomes for patients but also aid more efficient working.
- The trust had progressed a number of innovative initiatives and several services had received recognition from national organisations.
- The breast feeding service in Bournemouth had received UNICEF baby friendly accreditation and people using the service were particularly complimentary about it.
- The pain service had undertaken research on a specialist pain management programme (PMP) and had presented the research at international events; the development of an early pre-screening tool had been adopted by the faculty of pain at the Royal College of Anaesthetists.
- The children's learning disability service had won an innovation award from the Royal College of Psychiatry in 2014 for 'developing parenting groups as an Initial Intervention.'
- The Pathfinder service was a satellite of the forensic community team, with many staff working across both services. It was provided as an alternative to hospital treatment (typically in medium or high secure services) for offenders with a personality disorder.
- The wellbeing and recovery partnership (WaRP) had been developed jointly by the trust and the Dorset mental health forum across all of the acute wards.
- Patients had access to the recovery education centre, which offered many courses to enable them to understand their experiences, manage their recovery and also how to support others with their journey. Peer specialists provided recovery coaching to patients and staff on the wards and provided patients with personal support plans.
- The child and adolescent mental health service ran the wave project, which provided free surfing to young people with mental health problems. The wave project aimed to improve young people's wellbeing, social skills and mental health whilst teaching them to surf. Young people from Pebble Lodge were referred to the project (where appropriate) as part of their therapeutic activities. The ward transition nurse was also the wave project lead. The project was part of the national wave project, which used the Stirling child wellbeing scales to measure outcomes for young people participating in the project.
- The trust was committed participation in research and development and worked with its partners Bournemouth University, Southampton University and St Loyes Foundation to progress this.

Fit and Proper Person Requirement

- We interviewed the trust's chair and members of the senior leadership team regarding the implementation of the fit and proper person's test and were assured that all directors had received the appropriate clearance. We reviewed a random sample of executive members' personal files and found the appropriate documentation had been completed.

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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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment** **How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care or treatment because:** **Community health services inpatients** • Persons providing care or treatment did not always have the competence and skills and experience to do so safely. Regulation 12 (2)(c) • Equipment used for care or treatment was not always checked to ensure it is safe for use. Regulation 12 (e) • Medicines were not always kept safe in inpatient services. Regulation 12 (2) (g) • Procedures to assess, prevent, and control the spread of infections were not followed consistently. Regulation 12 (2)(h) **Community health services for children, young people and families** • Persons providing care or treatment did not always have the competence and skills to do so safely. Regulation 12 (2)(c) • Medicines were not always kept safe in sexual health services. Regulation 12 (2) (g) **Community health services urgent care** • National guidance on triage and clinical assessment in urgent care services was not followed to ensure provision of safe care. Regulation 12(1) • Patients attending MIU did not receive timely clinical assessment to identify their needs and any immediate risks to their health and wellbeing. Regulation 12 (2) (a) • Persons providing care or treatment did not always have the competence and skills and experience to do so safely. Regulation 12 (2)(c)

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- Equipment used for care or treatment was not always checked to ensure it is safe for use. Regulation 12 (e)
- Medicines were not always managed properly and safely. Regulation 12 (2) (g)

CAMHS community

- The trust did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. Staff were not compliant with mandatory training requirements. This was a breach of regulation 12 (1) (2)(c).
- The trust did not ensure that the risks to the health and safety of service users of receiving care and treatment had been assessed and had not done all that was reasonably practicable to mitigate any such risks. In the Bournemouth and Christchurch service and the Weymouth and Portland service we visited we found that there was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment. This was a breach of regulation 12 (1)(a)(b).

Wards for older people with mental health problems

- We found that patients were not being protected against unsafe care and treatment. Plans for mitigating risks were not safely reflected in all plans on Alumhurst or St Brelades Ward. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008

Community based mental health services for adults

- 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. Although serious incidents had been reviewed and thoroughly

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investigated, effective action had not been taken to remedy the situation, prevent further occurrences and make sure that improvements were made. This was a breach of regulation 12(1) & (2)(a)&(b)

Forensic/secure inpatient wards

- The ward did not have effective processes for reducing the risks to patients and staff. This included risks in the environment, gaps in policies for and implementation of procedural security, and the unsafe use of sharps bins. This was a breach of Regulation 12(1)(2)(a)(b)(c)(d)(e)(h)

Crisis and health base places of safety

- 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 contact the service through appropriate channels at all times.

Mental health rehabilitation services

- We found that patients were not protected against the risks associated with the unsafe use and management of medicines on Glendenning ward by ensuring the record of the administration of medication is accurate. This was a breach of regulation 12 (2)(g)
- We found that in Nightingale House there were 51 ligature risks identified. The trust had plans in place to mitigate the risks identified including transfer of patient if risk of self harm increased and areas of identified high risk to be locked. However we saw that three patients were at increased risk of self harm and the upstairs male bathroom was isolated, unobserved, unlocked and had no alarm system. This was a breach of regulation 12 (2)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities)
Diagnostic and screening procedures	

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Nursing care

Treatment of disease, disorder or injury

Regulations 2014: Staffing

How the regulation was not being met:

Community health services inpatients

- There were not always sufficient numbers of adequately experienced and skilled staff to meet the requirements set out in the fundamental standards. Regulation 18 (1)
- Not all staff received the appropriate training, support and clinical supervision to enable them to carry out the duties they are employed to perform. Regulation 18 (2)

Community health services for adults

- There were not sufficient numbers of staff in some community teams and the night nursing team, to meet the requirements set out in the fundamental standards. Regulation 18 (1)

Community health services for children, young people and families

- There were not sufficient numbers of school nursing staff to meet the requirements set out in the fundamental standards. Regulation 18 (1)

Community health services urgent care

- There were not always sufficient numbers of adequately experienced and skilled staff to meet the requirements set out in the fundamental standards. Regulation 18 (1)
- Not all staff received the appropriate training, support and clinical supervision to enable them to carry out the duties they are employed to perform. Regulation 18 (2)

CAMHS community

- The trust did not ensure there were sufficient numbers of suitably qualified, competent, and skilled staff to meet the needs of the people using the service. In the Bournemouth and Christchurch service and the Weymouth and Portland service we visited they were unable to provide a service to children and young people within target waiting times due to vacancies and staff sickness. This was a breach of regulation 18 (1).

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Community based mental health services for adults

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

Crisis and health based places of safety

- 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 Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance** **How the regulation was not being met:** **Community health services inpatients** • Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a) • Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b) • Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation (2)(e)

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Community health services for adults

- Systems were not in place to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2)(c)

Community health services for children, young people and families

- Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a)
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b)
- Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation (2)(e)

Community health services end of life care

- Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a)
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b)
- Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation (2)(e)

Community health services urgent care

- Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a)
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b)
- Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation (2)(e)

Wards for older people with mental health problems

- We found that the trust have not responded to feedback in a timely way when environmental risks on Chalbury Unit raised, no system in place to

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communicate how this feedback will lead to improvements. This was a breach of Regulation 17 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Community based services for older people with mental health problems

- Records were not always accurate, complete and contemporaneous in respect of each service user, including a record of the care and treatment provided to the service user 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 includes people's care plans, risk assessments and physical health assessments and on-going monitoring. It was not clear why decisions not to share information with individuals had been made. This was a breach of Regulation 17 (2) (c) HSCA (RA) Regulations 2014 Person-centred care

Community based mental health services for adults

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014: Premises and equipment** **How the regulation was not being met:**
Diagnostic and screening procedures	
Nursing care	
Treatment of disease, disorder or injury	

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Community health inpatient

- All premises and equipment was not always clean, clinical waste was not managed securely, Regulation 15 1(a)
- The provider had not ensured suction machines, were available in all clinical areas at all times Regulation 15 1(f)
- Processes were not followed to maintain standards of hygiene and ensure multi use equipment and devices were cleaned between patients and ready for use. Regulation 15(2)

Wards for older people with mental health problems

- We found that patients were not protected against the risks associated with unsafe or unsuitable equipment and premises. Monitoring and checking safety equipment was not carried out consistently with significant gaps in recording on Herm, Alumhurst and Chalbury wards. There was no clear and ratified fire procedure on Chalbury Unit. Bedroom doorframes at Melstock House did not allow wheelchair access. We found there was restricted access to the outside space on Chalbury Unit and Alumhurst wards and no formal arrangements in place to facilitate access. This was in breach of Regulation 15 (1) (b) (c) (e) (f) of the Health and social Care Act 2008 (Regulated Activities) 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment** How the regulation was not being met:

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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 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA (RA) Regulations 2014:** **Dignity and Respect** **Wards for older people with mental health problems** • We found that patients' dignity and privacy were not being protected suitably or monitored on Alumhurst Ward and Melstock House. There was no evidence of individual discussion about personal wishes around management of privacy. • The privacy and dignity of patients on Alumhurst ward accommodated in the bed bays were not being protected due to the sleeping environment. Beds were separated by curtains and personal care taking place within the bays. This was in breach of Regulation 10 (1) 10 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **Community based mental health services for adults** • Not all people who used services were treated with dignity and respect, as the registered person did not ensure the privacy of users at all times. Poor sound-proofing of interview rooms had been identified as an issue by staff but not adequately addressed. This meant that not all reasonable efforts had been made to ensure that all discussions about care and treatment took place where they could not be overheard. This was a breach of regulation 10(1) & (2)(a) **Mental health rehabilitation** • We found that some of the physical environments in the wards did not promote privacy for patients. In Nightingale Court the treatment room was also the
	Community health services urgent care • Systems and processes were not operating effectively as not all staff were up to date with training or confidently identifying and responding to child protection flags. Regulation13 (2)

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activity room with the room being divided by a curtain. We saw that patients involved in an activity could hear a staff member taking medical observations of a patient behind the curtained area. On Glendenning ward the premises was on the lower ground floor of a building shared with other teams in the trust. There was a glass panelled dividing door between the ward and the corridor of another service so patients in any state of undress could be easily seen by staff or visiting members of the public. This was a breach of regulation 10 (2)(a)

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