Requires improvement

Dorset Healthcare University NHS Foundation Trust

Community-based mental health services for older people

Quality Report

Dorset Healthcare University NHS Foundation Trust
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDY02	King's Park Hospital	Bournemouth East OPCMHT Bournemouth North & West OPCMHT	BH7 6JE
RDYX9	Westminster Memorial Hospital	Shaftsbury OPCMHT	SP7 8BD
RDYX4	Blandford Hospital	Blandford OPCMHT	DT11 7DD
RDYX8	Weymouth Community Hospital	Weymouth & Portland OPCMHT Melcombe Day Hospital	DT4 7TB
RDYY4	Yeatman Hospital	Sherborne OPCMHT	DT9 3JU
	Oakley House	Wimborne & Purbeck OPCMHT Ferdown & West Moors OPCMHT	BH21 1SF
RDY38	Fairmile House	Christchurch OPCMHT	BH23 2JT
RDY22	Alderney Hospital	Poole OPCMHT	BH12 4NB

Summary of findings

Haymoor Day Hospital
Intermediate Care Service For Dementia (ICSD)

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

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Overall summary

We rated Dorset Healthcare University NHS Foundation Trust as requires improvement because:

- There was limited access to psychological therapies. Patients who could have benefited from specialist psychological therapies were not always offered them. These included patients whose mental health difficulties were not responding to medication.
- Understanding and application of the Mental Capacity Act was variable and was not embedded in everyday practice in all teams.
- Caseload sizes varied between teams and in several teams they were very high.
- The quality of care plans was varied across the service. Some were not holistic, personalised or recovery orientated.
- The quality of risk assessments was varied across the service and not all risks identified fed through to the patients care plan.
- There was a lack of strategic oversight for older people's mental health and patients did not receive an equitable service across the county. There was no clear strategy for older adults with functional illness.
- There was no formal structure to share good practice across older people's mental health services.

However:

- The intermediate care service for dementia (ICSD) was a specialist crisis service for people with dementia in east Dorset. The team consisted of a team manager, nurses, a full time occupational therapist (OT), support workers and consultant psychiatrists. It was generally a nurse led service, operating 7am – 9pm, to prevent hospital admission, support discharge from hospital, support carers, families, residential and nursing homes and general hospital settings for up to six weeks. The team could provide intensive support up to four times per day, were able to access day hospital places and had an emergency social care budget to access emergency respite for up to two weeks. The ICSD provided very good crisis support for patients with dementia, although this was not available to patients in the west of Dorset.
- Deterioration in health was discussed as part of risk reviews at weekly multi-disciplinary team (MDT) meetings. This meant that all team members were aware of individual patients' risks.
- None of the teams we visited had waiting lists. Assessments were carried out within the four week target in all teams, and new assessments were discussed at the weekly MDT meeting.
- There was little use of bank or agency staff.
- Patients were allocated a care co-ordinator within a week.
- There was good medicine management amongst the teams and safe lone-working procedures.
- NICE guidance was being adhered to.
- Staff were friendly, kind and respectful and the interactions we witnessed were patient-centred, collaborative and compassionate. Patients and carers told us that they felt involved and were asked for their opinions and feedback.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Deterioration in a patient's health was discussed as part of risk reviews at weekly multi-disciplinary team (MDT) meetings. This meant that all team members were aware of individual patients' risks.
- The intermediate care service for dementia (ICSD) provided very good crisis support for patients with dementia. This meant that sudden deterioration in patient's health could be responded to promptly.
- There was little use of bank or agency staff.
- There was good medicine management amongst the teams and safe lone-working procedures.
- All the teams discussed incidents regularly in MDT meetings and there was a newsletter that included learning from incidents across the trust.

However:

- In one team base where we tested alarms they could not be heard in the upstairs offices. Although they could be heard by the receptionist there could be a delay in accessing help in an emergency.
- Caseload sizes varied between teams and in several teams they were very high.
- Teams varied in their completion rates for mandatory training. Five teams were below the 75% target for basic life support annual updates.
- The quality of risk assessments varied and not all risks identified fed through to the patients care plan.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There were 4.9 whole time equivalent (wte) psychologists for older people's mental health to cover nine community mental health teams for older people (OPCMHTs) in East Dorset, five OPCMHTs in West Dorset, six inpatient units and the memory assessment service. We saw examples in electronic records of patients who could have benefited from specialist psychological therapies but were not offered them, and cases

Summary of findings

where psychological assessment and formulation could have provided improved understanding of behaviours. These included patients whose mental health difficulties were not responding to medication.

- We were concerned that only 13% of OPCMHT staff had completed mandatory Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding training during the period 1 July 2012 to 30June 2015. Understanding and application of the MCA was variable and was not embedded in everyday practice in all teams.
- Most care plans were up to date, but the quality varied. Some were not holistic, personalised or recovery orientated.

However:

- New assessments were discussed at the weekly multi-disciplinary team (MDT) meeting.
- NICE guidance was being adhered to.
- The intermediate care service for dementia (ICSD) had exceeded their targets for preventing admission to hospital. Their target for the first year of operation for preventable hospital admission had been 60 and their data showed they had achieved 180.
- MDTs took place weekly and had clear agendas which demonstrated effective sharing of information and knowledge.
- Staff had regular supervision.

Are services caring?

Good

We rated caring as good because:

- Staff were friendly, kind and respectful and the interactions we witnessed were patient-centred, collaborative and compassionate.
- Patients were given information about treatments and medication including side effects, and were given time to ask questions.
- Advocacy leaflets were available in waiting areas and patients were aware of advocacy services.
- Patients and carers told us that they felt involved and were asked for their opinions and feedback.

However:

- Not all patients had been given a copy of their care plan. In some cases, this was because staff felt it was not appropriate, but written records did not always show the reasoning for this decision.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- All teams had a duty system that was able to respond to urgent referrals and had good access to psychiatrists in emergencies. Patients we spoke to said they could access help urgently when required. The intermediate care service for dementia crisis support for dementia patients was very good.
- Complaints were a standard item on multi-disciplinary team (MDT) meeting agendas in all teams and when complaints had been made these had been investigated, recommendations were made and an apology was issued.
- Assessments were carried out within the four week target.
- None of the teams we visited had waiting lists.
- Patients were allocated a care co-ordinator within a week of admission.

However:

- Memory assessment service (MAS) referrals had increased rapidly resulting in only 50% of patients being seen within the target time. Temporary bank staff had been employed within MAS to reduce the waiting list, but there was no clear plan to address the ongoing high referral rate.
- Patients in the west of the county could not access the intermediate care service for dementia. This meant that patients with dementia who needed crisis support did not receive equitable services across the county

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was no clear strategy for older adults with functional illness such as depression, bi-polar and schizophrenia
- There was a lack of strategic oversight for older people's mental health and people did not receive an equitable service across the county
- There was no formal structure to share good practice across older people's mental health services
- Staff across the trust told us that they felt disconnected from senior managers
- Some team leaders did not believe they had authority to put items on the risk register. However, the trust state that all locality managers can add to or edit the system and can identify additional staff to add to this if they wish.

Summary of findings

However:

- The trust had a vision for services for people with dementia and was working towards one strategy and one pathway
- All multi-disciplinary team (MDT) meetings had a regular agenda slot for incidents. Complaints, safeguarding, patients under the Mental Health Act and Mental Capacity Act were agenda items on all MDT meetings
- Key performance indicators (KPIs) were being used to measure performance and all teams were aware of the KPIs for waiting times and were meeting these
- All the community teams for older people demonstrated good support for each other and staff felt supported by team leaders

Summary of findings

Information about the service

The community teams for older people in Dorset were based in a variety of different geographical areas. Each team provided services clustered around GP practices. Local authority staff, such as social workers, worked to these geographical boundaries as far as possible while remaining responsible for residents of their employing local authority. The county was covered by three local authority areas. These were Dorset County Council, Poole Borough Council and Bournemouth Borough Council. Services were commissioned by Dorset Clinical Commissioning Group (CCG)

The community teams for older people provided assessment, treatment and care for older people with functional mental illness who required specialist mental health services. Functional mental illness means illness like depression, schizophrenia and bi-polar disorder. People with an organic mental disorder such as dementia, who required specialist input, for example, for behavioural or psychological issues, were also treated by the community teams for older people (OPCMHTs). The teams provided support or signposting to carers

The memory assessment service (MAS) was available for people experiencing memory problems, to enable early diagnosis and treatment. Referral was via the 'memory gateway' which was a partnership between the Alzheimer's Society and Dorset Healthcare and was available across the county.

The intermediate care for dementia service (ICDS) aimed to prevent unplanned hospital admissions and support timely and early discharge from hospital. They aimed to avoid admission into long-term care and reduce dependency on long-term packages of care to improve independence and minimise intervention into daily life. This service was only available in the east of the county.

Sherborne, Shaftsbury and Blandford OPCMHT were part of the north locality. The Shaftsbury team were based at Westminster Memorial Hospital, the Sherborne team at Yeatman Hospital and the Blandford team at Blandford Hospital

Ferndown & West Moors OPCMHT and Wimborne & Purbeck OPCMHT, based at Oakley House were part of the east locality.

Bournemouth East team and Bournemouth North & West team were both based at Kings Park Hospital and Christchurch OPCMHT was at Fairmile House

The service at Weymouth and Portland, including Melcombe day hospital, was based at Weymouth Community Hospital. The day hospital aimed to promote self-confidence, self-esteem and independence through a range of therapeutic activities and provide advice and support for carers.

Poole OPCMHT, Haymoor day hospital and the ICDS were based at Alderney Hospital and came within the Poole collaborative CCG. The memory assessment service (MAS) for the east of Dorset was also based at Alderney Hospital. Haymoor Day hospital provided assessment and monitoring of people with organic and functional illness to enable patients to remain in the community wherever possible and reduce the need for admission to hospital

Community mental health services for older adults had not been inspected previously.

Our inspection team

The inspection team was led by:

Chair: Neil Carr OBE, chief executive of South Staffordshire and Shropshire Healthcare NHS Foundation Trust

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

Summary of findings

The team that inspected community-based services for older people included two CQC inspectors and nine specialist advisors with experience in older people's mental health, including a consultant psychiatrist, six registered mental health nurses and two psychologists.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited nine community teams, two day hospitals, the intermediate care service for people with dementia (ICDS) and the memory assessment service.
- spoke with 68 patients and carers who were using the service
- spoke with the older peoples mental health strategy group
- spoke with five service managers and nine team leaders
- spoke with 56 other staff members; including doctors, nurses and social workers, occupational therapists and support workers
- interviewed the divisional director with responsibility for these services
- attended and observed six multi-disciplinary team meetings

We also:

- Looked at 58 treatment records of patient
- Observed 27 home visits and outpatient appointments and seven treatment groups
- Looked at five sets of staff records and supervision records for eight staff
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We heard many positive comments from patients about staff. Staff were described as supportive and kind. We spoke to patients attending a cognitive stimulation therapy group who said that they felt valued and had regained confidence. We spoke to people who had received carer's assessments and who had attended carers support groups and received respite. They told us that they felt supported. Patients and carers told us that they felt involved and were asked for their opinions and feedback. Memory assessment service patients were sent a feedback survey every three months and we saw that patients had given very positive feedback.

Good practice

Good practice

Summary of findings

- The Sherborne team were working with Sherborne and District Dementia Action Alliance to establish a dementia-friendly community in Sherborne so that people would understand more about dementia and people with dementia would feel included in their community
- An information pack had been produced by the Sherborne team for relatives and carers of people with mental health problems associated with old age. The pack explained the role of community mental health teams, carer's rights, gave emergency numbers and explanations of the common kinds of dementia and gave advice for helping people with memory problems, delusions or unusual beliefs.
- The trust was running a recovery education centre in association with the Dorset Health Forum. Courses were available for staff, patients and carers and included recovery well-being for older people, medication choices, understanding memory loss
- The Weymouth & Portland team had facilitated two groups of paramedic students from Bournemouth University to have observational placements with their team.
- The intermediate care service for dementia was a specialist crisis service for people with dementia. The team consisted of a team manager, nurses, a full time occupational therapist, support workers and consultant psychiatrists. It was generally a nurse led service, operating 7am – 9pm, to prevent hospital admission, support discharge from hospital, support carers, families, residential and nursing homes and general hospital settings for up to 6 weeks. The team could provide intensive support up to four times per day, were able to access day hospital places and had an emergency social care budget to access emergency respite for up to two weeks.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that care records are accurate, complete and contemporaneous. 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..

Action the provider SHOULD take to improve

- The provider should complete the planned review of caseload sizes across the county and identify ways to reduce these. Caseloads varied between teams and in several teams they were very high.
- The provider should 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 only available in the east of the county.
- The provider should 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. Community services for older people with mental health problems were fragmented and disjointed and people did not receive an equitable service across the county.
- The provider should review psychological provision for older people to ensure psychological therapies can be accessed by all patients who may benefit from them. There was variability of access to psychology for patients with complex needs. Some patients who could have benefited from specialist psychological therapies were not offered them.
- The provider should ensure that staff are trained in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and fully understand their responsibilities under the MCA. Understanding and application of the Mental Capacity Act MCA was variable and was not embedded in everyday practice in all teams.

Dorset Healthcare University NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bournemouth East OPCMHT Bournemouth North & West OPCMHT	King's Park Hospital
Shaftsbury OPCMHT	Westminster Memorial Hospital
Blandford OPCMHT	Blandford Hospital
Weymouth & Portland OPCMHT Melcombe Day Hospital	Weymouth Community Hospital
Sherborne OPCMHT	Yeatman Hospital
Wimborne & Purbeck OPCMHT Ferdown & West Moors OPCMHT	Oakley House
Christchurch OPCMHT	Fairmile House
Poole OPCMHT Haymoor Day Hospital Intermediate Care Service For Dementia (ICSD)	Alderney Hospital

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.

We were unable to confirm how many staff had received Mental Health Act (MHA) training as this information was not available. Staff were able to describe a good working knowledge of the Mental Health Act when we asked them.

The teams we visited did not have patients detained on community treatment orders when we inspected. In Shaftsbury there were eight patients receiving section 117 after-care. There was a regular slot on the team's multi-disciplinary team agenda to discuss these patients. Staff were aware of advocacy services and we saw leaflets about these services in waiting rooms.

Mental Capacity Act and Deprivation of Liberty Safeguards

We were concerned that only 13% of OPCMHT staff had completed mandatory Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training during the period 1 July 2012 to 30June 2015. Understanding and application of the MCA was variable and was not embedded in everyday practice in all teams. Mental capacity was discussed in multidisciplinary teams meetings (MDT's) and we saw the principles of the Act being used in practice when we observed home-visits with the Sherborne team. The Poole team used an MCA flowchart for guidance. There was a trust-wide protocol to routinely include capacity and consent to treatment in outpatient letters at first assessment and change of treatment. However, we looked at case notes to see if this protocol was been followed and saw that it was missing from some letters. We looked in case notes for assessments of capacity on RIO, the electronic care record system. We could only find this on one of the eight records we looked at in Bournemouth. We did not find any cases that led us to believe that patients were at risk because of the lack of training in the mental capacity act but were concerned that there was poor record keeping of capacity. Deprivation of Liberty Safeguards applications that had been completed by social workers were kept on the social services electronic records system and had to be scanned and uploaded onto RIO as social services notes were not accessible to health staff.

Good

Are services safe?

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

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

Summary of findings

We rated safe as good because:

- Deterioration in a patient's health was discussed as part of risk reviews at weekly multi-disciplinary team (MDT) meetings. This meant that all team members were aware of individual patients' risks.
- The intermediate care service for dementia (ICSD) provided very good crisis support for patients with dementia. This meant that sudden deterioration in patient's health could be responded to promptly.
- There was little use of bank or agency staff.
- There was good medicine management amongst the teams and safe lone-working procedures.
- All the teams discussed incidents regularly in MDT meetings and there was a newsletter that included learning from incidents across the trust.

However:

- In one team base where we tested alarms they could not be heard in the upstairs offices. Although they could be heard by the receptionist there could be a delay in accessing help in an emergency.
- Caseload sizes varied between teams and in several teams they were very high.
- Teams varied in their completion rates for mandatory training. Five teams were below the 75% target for basic life support annual updates.
- The quality of risk assessments varied and not all risks identified fed through to the patients care plan.

Our findings

Safe environment

- Teams either used hand-held alarms or had fixed alarm systems in the interview rooms. Most staff told us these systems worked well. However, we tested the alarms at Oakley House and found that they could not be heard in the upstairs offices although they could be heard by the receptionist. This could have delayed access to help in an emergency
- Clinic rooms at Shaftsbury and Poole were being refurbished at the time of the inspection. The clinic room at Bournemouth was well equipped and included scales, a fridge and examination table. Medication was stored in a locked cupboard
- The age and quality of buildings used by the community teams for older people varied. Some had been recently refurbished whilst others were situated in old buildings. They all provided comfortable furniture. The majority of people were seen in their own homes whenever possible
- All the sites we looked at appeared clean. However, we did not see the cleaning records at Bournemouth as they were not available on site. Staff told us that cleaning was carried out by a team based in Alderney hospital
- In Weymouth & Portland we saw hand-gel throughout the building. Hand-gel was available in the interview room and clinic room used by the Bournemouth teams but not in the main entrance. The hand-washing facilities in the staff toilets at Bournemouth were very poorly maintained with peeling paint around the basin and no tiles. Although these facilities were not used by patients, they could compromise hand hygiene for staff
- Equipment was regularly serviced and maintained.

Safe staffing

- Staff vacancies were generally low, although Poole had a vacancy rate of 20.7% at the end of May 2015. Poole had experienced 40% staff turnover in the previous year. This was mainly due to staff retiring
- We looked at caseload sizes in all the teams we visited. These varied between teams and in several teams they were very high. Caseloads consisted of a mixture of patients on enhanced care programme approach (CPA) who needed a high level of staff involvement, standard CPA and patients requiring memory clinic reviews only. One nurse's caseload was 74 in Poole. In Bournemouth

Good

Are services safe?

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

North and West team we saw a caseload of 70 and in Sherborne we saw a caseload of 67. Many nurses had over 60 cases. However, Bournemouth East and Blandford caseloads were generally under 40. We saw one team leader's caseload was 60 and another's was 11. We heard from nursing staff and team leaders that they regularly worked additional hours in order to manage their workload. Nurses had the highest caseloads. They found this stressful to manage and they felt it did not allowed them time to carry out therapeutic work with patients. People with mild memory problems made up a large volume of each team's caseload. These patients could have been seen by the memory advisory service (MAS).

- Social workers' caseloads were weighted to take account of their additional duties such as approved mental health practitioner (AMHP) and best interest assessor (BIA) roles and they did not care co-ordinate. All staff we spoke to, including managers, recognised that caseloads were too high and attempts were being made to reduce the numbers. In Poole, a caseload review took place in October 2014 which had resulted in approximately 40 people being discharged from the service. The MAS in Poole had been taking all memory clinic referrals since September 2014. Existing memory clinic reviews had been changed from six monthly to annually, and there was a plan for MAS to take on existing reviews. In Blandford and Shaftsbury, we heard about a proposed traffic light system to help staff identify patients needing different levels of input, but we did not see this in action on the caseloads that we looked at
- All staff we spoke to had regular supervision which included discussing caseloads
- None of the teams had patients waiting longer than a week for a care co-ordinator to be allocated
- Team members worked supportively amongst themselves to provide cover for staff absence. We observed a team meeting in Shaftsbury where team members arranged to cover each other's caseloads for annual leave. In Sherborne, staff told us that they were able to cover each other's workloads as they knew about all the patients
- There was very little use of bank or agency staff. Bournemouth East were using a member of bank staff for memory reviews. This meant these patients could be transferred from nurse's caseloads, reducing pressure on permanent staff. MAS in Poole were temporarily using bank staff to reduce their waiting time for assessment and treatment
- All teams told us that they could usually access a psychiatrist when required. Some of the Bournemouth psychiatrists were based at Alderney Hospital in Poole which made access more difficult although most staff said they could get a psychiatrist in an urgent situation
- Teams varied in their completion rates for mandatory training. Sherborne had achieved 100% completion on all mandatory training. Bournemouth had achieved less than 75% for all except equality and diversity training. Five teams were below the trust's 75% target for basic life support annual updates. Team leaders received regular e-mails to allow them to monitor staff attendance at mandatory training. In Wimborne & Purbeck and Fern Down & West Moors mandatory training had been booked for staff that were overdue.

Assessing and managing risk to patients and staff

- We looked at 58 care records and saw that most had an up to date risk assessment. In Weymouth and Portland all risk assessments were complete and up-to-date. In Bournemouth we looked at eight electronic records. All had a risk assessment and seven out of eight were up to date. However, the quality of risk assessments varied in the teams and not all risks identified fed through to the patient's care plan. For example, in Shaftsbury we saw safeguarding issues noted on a risk assessment that were not on the care plan. In Poole we saw two examples of excellent risk assessments but also saw an example which identified a potential risk of suicide but had very little detail and resulted in a poor quality management plan. In Bournemouth all initial assessments were carried out jointly with a psychiatrist to fully assess risk. All multi-disciplinary team (MDT) meeting agendas included risk as a regular item. We observed six MDTs and observed thorough discussions about risk taking place. We spoke to a memory assessment service nurse and saw there was a thorough risk checklist to prompt assessment of risk at specific points in a care pathway: post-assessment, at the end of titration of medication and then annually

Good

Are services safe?

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

- The east had access to the intermediate care service for dementia (ICSD). This was a specialist service for people with dementia and meant that sudden deterioration in patient's health could be responded to promptly.
- Deterioration in health was discussed at weekly MDT meetings. This meant that all the team were aware of individual patient's risk
- We saw examples of staff's knowledge and use of safeguarding. In Bournemouth East's multidisciplinary team meeting a decision was made to make a safeguarding referral for a patient who was a new referral to the team. Staff in Shaftsbury were able to describe the safeguarding process and told us there was a flow chart that had recently appeared on the intranet. We saw the flowchart on the wall in the team room. We observed an episode of care in Poole where the team had raised a safeguarding alert to the local authority and were visiting more regularly due to their concerns. We looked at the safeguarding alerts that had been made by the Weymouth and Portland team, and these were all appropriate referrals
- There were safe lone-working procedures in every team. We saw whiteboards in use that showed where team members were. Staff used RIO diaries and had mobile phones. Staff told us these procedures worked well
- There was good medicine management amongst the teams. Some teams had nurse prescribers and staff were able to describe safe medicine management and reconciliation. In some teams, medicine reconciliation was done by the consultant or GP. We saw that medication was stored in locked cabinets and some teams did not keep any medication on site.

Track record on safety

- We reviewed incidents for OPCMHTs that had been recorded between April 2014 and May 2015. There had been 136 incidents. No team recorded more than 20 incidents during that period. The vast majority were minor or no-harm. Incidents were discussed at team meetings so that lessons learnt could be shared with the teams

Reporting incidents and learning from when things go wrong

- There had been a recent roadshow around the trust to talk about learning from serious incidents that staff told us had been helpful
- Staff used about the Ulysses system of reporting. There was good knowledge amongst staff about how to use system to report individual incidents and staff knew what should be reported.
- All the multidisciplinary team meetings we attended had incidents as a regular item on the agenda. There was a newsletter that included learning from incidents across the trust. We heard about a serious incident that had occurred in Bournemouth. The team had met to reflect on the incident and it was investigated. The incident report was discussed with the team manager and the director of nursing and recommendations were shared with the team
- Staff felt that support following serious incidents had improved in the last six months. All staff were now offered a de-brief and teams felt more supported.

Are services effective?

Requires improvement

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

Summary of findings

We rated effective as requires improvement because:

- There were 4.9 whole time equivalent (wte) psychologists for older people's mental health to cover nine community mental health teams for older people (OPCMHTs) in East Dorset, five OPCMHTs in West Dorset, six inpatient units and the memory assessment service. We saw examples in electronic records of patients who could have benefited from specialist psychological therapies but were not offered them, and cases where psychological assessment and formulation could have provided improved understanding of behaviours. These included patients whose mental health difficulties were not responding to medication.
- We were concerned that only 13% of OPCMHT staff had completed mandatory Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding training during the period 1 July 2012 to 30June 2015. Understanding and application of the MCA was variable and was not embedded in everyday practice in all teams.
- Most care plans were up to date, but the quality varied. Some were not holistic, personalised or recovery orientated.

However:

- New assessments were discussed at the weekly multi-disciplinary team (MDT) meeting.
- NICE guidance was being adhered to.
- The intermediate care service for dementia (ICSD) had exceeded their targets for preventing admission to hospital. Their target for the first year of operation for preventable hospital admission had been 60 and their data showed they had achieved 180.
- MDTs took place weekly and had clear agendas which demonstrated effective sharing of information and knowledge.
- Staff had regular supervision.

Our findings

Assessment of needs and planning of care

- Initial assessment procedures were different across the county. Some were carried out jointly by a psychiatrist and a nurse, and in other teams nurses carried out the initial assessment and a doctor reviewed following this. Assessments were carried out within the four week target in all teams, and new assessments were discussed at the weekly multidisciplinary team (MDT) meeting. However, some MDT meetings were not attended by social workers, and there was very limited access to psychologists. This meant that psychological causes for certain behaviours were not always considered and social care issues might not always be identified at the earliest opportunity
- Memory assessment service nurses used a range of assessment tools including Addenbrooke's cognitive examination 3 and the geriatric depression scale and took detailed clinical history. Assessments were then discussed in clinical supervision with a psychiatrist and staff estimated that 80 percent of people had a brain scan
- We looked at 58 care records. Most care plans were up to date, but the quality varied. We saw some very good care plans in Poole and in Weymouth & Portland, which were recovery-focussed, personalised and holistic. All the records we looked at in Bournemouth had a care plan and seven out of eight were up-to-date but some were not holistic, personalised or recovery orientated. In Sherborne we looked at eight care plans. Care plans were present for most, but half of them were not up to date. All the records we looked at in Shaftsbury had a care plan and we saw a very good example of a care plan that was detailed, holistic and recovery focussed. However, most were not. Physical health care evaluations were missing in the majority.
- The trust used RIO which is a secure electronic patient records system. The teams were being issued with laptops to use on home visits. Social workers who were co-located in the community mental health teams for older people used a different electronic records system and there were different systems for each of the three local authorities. This meant that four different electronic records systems were in use in the county. Mental Capacity Act assessments and Deprivation of Liberty Safeguards paperwork were mainly held on the social services system. Social workers had to print and scan this information onto RIO. Health staff were not

Are services effective?

Requires improvement

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

able to access the social workers' electronic records although social workers could access RIO. This meant there was potential for double recording and important information being inaccessible to some staff.

Best practice in treatment and care

- Patients prescribed anti-psychotics, memantine and lithium were discussed regularly in multidisciplinary team meetings. We case-tracked two patients who were treated by the Wimborne & Purbeck team and found that NICE guidance was being adhered to. We spoke to staff, including psychiatrists, and they were able to demonstrate their knowledge of NICE guidelines and how they used them in practice including guidelines for prescribing medication.
- Patients with mild dementia or patients with anxiety and depression who did not have complex needs could be referred to the improving access to psychological therapies service. In Sherborne, an occupational therapy assistant was running a cognitive stimulation therapy group, as recommended in NICE guidance for people in the early stages of dementia. However, there was variability of access to psychology for patients with complex needs. At the time of the inspection there were 4.9 whole time equivalent psychologists for older people's mental health to cover nine community mental health teams for older people (OPCMHT) in East Dorset, five OPCMHTs in West Dorset, six inpatient units and the MAS. Therefore they could only provide direct psychological therapy such as cognitive behavioural therapy, cognitive analytic therapy and dialectical behaviour therapy to a very small number of patients. They mainly provided consultation and staff training so that staff from the community mental health teams could provide CBT. A small number of neuropsychological assessments were undertaken. Psychologists attended multidisciplinary team meetings at most teams monthly, to discuss possible referrals and provide advice. We saw examples in electronic records of patients who could have benefited from specialist psychological therapies but were not offered them, and cases where psychological assessment and formulation could have provided improved understanding of behaviours. These included patients whose mental health difficulties were not responding to medication.
- We looked at electronic records to see if physical healthcare needs were documented. Five out of eight care plans we viewed in the Bournemouth teams had a physical health evaluation in Bournemouth. At Bournemouth East team's MDT meeting we heard discussions about three patients who needed physical healthcare monitoring because of particular medications, and review dates were set for these. In Shaftsbury we attended an MDT meeting and heard annual physical health checks being discussed including patients with a diagnosis of dementia who were being prescribed anti-psychotic medication. All the care records we looked at in Weymouth & Portland had physical health checks of a good standard. We saw a new clinic room in Poole that was being set up so that people with psychosis could have their physical health monitored by the OPCMHT. This was not yet in operation when we inspected but we were told that staff would be able to carry out blood tests, ECGs, medical and nursing reviews
- The intermediate care service for dementia in Poole kept data that demonstrated they had exceeded their targets for preventing admission to hospital. Their target for the first year of operation for preventable hospital admission had been 60 and their data showed they had achieved 180
- Health of the nation outcome scales (HONoS) was completed as part of mental health clustering on RIO. However we did not see evidence of HONoS being used to inform care. Staff told us that the clustering tool took a long time to complete and they did not feel they had time to use outcome measures effectively. There was a lack of understanding of the clustering tool in two care records we case-tracked in Wimborne & Purbeck. This meant that patients whose cluster indicated that they should have been treated by Improving Access to Psychological Therapies services were under the care of the OPCMHT.
- We saw examples of medication audits, including use of anti-psychotics in dementia and a memantine audit. There was an audit of physical health checks underway for the current year.

Skilled staff to deliver care

- There was variation in the range of disciplines in the skill mix of the teams and inconsistency of how well integrated different disciplines were. Some teams had very limited access to occupational therapists (OTs) and

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psychologists. This meant that teams were not always able to offer holistic multidisciplinary assessments and care. In both Bournemouth teams there were social workers, consultants and junior doctors, and a support time and recovery worker (ST&R). Bournemouth N&W team had 0.6wte of OT. Psychologists were not based within the teams. This meant that they were not able to routinely discuss new referrals, assist with diagnosis or contribute to care plans and that patients did not always have to access appropriate psychological therapies. Many staff felt that increased availability of ST&R support would be helpful.

- All the teams we inspected had staff that were experienced and either had appropriate training or were qualified.
- We saw details of induction training called the mental health foundation learning pathway. This was scheduled to start from the end of June 2015 for all new staff during their first year and for existing staff as a refresher. It included sessions on the MHA and its implications in practice, MCA and DoLS, risk assessment and risk management, clustering in mental health practice, assessment of mental capacity, care programme approach, assessment, formulation and care planning. There was also training on recovery, working with depression and anxiety, personality disorder, working with psychosis and unusual experiences, managing self-harm, dementia, and enabling through education and training. Staff we spoke to were not aware of suicide prevention training being available and it was not listed on the learning pathway document.
- Most staff received supervision at least every three months. This was trust policy and some staff were getting clinical supervision more frequently. The team in Shaftsbury had monthly development meetings to get practice updates. Nurse prescribers in the memory assessment service had a monthly meeting and clinical supervision with a consultant psychiatrist.
- In the majority of teams, 100% of staff had received an annual appraisal. However three out of seven staff appraisals were outstanding in Bournemouth East. Consultants had a clear system of appraisal.

Multi-disciplinary and inter-agency team work

- We attended six multi-disciplinary team meetings (MDTs). These all took place weekly and had clear agendas which demonstrated effective sharing of information and knowledge. Lone working, risk, safeguarding and learning from incidents and complaints were discussed. Most MDTs were only attended by a psychologist once a month and not all meetings included social workers or OT's. The memory assessment service (MAS) nurses were more integrated in some teams than others. In Shaftsbury, the MAS nurse attended MDT meetings but this did not happen in all teams
- Links between inpatient services and the teams varied. Some teams were geographically distant from the inpatient wards. There were not always clear procedures in place to communicate information about patients being discharged
- The Shaftsbury team had recently moved into refurbished offices that were shared with a wide range of health staff including the community rehabilitation team and district nurses. This had made joint visits easier to facilitate.
- There were different arrangements for crisis support between the east and west of the county. The east had access to the intermediate care service for dementia (ICSD). This was a specialist service for people with dementia. It aimed to prevent unplanned hospital admissions, support discharge from hospital, avoid admission into long-term care and reduce dependency on long-term care packages. The ICSD provided very good crisis support for patients with dementia. We heard from staff, carers and patients in the west of the county who felt mainstream crisis support did not meet the needs of people with organic illness

Adherence to the MHA and the MHA Code of Practice

- We were unable to confirm how many staff had received MHA training because records were not available relating to non mandatory training. MHA training was not mandatory for staff working in mental health community older peoples services.
- Staff were able to describe a good working knowledge of the MHA when we asked them.
- Consultants were positive about the support they received from the MHA adminstrators, who maintained processes and systems to support compliance with the MHA and the Code of Practice

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- The teams we visited did not have patients detained on community treatment orders when we inspected. In Shaftsbury there were eight patients under section117 after-care. There was a regular slot on the team's MDT agenda to discuss these patients
- Staff were aware of advocacy services and we saw leaflets about these services in waiting rooms. The leaflet on independent mental health advocacy services was clear.

Good practice in applying the MCA

- We were concerned that only 13% of staff in the community mental health teams for older people (OPCMHT) had completed mandatory MCA and DoLS training during the period 1 July 2012 to 30 June 2015. Understanding and application of the MCA was variable and was not embedded in everyday practice in all teams. Mental capacity was discussed in multidisciplinary team meetings and we saw the principles of the Act being used in practice when we observed home-visits with the Sherborne team. The Poole team used an MCA flowchart for guidance. There was a trust-wide protocol to routinely include capacity and consent to treatment in outpatient letters at first assessment and change of treatment. However, we looked at case notes to see if this protocol was being followed and saw that it was missing from some letters. We looked in case notes for assessments of capacity on RIO. We could only find this on one of the eight records we looked at in Bournemouth. We did not find any cases that led us to believe that patients were at risk because of the lack of training in the Mental Capacity Act but we were concerned that there was poor record keeping of capacity. DoLS applications that had been completed by social workers were kept on the social services electronic records system and had to be scanned and uploaded onto RIO as social services notes were not accessible to health staff.

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**:**

- Staff were friendly, kind and respectful and the interactions we witnessed were patient-centred, collaborative and compassionate
- Patients were given information about treatments and medication including side effects, and were given time to ask questions
- Advocacy leaflets were available in waiting areas and patients were aware of advocacy services
- Patients and carers told us that they felt involved and were asked for their opinions and feedback.

However:

- Not all patients had been given a copy of their care plan. In some cases, this was because staff felt it was not appropriate, but written records did not always show the reasoning for this decision.

Our findings

Kindness, dignity, respect and compassion

- We observed 27 home visits, seven treatment groups and spoke to 68 service-users and carers. Staff were friendly, kind and respectful at all times. The interactions we witnessed were patient-centred, collaborative and compassionate. We saw that carers were included. It was evident that patients felt able to trust the member of staff that was visiting them. Staff knew their patient's individual needs well.
- We heard many positive comments from patients about staff. One carer rated the service as a '10 out of 10' and said they couldn't fault the service. Patients reported positive experiences of receiving services and felt the service was 'marvellous' and 'did a fantastic job'. Staff were described as kind and supportive.

The involvement of people in the care they receive

- We looked at 58 care records. Five out of eight people in Bournemouth had not been given a copy of their care plan. For some people this was because it was not felt to be appropriate but the written records did not clearly show the reasoning for this decision. We looked at eight patient's care plans in Sherborne and saw that none had been given a copy. Five out of the eight care plans we looked at in Shaftsbury had not been given to the patient.
- We observed out-patients appointments and saw that patients were given information about treatments and medication including side effects, and had time to ask questions. A carer of someone seen by Blandford team told us they had a copy of their relative's care plan. Another carer said they had been involved in detailed discussions about treatment and care options. We spoke to patients attending a cognitive stimulation therapy group who said that they felt valued and had regained confidence. A patient in Bournemouth told us she got a letter after her appointment, with a summary of what had been discussed, current treatment, and details of her next appointment
- We spoke to people who had received carers' assessments and who had attended carers support groups and who received respite. Carers we spoke to said they felt supported. One carer told us the support of the team had prevented his wife from going into care
- Advocacy services were provided by Dorset advocacy service, Rethink mental illness, and Dorset mental health forum. We saw advocacy leaflets in waiting areas and the patients that we asked were aware of advocacy services
- We saw evidence of patients being involved in service decisions and patient in Blandford told us that they had been involved in selecting new staff
- Patients and carers told us that they felt involved and were asked for their opinions and feedback. Feedback from a carer's group in Blandford had led to changes in the way that the leaflets were worded. In Shaftsbury the carers group were asked yearly for feedback on how they wanted to improve services and the group. MAS patients were sent a feedback survey every three months and we saw that patients had given very positive feedback.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated responsive as **good** because**:**

- All teams had a duty system that was able to respond to urgent referrals and had good access to psychiatrists in emergencies. Patients we spoke to said they could access help urgently when required. The intermediate care service for dementia (ICSD) crisis support for dementia patients was very good.
- Complaints were a standard item on multi-disciplinary team (MDT) meeting agendas in all teams and when complaints had been made these had been investigated, recommendations were made and an apology was issued.

However:

- Memory assessment service (MAS) referrals had increased rapidly resulting in only 50% of patients being seen within the target time. Temporary bank staff had been employed to reduce the waiting list, but there was no clear plan to address the on-going high referral rate.
- Patients in the west of the county could not access the intermediate care service for dementia (ICSD). This meant that patients with dementia who needed crisis support did not receive equitable services across the county

Our findings

Access, discharge and transfer

- We reviewed the trusts community mental health procedures document which gave clear criteria for eligibility for services.
- The trust had set targets which included: emergencies assessments were to be completed within 24 hours, urgent assessments within five working days and routine referrals were to be seen within four weeks. Key performance indicators (KPIs) were being used to measure the performance of teams. All teams were aware of the KPIs for waiting times. 85 – 93% of patients across the community mental health teams for older people were seen within four weeks. 100% of emergency and urgent referrals received in the 2 months prior to this inspection were seen within target. The memory assessment service (MAS) had a four week target for referral to diagnosis and treatment plan and targets were being met until August 2014. The memory gateway, a new service, had been commissioned at that time and referrals had increased rapidly resulting in only 50% of patients being seen within the target time. Temporary bank staff had been employed to reduce the waiting list, but there was no clear plan to address the ongoing high referral rate.
- All teams had a duty system that was able to respond to urgent referrals and had good access to psychiatrists in emergencies. Patients we spoke to said they could access help urgently when required.
- Inpatient beds for older people were available and there were no out-of-county hospital admissions at the time of our inspection
- Access to appropriate crisis support varied across the county. Patients in the east of the county could access the intermediate care service for dementia (ICSD), a specialist crisis service. The ICSD would be able to visit patients in their own homes up to four times a day and were able to access hospital beds within 24 hours They were also able to access respite services and the day hospital. The ICDS had been operating for 18 months. Where this service was available, crisis support for dementia patients was very good. In other parts of the county, all crisis support for older people was provided by the adult crisis and home treatment teams. These teams were able to meet the needs of patients with functional illness, but were not always felt to have adequate skills to work with patients with dementia
- In most teams there were difficulties accessing beds for older adults with a functional illness but beds for people with dementia could be accessed locally. Some teams were geographically distant from inpatient facilities. For example, patients seen by the Shaftsbury team would have to travel to Dorchester or Poole for their nearest inpatient unit. This meant that carers who wanted to visit could have long travelling distances.
- All the teams had procedures for contacting patients who had not attended planned appointments. Appointments were rarely cancelled, and staff covered for each other when necessary. Most patients were seen

Are services responsive to people's needs?

Good

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

in their own homes and the Wimborne & Purbeck and Fern Down & West Moors teams offered appointments in local GP surgeries if it was closer than travelling to the CMHT base.

The facilities promote recovery, dignity and confidentiality

- The day hospitals had facilities for group sessions. Interview rooms in Bournemouth were small and in a separate building. Interview rooms used by the Poole team were in a separate building but were spacious and comfortable. A new clinic room had been recently refurbished and had good facilities for undertaking physical health checks but was not yet being used. In Shaftsbury a large spacious room had been refurbished but was not yet in use. It had a kitchen area that could be used for OT assessments and was due to be used for groups
- All the rooms we reviewed had adequate sound proofing
- We saw information racks in waiting area that had a variety of leaflets informing patients and carers about local services including patient advice and liaison services (PALS), advocacy, concerns and complaints.

Meeting the needs of all people who use the service

- All the buildings had disabled access.
- Information leaflets in languages other than English were not widely available in any of the teams we visited.
- Poole day hospital had used the trust's interpreter service for assessment of a patient and was able to access culturally appropriate meals. The Weymouth and Portland team had also recently used interpreting services to assess and treat a patient.

Listening to and learning from concerns and complaint

- The older adult's community mental health teams received few formal complaints. Complaints were discussed in team meetings to ensure all staff were aware and lessons were learnt
- We saw friends and family cards being used across the trust. These asked service users and carers if they would recommend the service to family or people they knew. A "have your say" leaflet was available which explained how to make complaints, give compliments or raise concerns. One team had recently designed a new feedback card to meet the needs of service users. Most carers and patients said they knew how to raise a concern or complaint although some of the patients we spoke to did not know how to complain.
- Complaints were a standard item on MDT meeting agendas in all teams. The Poole team had a weekly 30 minute team briefing to share lessons learnt and complaints. The meeting was minuted and sent out as a newsletter to all staff so that learning was disseminated. We looked at documentation relating to two complaints in Sherborne that had been investigated by the team manager. These showed that recommendations were made and an apology was issued.

Are services well-led?

Requires improvement

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

Summary of findings

We rated well-led as requires improvement because:

- There was no clear strategy for older adults with functional illness such as depression, bi-polar and schizophrenia
- There was a lack of strategic oversight for older people's mental health and people did not receive an equitable service across the county
- There was no formal structure to share good practice across older people's mental health services
- Staff across the trust told us that they felt disconnected from senior managers
- Some team leaders did not believe they had authority to put items on the risk register. However, the trust state that all locality managers can add to or edit the system and can identify additional staff to add to this if they wish.

However:

- The trust had a vision for services for people with dementia and was working towards one strategy and one pathway
- All multi-disciplinary team (MDT) meetings had a regular agenda slot for incidents. Complaints, safeguarding, patients under the Mental Health Act and Mental Capacity Act were agenda items on all MDT meetings
- Key performance indicators (KPIs) were being used to measure performance and all teams were aware of the KPIs for waiting times and were meeting these
- All the community teams for older people demonstrated good support for each other and staff felt supported by team leaders

Our findings

Vision and values

- We asked staff about the trust's visions and values but they were not able to tell us what these were.
- There was no formal structure to share learning or good practice across older people's services. Teams had different operating models due to local commissioning priorities and there were differences between the east and the west of the county. The trust had a vision for services for people with dementia and was working towards one strategy and one pathway. However, there was no clear strategy for older adults with functional illness and a lack of strategic vision relating to the integration of allied health staff within the trust. This lack of strategic oversight meant that services were fragmented and disjointed and people did not receive an equitable service across the county
- Staff across the trust told us that they felt disconnected from senior managers. Most did not know who the senior managers were and only one team had been visited recently by a member of the executive team.

Good governance

- All staff received supervision. The frequency varied, but took place at least three monthly. In the majority of teams, 100% of staff had received an annual appraisal. We reviewed supervision records for eight staff at Weymouth & Portland and at Sherborne and saw that they were comprehensive
- The trust used the Ulysses system for incident reporting. Staff knew how to report incidents. We looked at examples of incidents that had been reported and found that these were appropriate. The system was also used to record training and complaints.
- Staff undertook a range of audits. For example, the Christchurch team had completed audits about community treatment orders, memantine, medicine security and hand-hygiene. They were awaiting actions plans from these. We also saw a peer review of risk assessments and a clinical audit report on cardiovascular monitoring in patients with acetyl cholinesterase Inhibitors
- All MDT meetings had a regular agenda slot for incidents and complaints. In Poole the team leader's weekly planning meeting agenda included complaints, performance, sickness, serious incidents and lessons learnt. Poole also had a leadership meeting attended by service manager, team leaders, senior practitioners and consultants to discuss exception reports, discuss physical health check planning, information from the

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medical director and senior management meeting. Poole also had a weekly 30 minute team briefing to share lessons learnt and complaints. The meeting was minuted and sent out as newsletter to all staff to ensure that learning was disseminated

- Safeguarding, Mental Health Act and Mental Capacity Act were agenda items on all MDT meetings. We found good awareness of safeguarding protocols across the teams but mental capacity procedures were not always adhered to and were not embedded in daily practice for all staff
- We saw that key performance indicators (KPIs) were being used to measure the performance of teams. All teams were aware of the KPIs for waiting times and were meeting these
- We saw a draft copy of a review of North Dorset Older Person's CMHTs covering Blandford, Shaftsbury, and Sherborne. This included plans to standardise and improve consistency of processes such as MDTs, business meetings, recording of clinical information, supervision, and duty processes. Caseload sizes were identified as needing action. The document identified key issues but did not have timeframes or priority rating
- Risk registers were held on Ulysses. Some team leaders did not believe they had authority to put items on the risk register and information that had been held on the system that was used prior to Ulysses had not been migrated to the current register for some teams. Appropriate risks were being put on the register when team leaders were authorised to do so and action plans were identified

Leadership, morale and staff engagement

- Sickness rates in the service were less than 5%. Reported sickness for the trust as whole was 4.7%
- We were not made aware of any bullying or harassment cases
- Staff felt able to raise concerns. One team told us that they had written to the chief executive to raise their concerns about high caseloads.
- Morale and job satisfaction varied. Team members within the intermediate care service for dementia had high morale and were motivated and enthusiastic about their roles**.** Other staff felt under pressure to achieve targets and felt there was little encouragement to develop and undertake performance development training. Some staff spoke about feeling de-skilled and unable to perform to the best of their abilities. However staff felt supported by team leaders and showed dedication.
- Three team leaders had undertaken leadership training
- All the teams demonstrated good support for each other and all said they felt their teams were supportive
- Staff were aware of the principles of duty of candour requirements
- There were no cross-trust forums for feedback or service development. In some areas staff felt service development changes had been made without consultation, and that there was a lack of understanding at senior management level about the pressures teams were experiencing. A service manager was leading a project to improve understanding and management of CMHT workloads. This would ensure staff had access to training and support and to ensure that patients received similar evidence based service regardless of where they lived in the county. This had not been completed at the time of our inspection.

Commitment to quality improvement and innovation

Good practice

- The Sherborne team were working with Sherborne and District dementia action alliance to establish a dementia-friendly community in Sherborne so that people would understand more about dementia and people with dementia would feel included in their community
- An information pack had been produced by the Sherborne team for relatives and carers of people with mental health problems associated with old age. The pack provided information on carers' rights, emergency numbers and explanations of the common kinds of dementia. It included advice for helping people with memory problems, delusions and unusual beliefs.
- The trust was running a recovery education centre in association with the Dorset Health Forum. Courses were

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available for staff, patients and carers and included arrange of subjects including recovery and well-being for older people, medication choices and understanding memory loss.

- The Weymouth & Portland team had facilitated two groups of paramedic students from Bournemouth University to undertake observational placements with the team.
- The intermediate care service for dementia was a specialist crisis service for people with dementia. The team consisted of a team manager, nurses, a full time OT, support workers and consultant psychiatrists. It operated from 7am – 9pm to prevent hospital admission, support discharge from hospital, support carers, families, residential and nursing homes and general hospital settings for up to six weeks. The team could provide intensive support up to four times per day, were able to access day hospital places and had an emergency social care budget to access emergency respite for up to two weeks.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The 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 is a breach of Regulation 17 (2) (c) HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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