

# Dorset Health Scrutiny Committee

**Dorset County Council**



Date of Meeting	22 May 2015
Officer	Director for Adult and Community Services
Subject of Report	<b>Independent evaluation of the Mental Health Urgent Care Service, West of Dorset</b>
Executive Summary	<p>This report presents the findings and recommendations of an evaluation to review the Mental Health Urgent Care Service (MHUCS) in the west of Dorset. The evaluation was commissioned by NHS Dorset Clinical Commissioning Group and was conducted by a team from the University of the West of England, Bristol (UWE).</p> <p>The independent evaluation of MHUCS West of Dorset (covering the period 1 May 2013 to 30 April 2014) aimed to assess how the service had been implemented and impacted on service users, carers, staff and stakeholder experience.</p> <p>The evaluation reviewed and captured data from a number of sources including; a review of existing data for inpatient acute services, the Community Mental Health Team (CMHT) and the Crisis Response Home Treatment team (CRHT); a survey of equal numbers of service users (n=22) and carers (n=22), interviews with both service users (n=6) and carers (n=6), staff (n=5) and stakeholder (n=6) interviews and a GP survey (n=8). Ideally the evaluation would have involved a larger number of participants at all phases of data collection, however uptake was lower than anticipated with a generally poor appetite for the study seen.</p>
Impact Assessment:	Equalities Impact Assessment: n/a

Please refer to the <a href="#">protocol</a> for writing reports.	Use of Evidence: Report provided by University of the West of England.
	Budget: n/a
	Risk Assessment:  Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: <del>HIGH/MEDIUM</del> /LOW (Delete as appropriate) Residual Risk <del>HIGH/MEDIUM</del> /LOW (Delete as appropriate)
	Other Implications: n/a
Recommendation	Members are asked to note and comment on this Report.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of Dorset's citizens.
Appendices	1 Report: Independent evaluation of the Mental Health Urgent Care Service, West of Dorset
Background Papers	<p>Briefing to Dorset Health Scrutiny Committee, 10 September 2014: <a href="http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/212A6CEB72AAED8F80257D47003955D2?OpenDocument">http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/212A6CEB72AAED8F80257D47003955D2?OpenDocument</a></p> <p>Briefing to Dorset Health Scrutiny Committee, 23 May 2014: <a href="http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/E8DCEA6BF2220C0D80257CE800346D26?OpenDocument">http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/E8DCEA6BF2220C0D80257CE800346D26?OpenDocument</a></p> <p>Briefing to Dorset Health Scrutiny Committee, 10 March 2014: <a href="http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/BDB6E7D1E6CD881880257C8D003FBBEC?OpenDocument">http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/BDB6E7D1E6CD881880257C8D003FBBEC?OpenDocument</a></p> <p>Report to Dorset Health Scrutiny Committee, 19 November 2013: <a href="http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/ADBFA26BE7DF2D8880257C21003424C1?OpenDocument">http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/ADBFA26BE7DF2D8880257C21003424C1?OpenDocument</a></p> <p>Report to Dorset Health Scrutiny Committee, 13 September 2013: <a href="http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/97CDF96F5ECE2EFF80257BDE002EA47E?OpenDocument">http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/97CDF96F5ECE2EFF80257BDE002EA47E?OpenDocument</a></p> <p>Report to Dorset Health Scrutiny Committee, 30 May 2013: <a href="http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/082BEACA585A7F9380257B7300529E61?OpenDocument">http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/082BEACA585A7F9380257B7300529E61?OpenDocument</a></p>

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**INDEPENDENT EVALUATION OF THE MENTAL HEALTH URGENT CARE SERVICE (MHUCS)  
WEST OF DORSET**

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## **Executive summary**

This report presents the findings and recommendations of an evaluation to review the *Mental Health Urgent Care Service (MHUCS) in the west of Dorset*. The evaluation was commissioned by NHS Dorset Clinical Commissioning Group and was conducted by a team from the University of the West of England, Bristol (UWE).

### **1. Aims and methods**

The independent evaluation of MHUCS west of Dorset (covering the period 1 May 2013 to 30 April 2014) aimed to assess how the service had been implemented and impacted on service users, carers, staff and stakeholder experience.

The evaluation reviewed and captured data from a number of sources including; a review of existing data for inpatient acute services, the Community Mental Health Team (CMHT) and the Crisis Response Home Treatment team (CRHT); a survey of equal numbers of service users (n=22) and carers (n=22), interviews with both service users (n=6) and carers (n=6), staff (n=5) and stakeholder (n=6) interviews and a GP survey (n=8). Ideally the evaluation would have involved a larger number of participants at all phases of data collection, however uptake was lower than anticipated with a generally poor appetite for the study seen.

### **2. Findings from the existing data**

Comparisons of incident data have highlighted three areas worthy of consideration. One is related to an increase in overnight stays following service change, though it should be noted that this remains low in number overall. The second relates to an apparent increase in the incidence of self-harm, although this is not corroborated in any other data. Thirdly, occupancy figures suggest the Rethink Recovery House was not being fully used.

### **3. Findings from the service user and carer surveys and interviews**

1. Those service users cared for by the CRHT team generally felt their needs had been met, with a number receiving a crisis care plan. An equal number agreed and disagreed that the CRHT team provided the most appropriate care at the time.

2. Most service users knew of the existence of the Crisis line and this had been used at different times. The service users and carers commented that there were occasions when on phoning the line they had had to wait for a response or were asked to leave contact details for someone to call them back later. The majority were positive, however some felt the person they spoke to was too busy and that the Samaritans offered a more empathetic service. Despite the issues, few made formal complaints.

3. Inpatient services had been used by a number of those responding. There were mixed experiences of care and discharge planning, with some being unsure if this had taken place. A period in hospital had helped some towards recovery. One person complained formally about their care.

4. The provision of education courses was not widely known. However, when used these were generally well received. Skills courses on offer had benefitted a number of service users. Information about the courses was reported as helpful. Staff providing the courses were seen as helpful and respectful. It was also suggested that the provision of education and activities overall could be expanded.

5. In total twelve carers were dissatisfied with the services offered to service users before the service change and had reported a worsening in services generally since the changes. Inpatient services were seen as worse/ somewhat worse by eight, home treatment, with home treatment in the community viewed this way by nine and support in the community perceived this way by ten. In total, though some felt there had been some improvement in inpatient services (2/15 better or somewhat better) and home treatment (3/15 better or somewhat better). Following the service change, a small number were satisfied with the level of support received, whereas the majority were not. The majority had experienced some difficulties in contacting the CRHT, especially out-of-hours, but felt unable to complain. All carers were aware of the Crisis line and many had used the service, but reported a range of problems.

6. Carers had also been dissatisfied with care delivery in inpatient units and the Rethink Recovery House, but had not formally complained. Carers also reported that the service changes had impacted on them. Some felt they now had to do more. The Rethink Recovery House was viewed as too remote for some to use, the geographical distance from home being an issue.

7. Those using the Rethink Recovery House had sometimes experienced delays in admission, though all felt in control of their treatment once admitted. There was general satisfaction with the care environment. It was suggested that there was scope to expand the activities on offer; however the service was generally viewed positively.
7. Engagement in the consultation process which preceded service changes was varied. Whilst some felt well informed and able to contribute, others did not. It was also suggested that individual views were not always taken account of and promised services have not been made available, for example GPs had understood there would be pump priming of community services prior to bed closures which did not materialise.
8. Locally established relationships with service providers had been lost as a result of the changes in service provision. In addition, the closure of local units had led to increased travel costs and distances travelled by users and carers to access services.
9. One larger inpatient unit available prior to the service change was perceived as intimidating, with changes resulting from its closure and new provision being positively received.
10. Experiences of care planning were varied, with some receiving these and others not.

## **6. Findings from the staff and stakeholder interviews**

1. Staff perceived that service users and carers had found the loss of local, small inpatient units difficult. They had been affected by a loss of familiar, responsive care providers and the need to travel greater distances for required care.
2. There were differing views on the management of the transition period, with some feeling involved and others less so. It was felt by some that the service change had been rapid and that staff recruitment had not been as speedy as required.
3. Changes in care pathways had seen service users discharged into the community, however it was suggested that extra resources were not made available.
4. Staff suggested improved communication was needed to ensure local communities had a better understanding of the new provision.
5. The rural location of Dorset was also challenging for some community staff, not helped by the lack of technological provision which necessitated additional travel.



6. It was suggested that the CRHT out-of-hours support required review. Current staffing levels were felt to be inadequate and there were ramifications for Emergency Department use. In addition, the lack of stepping up and down provision was noted.
7. Staff reported that care planning had improved, but required further development to ensure the inclusion of service users in this process.
8. It was felt overall that the CRHT was working well. Target times in the Emergency Department had been met. The team were working well with Waterston and the Rethink Recovery House. However, there was concern that a lack of emergency beds could be problematic, which required occasional service user transfer out of region. One person suggested improved communication was needed between the CRHT and GPs.
9. The provision of home care was seen as important to aid recovery and the inclusion of the Rethink Recovery House as part of the service provision was viewed positively.

## **7. Findings from the GP survey**

1. Many of the GPs in the small sample answered 'neither agree nor disagree' making it difficult to identify any trends.
2. There was generally a good awareness of services including the CRHT, however three Weymouth based GPs were unaware of the provision of the Rethink Recovery House.
3. GPs felt the communication between surgeries and the CRHT could be improved.
4. Weymouth based GPs suggested the area might be considered as a specific area of need.

## **8. Recommendations**

Based upon the results there are a number of areas that might be considered. The respondents highlighted that they felt that the consultation process did not engage all key stakeholders and service users equally and there is concern that ongoing communication issues remain. It is suggested that a communication plan is devised and implemented is contemplated that clearly communicates the changes and makes clear the role and function of the different services. This should be supported by the development of information that can be accessed by service users, relevant local organisations and providers.

There are a number of areas of the new service that might be reviewed and developed, including the out-of-hours response of the CRHT and the Crisis line provision, which does not appear to be meeting service user and carer need. Reliance on technology has increased following service change and staff working remotely report a need for greater IT provision. There is an additional need for the commissioners and service providers explore ways to improve the communication between the CRHT and GP practices.

Occupational therapy, activity/educational provision could be enhanced and the Rethink Recovery House might augment its current activity schedule. Review of step up and step down services, providing support between inpatient and community services, might also be considered. It may be worthwhile reviewing the care needs of Weymouth in particular and seeing whether it might be viewed as an area of special need. Pre-collected data suggests there may be a need to review the incidence and management of self-harm.

It was also noted that despite a number of users being unhappy with the service received, few were taking opportunities to submit formal complaints. It may be prudent to review how service users and carers are being supported to access and use the existing complaints procedure. It should be accessible to users and seated within a culture that welcomes feedback and sees this as an opportunity for service improvement.

Whilst care planning has improved, it was felt that certain aspects need further development. In particular, the need to consistently include service users in the process was noted. One respondent suggested development work was already underway to address some issues, though a further review and action planning may be required.

Areas of the new service are working well and the Rethink Recovery House has been seen as an important addition to the provision. The data received suggest the service is under used and that not all local GPs were aware of its existence. Its location is also problematic for some, and ways of improving access should be considered. Interestingly, there is financial support available, however none of the participants mentioned this and therefore promotion of this opportunity may need consideration.

## 1.0 Introduction

An independent evaluation of the Mental Health Urgent Care Service (MHUCS) in the west of Dorset was commissioned following the implementation of a new model of care in May 2013. The service improvement provided services for those adults experiencing acute mental health crisis and with severe mental health illness. These services were for west Dorset patients although other members of the Dorset-wide population can access them. West Dorset patients exclude those in Purbeck, Christchurch, Bournemouth and Poole.

## 2.0 Background literature

Supporting people experiencing a mental health crisis has been the object of many policies and guidance since the late 1990s. However it is only recently that crisis resolution has been given priority in the policy context (Department of Health, 2012, Department of Health, 2013). This overview of the literature will focus on the period 1997-2014.

A mental health crisis is described in the literature in different ways. For instance, the Department of Health (DH) *Guide to mental health in an emergency* suggests that a rapid worsening in someone's mental or emotional state can be seen as a mental health crisis and refers to examples of threats of suicide, extreme distress or intentionally reducing food intake. Mind, the national mental health charity, views crisis either as "acute", as an episode in one's life which requires support but not necessarily a referral to specialist services, or as a turning point in which people can reassess their life and potentially take a new direction (Mind).

While such descriptions focus mainly on behaviour, they often ignore the more experiential aspects of mental health crisis. The User Focused Monitoring (UFM) research on the experiences of being in a crisis (UFM, 2004) showed that the majority of participants in this position expressed having a complex and diverse set of feelings in response to complex emotional and practical issues. This echoed an earlier survey (Mental Health Foundation, 1997). What participants of the UFM project wanted most at times of crisis was emotional and practical support, but the response from services was mostly medication. Effectively the nature of crises calls for a response that meets individual which includes a range of alternatives to hospital admissions.

Crisis care and resolution has been part of the policy context since the late 1990s, specifically since the National Service Framework for Mental Health (NSF) (Department of Health, 1999) and the NHS Plan (The Secretary of State for Health, 2000), itself supported by the Mental Health Policy Implementation (DH, 2001). These early guides and drivers focused mostly on tackling mental health crisis through the creation of alternatives to hospital admissions and on early discharge. The DH in England and Wales has recommended crisis resolution and home treatment in its best practice and policy implementation guides since 2001 (DH, 2001) and the Sainsbury Centre for Mental Health (SCMH) played a significant role in supporting the development of CRHT teams nationally (McGlynn, 2006).

Crisis Response Home Treatment teams provide acute home treatment for people whose mental health crisis is so severe that they would otherwise have been admitted to an inpatient ward. Users of CRHT are typically suffering from severe mental illness such as psychosis, severe depression or bipolar affective disorder (manic depression). CRHT teams also allow people to be discharged earlier from inpatient wards and receive treatment in their homes whilst still in the acute phase of their illness (National Audit Office, 2008).

However, while teams developed rapidly in the 2000s and evidence showed that they have contributed to reducing pressure on beds and supporting early discharge (Barker et al., 2010, McGlynn, 2006), real changes and progress were hindered by problems, specifically related to a lack of key professionals and specialists and variation in local provision (National Audit Office, 2008). As a consequence, the new teams were not able to fully meet the needs of service users (Gyles et al., 2005). A report from the Mental Health Foundation (Faulkner et al., 2002) stressed the need of a supportive and non-judgmental environment, the need to offer not only a rapid service but also access to a range of services that meet the person's needs for those who experience a mental health crisis. Similar concerns and wishes were echoed in a later survey from the National Audit Office (Clark et al., 2008).

Despite the earlier enthusiasm for a rapid service, it took nearly another decade before crisis resolution benefitted from a new impetus and focus. New Horizons (DH, 2009) (which superseded the NSF), was followed by *No Health without Mental Health* (DH, 2011) which strongly supports the idea that a mental health crisis should no longer be considered an event to be contained and managed; instead clear crisis resolution outcomes are called for.

This is what the Mental Health Crisis Care Concordat (DH and Concordat Signatories, 2014) aims to do.

A new approach to crisis resolution: The Mental Health Crisis Care Concordat

The main purpose of the Mental Health Crisis Care Concordat launched in February 2014 (2014) (hereafter the 'Concordat') is to set and clarify immediate commitments and expectations for service users and carers. Its mission statement also includes a determination ensure that public services offer support to those with mental health issues achieve recovery. Recovery is thus established as the driving concept at every stage of the crisis resolution pathway. This is to be achieved by reducing inequality of access and outcomes for vulnerable people, especially those with mental health problems, in particular in terms of *“access to support before crisis point; urgent and emergency access to crisis care; the right quality of treatment and care when in crisis; recovery and staying well, and preventing future crises”*(p. 7).

One means of achieving quality crisis resolution which actively supports a recovery focus is through care planning, specifically through the Care Programme Approach (CPA) (DH, 1990). The care of people experiencing a mental health crisis has long been included as a prevention and treatment component of the care planning process (DH, 2007, NICE, 2012). The Concordat reiterates this key role and recommends joint care planning for those in mental health crisis in used to support crisis management”(DH and Concordat Signatories, 2014). The Concordat also emphasizes that the CPA approach supports the full and active participation of service users in the process, a significant point of any recovery strategy.

Finally, the economic case for early and supportive intervention (Knapp et al., 2011) which supports the goal of recovery must also be supported by effective commissioning. The Concordat highlights a departure from the traditional approach to crisis resolution by broadening the scope of action and the inclusion of more partners.

### **3.0 Aim and objectives**

The independent evaluation of MHUCS west of Dorset aimed to assess how the service had been implemented against the specification and how the new model had impacted service

user, carer, and staff experience of accessing, receiving and delivering care. The evaluation covered the period 1 May 2013 to 30 April 2014, which equated to the first year of operation.

The objectives included:

1. To explore service user experience of the service and its ability to meet individual needs at a time of crisis.
2. To explore the carer experiences of the new service.
3. To ascertain staff and key stakeholder views of service delivery.
4. To identify the impact of the new service on General Practitioner (GP) services.

## **4.0 Methods**

Given the complexities and sensitivities of the project a three phase approach was taken, which used a mixed methodology and allowed for a range of data collection approaches.

### **Phase 1: Review of existing data**

Data were received for inpatient acute services use for two specified time periods and covered admissions to the available wards/units in the west of Dorset. There are clear limitations in the data that was not collected for research purposes and could be incomplete, therefore only a brief overall picture is presented. The time periods considered included; Period A - pre service change: 23 April 2012-22 April 2013 and Period B – post service change: 1 May 2013- 30 April 2014. A change in IT systems took place prior to the service transformation, and not all data had been migrated across to the new RiO system. Patients not recorded on RiO as having both an admission and discharge within the timeframe were not included in the sample. It has been suggested by commissioners that this may be a significant number. As a result, a comparison of activity volumes cannot be made between pre and post service change. Therefore data were reviewed to identify any trends in service use. The reason for admission was not considered as it is not clear from the data which apply to the admission listed.

Data were also received related to the Community Mental Health Team (CMHT) and Crisis Response and Home Treatment team (CRHT) for the post implementation period only-1 May 2013- 30 April 2014. Pre-service data were not recorded in RiO and therefore not available. As a result no comparison of activity volumes could be made, and data were used to review a small number of trends in use.

## **Phase 2: Service user and carer data**

This included two stages: i) survey of service users and carers; ii) service user and carer interviews.

Stage i) The initial data capture was via a self-completion questionnaire. The questionnaires were developed with service user and funder input. The use of a questionnaire allowed for a broad capture of service user and carer views on the impact of the service change. In particular it explored through closed questioning issues of safety, accessibility, availability of information, knowledge of and access to independent advocacy, knowledge of and understanding of complaints procedure, positive changes and patterns of use as well as reasons for not using. The survey was made available online using Qualtrics<sup>®</sup>, an online survey building tool, and in paper format. In total, 114 paper copies of the service user questionnaire were distributed to key locations in west Dorset; CMHTs, inpatient units, Rethink Recovery House, Dorset Mental Health Forum (DMHF) and on request to support groups/organisations. In addition, the DMHF emailed all people on their mailing list with the links to the online survey and also put it on their web site as a key focal point for people with serious mental illness in west of Dorset. An additional four people contacted the University to request a paper copy.

A total of 60 paper copies of the carer questionnaire were distributed to key locations in west Dorset; carers forum, carers groups and CMHTs. An additional five people rang in to request a paper copy. At the start of the project service users and carers were made aware of the survey through poster displays and local staff/ service managers were also briefed on the evaluation project.

Recruitment to this stage was intended to start in August and end on 30<sup>th</sup> September 2014. As limited online replies had been secured at this point, the data collection period

was extended until 31<sup>st</sup> October 2014 with subsequent amended ethical approvals in place to extend recruitment. Further paper copies were distributed across the two time periods as identified in table 1 below.

Table 1 Distribution of the survey

	service user		carer	
	time 1 <sup>1</sup>	time 2 <sup>2</sup>	time 1	time 2
CMHT	25	18	2	18
DMHF	15	14		
Inpatient units		15		
Carers forum			15	14
Other third sector/vol. orgs		22		11
Recovery House		5		
Personal request		4		5

Service users and carers were offered the opportunity to take part in being interviewed by leaving their name and contact details on the questionnaire.

Stage ii) Service users and carers volunteered to take part in individual interviews, and were guided through a semi-structured interview schedule. The interviews were organised to take place on two consecutive days in four locations in the region- Bridport, Shaftesbury, Dorchester and Weymouth. Following consent, these were recorded and analysed for key emergent themes. This approach allowed the capture of detailed experience of the impact of service change. Service users and carers were able to claim for travel reimbursement and were provided with a fruit parcel to thank them for their input.

### Phase 3: Staff and stakeholder views

This included two stages, a GP survey and staff and stakeholder interviews.

Stage i) an online short questionnaire to concentrate on any impact on GP services and knowledge of the new service provision was implemented. The survey was developed with service user and funder input and was administered through Qualtrics<sup>®</sup> during November

<sup>1</sup> Time1= August- 30<sup>th</sup> September 2014

<sup>2</sup> Time 2= October 2014



2014. This survey was disseminated via two methods; through the GP internal bulletin and on the Clinical Commissioning Group (CCG) intranet. The invite in the bulletin went out every week during the month.

The four locality lead GPs in the west of Dorset were also asked to encourage GP completion.

Stage ii) Telephone interviews were completed with staff and stakeholders. Interview schedules were developed with service user and funder input and captured data on availability of service information, staffing levels, experience, patterns of use, any service user/ carer feedback. Recruitment was advised by the funder and included the following services and stakeholders: user and carer groups, Locality Chairs, the Dorset Health Scrutiny Committee, GPs, and Hughes Unit Support Group (HUGS).

All interviews were via telephone. Staff data were recorded on an interview schedule and analysed for key themes.

## **Ethics**

Ethics approvals for all stages of the work were secured from the University of the West of England, Bristol, Research Ethics Committee prior to any data collection. As a service evaluation the study did not require National Health Service (NHS) ethics approval. In line with the NHS Research Governance Framework 2005 the project was discussed with the Research and Development department of the provider Trust, Dorset HealthCare University NHS Foundation Trust (DHUFT) to ensure that we adhered to any local requirements for access to the communities, data and premises. The Data Protection Act 1998 was strictly adhered to.

## 5.0 Findings

### Phase 1: Existing data

#### Inpatient data

A total of 204 entries were included in the data set for period A: 23 April 2012-22 April 2013. The data from acute services obtained prior to the service change suggested that the service users were overwhelmingly white British in ethnic origin. The recorded admission was the first episode in hospital for the majority of users. The length of stay was often prolonged, and this was reflected across a number of units, although no one ward/unit stood out over another. The majority were discharged to their usual place of residence and this mainly occurred from the ward of admission, with minimal movement of service users between areas. A number of units were used: Stewart, Hughes, Linden, Melstock and Waterston. The data suggests Linden had the highest admission rate during this period. However it should be remembered that the original data used may be incomplete. A total of 484 entries were included in the data set for period B, post service change: 1 May 2013- 30 April 2014. A more ethnically diverse population was recorded, and it should be noted that there was a higher incidence of 'unknown/unable to request' being identified. Whilst for the majority the incidence was listed as a first episode, for several this was a fourth, seventh, ninth, twelfth or higher, episode. There was a sense that the length of stay was more prevalent in single figures. Where a longer length of stay was recorded these tended to be at Melstock, within the west of Dorset. The number of overnight/ one day stays listed for this period appear to have increased following service change, though remain in low numbers overall, totalling 24 mainly in Linden and Waterston. When the information was provided, 'usual place of residence' was listed as the most frequent discharge destination, with 24 cases being referred into the NHS 'Temporary place of residence' also featured more frequently than in data set A. Delayed transfers of care were limited. Following the change of service provision three wards in the west of Dorset were used; Waterston, Linden and Melstock. Other wards listed in the data set included; Dudsbury, Harbour, Herm, Alumhurst, Seaview, Glendinning and Psychiatric Intensive Care. Waterston appears to be the most frequently

accessed ward and more obviously used than previously. The majority of service users were also referred to the Community Mental Health Teams.

#### CMHT data

Community data was available for time period B only due to previous IT system mergers. A total of 4312 entries were included as part of the Community Mental Health Team service data, from 29,435 records (records do not equate to individual patients, but to all episodes recorded). Of these the majority were noted as having been referred internally within the CMHT or via GPs. Interestingly 83 were noted as being referred by carers. Smaller numbers had self-referred. In addition, referrals were seen infrequently from other services or staff such as health visitors, courts, other mental health services, Accident and Emergency (A&E) and drug service. Where recorded, the majority were white British/ English with only a small number of other ethnic or European groups noted. Those accessing the service were mainly located within the region, noted as postcodes DT, BH, SP, with small numbers originating from outside the Dorset region in areas such as Bath (BA), Langport (TA) Exeter (EX), London (SW), Oxford (OX), Brighton (BN), Truro (TR) and Reading (RG). Discharge from the CMHTs, when recorded, was mainly as the result of professional advice, though for some discharge was against professional advice or due to non-attendance. For a few, discharge was related to onward referral or inappropriate referral.

#### Crisis service data

A total of 4312 entries were received related to the CRHT service for time period B, from 35,924 records. Referral was commonly from GPs, the CMHT or inpatient services. Carers made a total of 173 referrals. In addition, approximately 500 of service users appear to have self-referred, though often other service referrals are noted under the same admission episode. Lower numbers of referrals were seen from other primary health care services, A&E, the police, the courts and Local Authority Social Services. In total; there were 1,405 of 35,924 records suggesting the service users were seen at home, mainly for assessment, advice and information and a couple for treatment.

### Rethink Recovery House data<sup>3</sup>

A total of 126 guests stayed at the Rethink Recovery House during the evaluation period (1<sup>st</sup> May 2013-30<sup>th</sup> April 2014). This equates to an average of 34% occupied rooms over the period. Table 2 shows the number of guests, % occupied rooms and geographical location of guests month by month over the evaluation period:

Table 2: Summary data for Rethink Recovery House

		Number of guests	%occupied rooms	Geographical location			
				Weymouth and Portland	North Dorset	Dorchester	Bridport
Q1	May 2013	12	36	no data	no data	no data	no data
	June	11	29	no data	no data	no data	no data
Q2	July	8	26	17	7	5	4
	August	13	19				
	September	12	60				
Q3	October	8	26	10	10	6	2
	November	11	26				
	December	9	29.4				
Q4	January	11	37	9	11	7	5
	February	5	36				
	March	16	44				
	April	10	41	1	5	1	3

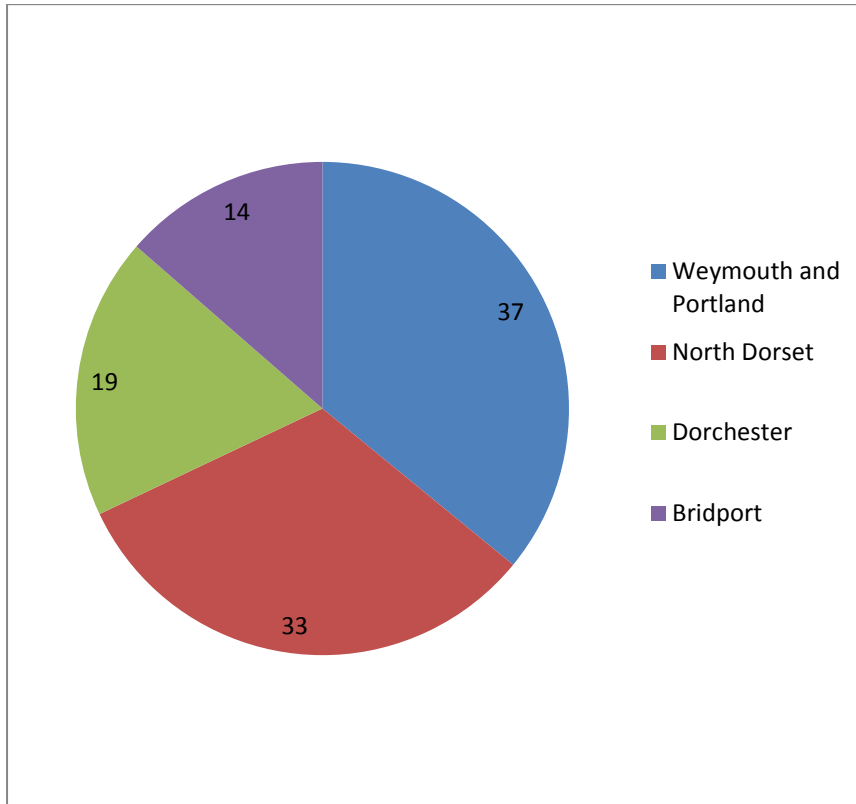
Geographical location data started being routinely collected from Q2. The pie chart below shows this breakdown. Service users from Weymouth and Portland or North Dorset areas

<sup>3</sup> Summarised from Rethink's Contract monitoring quarterly reports

make up around two thirds of the guests at the house. However, the table shows, at each quarter, the numbers from Dorchester and Bridport areas are increasing.

Occupancy varies in line with the CRHT caseload and at times 80% of their caseload will be residing at the Rethink Recovery House.

Chart 1: number of guests staying at the Rethink Recovery House by geographical location.



Recovery skills classes commenced at the Rethink Recovery House in Q2 which were open to people accessing services on the CRHT acute pathway. This included two inpatients from the Linden unit.

#### Incident Data for Adult Mental Health Settings

Table 3 shows recorded incident data over the two time points. Recorded deaths in CMHTs have remained similar pre and post service change. In the majority of the reports the cause of death is unclear or when clear are due to physical health problems such as heart attack or cancer. Examples of resourcing incidents are unsafe environments. Incidents around staffing (numbers in brackets in the table) are also recorded in this category. These relate to lack of suitably trained staff and agency staff in charge. Suicide or suspected suicide (numbers in

brackets in the table) is reported under self-harm. There were no recorded cases of suicide in inpatient units or by the CRHT. Reported cases in the CMHTs have fallen over the two time periods. Interestingly, self-harm incidence as a whole has increased in time period B.

This might be due to an actual increase in self-harm or due to improved reporting systems.

Violence and assault reporting has doubled in the CMHT setting centred predominantly on reports of verbal abuse from service users to staff members either face-to-face or on the phone. In contrast, there is a reduction in reports of such incidents on inpatient units. This may reflect a lack of reporting or an actual reduction in incidents.

Table 3: recorded incident data for adult mental health settings comparing two time points

Adult	Death of patient		Resources (staffing)		Other accident/incident		Self-harm (suicide/suspected)		Violence/assault	
	Time Point 1 <sup>4</sup>	Time Point 2 <sup>5</sup>	Time Point 1	Time Point 2	Time Point 1	Time Point 2	Time Point 1	Time Point 2	Time Point 1	Time Point 2
CMHT	9	10	1 (1)	11 (3)	1	3	9 (5)	28 (2)	8	16
Inpatient	2	0	62 (32)	27 (12)	29	22	40 (0)	82 (0)	208	165
CRHT West	1	0	1 (1)	8 (3)	5	0	0 (0)	2 (0)	1	5

<sup>4</sup> Time Point 1: 23<sup>nd</sup> April 2012 – 22<sup>nd</sup> April 2013

<sup>5</sup> Time point 2: 1<sup>st</sup> May 2013 – 30<sup>th</sup> April 2014

Table 4 shows the breakdown of the types of assault reported over the inpatient units. There is minimal change in the proportions; however there is an increase in sexual behaviour/assault reported.

There is limited data reported from the CRHT west. This might reflect a limited number of incidents or a lack of reporting.

Table 4: Type of reported assault in inpatient units over the two time points

<b>Type of incident</b>	<b>Time point 1 (%)</b>	<b>Time point 2 (%)</b>
Attempted assault	7 (3.3)	4 (2.4)
Physical	138 (66.3)	96 (58.2)
Racial	1 (0.5)	2 (1.2)
Sexual	1 (0.5)	10 (6.1)
Verbal	61 (29.3)	53 (32.1)

#### Staff Full Time Equivalent (FTE) and staff absence rate data

Data were obtained on staffing levels across two time points summarised in Table 5. Figures highlighted in blue show where the biggest increase of staffing has been. There has been an overall increase in FTE between the two time points - 17.1 FTE suggesting in these areas of service at least there has been more investment in staff. These increases are predominately seen in band 6 and 7 nursing roles and band 3 clinical support roles in all three of the settings. As expected the largest increase in seen in the CRHT team.

Table 5: Summary of FTE of staff across adult mental health settings

Staff FTE		Adult CMHT <sup>6</sup>		Inpatient units (inc Melstock)		CRHT	
		Time Point 1 <sup>7</sup>	Time Point 2 <sup>8</sup>	Time Point 1	Time Point 2	Time Point 1	Time Point 2
NURSING STAFF	band 5	0.50	0.25	22.60	21.60	0.00	0.00
	band 6	19.00	19.42	4.54	5.85	7.57	13.00
	band 7	4.10	4.60	1.85	3.00	1.00	1.50
	band 8	1.00	1.00	0.50	1.00	0.00	0.00
ADDITIONAL CLINICAL SERVICES	band 3	2.69	3.19	23.30	28.22	3.75	7.49
	band 4	0.33	0.37	0.00	0.00	0.00	0.00
	band 5	0.33	0.67	0.00	0.00	0.00	0.00
ALLIED HEALTH PROFESSIONALS	band 5	0.00	0.00	0.30	0.30	0.00	0.00
	band 6	4.84	3.84	0.00	0.00	0.00	0.00

Table 6 shows the cumulative percentage nursing staff absence rates data for inpatient units and CMHT, indicating a small percentage increase in the inpatient units and a decrease in the CMHTs.

	Time Period 1 <sup>7</sup>	Time period 2 <sup>8</sup>
Inpatient (Waterston, Linden, Melstock)	28.28%	31.50%
CMHT (Dorchester, Shaftesbury, Weymouth)	26.29%	10.95%

<sup>6</sup> Data on Bridport, Dorchester, Shaftesbury and Weymouth CMHTs only

<sup>7</sup> Time Point 1: 23<sup>rd</sup> April 2012 – 22<sup>nd</sup> April 2013

<sup>8</sup> Time point 2: 1<sup>st</sup> May 2013 – 30<sup>th</sup> April 2014



## Phase 2: Service user and carer data

### 1. Service user questionnaire data

Twenty-two service users completed the questionnaire; 10 via the online link and 12 using a paper version of the questionnaire. Sixteen service users logged on to the online version but failed to complete it. Six of the 10 who completed the online survey had identified the link in the following ways: five from the Dorset Mental Health Forum and one through a friend/relative.

Twelve paper copies were completed, four and a photocopy were obtained from a CMHT, two from service user/carers groups, two from inpatient units and three people called the University to request a copy.

#### Demographics of the service user participants

The total age range of the service user participants was between 18-74 years. Participants described themselves as female (n=15), male (n=5) and two did not answer. The majority of participants described themselves as being "White-British" (n=19) and one as "Mixed – other," while two did not disclose.

Most participants said they were home owners (n=8) while six declared living in rented accommodation (private or social housing) and two lived in supported accommodation or had no fixed abode. Most lived either near Dorchester (n=7), Bridport (n=5) or Shaftesbury (n=4).

The majority of participants (n=16) reported having used mental health services prior to the introduction of the new Mental Health Urgent Care Service. Thirteen service users disclosed their diagnosis; bipolar disorder (n= 5), schizoaffective-type disorders (n = 3), personality disorders (n = 2), depression-type disorders (n= 3).

#### Services used between 1 May 2013 and 30 April 2014

Of the service user participants who responded, most had used the CRHT team out of hours (n=12/16) or during office hours (n=9/15). Of the three inpatient units (Linden/Melstock and Waterston), the Waterston Unit had been the most used (n=6/12). While five out of

eleven reported having used the Rethink Recovery House, 11 out of 15 had used the skills courses provide by the Recovery Education Centre. Nine participants out of sixteen respondents had used the Crisis line and three out of twelve respondents had used the day treatment offered by the CRHT team.

#### Crisis Response and Home Treatment team

From the 21 who answered this question, 10 said they were assessed during the period under evaluation (May 1st 2013-April 30<sup>th</sup> 2014). When they were assessed, this mostly took place at home (n=6), in hospital (n=2) or in other places (n=2). In total, five felt that their needs had been assessed thoroughly and eight were happy about the length of the assessment.

In total 7/11 who responded that they had received a crisis plan and 6/9 agreed this was followed. Those who were visited by the CRHT team (n=9), four saw someone on a daily basis during office hours and at weekends/Bank Holidays while two were visited 2-5 times a week and the other did not reply.

Twelve respondents answered questions about satisfaction with the CRHT. In total, four said they had had enough contact with the team to meet their needs; five felt that the support they received helped them move towards recovery; three felt the support they received helped them develop their independence as well as their confidence and self-esteem.

Four said they felt the treatment and care they received offered a range of choices that met their needs and wishes; five that the information they received about their treatment and care was helpful; four that they felt in control of their treatment and care; four that the information about their treatment and care was easily available; eight that staff were friendly and that they were treated with care and dignity.

Whilst four felt that being under the care of the CRHT team at the time of a crisis was the most suitable option, four felt it was not. Of those who answered (n=12), an equal number of participants said they had had access or not to advocacy services and nine said their legal rights had been respected.

Three had not felt the need to complain about their care, five did not feel it was worth complaining and one person said they did not know how to complain.

#### Crisis line

Twenty respondents said they were aware of the existence of the Crisis line (two did not respond). Overall, 8/19 had contacted it during office hours (n=8) whereas 11/19 had contacted it out of office hours (evenings, weekends, Bank Holidays). Of those who contacted the Crisis line in office hours, six said it had been easy and seven had a similarly positive experience out of office hours.

Of those who answered questions about their experiences of using the Crisis line (n= 14), only one had been directed straight to answer phone. The majority (n= 10) were able to talk to someone and just two people experienced the line being engaged.

In total, eight participants out of 14 felt they had been listened to while four did not; eight felt that the person they talked to showed empathy while four did not. While five did not report feeling rushed to tell their story, eight did. Five felt that the person on the phone was too busy to give their full attention. Two people felt patronised by the person they spoke to.

Only 4 out of 12 who responded were satisfied with the crisis line service. Few complained when dissatisfied with the Crisis line, some informally (n=2) and one person formally.

Reasons for not complaining included not knowing how to complain (n=2) or because they did not think it was worth it (n=3).

#### Inpatient services

Eight patients had been admitted to an inpatient unit as a result of being in a crisis. For the majority (n=6), this was not their first admission. Three were admitted as voluntary patients while three were admitted under a section of the Mental Health Act and one was sectioned post admission. Three of the participants had had previous experience of being admitted under a section, mostly Section 5. During the period under evaluation five of the eight respondents had been admitted between two and five times and an equal number of people (n=2) were admitted for either 1-2 weeks, 2 to 4 weeks, between 5 to 12 weeks and more than 12 weeks.

Half of the participants (n=4) reported having a care plan meeting whilst in hospital but two did not know or did not have one. For the four who had a care plan meeting this took place within three days of admission. The majority were positive about the meeting (n=3) while two reported a fair process and all (n=4) were given a copy of their care plan.

Most of the eight participants (n=5) reported having a meeting to prepare for discharge while one person did not and two did not know. Of those who did have such a meeting, four reported not being given a copy of their discharge care plan. While just one participant reported that the CRHT team had not been involved in the discharge care plan, four said that they were. In the vast majority of cases, participants were discharged back to the CMHT (n=5) while one person was discharged back either to their GP or to the CRHT.

Half of the participants (n=4) said that their stay in hospital helped them move towards recovery, develop their independence and their sense of confidence and self-esteem. Three participants reported that the range of choices on offer met their needs and wishes while two disagreed. Five participants reported that the information that they had received was helpful and three reported that it was easily available. It is worth noting that in all these instances between three and five participants neither agreed nor disagreed. Similarly five participants could not decide whether they had felt in control of their care and treatment.

In total, four of the eight participants reported they felt safe on the ward while two stated the opposite. Overall they felt staff were friendly and treated them with respect and dignity (n=7) and four felt they had enough contact with staff on the ward to meet their needs and wishes.

Four participants said they had had access to advocacy services, an equal number had not. Four answering, suggested their legal rights had been respected. Two participants did not feel the need to complain while an equal number did not think their issues were worth complaining about. However one person did not complain because they were worried about what would happen if they did.

### Rethink Recovery House

Five of the 22 respondents had been a guest at the Rethink Recovery House and stayed either just once (n=3) or between 2 and 5 times (n=2).

Two of the participants lived within 0-20 miles, two within 21-30 miles and one within 40 miles or more. The average reported stay at the Rethink Recovery House ranged between 8-14 days. Three participants reported being dissatisfied with the wait to be admitted to the Rethink Recovery House, and an equal number reported not meeting with their care coordinator during their stay.

Once they were admitted, all five participants reported that their stay helped them towards their recovery. Three reported that it helped them develop their independence while two reported that it helped them develop their sense of confidence and self-esteem. Four reported that they were offered a range of choices that met their needs and wishes; and suggested that the information that they had received was helpful and all (n=5) said that it was easily available. All five participants reported that they felt in control of their care and treatment. All participants also had a plan in place during their stay. Most (n=4) reported being given enough support to achieve their goals.

Overall most of the five participants (n=4) felt that staying at the Rethink Recovery House had been the most appropriate service for them at the time of their crisis. Once they were discharged, they were handed back over to the CMHT (n=3), their GP (n=1) or to the CRHT team (n=1).

All participants (n=5) reported feeling satisfied with the general environment and most participants (n=4) suggested that they felt safe while one stated the opposite. All participants (n=5) reported that the staff were friendly and treated them with respect and dignity and that they had enough contact with staff to meet their needs and wishes.

Most participants (n=4) provided a mixed picture (neither agreed nor disagreed) about access to advocacy services during their stay. All participants reported that their legal rights had been respected. Two participants either did not think it was worth complaining when they were dissatisfied or they complained informally.

### Skills Courses

About half of the respondents (n=12) reported being given the choice of attending the Recovery Education skills courses. For five of the respondents, this had been agreed as part

of their care plan while two had heard about them either through their carer or through another service user.

Eleven participants attended the courses and most of them (n=6) did not have to wait long to start. Most participants (n=8) reported that the courses helped them towards their recovery and an equal number that it helped them develop their independence and that they were offered a range of choices that met their needs. Six participants reported that the courses helped them develop their confidence and self-esteem, four neither agreed nor disagreed.

Virtually all participants (n=10) reported that the information they received about the courses was helpful and easily available and an equal number reported that they were given enough support to attend the courses.

All participants (n=11) reported that the staff delivering the courses were friendly and treated them with respect and dignity and eight were satisfied and did not feel the need to complain.

## **2. Carer questionnaire data**

Twenty-two carers completed the questionnaire; 12 via the online link and 10 using a paper version of the questionnaire. Six carers viewed the online version but failed to complete it. Seven of the 12 completing the online survey reported they had found about the questionnaire from the Dorset Mental Health Forum (n=2), voluntary groups (n=3) and via a friend/relative (n=2). From the ten paper copies completed, three were obtained from CMHTs, two from a carers group and five people requested copies from the University. Of these, two had been encouraged to take part by a local voluntary group.

### Demographics of the carer participants

A total of 19 of the 22 carers identified themselves as informal carers (a friend or relative of someone with a severe mental health problem) with only two having a formal carer role with Power of Attorney (one did not answer). Twelve of the 22 were involved in daily care delivery, three weekly and four monthly and one never (two did not answer). Interestingly, five did not have consent from the service user to be involved in decisions about their care. Thirteen reported not having had a carer's assessment during the evaluation period (1<sup>st</sup> May

2013 and 30<sup>th</sup> April 2014) and three did not state if they had had an assessment. The majority of carers had experience of both previous and new services; however three carers reported that they had only been in contact with the new services. All of these confirmed that they had had a carers' assessment.

Nineteen carers responded to the question, "Does the person you care for live with you?" four said yes, eight sometimes and seven said no.

In total, 19 of the 22 carers provided demographic data. Table 7 shows the distribution of age, gender, background and town respondents live closest to (these are the towns where the Community Mental Health Teams are situated). The majority of carer respondents are white, female, in the 45-64 age ranges.

Table 7: demographic data of carers

AGE	26-34	35-44	45-54	55-64	65-74	74-84	84+
	1	0	5	7	3	2	1
GENDER	Male	Female					
	6	13					
ETHNICITY	White-British	White - Irish	White-Other	Mixed-White & Black African			
	15	1	2	1			
TOWN CLOSEST TO	Blandford	Bridport	Dorchester	Shaftesbury	Sherborne	Weymouth	
	1	7	1	4	1	5	

#### Use of previous services pre 1 May 2013

Sixteen of the 22 carers reported that the person they care for had used services prior to the new service change period. All but one reported multiple service use. Two carers reported that the service users had stayed in two out of the five inpatients units. Respondents

reported other services being used including A&E, early intervention teams, consultant psychiatrist home visit, St Ann's in Poole and the Hughes unit home treatment. Thirteen carers reported being dissatisfied with the services offered to the service user.

#### Carer support

Carers were asked about the range of support they had received and were asked to identify all areas of support accessed. The findings presented therefore do not necessarily equal the total number of respondents. All carers (n=22) answered this question. Thirteen responded that they received no support during the new service period. Five had received information about mental health issues and five had attended groups with other carers. Six people reported receiving one support option only. Two people reported having three different types of support and one of these was a carer who had not used the services previously. Two participants reported having one to one support with a carer support worker and three received respite from their caring role.

Three of the 22 carers stated they were very satisfied, satisfied, or somewhat satisfied with their experience of support for them whilst three were neutral. Sixteen were somewhat dissatisfied, dissatisfied or very dissatisfied with the support offered to them. Those who reported dissatisfaction had had experience of services prior to 1<sup>st</sup> May 2013. The three carers who had not used services prior to 1<sup>st</sup> May 2013 reported they were very satisfied, satisfied or neutral.

#### Crisis Response and Home Treatment Team

Fourteen of the 22 carer respondents stated that the service user had been assessed by the CRHT (May 1st 2013-April 30<sup>th</sup> 2014), one of these said that the assessment took place within four hours of contacting the team. Two carers stated that a crisis plan was drawn up after this assessment with only one respondent saying this was followed. No one reported that this was regularly updated.

Twelve of the 14 carers reported appointments or sessions had been changed, postponed or cancelled with one respondent saying this happened most of the time. Fourteen carers answered the question *How often have you tried contacting the CRHT about the person you care for during office hours (Monday – Friday; 9am-5pm), but you were not successful?* Nine



carers said this occurred sometimes or most of the time but three reported this never happening.

Thirteen of the 14 carers answered the same question but in relation to out of hours contact with the team (evenings, weekends and Bank Holidays). . One reported this never happening, five reported rarely happening, two reported it sometimes happening, three reported most of the time and two reported always happening.

In total, 13 of 14 participants answered the question about satisfaction with the CRHT service. Only one person said they were happy with the service so didn't complain with 12 being dissatisfied. One chose to complain through the official complaints procedure, three complained informally and the remaining eight chose not to complain, selecting either "they didn't think it was worth complaining" (n=1) or "that it might make things worse for the service user" (n=7). Most of the 13 carers (n=7) chose not to complain because they thought it would make the situation worse for the service user. Three did complain but this was only informally.

Asked if they thought the CRHT intervention was the most suitable option to meet the needs of the service user, two of 14 indicated yes and eight no. One felt they should have stayed at the Rethink Recovery House and two were unsure.

#### Crisis line

All 19 respondents to this question reported being aware of the Crisis line; 11 of these stated that they had used the line during office hours and 12 out-of-hours. Three carers reported not using the line at all. One person said they had used it and answered all other questions in the section but did not specify the time of day used. Two found it easy to use at any time, seven reported it was either hard or very hard to use in office hours, rising to ten for out of hours use.

Carers were asked a range of questions about their experience using the Crisis line. The majority of these were answered negatively as can be seen in Table 8 below. It should be noted that these questions were asked in relation to using the line in general so a conclusion cannot be drawn as to whether these problems occur during a specific time period.

Table 8: Carer responses to Crisis line questions

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
I felt listened to	4	3	4	2	0
The person I talked to showed empathy	4	2	4	3	0
The person gave me useful advice	5	4	4	0	0
I rang and the phone went to answerphone	1	3	3	4	4
I felt the person was too busy to give me their full attention	1	0	3	5	4
I rang but the line was engaged	0	1	4	7	2

### Inpatient services

Eleven of the 22 carers who took part said that the person they cared for had been an inpatient during the study period but only ten people answered the majority of the questions in this section. Four said that the inpatient unit was more than 40 miles away from the nearest CMHT. One of these commented that they could only visit because the service user paid for transport costs. Another said the long distance meant that they could not visit as much as they or the service user wanted. However, seven visited either weekly or more than once a week.

Carers reported not being involved in care planning (n= 6) nor discharge planning (n=8). Of those that had been given consent from the service user to be involved in care and had answered this question (n=9), four reported being involved in care planning and two involved in discharge planning and three had not been involved despite having consent to

do so. None of the 11 respondents reported feeling satisfied with the inpatient service. Similarly with the crisis service, people were dissatisfied with the inpatient service but more (n=6) reported complaining informally in this setting. Despite this overall dissatisfaction with the inpatient service, all carers overwhelmingly felt that being admitted to a unit was the most appropriate option to meet the needs of the service user.

#### Rethink Recovery House

Four carers from the 22 reported that the service user had used the Rethink Recovery House. Half said that the house was more than 40 miles away from where they lived and only one visited daily; the rest visited less than once a month. In total two reported they felt included in decisions either most of the time or sometimes, contrasting with the four at the inpatient unit. However, those carers with experience of both the Rethink Recovery House and the inpatient units reported in a similar way to both questions; one complained officially and one felt it would be worse for the service user to complain. Two felt that this was the most appropriate service to meet the needs of the service user. The remaining two carers felt the service user should have been admitted to inpatient units. One made the comment that this should be closer to home but the local unit has since been closed.

#### Quality of care and support

Carers were asked about how they saw the overall quality of care and support for service users now in various treatment options. In total, 15 of 22 carers responded to these questions. In the main carers report services have worsened; inpatients (n=9), home treatment (n=9), day treatment (n=10), night treatment (n=12). However, a small number reported improvements in two areas; inpatient services (n=2) and home treatment (n=3).

Lastly, carers were asked how they think the change in service has impacted on their workload as a carer. Again, 15 of 22 carers answered this question with nine reporting that they do much more now (five from the Bridport area, two from the Shaftesbury area, one from the Weymouth area and one from the Blandford area) and four reporting they do about the same (one from the Sherborne area, two from the Weymouth area and one from the Shaftesbury area).

### 3. Interview data: carers and service users

In total (n=12) respondents were interviewed, including six carers and six service users. The majority of interviews were conducted face-to-face (n=11) as close to respondents homes as possible. The following locations were used; Bridport, Weymouth, Dorchester, Shaftesbury. One respondent completed a telephone interview.

The data were transcribed to provide verbatim transcripts and analysed thematically by research team members, a process that enabled cross- checking of theme identification. In total seven themes were identified including; i. Service relationships and location, ii. Communicating service change, iii. CRHT, iv. Rethink Recovery House, v. Care planning, vi. Activities/education provision, vii. Progressive steps in transition. Verbatim data is presented to support the themes using coding C for carer and SU for service user.

#### *i) Service relationships and location*

##### *Smaller local provision*

Respondents from across the region highlighted the important relationships that existed between them and the services prior to change. They felt very familiar with staff. They also appreciated having local service provision which they could access easily.

“... an advantage at the Hughes Unit where the staff knew the service users.” (C 04)

“...because they were in the same place they didn't, they knew everybody's history, they didn't have to keep looking at a computer.” (C 02)

“I miss Stewart Lodge...I think we need something more like that, where it's a smaller environment, they are very one-to-one with you...it was more local.” (SU 02)

“Home treatment team then was very small, so you knew most of them, and they came every day to see me at home.” (SU 01)

“You’re much more likely to see someone you knew and it was just, and they gave you a fantastic service.” (SU 03)

In addition, those experiencing mental health crises often felt the need to remove themselves from the home environment, or to self-refer into a unit and this was facilitated more easily when local small local units existed.

“I realised that when I get really bad I need to get away from the house, so being able to go into the Hughes Unit was a real benefit.” (SU 01)

“At times [the Hughes Unit would] even take them [patients] in as inpatients overnight, and they knew the patients and they could talk to the patients about their conditions, their feelings and so on.” (C 05)

“The little acute unit in Dorchester at 20 Cornwall Road worked very well for me, it wasn’t everybody’s cup of tea but it worked very well for me ... It meant I could be admitted when I was high or low and I didn’t stay terribly long.” (SU 06)

“It was fantastic to be able to phone up the unit and get some advice about what to take if I sensed I was going manic to avoid hospital.” (SU 03)

### *Larger inpatient units*

Larger units proving in patient care were reported as intimidating for some and less homely. The Minterne unit used prior to the service changes in April 2013 was described as,

“..quite a secure unit, so it was guarded by fences, and it was bit like a prison.” (SU 02)

“...there was nothing healing about the ward. It was bleak and it was not very patient orientated, it was rigid, for example you could only have a cup of coffee once an hour, the kitchen wasn’t opened. You were only allowed to go out for a cigarette

once an hour and the door was locked. Even if you weren't a sectioned patient you still had to be locked in." (SU 06)

The Minterne unit is now closed, with provision being made at Waterston. When commenting on this new facility it was suggested;

"Now it's Waterston it is better, it's a rebuild and they've got pictures up on the walls and it's all quiet and cosy and comfortable." (SU 02)

"It's a lot better than it was before ... but there's definitely still things to do. I mean occupational therapy and stuff; it was only for about four hours a day and two hours in the morning, two hours in the afternoon, and then it would depend who was on as to whether they'd say open up the pool room or something in the evening." (SU 05)

After waiting for a bed, Linden was viewed positively by one service user who had accessed the service as an inpatient.

"Well when I got into Linden, because it was a while to get a bed ... the staff there were really nice, and they had good OT there ..." (SU 05)

"The Linden Unit itself was like the Hughes Unit used to be before the occupational therapy went." (C 05)

### *Distant locations*

Respondents reported having to travel further for inpatient stays and one carer felt this could be detrimental to recovery.

"In terms of locality the situation is fairly disastrous because if someone needed to be in a secure unit where they would go would be so far away that they would be cut off from family and friends." (C 01)

“Well I sort of see [name of worker] once every three weeks which is fine, but in a crisis then I would let it get to the crisis stage because I am aware that my family you know will have to travel an awful long way to see me if I went into a secure unit or into Weymouth.” (SU 04)

“... for friends and so on visiting [Linden unit] it was a nightmare. It was a lengthy journey. We got no help at all with fuel.” (C 05)

“Yeah, Linden was good, apart from the fact it’s so bloody far away.” (SU 05)

This fear led to reluctance to seek help.

“I am sure I would put off contacting anyone until it was in the crisis stage because of the distance that my family would have to travel to actually see me.” (SU 04)

## *2. Communicating service change*

### *Consultation*

It was apparent that service user and carer involvement in the consultation process prior to service changes was varied. One service user found out about proposed changes when residing in a local unit and then gained further information through the media. Some of the respondents interviewed remembered receiving written information on the changes in the form of leaflets, but reported really discovering changes when they or the cared for person next required care. Some reported hearing about the consultation meeting by chance.

“Rumours, the staff told us. Well [pause] you could believe the staff I mean there were that many of them who knew the rumours [yeah] because of course they were facing not knowing where they’d be working or if they’d have a job.” (SU 03)

“I just happened to hear about it from somebody else ... and we all went to a meeting in January, I think it was January 2012. To say we were involved, no we weren’t because we weren’t invited we just happened to hear about the meeting and went along.” (C 03)

The same respondent reported they were not being listened to during the consultation process,

“I can’t remember the name of the person who did the consultation, but to be standing in a room full of people saying this isn’t going to work, we know this is going to end in tears, this is not right and not even to ask why we’re saying that, I think it was, in my opinion, it wasn’t a consultation process, it was a box ticking exercise, they didn’t listen.” (C 03)

In contrast, two service users (SU 05 and SU 06) and one carer (C 05) had been involved and had attended a consultation meeting at Salthouse.

#### *Expectations of the new service*

There seemed to be confusion as to the role of the CRHT. One service user had started a peer support group for anyone to attend for friendship and to talk, when issues with the CRHT team had been discussed,

“A lot of us have had mixed dealings with crisis and what we have been told, some people have been told that they’re just a telephone answering service and some have been told that they are not twenty-four hour.” (SU 01)

“I think I’ve phoned the Crisis team because I was very depressed over the weekend [yeah] and spoke to my care co-ordinator and what they seem to do is, they do answer the phone but they get someone to ring you back who can deal with it. And it wasn’t particularly helpful but unfortunately when you’re severely depressed and feel suicidal [yeah] people, there aren’t any, it was phone support but it was pretty useless to be honest. (SU 03)

There was also a sense that the services that were promised during the consultation process failed to come to fruition.



“...it did actually transpire that the dual-partnership of community care and hospital care wasn’t running together and various things that they said they were going to undertake, weren’t undertaken like facilitating transport for people who were mentally ill from west Dorset to wherever they needed to be, things like that....The beds, the number of beds, apparently, in different places; the number of staff in different places. They said they’d undertake those two things and they haven’t. I think the number of crisis response staff as well, and untrained staff in that team haven’t.” (C 06)

“...I mean they promised things they have not honoured like a crisis house they intimated might be in Bridport there might be one there, no that hasn’t happened. They tried to sweet talk us an awful lot and they’ve broken, I wouldn’t say promises but information like a 24/7 access to, I can’t remember what was it now, oh Crisis Home Treatment Team, that hasn’t happened, they don’t come out in the middle of the night, absolute load of nonsense.” (SU 03)

### *Education provision*

It was apparent that the provision of education courses was not known widely;

“A lot of people don’t know about the recovery education service, a lot of people who that come to my group have never heard of it.” (SU 02)

“There is I believe a college that they run where you can run courses for, you can go if you want to do wellness courses and things like that, but none of that information has come from the CMHTs, it’s all come from word of mouth or going on the website.” (C 03)

### **3. CRHT**

The early Crisis line was viewed positively with some service users suggesting,

“I thought that was a good response... for night time really, when you didn’t have your CPN or someone to talk to.” (SU 02)

“It was very good, people came out once a day sometimes twice a day I was very depressed, suicidal at that the time. And I used the Crisis line at night and people were very helpful in re-framing my panic. And their visits were very useful.” (SU 06)

However, a number of issues with the current service were reported and some respondents felt the Samaritans service was more helpful.

“I find the Samaritans easier to talk to... It’s very gentle, very calming. They put me at ease.” (SU 02)

“...to ring the Samaritans and actually the Samaritans were quite helpful.” (SU 01)

“And they (the Samaritans) were far, far more help than anything that the NHS was offering.” (C 05)

There were also issues with the responses received from the CRHT reported by carers and service users, where needs in a crisis had not been met;

“Twenty-four seven crisis response, crisis response team which sounds like if there’s a problem somebody will come out, in actual fact it’s one nurse, one auxiliary, one telephone, you can’t get hold of them, they won’t come, I’ve been told on, I was told when my family member, another family member was ill in 2013 after the local service was shut, I was told that they don’t come out to North Dorset.” (C 03)

“The Crisis line for one thing can take hours to get through. Either you’d ring and they’d say, “Ring back I half an hour, 45 minutes,” .... And then when you got through they often wouldn't know what was going on with you.” (SU 05)

“Well, provided you get the people you know, and have had long-term dealing with, it’s okay, but if you get somebody who’s only got to type in the name and look at the computer screen to see what meds they’re on, what condition they’re diagnosed

with and one or two other bits and bobs about them, then it's a waste of time." (C 05)

"If you get a really good person on Crisis they'll look up your notes and ring you back, and they'll talk properly to you...if you are unlucky they'll tell you to have a hot drink and whatever." (SU 01)

"...the crisis team who you used to phone up or if you get blooming hold of them, you might speak to anyone, so what else ...As far as I'm aware if I need hospital there's a big chance I'll end up on a lock ward." (SU 03)

The CRHT was perceived as particularly difficult at times of acute crisis at night.

"Often it is difficult to get through to the Crisis team particularly at night, it's often the case that notes aren't available... the Crisis team will often say phone back in 10 minutes or you can't get an answer at all." (C 01)

Staffing was raised as being particularly problematic.

"And you could hear telephones ringing in the background and all the rest of it, and the person going frantic trying to answer all the calls, get people off the line as quickly as possible and so on. It was grossly understaffed." (C 05)

"The situation is that although there are meant to be I understand at least two people on duty so that someone can go out if they are called out. But that very, very often is not the case so there is nobody available." (C 01)

Two carers spoke about the lack of services which facilitate the transition between community and inpatient crisis care.

"This was at the end of all the problems that we did have, that we could actually phone them up and if they had a bed, they would admit her and give her Lorazepam

to calm her down and then monitor and then slowly release her back into the community again.” (C 06)

“And you then get discharged maybe to the Hughes, you get transferred to the Hughes Unit [unclear – 02:12] stay there which is a very good kind of introduction back into the community because it’s a different regime that’s more ... Oh it was a fantastic unit I could give you details about it.” (SU 03)

#### ***4. Rethink Recovery House***

The Rethink Recovery House was perceived as difficult to access by one service user, as there was a requirement for inpatient treatment within three months of a previous admission.

“I needed to go in somewhere, there was nowhere for them to offer me and it took a lot to get into the Recovery House,” (SU 01)

It was reported that the Recovery House was not always full and that it could be used more often,

“This is really wrong, that there [are] beds in here free and probably people out there that need them.” (SU 01)

“I think the Recovery House could work well if it was utilised more, I don’t think it has enough people in it not many people get referred there which I think is a pity.” (SU 06)

A further service user had used the Rethink Recovery House when in crisis and following Community Psychiatric Nurse (CPN) and psychiatrist recommendation and found the experience positive.

“I felt the Recovery House was really helpful, I found them really warm and friendly in there. We played games and it was a nice environment.” (SU 02)

However it was suggested that the Rethink Recovery House might develop the range of activities offered;

“I feel they could do more activities with you. Because all the activities I did when I was there was the bicycle and playing scrabble. At Stewart Lodge... you had more activities organised like group therapy, meditation, art workshops....” (SU 02)

One service user had declined to use Rethink Recovery House due to the locality and due to an expectation for patients to be able to cook and clean for themselves.

“To be honest I declined it because I felt that I would be more unsafe... .. in the Recovery House you have to be able to cook for yourself and clean your stuff and it’s in Weymouth which is miles away. So basically I had to have no visitors, no friends. I wasn’t in any fit state to cook for myself or sort my own medication out.” (SU 05)

One carer also reported location difficulties associated with Rethink Recovery House use.

“He stayed for two weeks in The Recovery House. He rang me every night to say please can I come home, please can I come home . . .he hated being so far away from home . . .”(C 03)

Whereas when based more locally there were less difficulties,

“ . . . I was able to go and see them, they could say mum can you please come and see me and I can nip over and see them after work, especially Sherborne. . . To get to Weymouth, to get to Dorchester, sorry to get to the Forston which is the outside of Dorchester is a good hour. Weymouth is a good three hour round trip from where we live, more if there’s a lot of tourist traffic in the summer.” (C 03)

## 5. Care planning

Not all service users were able to say if they had received a care plan or discharge plan and one carer commenting the cared for person, “had never received a care plan”.

“I wasn’t given a copy, I don’t know whether he was given a copy.”

(C 03)

“Care plan? I don't know, I ... there was some paperwork they gave me in Forston but to be honest I wasn't in any fit state to read it.” (SU 05)

“Well we have had meetings. I don't know whether a care plan actually exists.” (C 05)

Others however had had care plans and discharge plans.

“I found they [Recovery House] had put a good plan together with me, a care, plan, which I kept to.”

“ I would carry on seeing my CPN.” (SU 02)

“Yeah, my oldest son has a care plan. Son number two has, it’s more a statement of intent that if he becomes ill again ...” (C 03)

One service user reported to be happy with their care plan, which had been developed in partnership with the service user and professionals involved.

“My crisis plan is very well documented and is very thorough and I go by that because that contains early warning signs, what to do at certain stages, when to phone in treatment.” (SU 06)

This service user had also completed an advance directive, "...like an advance statement which is now also on the computer so that pops up if I was to ring..." (SU 06)

## *6. Activities/ Education provision*

There was a sense that more activities and education was needed for service users;

"I feel that what people need is things like occupational therapy, things to do." (C 01)

"And also they used to go on outings, community outings once a month, I think it was, on a particular day which [name]who still, I think, very much resists her diagnosis, was prepared to go on and really enjoyed. They went to Lulworth Cove and things like that." (C 02)

Respondents placed a high value on service users receiving occupational therapy to aid their recovery. The occupational therapy service pre-service change was highly regarded by respondents; however some respondents felt that improvements were needed in the new service provision:

"There was an excellent occupational therapy both for inpatients and particularly for outpatients. This helped outpatients and inpatients to develop a social network, to do things with their hands, which is an extremely important aspect of occupational therapy." (C 05)

"There doesn't seem to be anything (post service change). There used to be ... there was OT available and all sorts of things." (C 03)

"I mean I know they've opened this thing on Down Street but it's not the same as having regular OT and it's ... I don't know. Yeah, I don't know, but I mean you used to be able to drop in and stuff." (SU 05)

“As an outpatient ... they did various things like an explorers group where it was a mixture of outpatients and inpatients and they’d take you somewhere, just for a coffee or something, or a walk or whatever.” (SU 05)

A number of service users had taken part in new education courses provided finding these helpful;

“I’ve been on a lot of the recovery education skills ones [courses], and I find the peer specialists are excellent and when you hear their stories and then they’re stood there training, it gives you hope... I’ve gathered friends too.” (SU 01)

Two felt they could be improved;

“Yeah they were quite good, they were quite useful. Sometimes they were a bit vague, but they were quite good. I feel they could be better in developing onwards....how you can develop or maybe get jobs.” (SU 02)

“...well, they’ve introduced these courses which are supposed to take place fairly spread across the whole trust, and they are things like mindfulness and recognising your symptoms and all the other sorts of things ... They’re things you talk about ... not actually hands-on-doing-things type courses ... these ... happened in our area here far, far later than elsewhere and in far, far smaller quantities. Secondly, later on was introduced a thing, a type of course which I think has now stopped because they’re knocking the Hughes Unit around, physically the building, to turn it all into offices.” (C 05)

### **Phase 3. Staff and stakeholder views**

#### **1. Staff interview data**

Five front line staff (one community team and four inpatient services) from across the region agreed to take part, presenting and speaking from a specific point of view.



### *i) Transition period*

Pre-service change the advantage was having both services on the Waterston site so, if one side was low on staff, the other side could help out. Staff 4 felt that this worked to a degree, however it did not meet the crisis needs of service users because it operated as an outreach service and not as a crisis service, making it varied and unpredictable.

The service re-design was based on national guidance and learning from other crisis services around the country that were reported to be “*shining lights*”. Changes were promoted by an interest in the challenges faced by rural areas as well (Staff 4).

There was recognition that pre-service change; there were more local, smaller inpatient units, which provided tranquil environments especially for those with repeated admissions. The environment and staff group was familiar to service users, which caused less distress. The CRHT was based in the locality that it served with good interface between the crisis workers and the local Community teams (Staff 5). The closure of the beds impacted on the availability of acute beds when someone had been assessed or was in a crisis, with some service users being admitted out of area on occasions (Staff 5).

It was suggested that communication still needs working on; services used to provide leaflets however these become out-of-date so quickly, so they are no longer used (Staff 4).

### *ii) Service location*

Front line staff described how a number of carers had said they were struggling with the increased distance to travel. This issue is exacerbated when carers rely on public transport (Staff 4). One member of staff also pointed out the distress felt by some inpatient service users if they are cared for a long distance from their communities, for instance being able to collect personal belongings or toiletries or being able to check their home was safe (Staff 5). However, not all staff agreed. Staff 3 felt that distances were not necessarily an issue as transport is provided; suggesting that the mental health service is the same as it is for acute services.

The rural aspect of west Dorset was highlighted as an issue for both the community team and CRHT (Staff 3 and Staff 5). There is also an issue with the distance travelled for the CRHT.

### **iii) Technology**

A lack of appropriate technology results in staff having to go back to the office to input into service user records, which is wasteful of valuable time (Staff 3). However, Staff 3 suggested that the technology issue is currently being addressed and that staff should be able to complete service user records “*on the road*” from early 2015.

The rural locality was also raised as a barrier to the community team visiting service users due to the travelling time and distance, which results in reduced hospital visits from care coordinators and support workers (Staff 5).

### **iv) CRHT Team**

It was highlighted by Staff 3 that out-of-hours support needs reviewing. Staffing is at recommended levels; however it was felt that having two people working on some nights was not adequate to cover the whole locality.

Staff 3 felt that the CRHT was good in terms of responsiveness and that it has access to two consultants who come to reviews.

Adequate staffing at night time was reported as being more difficult (Staff 4). One respondent pointed to gaps in the CRHT team cover in the early hours of the morning in the emergency department (ED) resulting in patients being inadequately looked after, stressing that ED was not a place of safety (Staff 4). Another respondent noted that there was a need to invest more in psychiatric liaison service so that the CRHT can concentrate on their core business (Staff 3).

The pressure on beds was highlighted and the need for “stepping stone” accommodation highlighted (Staff 5).

### **v) Care Planning / Discharge Planning**

All staff interviewed considered that care planning was better now following the new service design and the introduction of RIO, with two staff members (Staff 1 & Staff 3) suggesting that care and discharge planning was historically a weak area. The practice is more coherent now, with shared care plans between parts of the services (Staff 5).

Service users are involved in their care plan. The process is explained to them on admission. Staff 3 felt the care plans and risk assessments are recovery focussed and people are offered home treatment. This gives them a chance to input to the planning process and a copy is printed off and given to the service user who can make changes.

However, Staff 2 highlighted that although care planning is "*much better now*", it can also take much longer which can have an impact on the ED. Staff 3 suggested that although care plans developed by/with the CRHT are good (substantiated by Staff 4), that inpatient care plans are not always written with the service user. However, there is a Trust action plan in place to address this (Staff 3).

Discharge care plans are well established now. Meetings with service users are happening once a week to look at barriers to discharge (such as housing issues) on top of the daily clinical meetings. Service users are involved (Staff 5) and no discharge takes place without a care plan (Staff 4).

Staff 4 felt that whilst a care coordinator is nominated within 24 hours there can be delays in discharge, although letters to GPs were sent more promptly. Staff 1 also felt that discharge planning could still be improved so that service users have continuing support when people go back home to achieve their goals. People might feel safe in the Rethink Recovery House because they are away from what may be going on in their life but they may still need support once they get home. Therefore, care planning and organising the right support/involvement of Care Co-ordinators still needs some improvement (Staff 1).

#### *vi) Service still being developed*

In general there was recognition from the staff that the new service was still in development and that there was still work to be done to improve (Staff 4).

There was recognition that work is required on improving public relations, especially with the politics of bed closure and service users and carers having to travel further (Staff 4).

In terms of accessing the ED, Staff 2 felt that work was still needed for both the ED and CRHT team staff in terms of how each service could support the other in ensuring service users with mental health problems were well treated (e.g., ED staff to know what the CRHT

team do and how they can help; and the CRHT team staff not sending service users to hospital unless they were physically unwell).

However, there was a difference in opinion as to how well the changes had been publicised and what people (staff and service users) knew. Staff 3 considered that people are now aware of the Rethink Recovery House; and Staff 4 felt that it's taken quite a while for the staff team to catch up with the process. However, staff felt that now everybody knows to contact the CRHT when someone is in a crisis.

A discrepancy between service users already in the system and new service users was highlighted by Staff 2, who felt those not in the system and new users were not necessarily aware of what is available. It was also noted by Staff 2 that some service users are accessing ED inappropriately and that a place of assessment/safety is required in Dorchester without involving ED.

#### *vii) What's working well now?*

Two staff members (Staff 4 and Staff 5) reported that the CRHT have merged into one new team. This presented some challenges with people getting used to new colleagues and new ways of working. On the whole it is working well, the team is described as cohesive and being well led, with a shared vision, common goals and a single operational policy.

The new service is also very responsive. Staff 4 felt that target times in A&E were met and that the service provides good home treatment to people in west Dorset. Staff 4 felt that accessibility of the service overall has been greatly improved

Timeliness has improved with the establishment of the CRHT. There is a single point of entry. Any request for a bed or urgent assessment goes to the CRHT, which was considered to be clear to all (Staff 4).

#### *viii) Team working across agencies / services*

The lack of psychiatric bed availability to enable transfer out of the emergency department was now considered to be problematic by Staff 2, who mentioned that if service users need to go to Bournemouth, there are issues about taking people there. They reported that the Police consider it is not their problem and that the Ambulance service is not aware of

what they should be doing or where they should be taking people (Staff 2). However, Staff 3 felt that there were good working relationships between CRHT and Waterston as they share the same site, which enables facilitation of early discharge from Waterston. This was not felt to be the same for Linden, which Staff 3 felt was “more disjointed” as not on the same site and therefore travelling distance was an issue. The CRHT and Rethink Recovery House were also felt to work well together (Staff 3).

#### *ix) Home Treatment*

Due to the reconfiguration of services in west Dorset, Staff 4 highlighted a reduction of nearly 40% of beds in west Dorset (Stewart Lodge, Bridport, Weymouth and the Minterne unit) This means more people who would previously have been admitted to hospital are now treated at home. Staff 4 felt that people get better by being treated at home than before and reported that the bed usage in west Dorset is about right.

Staff 4 felt that the care culture has changed in the service but not in the population it serves, as some people expect to be admitted to hospital when they are in a crisis, which can generate disgruntlement. The CRHT act as gatekeepers and facilitate discharge (Staff 4) which is considered positive.

#### *x) Rethink Recovery House*

The Rethink Recovery House was considered to be a useful addition especially for those admitted previously to hospital but who may no longer need that level of clinical staffing (Staff 5). Staff 5 also felt that the Rethink Recovery House focuses on recovery and that it also functions now as (a place for) planned respite.

#### *xi) Support / preparation for staff for service changes*

Support (meetings, supervision, handovers) to facilitate new roles were viewed positively by Staff 1, who was supportive of the close working between the Dorset Clinical Commissioning Group (CCG) and the CRHT.

However, Staff 2 reported they had received no support / preparation.

## 2. Stakeholder interview data

The following presents the interview data recorded from the telephone interviews of stakeholders representing different perspectives including user and carer groups, Locality Chairs, the Dorset Health Scrutiny Committee. It has been presented using the headings from the interview schedules.

### *i) Previous Service*

The previous system in place at Bridport and Sherborne was described as easily accessible both from a transport perspective and as an informal self-referral drop-in centre that could be accessed when needed to prevent a crisis. This service was often described as being responsive where staff, service users and their carers knew each other well. However staffing levels were problematic prior to changes (TI 06) and also the service was not used as it should have been and there needed to be a recovery system (TI 01).

The location of services was also important for other reasons. For example Weymouth and Portland were fully stretched due to the number of people diagnosed with schizophrenia in particular, which meant it was harder for other people to access the service when needed (TI 03).

### *ii) Transition period between services*

When respondents were asked about the transition period, some felt they had been more involved than others (TI 06). Those more fully involved in the process, described a lot of discussions within teams or at senior level, so it did not feel like an overnight change and there were perceived opportunities for open communication (TI 00). However some respondents were less positive about the process (TI 06). Another respondent suggested the information given was not helpful (TI 00).

It was felt that assessments were taking place in some areas (Weymouth and Portland) but more people were placed out of area as a result of bed reductions (T1 03). People with psychosis and schizophrenia were discharged from secondary care mental health pathways

which was seen as a good thing, however no extra resources were provided in the primary care system to provide ongoing care (T1 03).

### *iii) Post introduction service*

It was felt that the new service tries to promote care planning and prevention of crisis management, however it relies on people being well enough to recognise that they need help (T1 01).

The fact that the service was no longer local was acknowledged as a change that had affected some users. However one stakeholder felt that if a person was unwell the location of their care was not a priority but the care should be. There were issues with travel, especially for carers who want to be able to visit their loved ones.

One participant was disappointed, that fewer inpatient beds were going to be available therefore the service would be reduced (T1 06). GPs were reassured that money would be made available to pump prime community services but commented that this was not delivered (T1 06).

One respondent suggested that there is reduced communication between CRHT and GPs, however the new consultant is working hard to build bridges, and it may be too early to tell if there has been a cultural change (T1 06).

### **3. GP Survey data**

In total eight questionnaires were completed and subjected to descriptive analysis. A further two GPs logged on but did not complete the questionnaire.

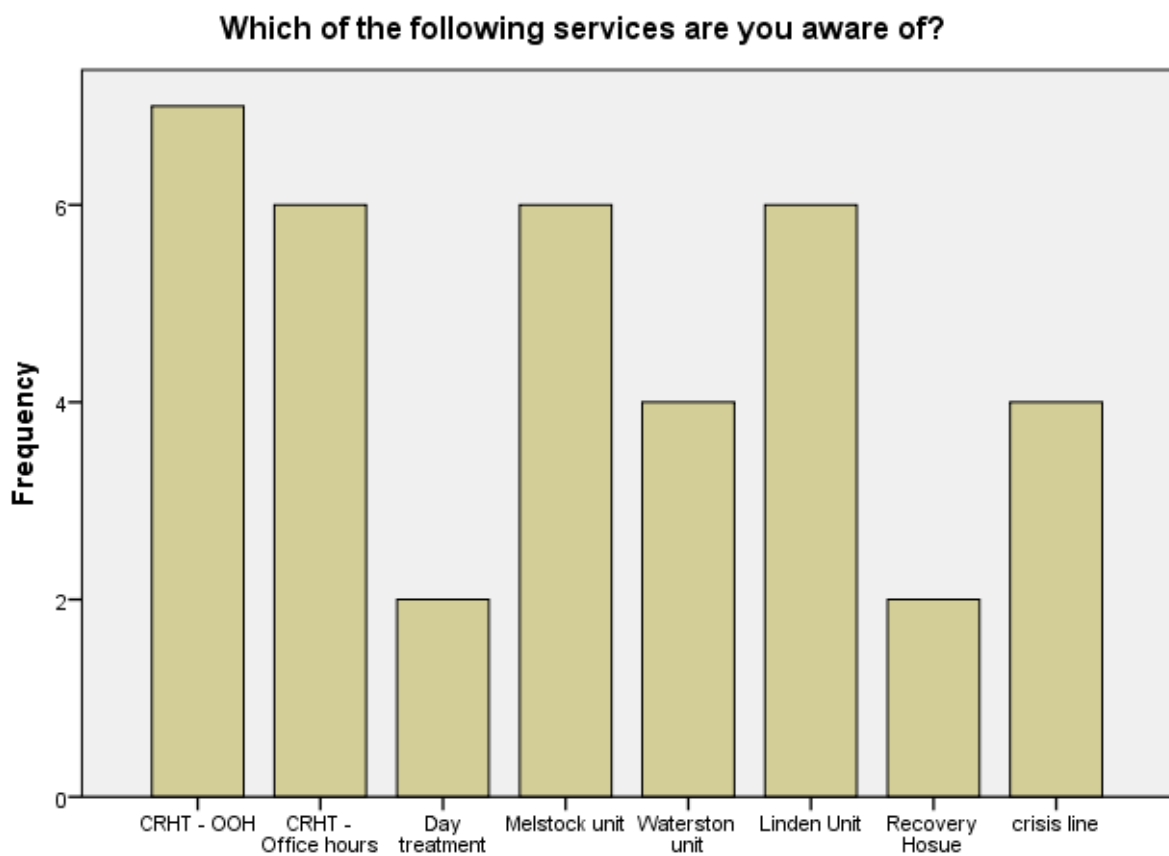
In total, five reported coming from Weymouth, one from Blandford and one from Dorchester. There were no respondents from those areas experiencing inpatient bed closures.

Questions centred on satisfaction with the CRHT, the MHUCS model as a whole, the change in quality of care for patients since the new service was introduced, workload impact and patient feedback. Many of the GPs in this small sample answered 'neither agree nor

disagree' or there was an even spread across the spectrum meaning that identifying trends has been difficult in this sample.

Graph 1 represents the awareness of the services related to the new service. GPs in this sample show good awareness of some of the services available, the CRHT especially. It is interesting to note that despite the Rethink Recovery House being located in Weymouth, three of the local GPs were not aware of its existence.

Graph 1: GP awareness of services from MHUCS



In total, five out of six of respondents agreed or strongly agreed that there was poor communication between the surgery and the CRHT team.

GPs were invited to offer qualitative comments at the end of the survey. Three specifically made comments about the Weymouth area. These indicted problems in the area with “poor



provision”... “impacting on primary care”. There was the suggestion offered to separate Weymouth from west Dorset as the incidence of mental health is much higher.

## 6.0 Limitations

Prior to the discussion it is important to note the limitations of the study.

The pre-existing data used for the report was not collected for research purposes and spans periods of time when different reporting systems were in place. The IT systems changed prior to the introduction of the new service and not all data had been migrated to the RiO system. This may mean that changes in data could reflect more rigorous and reliable reporting rather than actual service changes. It is difficult to compare the staff data with the absence data as some data for CMHT staffing was missing.

There were more limited responses to the service user and carer survey than anticipated, despite extending the data collection period and increasing the availability of paper based questionnaires. Furthermore not all surveys were fully completed resulting in lower responses for particular questions. In addition, actions taken by a local interest group to encourage survey completion were not part of the planned project recruitment strategy and not subject to ethical approvals which seek to ensure an unbiased approach to recruitment. As the survey was used to recruit volunteers for individual interviews, the limitations presented above have also impacted on this stage of data collected. Those service users completing the survey were located in Dorchester, Bridport and Shaftesbury.

It was not possible to identify trends in the GP online survey as the sample replying were small and provided disparate feedback.

The number of staff volunteering to come forward for interview was particularly low, with only five respondents, again despite employing various recruitment strategies. This may have been impacted by a management restructure process that was being implemented during the evaluation period.

## 7.0 Discussion

The discussion reflects the emergent findings from the range of data collection approaches employed, identifying any corroboration seen across the sources.

### Incident data

Comparisons of the incident data prior to and following service change show an increase in overnight or one night stays, though these remain low overall. Additionally there is an increased incidence of self-harm, a number of which are medication related. These findings were not corroborated in any other data obtained, but highlight an issue that may warrant exploration.

### Introducing change

Stakeholders had commented that the previous service was not always well staffed and there were issues with inappropriate use. It was evident that those service users, carers and stakeholders responding had had varied involvement in, and information about, the service change. Whereas some felt involved and well informed, others were reliant on speculation and media reporting. There was also a feeling from stakeholders that the transition between services was not as well funded and managed as it might have been. In addition, some expectations of the new service do not seem to have come to fruition, one example being the provision of a Crisis House located at Bridport.

There also remains confusion about service provision, in particular the role and availability of the CRHT and the provision of education services. Additionally, whilst having a generally good awareness of services, GPs were less aware of the existence of the Rethink Recovery House. Staff commented on the need for on-going communication with service users about the new service provision. They felt this was particularly needed for new service users coming into the system, but also would help current service users.

### Impact of service change

Staff recognised that service changes had impacted on service users and carers, particularly due to local bed closures and the resultant increased distances travelled to access community and inpatient services.

Service users, carers and stakeholders felt important local relationships had been lost, as had the ability to easily access local services when needed. Respondents reported having to travel further to access services, which was particularly difficult for those reliant on public transport. Some staff agreed this was an issue, whereas others were less concerned suggesting the service provision was comparable with acute health services. Additionally, there was a view that occupational therapy services seen as vital for recovery had been reduced and that the education courses provided, whilst welcomed, were not always meeting needs.

Staff themselves acknowledged the difficulties of working across a geographically spread rural location. It was seen as a particular issue for the community and CRHT, an issue compounded by the lack of available technology to assist community working.

### Care planning

Care planning is a central tenet in the delivery of a recovery focussed crisis service (DH 2007; NICE, 2012; DH and Concordat Signatories 2014). Staff suggested care planning was better following the service redesign, as a result of using the RiO system. There was also some progress made in working collaboratively with service users to develop care plans. However, it was highlighted that care planning can cause delays in the ED and that inpatient care plans are not always developed with service users, though the Trust have an action plan in place to address this.

Service user feedback seems to support the staff experience, as not all remembered being involved in care planning and not all had received a copy of a care plan. Carers also reported not being involved in care planning.

Staff confirmed that discharge planning was supported by care plans delivered with user input, however there were still areas requiring improvement and care planning could lead to delays in discharge. One member of staff felt discharge plans were not always effective and there was room for development. This seemed to be borne out by varied service user experiences, where some recalled being involved in preparing for discharge and others did not.

#### Crisis Response and Home Treatment team

Feedback from service users suggested this service was generally positively viewed, with favourable assessment and a range of treatment offered. This said, some people have had difficulties in getting through to the CRHT and this was more problematic out of hours. However, it was suggested that service users were not always clear what the service included.

In contrast, carers presented a less positive picture suggesting they felt the treatment received was worse. Three respondents using the services for the first time after the 1<sup>st</sup> May 2013 were less negative than those with experience of the previous service.. These respondents had difficulties accessing the CRHT, especially out of hours and most felt the service user should have been admitted to an inpatient unit at the time of crisis.

One staff member reported the CRHT as working well in terms of responsiveness and felt the service was providing better treatment for people at home. Other staff also suggested that the users were benefiting from receiving treatment at home. This suggests the service is facilitating home treatment for users who would otherwise have been treated as an inpatient, thus supporting current policy (National Audit Office, 2008). However, it is also worth noting that whilst aware of the service, GPs were unsure how satisfied the service users were and there were concerns that the communication between the service and GPs could be improved. In addition, the majority felt the communication between general practice and the CRHT team was poor.

Staff also commented that whilst CRHT assessment waiting times were being met and ED , there was a need for the ED and CRHT to work together more effectively. A particular related issue was cited as the pressure on remaining inpatient beds and it was suggested

that there is a need for a stepping stone service to bridge the gulf between inpatient services and community care, which is not necessarily being met.

#### Crisis line

Awareness of the service amongst the service users responding was high, and use was also significant. Reported experiences were varied, with some experiencing a strongly supportive service whereas others reported difficulties in access and treatment. Carers also experienced difficulties accessing the service and when they were able to get through they did not feel they were getting useful advice or being dealt with effectively.

Employing a support line system across the region means most staff taking calls were not familiar with individual service users and needed to access individual notes and care plans. However, there was inconsistency in practice and users suggested staff often failed to access case notes resulting in inappropriate advice being offered. Interestingly, some service users saw the Samaritans (an open access support line) as offering a more supportive service. Despite these difficulties, most service users and carers were not submitting formal complaints, for a number of reasons; such as a lack of understanding of how to complain and fear of making the situation worse.

Staff reported that whilst the service was fully staffed, the current staffing levels at night (two) were not adequate, although they are in line with guidelines. The perceived lack of capacity resonates with user and carer experiences. When calling the line they waited a considerable time for calls to be answered, often heard phones ringing in the background, were diverted to answer phones and waited for staff to call back.

#### Inpatient services

Changes to the inpatient service included the closure of beds and of particular units. As mentioned earlier, the closure of local units has caused difficulties in access, particularly reported by carers but also noted by some service users. In addition, stakeholders suggested that bed closure had led to more people being placed away from local communities and family.

Some carers felt the support offered from the new service was worse, though this was not a consistent view, with a small number of carers suggesting the new inpatient service and home treatment service were better. In reviewing the questionnaire responses, all carers who had experience of both pre and post service change rated services being worse or somewhat worse since the change and suggested this has impacted on their workload as a carer. . Despite the problems there was recognition that the inpatient service was the most appropriate placement at the time of crisis.

Service users seemed to have a more positive view of the services overall. One large inpatient unit (now closed) had been intimidating and rather “*prison like*”, with the newer units comparing more favourably to this as they were more homely. Activities offered were viewed positively, though ideally more would have been made available. One service user had complained about the service received, the others had mixed views in terms of safety, information provision and access to advocacy services. The majority felt they had been treated with respect whilst using the service.

Staff reported the benefits of co-locating the CRHT within an inpatient site as joint working was perceived to be better. It is interesting to note that GPs located in Weymouth felt there was poor provision in the area and suggested that given the higher incidence of mental health issues it should be managed separately.

#### Rethink Recovery House

The Weymouth located Rethink Recovery House is recorded as running with a low occupancy rate of 34%, something that has also been commented on in the service user and carer interviews. The reasons for this are likely to be complex though it is interesting to note the location of the unit has been problematic for some service users and carers and some did decline invitations to stay there for this and other reasons. For example, one person had heard about a resident’s suicide and another suggested they didn’t feel their needs would be met as they understood they needed to cook and clean for themselves and didn’t feel well enough to do this. One carer commented on the problems caused for a family member who felt isolated whilst staying at the House due to the distance from home. Currently the

majority of guests are from Weymouth, Portland and North Dorset, though there are increasing numbers attending from both Dorchester and Bridport. Furthermore, three Weymouth GPs were unaware of the service. Staff felt that while there was more general awareness of the service this was still developing. Both the location and continuing lack of awareness of the service are factors, which may be impacting on service uptake.

When accessed, the Rethink Recovery House was reported overall as being helpful to recovery and providing a safe environment. Those carers with experience of the Rethink Recovery House were mainly positive about the service, though they were not always sure this was the most appropriate service for the user and not all had felt able to complain. Staff suggested the House had been a useful addition to the service and also provided for planned respite. The areas identified as issues related to delayed access and one service user felt the services offered needed development to include more occupational therapy and varied activities.

## **8.0 Recommendations**

The findings support a number of recommendations for consideration by the commissioner and service providers.

- Consider launching a campaign to communicate the new service provision which includes its scope and makes clear the role of different services
- Review incidence of self-harm and consider further exploration as appropriate
- Monitor the achievement of action plans to ensure service user involvement in care planning
- Continue with plans to improve technology use for community team and Crisis staff working remotely
- Review the ability of the CRHT to respond to service user and carer needs, especially during out of hours
- Review the provision of step up and step down services between inpatient and community services
- Develop mechanisms to improve communication between the CRHT and GP surgeries

- Review investment in staffing the Crisis line, making technology available to allow easy access to service user records and developing a standard for telephone service response
- Discuss whether Weymouth should be viewed as a specific area of need
- Review the culture, processes and mechanisms in place to support formal service complaints
- Reflect on ways in which the use of the Rethink Recovery House might be increased which should include information provision to local GPs
- Explore the potential to develop activities offered at the Rethink Recovery House and through inpatient services
- Review current occupational therapy and educational course provision and its profiling

## 9.0. Conclusions

Overall there was a general lack of engagement with the evaluation with low recruitment seen in all phases of the study, the exception being more buoyant uptake from those service users and carers linked to an interest group located in an area affected by unit closure. There was particularly poor engagement from staff, which may reflect the impact of a re-organisation of local management set in train during the study. This said, any explanations for the overall low recruitment can only be speculative.

Despite the low response, a number of key findings have emerged. Those taking part have been able to provide some insights into their experience as service users and carers. In addition there is feedback available from a range of stakeholders, GPs and some staff. Recommendations arising from the findings have been made and are available for the consideration of the commissioner.



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