Mental Health Act 1983 monitoring visit

Provider:	Dorset Healthcare University NHS Foundation Trust
Nominated Individual:	Paul Lumsdon
Region:	South
Location name:	Dorset Healthcare University NHS Foundation Trust
Location address:	Sentinel House, Nuffield Road, Poole, Dorset, BH17 0RB
Ward(s) visited:	Admission and Assessment visit
Ward type(s):	Acute admission
Type of visit:	Announced
Visit date:	12 and 13 December 2013
Visit reference:	29878
Date of issue:	08 January 2014
Date Provider Action Statement to be returned to CQC:	28 January 2014

What is a Mental Health Act monitoring visit?

By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. We do this by looking across the whole patient pathway experience from admission to discharge – whether patients have their treatment in the community under a supervised treatment order or are detained in hospital.

Mental Health Act Commissioners do this on behalf of CQC, by interviewing detained patients or those who have their rights restricted under the Act and discussing their experience. They also talk to relatives, carers, staff, advocates and managers, and they review records and documents.

This report sets out the findings from a visit to monitor the use of the Mental Health Act at the location named above. It is not a public report, but you may use it as the basis for an action statement, to set out how you will make any improvements needed to ensure compliance with the Act and its Code of Practice. You should involve patients as appropriate in developing and monitoring the actions that you will take and, in particular, you should inform patients of what you are doing to address any findings that we have raised in light of their experience of being detained.

This report – and how you act on any identified areas for improvement – will feed directly into our public reporting on the use of the Act and to our monitoring of your compliance with the Health and Social Care Act 2008. However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.

Our monitoring framework

We looked at the following parts of our monitoring framework for the MHA:

Domain 1 Assessment and application for detention		**Domain 2** Detention in hospital		**Domain 3** Supervised community treatment and discharge from detention	
☒	Purpose, respect, participation and least restriction	☐	Purpose, respect, participation and least restriction	☐	Purpose, respect, participation and least restriction
☒	Patients admitted from the community (civil powers)	☐	Admission to the ward	☐	Discharge from hospital, CTO conditions and info about rights
☒	Patients subject to criminal proceedings	☐	Tribunals and hearings	☐	Consent to treatment
☒	Patients detained when already in hospital	☐	Leave of absence	☐	Review, recall to hospital and discharge
☒	People detained using police powers	☐	Transfers		
		☐	Control and security		
		☐	Consent to treatment		
		☐	General healthcare		

Findings and areas for your action statement

Overall findings
Introduction:
Prior to June 2011 Dorset Community Health Services (DCHS) and Dorset Healthcare University NHS Foundation Trust (DHUFT) were responsible for provision of mental health services in the west and east of Dorset respectively. DUHFT also held responsibility for services in Bournemouth and Poole. In June 2011 DHUFT took over responsibility for the services in the west of Dorset from DCHS. This included responsibility for Weymouth as the largest urban area outside that of Bournemouth and Poole. A Mental Health Act (MHA) multiagency group meets bi-monthly to provide opportunities for regular communication between professionals involved in the MHA assessment and application process across partner agencies. The group includes a comprehensive membership of healthcare, social services, police and ambulance staff with the exception of medical staff. Service users and carers are not yet represented on the group. DHUFT provides a range of admission and assessment inpatient mental health facilities across Dorset. The Waterston assessment unit in Forston Clinic, Dorchester was opened earlier this year following the closure of Minterne ward and the subsequent refurbishments. In 2013 St Ann's Hospital, Poole also opened two new wards to replace existing wards. The St Ann's Hospital development included a new section 136 suite. Older person's mental health (OPMH) and child and adolescent mental health services (CAMHS) have their own admitting wards and alternatives to admission. We were told that arrangements were in place for patients with a learning disability to be admitted to the admission ward at St Ann's Hospital. Evidence provided by the trust showed that most patients detained under the MHA are admitted to Merley assessment unit at St Ann's Hospital or to the Waterston assessment unit at Forston Clinic. In 2013 two acute adult inpatient units in the west of the Dorset were closed. One of these was the Hughes unit at Bridport and the other was Stewart Lodge in Sherborne. DHUFT consulted widely prior to the closures. As part of the consultation process Dorset Health Scrutiny Committee (DHSC) scrutinised DHUFT proposals. We found the impact of the closure of these two units formed a focus for discussion throughout the visit. DHUFT also provides two Crisis Response Home Treatment services (CRHT) covering the whole of Dorset which aims to provide home treatment for patients who would otherwise need hospital admission. We found the teams also aimed to act as 'gatekeepers' to acute mental health services and to facilitate "accelerated

discharge”. No day hospital facilities are provided.

How we completed this review:

Two Mental Health Act (MHA) Commissioners and an Expert by Experience (ExE) undertook an announced ‘Assessment and Application for Detention’ monitoring visit to Dorset Healthcare University NHS Foundation Trust and Dorset County Council (DCC) on 12 and 13 December 2013. A MHA operations manager and compliance manager accompanied the monitoring team for part of the visit.

The focus of the visit was to monitor how DCC and DHUFT addressed the assessment and application for detention under the MHA for people living in the county of Dorset.

As part of the visit we also considered how DCC, DHUFT and other agencies could demonstrate regular engagement and partnership working so that people who may be liable to be detained under the MHA experienced a timely, participative and appropriate assessment.

The outcomes and experiences for patients were considered under the following lines of enquiry from the MHA monitoring framework and the guiding principles of the MHA Code of Practice (MHA CoP):

- Purpose, respect, participation and least restriction
- Patients admitted from the community (civil powers)
- People detained using police powers

We looked at evidence in support of these lines of enquiry from a number of sources:

- Discussions with three members of the Dorset Mental Health Forum and three service users
- Discussions with the Chair and representatives of the Hughes Unit Group
- Discussions with six carers
- A telephone discussion with two carers, one of whom complained about the service his relative was currently receiving
- Discussions with four independent mental health advocates (IMHAs)
- Discussions with twenty-two AMHPs (including Out of Hours Service)
- Discussions with senior staff from DHUFT and DCC
- Discussion with senior officers representing Dorset Police and South West Ambulance Service NHS Foundation Trust
- Discussions with representatives of the Dorset Clinical Commissioning Group
- Discussions with representatives of the West Dorset Crisis Home Treatment Team
- Scrutiny of forty AMHP reports

- Visit to the recovery house in Weymouth and discussions with the manager
- Review of information about services on DHUFT and DCC websites

We also took into consideration the additional supporting information provided by the DCC AMHP lead, DUHFT mental health legislation manager, members of the Hughes Unit Group (HUG), service users and carers and copies of reports supplied to the DHSC.

What people told us:

DHUFT and DCC senior management

Representatives of senior DHUFT and DCC management staff told us that the bed closures of the Hughes Unit and Stewart Lodge had placed increasing demands on community services with increased referrals, caseloads and pressures on the AMHP service. We were told that the re-opening of Waterston assessment unit at Forston Clinic had been completed and the Weymouth recovery house was in operation. We were told decisions about reopening the Betty Highwood unit (OPMHS) had not yet been made.

We were told that the initial impact of bed closures had resulted in “a fair number” of out of county referrals. We were provided with data produced by DHUFT and DCC which showed about 30 patients had been admitted out of county since April 2013. At the time of the visit eleven patients were in hospital out of county, a number of which had been in St. Ann’s Hospital or Forston Clinic prior to transfer. We were told that the use of out of county beds had decreased recently. We found the last out of county admission had taken place on 12 November 2013.

We heard that older patients with dementia were more likely to meet the criteria for detention at the point of assessment. However, we were also told of examples where the lack of beds had meant that older patients had to be supported in their living environment until a bed could be found. We were told on one occasion this had been over a whole weekend period.

We were also told of the impact on services for patients detained under section 136 MHA and their carers in the west of Dorset due to the closure of the section 136 suite at Forston Clinic, Dorchester. We were told of plans to implement ‘Street Triage’ by April 2014. We were told this should result in less people being detained under section 136.

Dorset Clinical Commissioning Group

Representatives from the Dorset Clinical Commissioning Group told us that they were awaiting an independent service evaluation to influence and lead their commissioning decisions before developing further services for the local community, service users and carers. We were told the group recognised some challenges to progress including the importance of strengthening partner relationships and joint working, the impact of geographical issues and the challenges of tendering against a single provider. We were told of considerations to alternatives to admission and

facilitation of discharge with initiatives such as 'Shared Lives' programmes and 'Home from Home' respite care for people suffering from dementia. We also were told about the "Supporting People" strategy and a recognised need for additional housing opportunities for people with a mental illness.

We were given a copy of the Joint Strategic Needs Assessment which included detailed information in relation to mental health needs.

Dorset County Council Approved Mental Health Professional (AMHP) service

DCC AMHP lead told us about their struggle to recruit AMHPs, high sickness levels and the resulting shortage of AMHP's. We were told the current complement of AMHPs included sixteen full-time AMHP's and twelve part-time. We were told that DCC had funding to train six AMHPs, but only three professionals had taken this opportunity. We were told that DHUFT was reluctant to release nursing staff to train as AMHPs. We were also told of a significant pay differential between AMHP's working for the two county councils in Dorset and Bournemouth.

DCC senior staff described their plans to introduce a "hub" model of AMHP services to improve accessibility and workload.

AMHP's told us about the impact of DHUFT service changes combined with the shortage of AMHPs on their workloads and clinical practice. AMHP's described a service which was "getting to the point where we must draw a line". One AMHP said "I feel completely lost" and another said the current situation "makes us feel very unprofessional". Having one 136 suite for the whole of Dorset compounded by the lack of access to beds was described as "ridiculous". AMHPs told us bed availability had resulted in out of county admissions including options of admissions to Yorkshire, Cambridge and a suggestion of a bed in Belfast. AMHPs told us of the knock on effect of bed shortages on their ability to access appropriate conveyance and police support especially across county boundaries.

We were told of difficulties accessing community psychiatrists to undertake the MHA assessments they had requested. We were told medical staff did not consider it their role to find a bed which added to delays. AMHP's also told us about the lack of housing for people on discharge was having an effect on service users and the discharge planning arrangements. We were told that out of hours AMHPs did not have access to the patient electronic record and difficulties identifying nearest relatives.

AMHPs also told us that if they went out on a visit in the afternoon to undertake an assessment, nobody monitored their work during the evening. Some AMHPs told us of informal arrangements that they had with colleagues.

AMHPs also told us of a lack of regular clinical supervision in respect of their AMHP work and inequality of resources and pay. We heard from some AMHPs had accrued a considerable amount of time off in lieu which they had not been able to take. Other AMHPs told us that CMHT managers did not like them taking time off as it impacted on the "day job".

AMHPs told us they considered interagency working needed to be improved and administrative support put in place.

Dorset Service Users Forum representatives, service users and carers

We found that people using services had differing views about unit and bed closures but were, overall, concerned about the lack of availability of beds especially for people living in West Dorset.

One service user, not opposed to bed closures, said it would have been better if day services had been put in place as promised before beds were closed. Another service user expressed concern that people were being “shipped out of county” in crisis with no support or stepping stones for recovery on return. We found some service users had not been made aware of initiatives such as the recovery house.

Service users providing peer support felt that people admitted to hospital were very unwell and were sent home too early due to bed shortages. We were told that sometimes patients were only being informed the day before discharge. This view was shared with almost all the carers we spoke with and who felt their views were not sought or listened to. One service user also had a considered view that home treatment may not be beneficial to everyone and inpatients beds were necessary close to home.

In general service users were positive about home treatment and services provided once admitted to hospital. One service user described Waterston Assessment Unit as “brilliant”. Another service user considered the Hughes Unit had been a “life saver”. Admission to St Ann’s hospital was not described as such a positive experience. Service users felt staff had a different approach and considered care was something “done to you rather than a relationship.” Two carers made positive comments about the home treatment team saying the team “couldn’t have done better” and they had “nothing but praise” for the support they had received.

We were told that both service users and carers had concerns about access to services in crisis and the support and care provided. One service user described accessing crisis services as “a lottery”. A carer described accessing the service as “catastrophic” and they had “given up”. We heard that is was easier and more helpful to contact the Samaritans as the crisis services had “no time to talk”. Overall people living in the west and north of the county were more dissatisfied with the difficulties it appeared the crisis team had in accessing more rural areas. We were told by one carer that in desperation he had taken his son into the street to enable police to use section 136 of the MHA due to his difficulties accessing crisis services.

Carers expressed concern about the distances they had to travel to visit their relatives who were in hospital. One carer said that he had to travel 35 miles to see his wife but he was fortunate to have a car. We were told that some carers did not have cars which presented major problems given the availability of public transport. We were told that the closure of the Betty Highwood unit in Blandford meant that people in North Dorset had some considerable way to travel.

The Hughes Unit Group (HUG)

We found some members of the community were unhappy about the closure of the units and we met with several members of HUG (Hughes Unit Group).

Representatives of the HUG group told us of their very similar concerns to service users and carers we spoke to. This related to the support and help they had previously received in rural areas of west Dorset when the Hughes unit was open. The group described the very real geographical disadvantages of accessing services in rural areas of Dorset since the closure of the unit. A further point that was made was about the inequality of the services in the west of the county in relation to the east of the county.

We were told of the help and support service users who had used the unit had received. We were told this help extended out of hours and if service users phoned at night staff would have time to talk to them. The group were concerned that community mental health services appeared to be "unable to cope".

We were told that since the Hughes Unit had closed no alternatives to admission had been put in place by statutory services as had been promised. The group told us they considered the recovery house was underused and there was a strong need for a local day hospital. We were told that the closure of the section 136 suite at Forston Clinic had compounded the difficulties. We were told patients and carers had to travel across the county for assessment and admission. Once ready for leave, travel was again a problem as were section 17 leave arrangements leaving patients isolated away from home and loved ones.

We found the group considered that the trust had not listened to or understood their concerns about the impact of the closure of the Hughes Unit and they had had no option but to escalate their concerns to various bodies such as the health scrutiny committee and their Member of Parliament.

The group told us they had expected to be involved in setting the terms of reference for the independent service evaluation. We were told that to date this has not happened.

Representatives of the Crisis Response and Home Treatment Service (CRHT)

We were told DHUFT provided CRHT 24 hours per day seven days per week accessed by a manned dedicated telephone line. We were told that the West Dorset CRHT had undergone significant changes since April 2013 with an increase in the number of staff and scope of their work. We were told the CRHT teams acted as gatekeepers to all hospital admissions. We were told that service users were expected to travel to CRHT services for assessments which were often carried out in a general hospital setting out of hours. The representatives we spoke to did not have any concerns about the running of the service and were not aware of difficulties accessing services, views about the nature or quality of care or any untoward incidents arising. This was concerning in light of the number of negative comments made by people that we spoke to.

Independent Mental Health Advocacy Service

The Independent Mental Health Advocacy (IMHA) representatives we spoke to shared many of the views of service users and carers.

We were told that the IMHA Forum had been approached by patients and carers about impact of bed closures. Concerns raised with IMHAs included early discharge and difficulties with travelling and accessing section 17 leave arrangements; losing contacts with family and friends when placed away from home (even within county) and longer detentions as community outreach teams cannot visit as frequently from the west and north of the county.

The Waterston assessment unit was described as a "significant change for the better". We heard that nursing staff were making more referrals for specialist IMHA and at an earlier stage in the patient's journey. "New staff take the initiative" was one comment made. We were told that at St Ann's Hospital there was still a lack of knowledge about the specialist IMHA role and information for patients such as posters were often removed due to confusion over other forms of advocacy available.

Police and ambulance services

The representatives from Dorset Police and South West Ambulance Service NHS Foundation Trust were clear about their respective roles and responsibilities in supporting the assessment and admission process. We found the local policies governing all aspects of the use of section 135 and 136 (police powers and places of safety) and procedures for conveying patients had recently been reviewed and updated. We heard that progress was being made in interagency working, cooperation and service developments.

The police and ambulance services had differing views of working relationships and access to services. Both services told us of their difficulties in providing support for assessment and conveyance of patients out of county. Both services told us that they thought the implementation of street triage would have a positive impact on services.

Police representatives told us they considered working relationships with partner agencies to be good but could be improved in terms of sharing and acting on information identified in the multi-agency group (MAG) at a strategic and operational level. We were told police found the section 136 suite process at St Ann's Hospital was much improved and enabled officer release to be more prompt. We were told there was a joint risk assessment in place which was effective. We were told the main factor involved in taking people detained under section 136 to a police station was usually associated alcohol misuse. We were told that delays in mental health assessments in police station under section 136 were still apparent.

The ambulance service representative told us that a new role of clinical development officer would include more emphasis on the MHA following the outcome of a serious incident review. We were told patients were always

accompanied by the highest qualified member of staff and not restrained or sedated. We were told ambulance staff were not always provided with the legal authorisation to transport patients against their will which was of concern to them. Ambulance staff did not consider they had a role in transporting patients to assessments in general hospitals or other planned MHA interventions. We were told that limited options were available to the ambulance service for conveyance especially out of hours.

We found that working relationships with the ambulance service and CRHT teams needed to be improved. We were told that it appeared to ambulance staff that "crisis was in crisis".

The recovery house

We visited the Weymouth recovery house and met the manager. We were told that the recovery house opened in April this year. We found the house could accommodate seven guests and was available during the day up until 17.00 hours. On the day we visited there were only two guests. Since the unit opened it has only been full on a limited number of occasions. Staff of the crisis team and AMHPs considered a review of the hours of access and admission criteria may be helpful.

Information available about services on the DHUFT and DCC websites

We found the DHUFT website bright and easy to navigate. However, a leaflet which still stated that the Hughes Unit and Stewart Lodge were both inpatient facilities, when they have both closed. We found acronyms were used which could be bewildering to people unfamiliar with their meaning. We found the DCC website was not as clear and required intensive navigating to locate different information.

Overall we found we would like to see more information on the Mental Health Act (MHA) on the websites for people who have little knowledge of it, and are maybe finding it relevant to themselves or a loved one for the first time.

Past actions identified:

We undertook a previous 'Assessment and Application for Detention' monitoring visit involving DHUFT in March 2013. DHUFT produced a provider action statement dated 22 May 2013 following this visit. We found that a number of action points to concerns common to DUHFT services and the findings of this current visit which do not appear to have been addressed by DHUFT.

We found the MHA multi-agency group minutes documented discussions about the inclusion of service users and carers and the intent to approach Dorset Mental Health Forum. We found the minutes of the meeting had not been circulated to service user or carer groups. Although a carer had been identified has having an interest in attending the group, neither party had attended to date.

We found that, in the response to our last visit, it indicated that DUHFT did not accept our concerns about the trust crisis service we expressed in March were

representative of the service. We were told that if any action was needed it would be taken following a review of the service by March 2014. We have found similar significant concerns during this current visit involving DHUFT crisis services.

We identified past actions necessary about bed availability within DUHFT. In March 2013 we were told that bed occupancy rates often ran at 95% occupancy. Since then acute adult inpatient units in Bridport, Sherborne and Blandford (Older Persons Mental Health Service) have been closed. DHUFT informed us that discussions about bed availability would be included in the MAG minutes. We could find no reference to bed occupancy discussions in the MAG minutes provided to us of July 2013, August 2013 or October 2013.

We have also previously raised concerns about joint working of DHUFT medical staff within the admission and assessment process. DHUFT did not produce an action statement to this concern as it was not understood.

We found it disappointing that these issues have had to be raised again in this report.

Domain areas

Purpose, respect, participation and least restriction:

Purpose principle

We heard evidence about lack of effective co-operation between partner agencies involved in MHA assessments leading to decisions made under the Act about assessment and admission being delayed.

We found ten patients had been illegally detained in the reporting year October 2012 to September 2013.

We found that the closure of two acute adult mental health wards and one older persons unit had influenced decision making. We found a lack of bed availability meant patients were admitted away from home, had difficulties with accessing leave and may be discharged early. We found interpretation of MHA admission data to evidence any impact could not be reliable due to the complexity and timings of service changes.

Overall, service users and carers described difficulties accessing services, concerns about the quality of service provided and an apparent focus on risk, not care which did not promote recovery. We found that there were conflicting views as to whether the views of patients and carers, especially those living with the patient, were fully taken into consideration in considering the factors in deciding whether patients should be detained.

We found access to IMHA services was good at Waterston assessment unit but less often requested by staff at St Ann's Hospital. Overall, where requested by the patient for a familiar person or advocate to be present at the assessment, this was

arranged. However, we found evidence that there was some confusion in regard to independent mental health advocacy and general advocacy services available to young people and adolescents detained at Pebble Lodge. We have addressed this issue independently of this report with CAMHS.

Least restriction principle

We found evidence that partner agencies considered alternative means of providing care and treatment to promote recovery other than detention in hospital. We found these included crisis services and home treatment services, a recovery house in Weymouth, consideration of development of 'Shared Lives' and 'Home from Home' initiatives.

We found the Crisis Response Home Treatment (CRHT) services were the gatekeepers for admission to hospital. We found their operational policies indicated services could be accessed by service users, carers and all partner agencies with the omission of ambulance services.

We found DCC had comprehensive arrangements in place relating to potential use of the Mental Capacity Act (MCA) including dedicated MCA lead staff, policy guidance and training. We were told by the AMHP service this was on occasion to the detriment of MHA guidance support and training.

Respect principle

We heard that some service users from the west of the county described services in place were "model driven" and did not consider the particular circumstances of people living in rural areas. We found the HUG group did not feel their views were considered in the DHUFT decision to close the Hughes Unit and Stewart Lodge.

Participation principle

We found that Dorset Service User Forum and Peer Specialists had opportunities to be involved in discussions about service developments. We found service users and carers representatives had been invited to attend the multi-agency group since our last visit but had not been provided with copies of the minutes. All the carers we spoke to received annual carers' assessments. We found evidence this may not be representative of the county as a whole. Overall carers we spoke to did not think their views were fully taken into consideration or seriously.

Effectiveness, efficiency and equity principle

We heard evidence that closures of the Hughes Unit and Stewart Lodge had not resulted in the intended development of day services in rural areas. We heard that the lack of bed availability had a detrimental impact on service users, carers, community services, the AMHP services and ambulance services. We found the closure of the 136 suite in Forston had also impacted negatively on patients in rural areas having to travel longer distances. We heard positive comments about the new 136 suite at St Ann's Hospital from all agencies we spoke to.

We found evidence to the health scrutiny committee that the decision to deviate from the proposed model was taken in the interest of patient safety due to staffing concerns.

We found the issues raised about the AMHP service were of such significance that we had concerns about the safety of the service. DCC senior management staff told us they did not share this view but recognised that the service was "on the brink". We have therefore written formally and separately to this report to the Director for Adult and Community Services detailing our concerns.

Patients admitted from the community (civil powers):

We found the Crisis Response and Home Treatment team (CRHT) were involved in the assessment process before it was decided hospital admission was necessary. We were told that the consultant psychiatrist made the decision to proceed to MHA assessment in consultation with CRHT colleagues. We heard the psychiatrist with knowledge of the patient did not necessarily meet with the patient or attend the MHA assessment. We found AMHPs must always considered the alternative options to admission but we were told these were limited.

We found MHA assessments were often delayed after a decision to assess had been made due to a number of factors. These factors included geographical distance from services, lack of AMHP's and difficulties with availability of doctors approved under section 12(2) of the MHA.

We found DCC had not ensured that sufficient AMHPs were available to carry out their roles under the Act. We found evidence documented in quality assurance reports of April -June 2013 that the AMHP service had been "struggling to provide a service" and ""unable to cope with cope with the pressure".

This point is addressed in more detail later in this report as an action point.

We were told that it was not uncommon for doctors involved in the MHA assessment to have no previous acquaintance with the patient. We were told doctors making medical recommendations for detention in hospital would usually expect the AMHP to ascertain bed availability in collaboration with the DHUFT bed manager. We found this was not a locally agreed expectation of the AMHP service. It was not clear who had responsibility for ascertaining bed availability if neither doctor was employed by DHUFT.

We found the AMHP service had difficulties in identifying the Nearest Relative (NR) especially out of hours when to do so could involve unreasonable delay. We were told the systems in place to complete this piece of work were not robust and compounded by AMHP's not having access to the patient electronic record. This point is addressed later in this report. There was no system in place to monitor the quality of AMHP reports or to ensure that any follow up work was carried out.

AMHPs described a "regular pattern" of long delays before admission and bed availability could influence decision making.

We found that following closure of the Hughes Unit, Stewart Lodge and the Section 136 suite at Forston Clinic patients had to travel long distances to an available bed, including out of county as far as Cambridge and Kent. We were told that geographical distances from patient's homes and locally available beds often did not meet patients' needs or those of their carers. We found patients could feel isolated from friends and family and unable to have appropriate leave, delaying discharge. We found patient and family views could not always taken into account.

We were told that the Intermediate Dementia Care Service (ICDS) had found an increase in patients detained in hospital. However we were told that ICDS only operated in the east of the county and that there was no crisis service available for older people with a mental illness.

We found that consideration was given to appropriate legal frameworks for the treatment of children and young people and children and young people were detained in age-appropriate services. However, we found that between April 2012 and March 2013 five young people under the age of seventeen years detained under section 136 were subsequently admitted out of county. However we found that it was sometimes difficult to ensure professionals with particular expertise for this group and for patients with learning disability.

We found that once assessment had been completed the local ambulance service had a limited choice of vehicles for conveyance to hospital. Police and ambulance services gave clear descriptions of standards of dignity and respect they considered were involved should their assistance be required in conveyance. Overall, we found patients were conveyed to hospital in an appropriate way. We found that interagency understanding of available services was limited especially in regard to the understanding between the CRHT and AMHP's about police/ambulance resources and competing priorities out of hours. We found where restraint was used at the time of the assessment or during conveyance, this was appropriately considered, assessed and recorded. We heard that patients would never be sedated during conveyance or handcuffed to external vehicle structures.

Patients subject to criminal proceedings:

We found that DHUFT had systems in place to monitor the number of patients subject to criminal proceedings. In the reporting period July 2012 to September 2013 data provided indicated that very few patients subject to criminal proceedings had been detained by hospital managers. We noted evidence of six conditional discharges during this period.

We did not focus on monitoring the admission and assessment process for these patients during this visit.

Patients detained when already in hospital:

We also found that DHUFT had systems in place to monitor the use of holding powers available to doctors and approved clinicians under section 5(2) of the Act and to certain nurses under section 5(4).

Data provided indicated numbers of use of the holding powers by quarter varied between twelve and thirty-three at St Ann's Hospital and one and eleven at Forston Clinic. Data provided was not broken down to indicate which holding power had been used or whether the patient had been detained.

We did not focus on monitoring the admission and assessment process for these patients during this visit.

People detained using police powers:

We were provided with an audit of assessments under section 136 between 1 April 2013 and 31 March 2013 indicating the potential use of section 136 in the DCC catchment area.

We found 32% of detainees had address in Dorset, outside Bournemouth and Poole. We found the Weymouth police station was used as a place of safety in 10 % of cases and 14% in Forston Clinic for the period it was in operation. Data from the AMHP service quality assurance reports showed a trend for an increase in the numbers of assessments in Weymouth and Purbeck with a decrease in Bridport.

We found the MAG group had jointly agreed a local section 136 policy. We found the policy provided clear guidance for professionals in the agencies involved.

We found partner agencies had a system in place whereby monitoring and review of the policy took place on a regular basis. We found local audit of the use of section 136 took place and findings were communicated and disseminated via the MAG group. It was less clear how lessons learned were shared and acted upon.
We found a process supporting admission to a place of safety including documentation detailing admission, a leaflet explaining patients' rights, section 136 monitoring documentation and joint handover and risk assessment guidance notes.

We found it was difficult to consider if the place of safety was appropriate in all circumstances due to the recent service developments, the way data was collated and varying views from people we spoke to. We were told that since the place of safety at Forston Clinic had been closed patients from rural areas had to travel longer distances to St Ann's Hospital 136 suite and on occasion back to Forston Clinic to be admitted. We noted from the audit data provided that fifteen young people under the age of seventeen had been detained with the youngest patient being thirteen years old. We found that 33% of these young people had been taken to a police station as a place of safety. We could not identify from the data provided where these young people lived.

Other areas:

We found evidence that the interagency working in place did not appear to be as effective as hoped. We found a number of concerns which could be dealt with through better inter-agency working. These included:

- issues raised at our last admission and assessment visit did not appear to

have been shared or addressed

- attendance at the MAG group was not consistent for some attendees or their representatives
- evidence that the MAG group had no strategic or operational responsibility and was documenting but not acting on identified risks
- lack of clarity on how information about service developments and performance concerns were shared with medical staff involved in assessment for detention under the Act
- key information and awareness about service developments such as the hub and street triage were not apparent to all partner agencies
- difficulties in completing the conveyance policy
- the lack of service users and carers on the MAG group may have contributed to dissatisfaction and misunderstandings
- sharing of information about the impact of performance of CRHT on a serious untoward incident for the ambulance service had not occurred
- AMHPs were unaware of many interagency operational issues

Section 120B of the Act allows CQC to require providers to produce a statement of the actions that they will take as a result of a monitoring visit. Your action statement should include the areas set out below, and reach us by the date specified on page 1 of this report.

Domain 1 Purpose, Respect, Participation, Least Restriction	**MHA section:** **CoP Ref:** Chapter 1.6, Chapter 4.4, 4.13 and 4.32

We found:
The MHA Code of Practice chapter 4 paragraph 32 says: … Because a proper assessment cannot be carried out without considering alternative means of providing care and treatment, AMHPs and doctors should, as far as possible in the circumstances, identify and liaise with services which may potentially be able to provide alternatives to admission to hospital. That could include crisis and home treatment teams … We found the CRHT team acted as the gateway for admission and aimed to provide this alternative means of providing care and treatment to hospital admission in conjunction with the recovery house based in Weymouth. We found day care services had not been put in place following the closure of the two inpatient acute adult wards. We heard alternatives to admission such as 'Home from Home' and 'Shared Lives' were not yet in place. We found the perceptions of many users and carers we spoke to were that people living in rural areas were disadvantaged. We found that service user and carers perceptions of crisis services were not favourable. We were told that help in crisis "basically doesn't exist", was "catastrophic", "appalling" and "a lottery". The representative from the ambulance service told us "crisis is in crisis". We were told of long delays for assessment and long distances to travel for these assessments. We found assessments out of hours could not take place in service users own homes they were asked to travel to the general hospital to speak with CRHT staff. We were told ambulance services were asked to take patients to emergency departments. We found service users and carers who were aware of the recovery house thought it was underused. Staff told us they felt the criteria for the recovery house were too strict and admission was not available at times of highest demand.

Service users and carers told us it was difficult to contact the CRHT and they were often asked to call back. We found there was a perception that CRHT staff had "no time to talk" and at times offered very basic advice. We were told that the Samaritans were easier to contact and more helpful. One carer told us the CRHT "does not listen to carers".

We found that AMHP's had no access to the patient electronic record out of hours and had difficulties in identifying nearest relatives and accessing relevant clinical information.

We were concerned to note that the CRHT staff we spoke to "had a vague memory" about a serious incident reported to us and investigated by the ambulance service. We were told that in this case ambulance staff were not informed that the patient was detained under section 3 MHA and on section 17 leave when they were called by the CRHT following the patient taking an overdose. This vital information resulted in ambulance staff relying on the MCA.

Sainsbury Centre for Mental Health (SCMH) 2006 describes the "challenge ahead" for crisis teams "is to make them work to their full potential and to sustain the initial enthusiasm and energy" and emphasises the importance of "well-functioning systems and management". The crisis team appeared to be having difficulty in meeting this challenge.

We found it difficult to conclude on the evidence we found how the CRHT and recovery house could be considered effective alternative means of providing care with least restriction, if service users, staff and carers had difficulties accessing the service.

Your action statement should address:

How the trust will improve compliance with the MHA Code of Practice chapter 4 paragraph 4:

… Before it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept …

How the trust will demonstrate that decisions made about crisis services do not disadvantage people living in rural areas in compliance with the MHA Code of Practice chapter 1 paragraph 6:

… People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken …

Domain 1 Patients admitted from the community	**MHA section:** 13 **CoP Ref:** Chapter 4.33

We found:

The MHA Code of Practice chapter 4 paragraph 33 says:

… LSSAs are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, LSSAs must have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs …

Overall, we found DCC had not ensured that sufficient AMHPs were available to carry out their roles under the Act. We found this had a significant and negative impact on admission and assessment under the Act.

We were told that within the county there are 29 AMHPs available for daytime work some of whom were part-time. Within that number there is one occupational therapist and a community psychiatric nurse both of whom are employed by DHUFT. We were told that guidelines suggested that a county the size of Dorset should have 41 AMHPs.

We found that there also appeared to be a lack of interagency working and any agreement between the council and DHUFT to facilitate AMHP training.

AMHPs told us that they regularly work extra hours in order to complete mental health act assessments. This involves them working into the evenings and working on their day off. .

On a related point, we also heard that DCC also expects AMHPs to undertake further MHA assessments of patients already detained in hospital out of county involving many hours of travel including overnight stays in some isolated cases further depleting local AMHP resources.

Your action statement should address:

How Dorset County Council will demonstrate compliance with MHA Code of Practice chapter 4 paragraph 33:

…LSSAs are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, LSSAs must have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs …

Domain 1 Patients admitted from the community	**MHA section:** **CoP Ref:** Chapter 1.6 and 1.7

We found:

We further found there did not appear to be effective arrangements in place to manage the service and to deal with the various issues that may emerge and impact on professional AMHP practice. We found that as a result AMHPs feeling demoralised, overworked, vulnerable and professionally unsupported by senior management staff.

We found that AMHP's working within CMHT's also told us they had little support from integrated team management staff around issues relating to their AMHP work particularly time off in lieu of extra work.

We were told that AMHPs had no administrative support and out of hours AMHPs had no access to the patient electronic record.

We found evidence that this probably also had an impact on the quality of AMHP work. One example of this would be evidence of delays of over three hours for AMHPs attending section 136 assessments which has risen from 34% incidences in the last reporting year to 37% this year. We also found evidence of ten unlawful detentions since October 2013. We found issues relating to nearest relatives in AMHP reports which were identified out of hours but not followed up.

AMHPs told us they did receive professional training and kept their own training portfolios. They considered there was a focus on MCA training over MHA training and that they needed additional training around legal updates. AMHPs expressed concern that they were expected to share the current recognised MHA manual and had to complete and submit forms if they needed additional legal advice.

We were told that individual clinical supervision was lacking or often cancelled. The only supervision was peer group supervision started by the AMHP lead if and when they were able to attend.

We found that AMHPs did not appear to have been kept abreast of interagency policy agreements. These included examples they gave us about requesting police assistance and accessing ambulance services for planned assessments and out of county transfers. The AMHPS we spoke to were not aware of the plans for street triage.

We were told that if AMHPs go out on an assessment late in the afternoon there is no system consistently in place to protect them in the event of an incident.

Your action statement should address:
How partner agencies will ensure compliance with MHA Code of Practice chapter 1 paragraph 6: "People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken". How Dorset County Council will ensure compliance with the MHA Code of Practice chapter 1 paragraph 7: "All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998".

Domain 1 Patients admitted from the community	**MHA section:** **CoP Ref:** Chapter 4.31, 4.51 and 4.77

We found:

We found that the apparent lack of availability of inpatient beds was of importance to service users, carers and representatives of partner agencies we spoke with during the visit. We found concerns focused on the numbers and availability beds following the closure of the Hughes Unit and Sherwood Lodge and difficulties experienced due to distances from service users home and families.

Some service users welcomed bed closures but were disappointed at the lack of alternatives to admission. Service users and carers from rural areas felt that bed availability was not appropriate to the patient's needs for recovery due to difficulties in contact with friends and relatives and leave arrangements. Many carers did not feel their views were taken into account.

AMHPs described a "regular pattern" of long delays before admission and bed availability influencing their decision making. We were told that patients may spend weeks in inappropriate ward environments awaiting bed availability in DUHFT.

The annual report 'Monitoring the MHA in 2011/2012' raises concerns about bed occupancy levels and that patients may be being discharged too early without sufficient support in place. Several groups we spoke to including service users, carers and IMHAs thought that discharge from hospital could be premature at times to make beds available with very little notice.

The MHA Code of Practice Chapter 4 paragraph 92 says :

"Once an application has been completed, the patient should be conveyed to the

hospital as soon as possible, if they are not already in the hospital. But patients should not be moved until it is known that the hospital is willing to accept them".

AMHP's expressed concern about the 'knock-on' effect of bed shortages and delays on conveyancing across county boundaries. They gave an example of a patient having to be "held in restraint for hours" while such issues were resolved. The police and ambulance service were also concerned about limitations on conveyance for patients admitted out of county.

We were told that the IMHA service had been approached by patients and carers about bed availability, suggestions of premature discharge and difficulties with travel for carers and patients with section 17 leave admitted at a distance from their homes.

We found a very strong sense of feeling about the lack of inpatient beds and paucity of day services especially in rural areas. This appeared seemed in conflict with papers presented to the health scrutiny committee by DHUFT.

We were particularly concerned about evidence presented by the AMHP service that bed availability was affecting clinical decision making and if the criteria for application for detention were met and whether an application for detention should be made.

Considering the evidence we found during the visit we struggled to understand how doctors were able to make medical recommendations as to where appropriate treatment was available for the patient if all the above factors were taken into account.

Your action statement should address:

How partner agencies will ensure bed availability enables compliance with the MHA Code of Practice chapter 4:

"How partner agencies will ensure compliance with the MHA Code of Practice chapter 1 paragraph 6 guiding principle of effectiveness, efficiency and equity with regard to bed availability".

People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

Domain 1 People detained using police powers	MHA section: 136 CoP Ref: Chapter 10.24

We found:

We found that the MAG multi-agency group had amalgamated with the section 136 monitoring group since our last visit. We found evidence that the partner agencies considered this would “provide an avenue to review the process of section 136 assessments and the issues that arise from assessments.”

We found that the 136 suite at Forston Clinic Dorchester had been closed. We found this had not been corrected in the section 136 policy documents.

We found that patients from rural areas detained under 136 MHA were conveyed to St Ann’s Hospital 136 suite for assessment. We found that the perception of some service users, carers and professionals living and working in rural areas was different from the views of police. Police considered the process of assessment at St Ann’s Hospital was more efficient and enabled people detained under section 136 to be assessed more promptly.

We found AMHPs found that travel times to St Ann’s from areas such as Bridport, Weymouth and North Dorset could delay assessments and cause undue distress to patients.

We heard that on occasion once assessment had been completed the patient then had to wait for transport back to Forston Clinic for admission or long travel times back to their homes and families.

Service users told us that the police treated people detained under section 136 with dignity and respect but since the closure of the 136 suite at Forston Clinic it was distressing for service users to spend sometimes up to “nine hours on the road”.

We noted that it was the intent for the MAG multiagency group to review all service users who have had more than three Section 136 assessments per year to identify lessons to be learned in care planning and sharing of information.

We heard of plans to introduce street triage in the new year.

Your action statement should address:

How partner agencies will improve patient experience and compliance with MHA Code of Practice chapter 10 paragraph 24;

… In identifying the most appropriate place of safety for an individual, consideration should be given to the impact that the proposed place of safety (and the journey to it) may have on the person and on their examination and interview. It should always be borne in mind that the use of a police station can give the impression that the

person detained is suspected of having committed a crime. This may cause distress and anxiety to the person concerned and may affect their co-operation with, and therefore the effectiveness of, the assessment process …

Provision of evidence of the review of service users who have had more than three Section 136 assessments per year and related action plans.

Domain 1 Patients admitted from the community	**MHA section:** **CoP Ref:** Chapter 10.28, Chapter 13.5, Chapter 4.73 and 4.75

We found:

We found evidence in the information provided by DHUFT that the MHA lead consultant psychiatrist had left the trust and appointment of a successor was pending. We found the last clinical/medical audit was undertaken in 2012. We were told the MHA lead consultant also took the lead in medical scrutiny. We found that there was no medical representation on the MHA multiagency group. We were therefore unclear as to how medical staff could contribute to matters relating to the MHA or work effectively with partner agencies.

We considered if this may have contributed to our observations and findings.

We found that the latest section 136 audit showed that in 19% section 136 assessments the first doctor failed to attend within the three hour agreed target. This represented a rise from 12% since the last audit. This delay was not replicated by attendance of the second section 12 doctor which showed an improvement in delay experienced. We found evidence that a trial of only one section 12 attending assessments had been considered.

We found that a lack of attention to the importance of accuracy in completing medical recommendations had led to one illegal detention as the doctor had not signed the medical recommendation.

AMHPs also told us that availability of section 12 doctors for MHA assessments was limited. We were told it was difficult to ensure a doctor had previous acquaintance with the patient as the CMHT consultant psychiatrists and crisis team consultant psychiatrists appeared reluctant to attend even when they had initially asked for the MHA assessment.

We were also told that doctors completing medical recommendations did not consider they had any responsibility to secure a hospital bed where in their judgement appropriate medical treatment would be available for the patient. We heard this could lead to conflict with AMHP colleagues and delays in admission.

Your action statement should address:
How the provider will improve compliance with MHA Code of Practice chapter 10 paragraph 28: “Assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. Where possible, the assessment should be undertaken jointly by the doctor and the AMHP”. How the provider will improve compliance with MHA Code of Practice chapter 13 paragraph 5: … People who sign applications and make the supporting medical recommendations must take care to comply with the requirements of the Act. People who act on the authority of these documents should also make sure that they are in the proper form, as an incorrectly completed or indecipherable form may not constitute authority for a patient’s detention … How the provider will improve compliance with MHA Code of Practice chapter 4 paragraph 73: … Where practicable, at least one of the medical recommendations must be provided by a doctor with previous acquaintance with the patient. Preferably, this should be a doctor who has personally treated the patient. But it is sufficient for the doctor to have had some previous knowledge of the patient’s case … How the provider will ensure compliance with MHA Code of Practice chapter 4 paragraph 75: … If the doctors reach the opinion that the patient needs to be admitted to hospital, it is their responsibility to take the necessary steps to secure a suitable hospital bed. It is not the responsibility of the applicant, unless it has been agreed locally between the LSSA and the relevant NHS bodies that this will be done by any AMHP involved in the assessment …

Domain 1 Purpose, Respect, Participation, Least Restriction	**MHA section:** **CoP Ref:** Chapter 1.6

We found:
The MHA Code of Practice chapter 1 paragraph 6 says: “People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken”. We found that there were a lack of housing options when patients were ready to

leave hospital. We were told that this meant that sometimes patients did not receive an appropriate level of support on discharge or that discharge could be delayed. We heard that some patients and carers found transitions from hospital to home were difficult and they needed more support and advice on how to navigate housing availability and services.

Your action statement should address:

How partner agencies will ensure that more emphasis is placed on meeting the housing needs of patients when they are discharged from hospital to enable compliance with the MHA Code of Practice.

Domain 1 Other areas	**MHA section:** **CoP Ref:** Chapter 1

We found:

We found evidence that the interagency working in place did not appear to be as effective as hoped. We found a number of concerns which could be dealt with through better inter-agency working. These included:

- issues raised at our last admission and assessment visit did not appear to have been shared or addressed
- attendance at the MAG group was not consistent for some attendees or their representatives
- evidence that the MAG group had no strategic or operational responsibility and was documenting but not acting on identified risks
- lack of clarity on how information about service developments and performance concerns were shared with medical staff involved in assessment for detention under the Act
- key information and awareness about service developments such as the hub and street triage were not apparent to all partner agencies
- difficulties in completing the conveyance policy
- the lack of service users and carers on the MAG group may have contributed to dissatisfaction and misunderstandings
- sharing of information about the impact of performance of CRHT on a serious untoward incident for the ambulance service had not occurred
- AMHPs were unaware of many interagency operational issues

Your action statement should address:
How partner agencies will ensure improvements in interagency working Provision of evidence of a commitment to these improvements with reference to the guiding principles of the MHA Code of Practice

During our visit, patients raised specific issues regarding their care, treatment and human rights. These issues are noted below for your action, and you should address them in your action statement.

Individual issues raised by patients that are not reported above:

Patient reference:	**A**
Issue:	
We heard that patient A had been initially detained at Pebble Lodge but transferred out of area. We heard that this had meant the patient's relatives had difficulty in visiting the patient. Concern was also expressed about the availability of IMHAs and consultation with the patient's relatives about transfer. We have already raised this issue with DCC senior management staff for speedy resolution if immediate issues.	

Information for the reader

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