Agenda Item:

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	16 November 2015
Officer	Director for Adult and Community Services
Subject of Report	**Dorset HealthCare University NHS Foundation Trust Care Quality Commission (CQC) Inspection Outcome Report 2015**
Executive Summary	The CQC undertook a comprehensive announced inspection of Dorset HealthCare University NHS Foundation Trust (the Trust) in June 2015. They inspected 14 core services and 2 specialist services against five domains of quality: safe, effective, caring, responsive, well-led. The final reports were published on the CQC website on Friday 16 October 2015. The overall Trust rating is 'Requires Improvement'. The CQC expressed their clear confidence in the Trust and that they have seen major improvement. In the body of the report, the CQC were very complimentary about many services and found: • Kind, caring, compassionate and passionate staff who treated people with dignity and respect, want to deliver good quality care and want to improve; • Good multidisciplinary team working in many areas across the Trust; • They observed outstanding and good care and treatment in both community health and mental health services. • Areas rated as Outstanding: ~ acute wards for adults of working age and psychiatric intensive care unit; ~ the community forensic mental health team. • Areas rated as Good: ~ community services for people with a learning disability; ~ forensic in-patient/secure wards;

	~ child and adolescent mental health wards; ~ community health services for adults. • Areas rated as Requires Improvement: ~ community adult mental health services; ~ long stay/rehab adult mental health wards; ~ community health services for children, young people and families; ~ urgent care services; ~ mental health crisis services; ~ community older people's mental health services; ~ specialist community mental health services for children and young people; ~ older people's mental health wards; ~ community health in-patient services; ~ end of life care. • No service was rated as Inadequate.
Impact Assessment:	Equalities Impact Assessment:
	Use of Evidence: Report provided by Dorset HealthCare University NHS Foundation Trust.
	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: ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate) Residual Risk ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate)
	Other Implications: None.
Recommendation	That the Health Scrutiny Committee consider and comment on the Summary of the CQC Inspection Report
Reason for Recommendation	The work of the Health Scrutiny Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of all Dorset's citizens.
Appendices	1. Core Service Inspection Ratings by Domain 2. Regulation activity, issues identified and service area

Background Papers	The full report can be found at the website link www.cqc.org.uk/provider/RDY
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Chief Executive
Dorset HealthCare University NHS Foundation Trust
November 2015

Dorset HealthCare NHS
University NHS Foundation Trust

CQC Inspection Outcome Report

1. BACKGROUND

1.1 The CQC undertook a comprehensive announced inspection of Dorset HealthCare University NHS Foundation Trust (the Trust) during the week commencing 22 June 2015. They inspected 14 core services and 2 specialist services against the five domains of quality:

- Were services safe?
- Were services effective?
- Were services caring?
- Were services responsive to people's needs?
- Were services well-led?

1.2 This was preceded by a twenty week lead in period which involved three detailed data collections, including details of all the clinics taking place during the inspection week. During this time CQC also held events for service users to gain feedback on their experience of our care.

1.3 During the inspection week 113 CQC inspectors spent four days inspecting the 16 service areas and conducted Mental Health Act monitoring visits to those locations where people are detained.

1.4 They also:

- Collected feedback from 182 people who use services, using comment cards
- Spoke with over 429 patients, carers and family members
- Observed how staff were caring for people in all community hospitals and mental health in-patient units, including 52 locations delivering care in the community
- Observed 91 episodes of care in the community
- Looked at the personal care or treatment records of 539 patients
- Interviewed over 624 individual frontline members of staff and 67 managers
- Held focus groups on several different sites across the region for a range of staff groups
- Attended multidisciplinary team meetings
- Observed handovers
- Reviewed information we had been asked to provide
- Liaised with local stakeholders, commissioners and local authority representatives
- Interviewed corporate staff and members of the board
- Met with Trust non-executive directors

1.5 The draft reports were shared with the Trust, NHS England and Monitor on 16 September 2015. We then had 10 working days to check the reports for factual accuracy and feedback to CQC. This was our opportunity to challenge any rating decisions.

1.6 The CQC presented their findings from the inspection to our stakeholders at the Quality Summit held on Friday 9 October 2015. This was attended by representatives from Dorset CCG, the 3 local authorities, HealthWatch, Dorset Mental Health Forum, Bournemouth University and Dorset Health Scrutiny Committee.

1.7 The final reports were published on the CQC website on Friday 16 October 2015.

2. CQC FINDINGS

2.1 Ratings are awarded for each core service against each of the 5 domains. These are then aggregated to give a Trust score for each of the domains and an overarching rating. See Appendix 1 for the core service ratings.

2.2 The Trusts' overarching rating is 'requires improvement' and this is made up by:

Are services safe?	Requires improvement	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive	Requires improvement	
Are services well-led?	Requires improvement	

2.3 Two services have been rated as outstanding and these are the acute mental health wards for adults of working age, including the psychiatric intensive care units, and the community forensic service. The CQC informed the Trust that this is the first time an 'outstanding' rating had been awarded to acute wards for adults of working age and psychiatric intensive care units in England.

2.4 Two core services received an inadequate rating for the safe domain; they were specialist community mental health services for children and young people, and the minor injury units.

2.5 The crisis and health based place of safety (s136 suite) were inspected but not rated for the safe domain due to conflicting information around staffing for the service, meaning that CQC cannot award a definitive rating. Overall the service is rated as requires improvement.

2.6 Four services have been rated 'good' and the remainder (ten service areas) are rated as 'requires improvement'.

2.7 The majority of services were rated either good or outstanding for the caring domain. The full report can be found at the website link www.cqc.org.uk/provider/RDY

Areas of Concern

2.8 The CQC highlighted two areas of serious concern, the Child and Adolescent Mental Health Services (CAMHS) in Weymouth and Portland and in Bournemouth and Christchurch, and the Weymouth, Portland and Bridport Minor Injury Units.

2.9 The CAMHS in Weymouth and Portland and in Bournemouth and Christchurch did not assess risks to young people waiting for assessment or

treatment effectively. Teams were unable to meet the waiting time targets because of the number of vacant posts and staff who were on sick leave.

2.10 At Weymouth, Portland and Bridport minor injuries units there was a lack of clinical leadership. There was no clearly defined system for triage and clinical assessment of patients arriving at the units. This meant that the service was not assessing and responding to potential risks, and patients could be waiting for some time without clinical assessment, when possibly needing urgent or more acute care and treatment. This was not in line with the Trust's service operational policy or national guidance. There were staff shortages and a lack of an appropriate skill mix across the service, and on occasions agency staff were working alone without adequate support or induction.

2.11 The CQC reported that the Trust responded very quickly and positively when the concerns were raised about the risk assessment process for children and young people on waiting lists in the Weymouth and Portland and Bournemouth and Christchurch CAMHS. They felt that we took prompt action to review and reduce the highest risks. We drew up an action plan to review all waiting lists, caseloads and the risk assessment process, and we have kept CQC updated on the positive progress with this.

2.12 We also responded quickly and positively to concerns about the safety of services delivered in Weymouth and Portland minor injuries units. We were able to assure CQC that only experienced clinicians would work at these units. All units would have a band six nurse at all times as a minimum. The opening hours at Portland were changed whilst there were staff shortages, with no weekend working, and there would always be receptionist cover during opening hours. The Trust had recently appointed a senior clinical lead to improve the clinical governance for its minor injuries services and to support teams in raising standards of care, environment and their training.

2.13 CQC also found some significant variance in the quality of care delivered between teams and across the Trust. There were inconsistencies in the planning and delivery of a number of services across the Trust.

2.14 Several areas of non-compliance with regulations (not meeting fundamental standards of quality and safety) were identified and we will be required to meet the requirements of the compliance actions. These are termed requirement notices.

2.15 The quality of patient records in community health services was found to be variable.

2.16 There were deficiencies in monitoring and checking safety and emergency equipment across older people's mental health services and inpatient wards in community hospitals.

2.17 CQC found high levels of detention under the Mental Health Act in our rehabilitation services. At Nightingale House and Nightingale Court patients were not able to access comprehensive rehabilitation programmes in the community. Patients in rehabilitation services were observed to be spending much of their time smoking.

2.19 There was conflicting evidence about staffing and sickness levels in the east Dorset crisis team but evidence to indicate that this had a marked adverse effect on the team's ability to provide a robust home treatment service and

provide a responsive crisis telephone helpline at night, potentially posing a significant risk.

2.20 When presenting these findings to our stakeholders the Inspectors did stress that they have every confidence that we will address these issues.

Areas of Good Practice

2.21 It was very pleasing to see that the CQC identified 41 areas of good practice across all areas in the Trust. The Lead Inspector stated that this is a high number of good practice points compared to other inspections.

2.22 The areas of good practice include:

- Kind, caring, compassionate and passionate staff who treated people with dignity and respect, want to deliver good quality care and want to improve;
- Good multidisciplinary team working in many areas across the trust;
- They observed outstanding and good care and treatment in both community health and mental health services.

2.23 Inpatient mental health services - CQC found that the model of care and acute care pathway optimised patients' recovery and that there was a strong emphasis on recovery-orientated therapeutic programmes, many of which were instigated by patients.

2.24 The Forensic Community Pathfinder service worked with patients with a personality disorder who were at risk of offending to improve their outcomes and at significantly lower cost than being in hospital.

2.25 Other areas of good practice include:

- Relatively new leadership team – positive, passionate, energetic, open and transparent – cohesive team that shared a common purpose;
- Recognition that there were areas to improve and a clear plan to do this;
- Clear strategy based around driving clinical improvements;
- Positive engagement with stakeholders;
- High quality governance systems that were being rolled out – the CQC are confident that areas of concern would be identified and dealt with in future;
- New locality model at early stages of development and implementation – However there is more work to do to engage some staff fully and ensure the model works for all services;
- Patients, carers and others who CQC spoke to, in the majority, said that their experience at Dorset HealthCare was positive and that staff were caring;
- Out of 188 comment cards, 91.2% (166) contained positive comments. Only 3 contained negative comments, the remaining 19 were neutral.

2.26 To conclude the overview of the findings, the CQC stated that;

'It is our view that the provider had made significant progress in developing services and bringing about improvements.

We saw that it was well led by its new leadership team and was in the process of deploying effective systems that we were confident would result in the delivery of improved, high quality services for the patients it serves in the near future.'

3. SERVICE REPORTS

3.1 The CQC has issued a report for each core services (16) plus an overarching Trust Quality report. Each of the reports presents the findings for each domain including good practice and areas for improvement.

3.2 The areas of improvement are detailed as 'must do' actions and 'should do' actions. The 'must do' actions are related to breaches in regulations. The 7 regulations we are found to be breaching are highlighted in the Table below.

Regulation Number	Subject
8	General
9	Person centred care
10	**Dignity and respect**
11	**Need for consent**
12	**Safe care and treatment**
13	**Safeguarding service users from abuse and improper treatment**
14	Meeting nutritional and hydration needs
15	**Premises and equipment**
16	Receiving and acting on complaints
17	**Good governance**
18	**Staffing**
19	Fit and proper person employed
20	Duty of candour
Other regulations which are part of the fundamental standards but not generally inspected against	
4	Requirement where the service provider is an individual or partnership
5	Fit and proper person: directors
6	Requirements where the service provider is a body other than a partnership
7	Requirements relating to registered managers

3.3 Each core service has specific areas identified in their detailed report to address in order to be compliant with the regulation (see Appendix 2 for more detail).

4. NEXT STEPS

4.1 Each core service has specific areas identified as 'must do's' as well as some 'should do's'. These will be developed into action plans to address the shortfalls and ensure the Trust is meeting the requirements of these regulations. This action plan will be shared with CQC who will monitor our progress with the implementation.

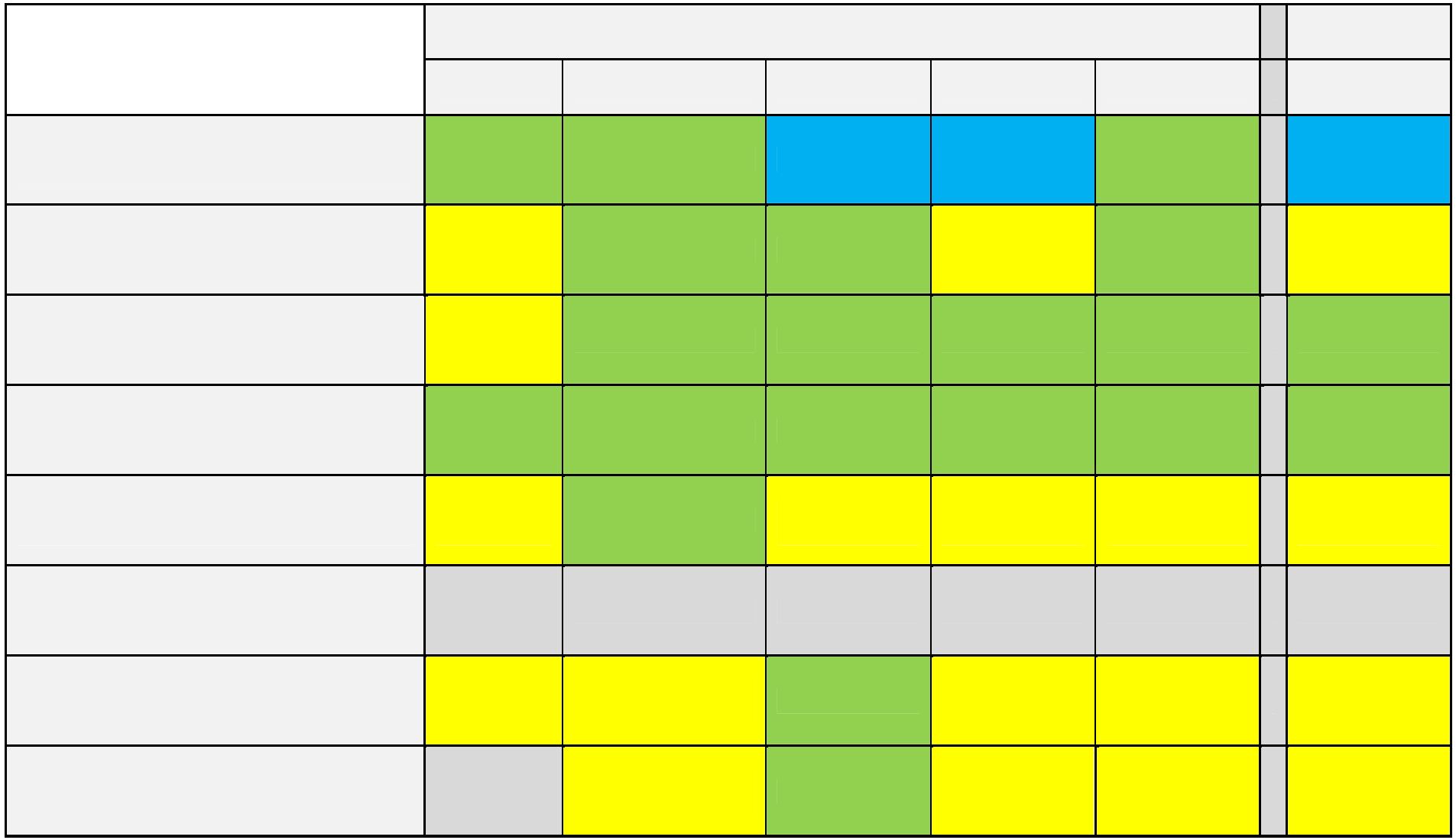
4.2 It is important to note that some actions require the support of our partners and CQC will be supportive in the development of these joint actions.

4.3 A further positive point to note is that CQC are not taking any enforcement action against the Trust as a result of their findings.

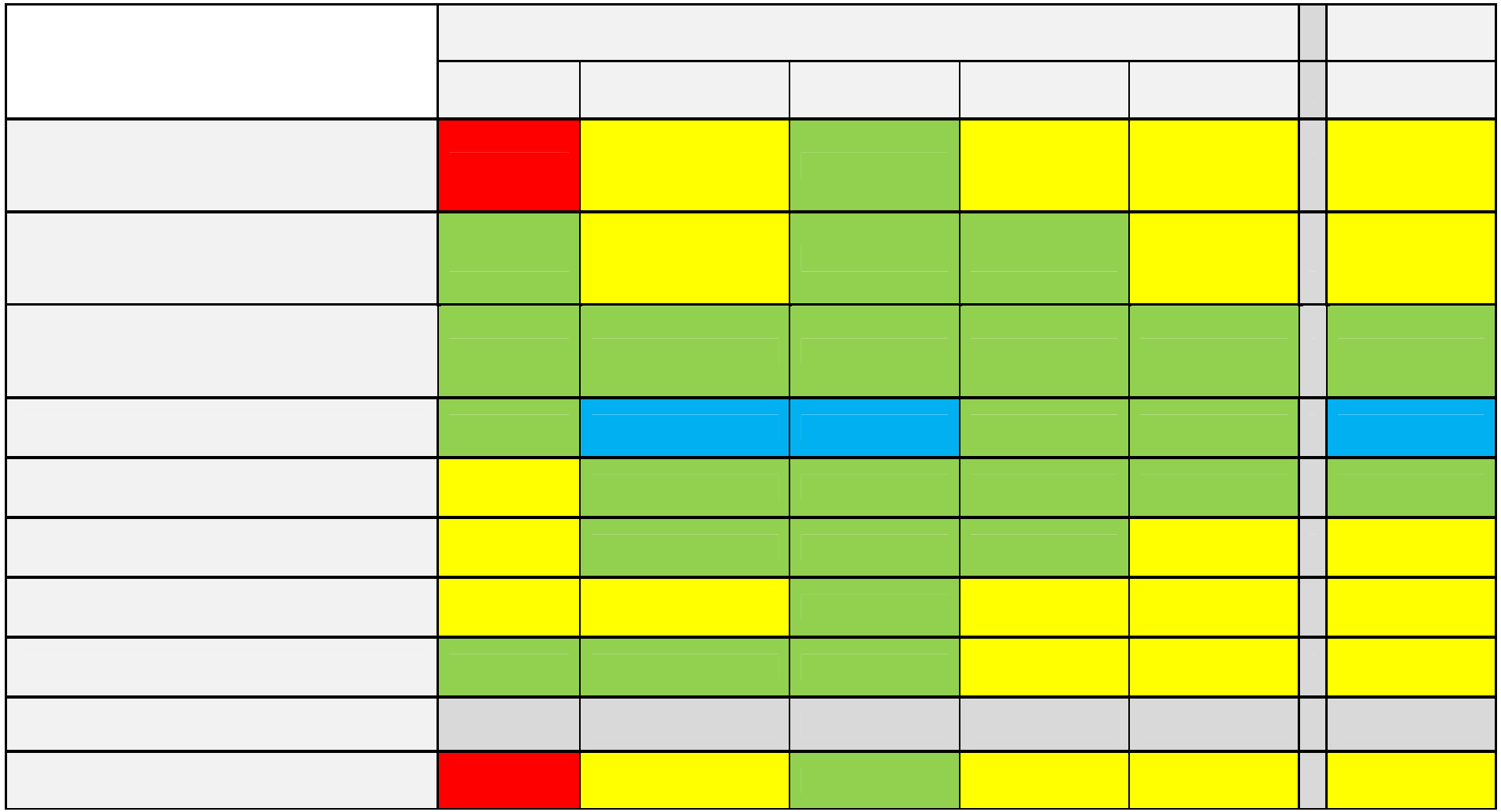
5. RECOMMENDATIONS

5.1 The Dorset Health Scrutiny Committee is asked to note and comment on the report.

CORE SERVICE INSPECTION RATINGS PER DOMAIN AND OVERALL **Appendix 1**



CORE SERVICE INSPECTION RATINGS PER DOMAIN AND OVERALL **Appendix 1**



REGULATION ACTIVITY, ISSUES IDENTIFIED AND SERVICE AREA **Appendix 2**

REGULATION	ISSUES FOUND	SERVICES BREACHING
Regulation 10 HSCA (RA) Regulations 2014: **Dignity and Respect**	• Patients privacy and dignity not protected on Alumhurst ward and at Melstock House • Privacy of community based mental health service users not protected due to interview rooms not being soundproofed. • Some physical environments did not promote privacy for patients in rehabilitation services.	• Wards for older people with mental health problems • Community based mental health services for adults • Mental health rehabilitation
Regulation 11 HSCA (RA) Regulations 2014: **Need for Consent**	• Unable to demonstrate acting in accordance with the Mental Capacity Act.	• Community based mental health services for adults
Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: **Safe care and treatment**	• Risk assessments not always detailing risks or management of risk • Staff skill, competence, experience and compliance with mandatory training • Medicines not managed safely or properly • Equipment not checked to ensure safe for use • Infection prevention and control procedures not followed consistently • Lack of clinical triage at MIU's	• Community health services inpatients • Community health services for children, young people and families • Community health services urgent care • CAMHS community • Wards for older people with mental health problems • Community based mental health services for adults • Forensic/secure inpatient wards • Crisis and health base places of safety • Mental health rehabilitation services
Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014: **Safeguarding service users from abuse and improper treatment**	• Not all staff are up to date with safeguarding training, confidentiality or responding to child protection flags.	• Community health services urgent care

REGULATION ACTIVITY, ISSUES IDENTIFIED AND SERVICE AREA **Appendix 2**

REGULATION	ISSUES FOUND	SERVICES BREACHING
Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014: **Premises and equipment**	• Cleanliness, hygiene and management of clinical waste in community health inpatient services • Unsafe or unsuitable premises and equipment.	• Community health services inpatients • Wards for older people with mental health problems

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: **Good Governance**	• Appropriate systems and processes not established or operating effectively to:
	  ○ Assess, monitor and improve quality and safety
	  ○ Assess, monitor and mitigate risk
	  ○ Seek and act on feedback to evaluate and improve services
	• Poor record keeping, including care plans and risk assessments
		• Community health services inpatients
		• Community health services for adults
		• Community health services for children, young people and families
		• Community health services end of life care
		• Community health services urgent care
		• Wards for older people with mental health problems
		• Community based services for older people with mental health problems
		• Community based mental health services for adults
		•

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014: **Staffing**	• Insufficient numbers of adequately experienced and skilled staff • Not all staff receiving the appropriate training or support including clinical supervision	• Community health services inpatients • Community health services for adults • Community health services for children, young people and families • Community health services urgent care • CAMHS community • Community based mental health services for adults • Crisis and health based places of safety