AGENDA

JOINT HEALTH SCRUTINY COMMITTEE

Date: 12 FEBRUARY 2014

Time: 6:00PM

Place: COMMITTEE SUITE, CIVIC CENTRE, POOLE

Membership:

Poole Councillors: Mrs Evans, Mrs Hodges, Matthews, Meachin, Pawlowski, Rampton, Mrs Pratt, Wilkins, Mrs C Wilson, G Wilson

Bournemouth Councillors: Mrs Baxter, d'Orton Gibson, Davies, Mrs Johnson, Mrs Price, Mayne, Mrs Stollard, Weinhonig, J Wilson

HEALTHWATCH DORSET co-opted Poole Member:

Chris Wakefield

Enquiries to:

Victoria Mainstone, Team Leader (Overview and Scrutiny)
Civic Centre, Borough of Poole, Civic Centre, Poole, Dorset, BH15 2RU
Telephone: 01202 633023
Email: v.mainstone@poole.gov.uk

PLEASE NOTE, PUBLIC ENTRANCE TO THE CIVIC CENTRE FOR EVENING MEETINGS IS VIA THE MEMBERS' ENTRANCE OPPOSITE POOLE PARK GATES. THERE IS FREE PUBLIC CAR PARKING AVAILABLE (AFTER 6.00PM) IN THE PAY AND DISPLAY SURFACE CAR PARK, CIVIC CENTRE

A G E N D A

1. **ELECTION OF CHAIRMAN**

2. **APOLOGIES FOR ABSENCE**

   To receive any apologies for absence.

3. **DECLARATIONS OF PECUNIARY INTEREST**

   To receive any declarations of any disclosable pecuniary interest(s) of Members/Officers and applications of the political 'Whip' in matters appearing on the Agenda.

4. **TERMS OF REFERENCE**

   To note that the Joint Scrutiny Committee is constituted for one meeting in line with the Bournemouth, Dorset and Poole Joint Health Scrutiny Protocol, to consider the specific issue of Dorset Healthcare University Trust – Quality Governance.

5. **DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST (DHUFT) – QUALITY GOVERNANCE**

   - To receive a Report from the Chief Executive of the Trust and Executive Director of Nursing, Quality and Research (Appendix 1 - to follow).
   - To receive a Report from the Clinical Commissioning Group on the DHUFT (Appendix 2 - attached).
   - To receive a Report from Healthwatch Dorset on the DHUFT (Appendix 3 - to follow).
   - Reports taken from Poole Health and Social Care Overview and Scrutiny Committee on 4 November 2013, on the outcome of CQC Inspections at St Ann's Hospital (Appendix 4, A-D – attached), and extract of the Minute from the meeting (Appendix 5 – attached).
   - Extract of the Minute from Poole Health and Social Care Overview and Scrutiny Committee on 9 December 2013, on the verbal report provided by the Interim Chief Executive of the Trust on their Improvement Plan (Appendix 6 – attached).

6. URGENT BUSINESS

To consider any item(s) which the Chairman may consider is/are urgent and may be considered at this Meeting.

Tim Martin, LLB Solicitor
Head of Legal and Democratic Services
4 February 2014

BOURNEMOUTH AND POOLE COUNCILS TASK AND FINISH JOINT SCRUTINY ON QUALITY GOVERNANCE AT DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST – 12 FEBRUARY 2014

The Joint Scrutiny Committee is aware through previous discussions that Dorset Health University NHS Foundation Trust (DHUFT) is in non-compliance with its Terms of Authorisation as a Foundation Trust. The regulator, Monitor, therefore required actions to be taken to restore the Trust to compliance with its Terms of Authorisation. This report summarises the progress to date.

The original concerns related to inspections carried out by the Care Quality Commission in 2012/13 regarding improvements that needed to be made in a number of the Trust wards. Unfortunately, the Trust's process of governance and assurance were such that the Board gave false assurance to the regulators that these issues had been resolved, when they had not.

Sir David Henshaw was appointed by the regulator as the Interim Chairman on 7th October 2013.

Since the last Trust report to the Health and Adult Social Care Overview and Scrutiny Panel in October 2013, significant progress has been made. In the formal meetings with Monitor the Trust is demonstrating progress and is hopeful that the necessary assurance is provided to the regulator by May/June 2014 such that the Trust will no longer be in breach of its Terms of Authorisation.

Sir David has successfully recruited four new high calibre Non-Executive Directors all of whom have now taken up appointment (Appendix 1).

Ron Shields has with effect from 28th October 2013 been appointed as the Interim Chief Executive.

Interviews for a permanent Trust Chairman are taking place on 6th February 2014 and there is a good field of competition for this vital position. Arrangements are in hand to recruit a permanent Chief Executive in March 2014.

The latest position in respect of the Trust Recovery Plan as at 27th January 2014 is in the table below.

Number of actions submitted to Monitor 27.09.13	302
Number of new actions	29
Total	**331**
Number of outstanding actions as at 27.01.2014 • Red- open and missed deadline date • Red/Amber- open but not on track to deliver on time • Amber- open and on track to deliver on time	**45** 17 2 26
Completed actions	**286**
Total	**331**

All of the shortcomings that gave cause for concern initially have now been satisfactorily addressed. However, some other issues have arisen and these are now being attended to. The Trust identified that it was non-compliant with the provision of appropriate gender separation in eight of the Trust wards. Six of these have now been addressed through changes in operational arrangements and the remaining two, Flaghead Unit and Stanley Purser Ward, Swanage Hospital will be compliant through small building schemes that have already been commissioned.

The Trust has concerns about the standard of accommodation in the old block of St Ann's Hospital and is working on what interim solutions can be found pending the approval and building of new long term accommodation.

The Trust Board is working with external consultants to develop the Business Plan for 2014/15 and a 5-Year Strategy and Blueprint for the Trust.

DHUFT is essentially a provider of community services in addition to which it is responsible for the running of 11 community hospitals and the county's inpatient mental health services. At the heart of the Trust's strategic ambitions will be to deliver more personalised, integrated care in localities. It is actively engaging with Local Authority colleagues and with GP commissioners to make that vision a reality for the people of Dorset.

Ron Shields
Chief Executive **4th February 2014**

APPENDIX 1

DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST

Non-Executive Appointments

Name	Start Date
Ann Abraham	01.12.13

Ann Abraham was Parliamentary Ombudsman for the UK and Health Service Ombudsman for England from 2002 to 2011. During her time in office she published a number of high profile reports that identified failings in NHS care, including the care of older people (*Care and compassion?)* and people with learning disabilities (*Six lives*).

Ann was Legal Services Ombudsman for England and Wales from 1997 to 2002 and Chief Executive of the National Association of Citizens Advice Bureaux (now Citizens Advice) from 1991 to 1997. Her earlier career was spent in local government and the Housing Corporation, where her particular focus was on housing and services for people with special needs.

Ann served on the UK Committee on Standards in Public Life from 2000 to 2002 and was Chair of the British and Irish Ombudsman Association (now the Ombudsman Association) from 2004 to 2006.

Currently Ann is a Non-Executive Director of Health Education England, an Arms-Length Body of the Department of Health, which provides national leadership, and funding, for the education and training of the healthcare workforce. She is also a Trustee of the Picker Institute Europe, a not-for-profit organisation that works with patients, professionals and policymakers to make patients' views count in healthcare.

Name	Start Date
Lynne Hunt	01.12.13

Lynne qualified as a nurse in Dorset and after completion of her training she moved to London. She worked in a range of clinical roles including as a Charge Nurse and Modern Matron. She was the Associate Clinical Director of Forensic Services in Ealing. As Director of Nursing and Quality at West London Mental Health NHS Trust, Lynne's role included responsibility for services at Broadmoor Hospital. She worked in this role for a number of years leaving the organisation in 2001 to take up the role of Executive Director of Nursing and Service Development at Barnet, Enfield and Haringey Mental Health NHS Trust and she also took on the remit of the Deputy Chief Executive in this organisation.

After three years Lynne moved into the role of Deputy Chief Executive, Director of Nursing and Partnerships and Chief Operating Officer at East London NHS Foundation Trust. Lynne now lives in Dorset and has been working full time in independent consultancy within the healthcare sector. Lynne is also a member of the National Coastwatch Institution, giving her time as a volunteer watch keeper.

<table>
<tr><th>Name</th><th>Start Date</th></tr>
<tr><td>Ian Cordwell</td><td>09.12.13</td></tr>
<tr><td colspan="2">Ian trained with Coopers and Lybrand and after a variety of accounting roles, including working for M & S Financial Services as Finance Director, where the culture was all about caring for the customer and adding value.

Ian joined Liverpool Victoria, eventually being appointed Managing Director of the Life and Pensions business, as well as the LV Bank.

After two years in an interim position with the Pensions Regulator, Ian was appointed substantively to his current role as Finance Director of the Police Mutual – he feels a strong connection with the organisation as it is a membership organisation set up by, and run for the membership.</td></tr>
<tr><th>Name</th><th>Start Date</th></tr>
<tr><td>David Brook</td><td>23.01.14</td></tr>
<tr><td colspan="2">David joined the RAF in 1987 and held early roles as an Engineering Officer. He spent time in Saudi Arabia and then as Senior Engineering Officer.

After completing his MA in Defence Studies, David led the formulation and development of RAF engineering strategy and policy.

In 2004, David was appointed to RAF Odiham as Officer in Commanding Forward Support Wing. In 2006, David was promoted to Group Captain and moved to HQ Strike Command.

David spent a significant amount of time in the North East of Scotland during this time and was ultimately responsible for the procurement of technical accommodation, upgrade of runways and aircraft operating services, security systems, domestic accommodation, upgrade of electrical, water and drainage systems.

In 2007 he joined the RNLI as Engineering and Supply Director. Reporting to the CE and Board, David is now the Chief Technical Officer and a member of the Executive Team and leads the technical department of over 400 personnel dispersed throughout the UK and Republic of Ireland.</td></tr>
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Appendix 2

REPORT TO THE BOURNEMOUTH BOROUGH COUNCIL AND BOROUGH OF POOLE HEALTH OVERVIEW AND SCRUTINY COMMITTEES

FEBRUARY 2014

REPORT BY THE DORSET CLINICAL COMMISSIONING GROUP ON DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST

1. INTRODUCTION

1.1 This report provides information and assurance on the process that the Dorset Clinical Commissioning Group (Dorset CCG) employs in order to monitor the quality of services provided by Dorset HealthCare University NHS Foundation Trust (DHC).

1.2 The CCG holds a contract with the Trust, which includes a requirement to meet a large number of performance and quality indicators. These standards are based on national guidance and best practice.

1.3 Monthly contract review meetings are held between senior members of the CCG and of the Trust, to review the Trust's performance against these standards. GP Locality Leads also attend these meetings. Contractual penalties are imposed when requirements are not met.

1.4 Specific quality matters relating to DHC are considered in more detail at the CCG's Quality Group which reports through the CCG's Audit and Quality Committee. The CCG Governing Body receives a report at each meeting detailing any concerns about performance or quality of provider organisation commissioned by the CCG.

1.5 In addition to analysis of the contractual performance and quality indicators, a range of activities are undertaken on a day to day basis to gain intelligence on the quality of service provision, to identify any 'early warning' signs of service failures and to work with the Trust towards quality improvements.

1.6 As part of this process, unannounced visits are undertaken to DHC on a planned programme basis throughout the year, as well as in response to any alert of a concern in a specific area. These visits include talking to patients and carers and asking about the experience of care they are receiving, reviewing staffing levels, documentation and an environmental audit. The outcome is then shared with the Director of Nursing and Quality.

1.7 In addition, regular one to one meetings are held between the Director of Quality and the Director of Nursing and Quality. The Medical Director is now also invited to these meetings.

1.8 In order to strengthen this process, it is proposed that during 2014/15, joint planned visits will be undertaken between the quality leads of the CCG with the Director of Nursing and Quality for DHC. The CCG has also approached Healthwatch to request that they join the CCG on some unannounced visits.

1.9 The CCG also meets regularly with the CQC and Local Authorities to share local intelligence. Monitor also meet with the Chair and Chief Officer of the CCG.

2. REPORT ON DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST'S CURRENT SITUATION

2.1 The Trust is achieving the majority of its contractual quality performance indicators. Hospital acquired infection rates are low and there has been a marked improvement in the rates of C Difficile from previous years. The percentage of staff receiving safeguarding training has improved and is now at acceptable levels.

2.2 The Trust has introduced the Friends and Family Test across all units. The response rate and scores for inpatients has been very good.

2.3 The Trust is now fully compliant with CQC Standards at Blandford Hospital, where there was previously a warning notice in place.

2.4 There are still a number of CQC non-compliant areas with moderate impact at Forston Clinic Waterston Unit and at Bridport Hospital and follow- up visits by the CQC are expected.

2.5 Following the re-opening of Waterston unit in April 2013, the CCG have visited the Unit on more than one occasion and have been closely monitoring the service. An unannounced visit to Waterston was undertaken by members of the CCG during November 2013 and some improvements were seen.

2.6 In September, Monitor imposed an additional condition on the trust's license due to concerns that the Trust was failing to improve sufficiently on quality and governance concerns. An Interim Chair and Interim Chief Executive are now in place, recruitment is underway for these permanent positions and Jane Elson has commenced as Director of Mental Health. New Non- Executive Directors have also been appointed.

2.7 Paul Lumsdon, Director of Nursing and Quality is leading the response to all of the ongoing quality concerns. The CCG Quality team meet regularly with Paul and his team to discuss all quality concerns, and good progress is being made in addressing these.

2.8 Some complaints and adverse patient/carer feedback have been received in relation to the Crisis mental health response service in both the east and west of the County. This issue has been raised through the contract meetings and work is being undertaken to address the concerns about this service. An independent review of the mental health urgent care services in the West of the County is also being commissioned.

2.9 There have been a number of concerns raised by GPs about the staffing levels and changes in working practice within the district nursing teams. In addition, some adverse incidents and safeguarding alerts have been received about this service as well. This has been raised at the contract review meetings and the Trust is actively working to recruit staff and is working with the CCG on achieving improvements.

2.10 Recruitment to vacancies across the service is proving challenging. The Trust is providing a detailed report on vacancies, and the CCG is working with them to gain assurance that appropriate clinical cover is being maintained and that patient safety is not compromised due to the vacancies.

2.11 Some investment into community nursing, which was previously agreed, is being made by the CCG. This is being linked to actual recruitments and to achievement of required outcomes, as set out by the CCG.

2.12 An independent investigation into a homicide committed by a mental health service user in 2010 has recently been completed, and is about to be published. This report contains a number of recommendations for the Trust. The CCG will be closely overseeing the action plan produced by the Trust, to ensure these recommendations are implemented and that learning from this and other Serious Case reviews is embedded within practice.

3. CONCLUSION

3.1 DHC continues to face some challenges in delivering high quality care to all service users. However, improvements have been made over the past few months, and new leadership is in place to continue this improvement.

3.2 The CCG is committed to working with the Trust and its partners to achieve the required improvements and to ensure the Trust is providing high quality care for all.

Sally Shead
Deputy Director of Quality
NHS Dorset Clinical Commissioning Group

Appendix 4

BOROUGH OF POOLE

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

4 NOVEMBER 2013

OUTCOME OF CARE QUALITY COMMISSION (CQC) INSPECTION – ST ANN'S HOSPITAL

1. PURPOSE

To provide Members with information on the outcome of the recent CQC Inspections at St Ann's.

2. RECOMMENDATION

That the Committee to note and comment on the Report.

3. BACKGROUND

3.1 The Care Quality Commission (CQC) made a routine inspection of five wards of the six wards at St Ann's Hospital, on 5th February 2013. This visit was a routine, unannounced inspection. A copy of the inspection report is attached at Appendix A and findings set out in the table below.

	Standard Inspected	Finding	Concern level
1	Consent to care and treatment	Met this standard	
2	Care & welfare of people who use the services	Action needed	Minor
3	Safeguarding people who use the services from abuse	Action needed	Minor
4	Management of Medicines	Met this standard	
5	Safety and suitability of premises	Action needed	Minor
6	Complaints	Met this standard.	

3.2 A report on actions required to meet essential standards is attached at Appendix B.

3.3 The Care Quality Commission made a further inspection on 25th and 26th April 2013 in response to anonymous information of concern posted on the CQC website. The CQC visited four of the hospital's six wards: two separate wards for male and female patients, a mixed acute admission ward and a male low secure forensic ward. A copy of the inspection report is attached at Appendix C and findings set out in the table below.

	Standard Inspected	Finding	Concern level
1	Respecting and involving people who use the services	Action needed	Minor
2	Staffing	Met this standard	
3	Assessing and monitoring quality of service provision	Met this standard	
4	Records	Met this standard	

3.4 A report on actions required to meet essential standards is attached at Appendix D.

3.5 The resulting action plans to ensure compliance with the CQC Essential Standards have all been completed. The Trust believes we are now providing a service which meets all the CQC Essential Standards. Performance is monitored on a monthly basis to ensure we provide consistent standards of care for service users.

Contact Officer:

James Barton, Director, Mental Health Services, Dorset Healthcare University NHS Foundation Trust

APPENDIX A

Care Quality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St Ann's Hospital

69 Haven Road, Canford Cliffs, Poole, BH13 7LN

Date of Inspection: 05 February 2013

Date of Publication: May 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Standard	Outcome
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✗ Action needed
Management of medicines	✓ Met this standard
Safety and suitability of premises	✗ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Dorset Healthcare University NHS Foundation Trust
Overview of the service	St Ann's Hospital provides assessment and treatment to adults with mental health needs. The hospital can accommodate up to 94 people. It has an acute admission ward for all newly admitted people and two wards (one male, one female) for people who need in-patient treatment. There is a ward for older people with functional mental health problems, a small intensive care unit/ward and a low secure forensic ward/unit.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 5 February 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

We carried out a joint inspection with three Mental Health Act Commissioners (MHA Commissioners). We looked at issues where we had required improvements at other locations also managed by the provider. They concerned obtaining consent from people to their care and the use of seclusion and restraint.

Our MHA Commissioners looked at the rights of detained patients to ensure they were upheld. A separate report was produced about this.

We visited five of the hospital's six wards and spoke with sixteen people who had received treatment. One person had been kept in seclusion. We also spoke with a visiting relative and a range of staff members, including the hospital manager, complaints and ward managers, doctors, trained and student nurses, support workers and the Mental Health Act manager.

Where people's wishes were not upheld in relation to the care they received this was because it could prevent them engaging properly in their treatment programmes.

The physical health needs of people were not always included in plans for their care and treatment. Limited leisure activities meant that people's individual needs were not always met.

Safeguarding procedures were robust but the monitoring of the use restraint was not sufficiently robust.

Medication was managed appropriately and safely.

Seclusion facilities were not totally suitable and their use could compromise people's

dignity.

There were comprehensive arrangements for managing people's complaints.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 22 May 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

People's people's wishes were respected in relation to the care and treatment they received.

Reasons for our judgement

An information booklet was available to patients. The booklet set out the hospital's commitment to involve people in the treatment and care they received and included the following statements.

"Shortly after arriving you will usually be seen by a Doctor and a Nurse. They will talk to you about the difficulties you have been experiencing and what can be done to help you feel better. They will use what you tell us to plan your support, care and treatment with you.

The multi-disciplinary team will regularly review your care plan. If you wish, your next of kin/carer or representative can request to speak to the Consultant Psychiatrist or Doctor regarding the care you are receiving. Following the first assessment, your Key Nurse will work with you to identify your treatment choices and preferences for inclusion within your care plan. This will be regularly reviewed with you to reflect changes in your condition/wishes.

The Tidal Approach of care concentrates on working collaboratively with you and your carers and engaging with you when planning your care whilst on the ward. It enables you to take responsibility for your recovery. The nurses' role is to assist and guide you through the process of gaining understanding and finding ways of helping you to recover."

On Branksome Ward our Mental Health Act Commissioners were told a restriction was placed on what people could do. They found that bedrooms were locked daily between 09.30 a.m. and 12 noon and again between 3.15 p.m. and 5 p.m. The Mental Health Act Commissioners saw that this resulted in people sleeping on chairs in the main lounge at these times.

A clinical team manager told us that the rooms were locked to discourage people returning to their beds which could disrupt or delay their engagement in programmes and activities

important for their treatment. The ward manager told us that if people were unwell they would not be prevented from remaining in bed and that if anyone needed to get access to their room to get something there were always staff available to allow this.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People's welfare was compromised because plans were not always in place to manage risks to their health and the care and treatment they received did not always meet their individual needs.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's needs were not always assessed and care and treatment was not always planned and delivered in line with their individual care plan.

On Haven Ward we looked at the care plans of three people. We saw that assessments of most needs and potential risks to their well being had been carried out and corresponding care plans had been developed.

We saw that some potential risks had been assessed. They included violence and aggression, absconding, disinhibition and physical health needs.
We saw that care plans had been reviewed and the progress people had made with treatment was reviewed at regular ward rounds. For example we saw that one person's plans included the management of eczema. For another person we saw their plans had been updated following observations that their ability to care for themselves had deteriorated due to a neurodegenerative disorder. Staff consequently had to prompt and remind the individual to carry out personal hygiene tasks.

We were however made aware that one person suffered from asthma. Staff on the ward were unable to show us that an assessment had been carried out and corresponding plan put in place to manage risks associated with the person's asthma. This meant that in the event of the person suffering a serious asthma attack, staff did not have clear instructions about what action they needed to take.

On Branksome Ward our Mental Health Act Commissioners found that the care plans of two people had not been reviewed on a regular basis. This meant that staff may not have always had up to date information on how to meet those people's needs.

On the same ward our Mental Health Act Commissioners noted there were social activities organised which people could participate in. These activities included village walk, art

group, wood work project, pub quiz, Wii group and fruity Friday. They found however limited little evidence of psychological or discharge planning activities. There was no occupational therapist allocated to the ward and limited psychological input to therapeutic activities. Only two of the twenty-five patients on the ward were engaged with formal psychological interventions.

Patients complained to the Mental Health Act Commissioners of feeling bored with what they considered limited leisure activities. This meant that the care and treatment provided did not always meet people's individual needs.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who used the service were not fully protected from the risk of harm. The provider had taken steps to enable the possibility of abuse being identified but did not have suitable arrangements in place to protect people against the excessive use of restraint.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People who used the service were protected from the risk of harm because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

From our knowledge of The Dorset Healthcare University NHS Foundation Trust (the Trust) we were aware they had comprehensive policies and procedures in place that set out their arrangements to protect vulnerable people from harm. They described the types of harm people could be subjected to and the actions staff were required to take if they suspected or knew a person had been harmed.

All the staff we spoke with on the wards told us that they had attended relevant training. We saw staff training records that confirmed this.

We also saw some examples of recent concerns that ward staff had referred to a local authority safeguarding team. They showed that staff understood what constituted abuse and had taken appropriate action.

The Trust provided clinical staff with training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLs). This legislation was implemented to protect the rights of people who lacked capacity to make decisions for themselves and prevent restrictions being imposed arbitrarily on people's freedom.

All nursing staff and support workers we spoke with told us they had received training in physical intervention. We looked at staff training records and they confirmed this. The training was to ensure that if staff had to use physical intervention to manage people's behaviour it would be done safely and properly. However we found that people were not protected against the risk of unlawful or excessive control or restraint.

Two of the five wards we visited had facilities that could be used to help manage the

behaviour of people who put themselves or other people at the risk of harm. The facilities consisted of a low stimulus unit which provided a quiet space for people when they experienced high states of arousal that could result in harm and a lockable seclusion room where highly disturbed or high-risk people could be managed away from the main ward area.

We noted that very detailed records were kept about the use of the seclusion rooms including observations of their occupants at least every fifteen minutes. We saw that regular checks were carried out by medical staff. This ensured the welfare of people when in the seclusion rooms was monitored.

We spoke with one person who had been placed in the seclusion room on one occasion. They said, "I was in there about six hours. They checked on me all the time. I was given some food and something to drink and a doctor came and looked at me while I was in there".

We saw that the Trust had an operational policy about seclusion that set out criteria for its use which stressed that seclusion was a measure of last resort. We were provided with information about the Trust's governance system intended to ensure that as far as possible seclusion facilities were not misused.

Staff told us the low stimulus units were helpful as "a calming atmosphere away from other people when someone was anxious and agitated".

Healthcare staff we spoke with on both Twynham Ward and Haven Ward did not consider the use of the low stimulus unit or supervising a person in the seclusion room with the door open as seclusion. The Mental Health Act 1983 Code of Practice at 15.43 states, "Seclusion is the supervised confinement of a patient in a room, which may be locked".

We were told by staff that the 'low stimulus' unit on Twynham Ward was used frequently for "de-escalation" but such episodes were not recorded in the same detail as the use of the seclusion room. The use of the low stimulus unit was not therefore subject to the same degree of record keeping, monitoring, oversight and governance. Consequently there was a risk that patients were not properly safeguarded against the excessive use of this form of restraint.

Senior staff from Dorset Healthcare University NHS Foundation Trust told us patients supervised in the low stimulus unit were not subject to the same level of monitoring because their needs were such that it was not required.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected from unsafe administration of medication.

Reasons for our judgement

When we inspected St Ann's Hospital on 16 March 2011 we noted that medication procedures failed to comprehensively protect people from unsafe practice. The medication policy did not state that staff who gave out medicines had to observe people had actually taken their prescribed medicines before they signed the relevant medicine administration record.

On this occasion we saw The Dorset Healthcare University NHS Foundation Trust's amended "Policy for the administration of medicines". We saw the original policy had been issued in February 2008 and reviewed and amended in October 2011.

We noted the following instruction in the policy.

"The authorised practitioner who has administered or supervised the administration of the drug must, at the time of administration, sign with initials in the appropriate column on the medicines chart. They must not leave a patient without ensuring he/she has taken the medicine and must never sign for a drug until it has been administered".

This meant that medicines were administered safely because the instruction in the policy states that people must have actually taken their prescribed medicines before the relevant medicine administration records are signed.

There was no risk people could store medication and then later take unsafe amounts or give medication to other people. Consequently people were being protected from risks associated with the unsafe use and management of medicines.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who used the service were not properly protected against the risks of injury that could occur because of some features in seclusion rooms. The dignity and safety of people was compromised because of the way the seclusion rooms were managed.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Care was provided in an environment that was not suitably designed.

We looked at the condition of the hospital's two seclusion suites. One was located on the low secure forensic unit for males (Twynham Ward). The other was on the psychiatric intensive care unit (Haven Ward). They were very similar and consisted of a 'low stimulus unit' that led to a seclusion room with bathroom facilities.

The seclusion suites were situated adjacent to the main ward areas and in close proximity to the main nurses' stations and resuscitation facilities. Both seclusion suites included external entrance lobbies in addition to entrances directly from the ward area.

The seclusion rooms were spacious and we were told they could accommodate one patient and up to maximum of six staff when required. They were quiet (but not sound proofed) and generally in good repair. We saw some minor damage to the plasterwork in the seclusion room on Haven Ward.

Nursing staff we spoke with told us the design and layout of the suites enabled them to observe occupants of the suites at all times through observation panels. The panels fitted to bathroom areas had privacy screens.

There were clocks that were visible to people accommodated in the seclusion suites and furniture was specially constructed to reduce the risk of people harming themselves of others. Mattresses were wipe-clean and thick enough to prevent suffocation and sharp corners had been minimised.

Neither seclusion room had the means available for the occupant to call for attention. The Mental Health Act 1983 Code of Practice at 15.60 states" The room for seclusion should be quiet but not soundproofed and should have some means of calling for attention (operation of which should be explained to the patient)".

Senior staff from Dorset Healthcare University NHS Foundation Trust (the Trust) told us that they thought this was not necessary because 15 minute observation were carried out when people were in seclusion and they were within sight at all times. However we noted that mattresses provided in the seclusion rooms could be used to obscure/block observation panels.

We saw that shower tray and radiator covers in the seclusion room on Twynham Ward could be potential hazards because people could injure themselves on the sharp corners. Senior staff from the Trust told us the corners were not considered to be sharp and items and fittings in the seclusion rooms had been risk assessed.

This showd the seclusion rooms were not totally suitable for their purpose.

From our review of seclusion records we saw that people accommodated on other wards were moved to through the hospital to the seclusion room on Twynham Ward. This included female patients who were escorted through a male ward to be placed in the seclusion facilities on Twynham Ward. We were told the movements of people on Twynham Ward were limited when this occurred.

The movement of people from other parts of the hospital to seclusion rooms could be witnessed by other people. and on occasions females were cared for in the seclusion room on a ward which was designated for males. This meant the management and operation of the seclusion rooms could result in people's dignity being compromised.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system in place. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People were made aware of the provider's complaints system and were supported to make comments or complaint where they needed assistance.

We saw that the Trust's complaints procedure was referred to in a leaflet that was readily available on the wards. The leaflet included references to the confidential Patient Advice and Liaison Service (PALS), the Independent Complaints Advocacy Service and the Parliamentary and Health Service Ombudsman.

We also noted that information about (PALS) was advertised on posters in the wards and various locations around the hospital. An information pack that was given to everyone using the service also contained information about advocacy services that could be contacted.

During our inspection we saw an office that was used by the local Citizens Advice Bureau three days a week.

This all showed that people were able to obtain help and advice from independent organisations if they had concerns or were unhappy about the treatment they received.

One person we spoke with told us that regular community meetings took place on their ward at which they were encouraged to raise any issues or concerns. We saw notice boards on the wards that displayed information about the community meetings. They displayed summaries of issues people had raised and details of the actions taken to address them. For example we saw on one ward that people had complained about water pressure in shower rooms. We noted that action taken had been to order new valves and arrange for their installation.

People had their comments and complaints listened to and acted on.

We spoke with the hospital manager and the hospital complaints manager about the provider's complaints procedures. We saw that the Trust had a comprehensive policy and procedures about "the investigation of incidents, complaints and claims". We saw evidence that complaints had been investigated and action had been taken in response to complaints raised in person or as the result of complaints brought to the notice of the hospital in correspondence. For example we saw that information had been added to

menu cards about medical terminology as the result of one complaint. We also saw a commitment in correspondence to a complainant to change working practices and procedures on one ward to ensure that people's physical needs would be properly met.

Documents that we looked at showed that the Trust recorded all complaints it received either from patients or carers. They showed the Trust had a system in place to check how well its procedures were followed concerning response times and compared its performance to the previous 12 months.

We saw a document that showed the Trust collated and analysed information about complaints. This was in order to identify themes or trends and see where changes could be made to improve services.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Regulation 9(1) (a) and (b) (i) and (ii) People are not always protected against unsafe treatment or care. Plans are not always put into place to ensure that people's physical health and other individual needs and wishes are met.
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: Regulation 11 (2) (b) The arrangements in place to protect people against the excessive use of restraint are not sufficiently robust or comprehensive.
Regulated activity	Regulation

This section is primarily information for the provider

Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: Regulation 15 (1) (a) and (c) People are not properly protected against the risks associated with unsuitably designed premises and the way the premises are managed and operated.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 22 May 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

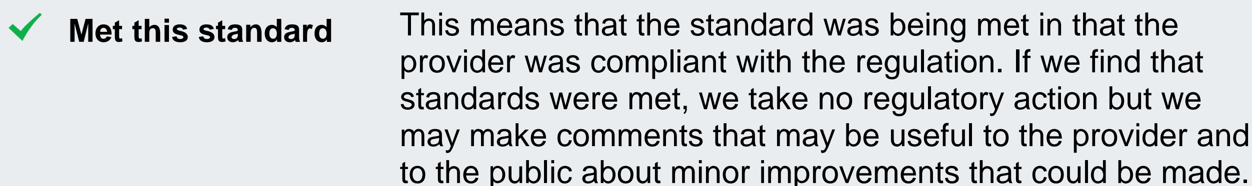
In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

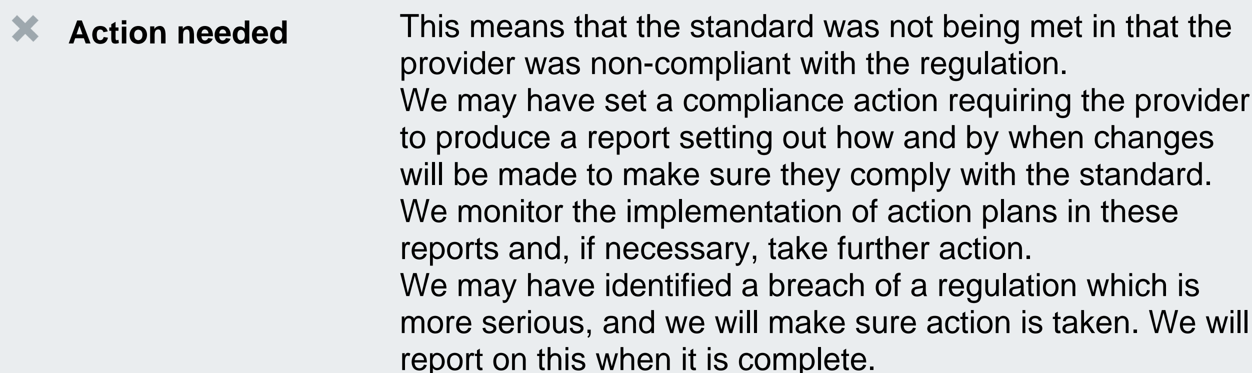
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

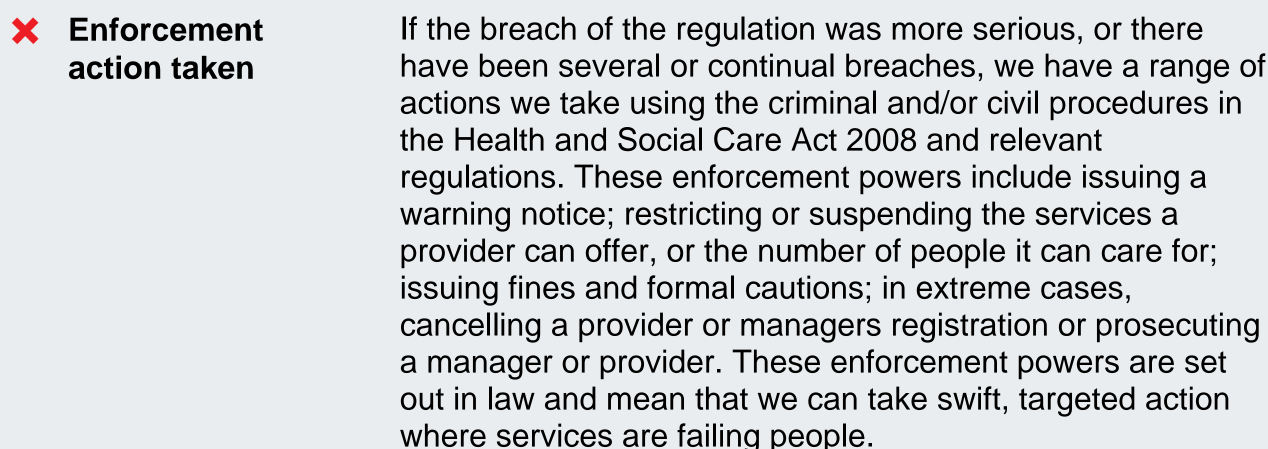
We reach one of the following judgements for each essential standard inspected.



✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.



✗ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.



✗ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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APPENDIX B

Report on actions you plan to take to meet CQC essential standards
Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	
Our reference	INS1-574574123
Location name	St Ann's Hospital
Provider name	Dorset Healthcare University NHS Foundation Trust

Regulated Activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
	How the regulation was not being met:
	Regulation 9(1) (a) and (b) (i) and (ii) *People are not always protected against unsafe treatment or care. Plans are not always put into place to ensure that people's physical health and other individual needs and wishes are met.*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. **Care Plans had not always been produced to manage Service User's physical conditions.**

(a) The Ward Manager will ensure all service users have an associated care plan for any significant physical health conditions.

Action: **Ward Managers**
By: **end July 2013**
Status: **Complete**

2. **On Branksome Ward some care plans are not reviewed on a regular basis**

(a) The Ward Manager will ensure care plans are reviewed as part of the MDT review, and this will be recorded within the patient record

Action: **Ward Manager**
By: **end July 2013**
Status: **Complete**

3. **Limited evidence of psychological or discharge planning activities on Branksome Ward.**

(a) In line with action outlined in the MHA CQC Visit Reference Number: 27242, 5 February 2013 St Ann's Hospital (Thematic Visit), the ward activities programme will be reviewed, this will also include pre discharge planning groups and psychosocial groups.
Action: **Ward Manager/Professional Head OT**
By: **end Sept 2013**
Status: **Complete**

4. **Patients on Branksome Ward felt there were limited facilities for leisure activities.**

(a) Service user views will be sought via community meetings and this will inform the reviews/ provision of activities.

Action: **Ward Manager**

	By: **end July 2013** Status:
Who is responsible for the action?	See above
How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?	
1 and 2 Care plans will be reviewed during monthly management supervision using supervision pro forma. 3 (a), The outcome of the review of ward activity programmes will be reported to the Inpatient Management Group. 4(a) Community meeting minutes will be reviewed by the Ward Manager on a monthly basis to establish Service Users opinions on activities.	
Who is responsible?	See above
What resources (if any) are needed to implement the change(s) and are these resources available?	
Date actions will be completed:	See above
How will not meeting this regulation until this date affect people who use the service(s)?	

Completed by (please print name(s) in full)	James Barton
Position(s)	Director of Mental Health
Date	

<table>
<tr><th>Regulated Activity</th><th colspan="2">Regulation</th></tr>
<tr><td rowspan="3">Assessment or medical treatment for persons detained under the Mental Health Act 1983</td><td colspan="2">Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010
Safeguarding people who use services from abuse</td></tr>
<tr><td colspan="2">How the regulation was not being met:</td></tr>
<tr><td colspan="2">Regulation 11 (2) (b)

The arrangements in place to protect people against the excessive use of restraint are not sufficiently robust or comprehensive.</td></tr>
<tr><td colspan="3">Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve</td></tr>
<tr><td colspan="3">1. Low stimulus unit on Twynham Ward is frequently used for de-escalation, however, it is not subject to the same degree of record keeping, monitoring, oversight and governance as a seclusion room.

a) A record of the entry and exit times of the low stimulus room will be kept.
Action: Matron, Forensic Services/ Service Manager
Status: Complete

b) This will be monitored by the Directorate Management Group initially on a monthly basis.

Action: Business Manager
By: August 2013
Status: Complete</td></tr>
<tr><td colspan="2">Who is responsible for the action?</td><td>See above</td></tr>
<tr><td colspan="3">How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?</td></tr>
<tr><td colspan="3">1. Low stimulus unit on Twynham Ward is frequently used for de-escalation, however, it is not subject to the same degree of record keeping, monitoring, oversight and governance as a seclusion room.

a) Where there are outliers or a pattern emerges this will be investigated and appropriate action taken.

Action: Matron, Forensic Services/Service/Ward Managers
Status: Complete</td></tr>
<tr><td colspan="2">Who is responsible?</td><td>See above</td></tr>
<tr><td colspan="3">What resources (if any) are needed to implement the change(s) and are these resources available?</td></tr>
<tr><td colspan="3">No additional resources are required.</td></tr>
<tr><td colspan="2">Date actions will be completed:</td><td>See above</td></tr>
<tr><td colspan="3">How will not meeting this regulation until this date affect people who use the service(s)?</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Completed by (please print name(s) in full)	James Barton
Position(s)	Director, Mental Health
Date	3rd July 2013

Regulated Activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises
	How the regulation was not being met:
	Regulation 15 (1) (a) and (c) *People are not properly protected against the risks associated with unsuitably designed premises and the way the premises are managed and operated.*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Minor damage to the plasterwork in the seclusion room on Haven Ward.

a) This damage has been repaired.

Status: **Complete**

2. Seclusion rooms lack the means available for the occupant to call for attention.

a) All patients in seclusion are observed at all times by a member of staff and therefore have the ability to summon help or attention.

Status: **Complete**

3. Mattresses could be used to obscure observation panels.

a) Staff will summon other staff (through a personal alarm) if a Service User begins to attempt to block themselves from visibility.

Action: **Matron, Forensic Services/Service/Ward Managers**
Status: **Complete**

4. Female patients crossed through a male ward to be placed in seclusion.

a) The Vulnerable Person's Unit has been completed and will reduce the instances of female Service Users being placed in seclusion on Twynham ward, once appropriate staffing has been recruited.

Action: **Matron, Crisis & Acute Services/Ward Manager**
By: **December 2013**
Status: **Complete**

b) The Trust seclusion policy is being reviewed and amended to include guidelines for female Service Users.

Action: **Matron, Forensic Services**
By: **September 2013**
Status: **Complete**

Who is responsible for the action?	See above

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?	
2 (a) and (b), 3 (a) Hospital Managers are satisfied that the current processes in place to ensure Service Users have the means to summon staff are appropriate. 4 (a) The Trust is actively recruiting staff during July 2013 and will aim to fill all available vacancies. This is dependant upon the number and calibre of applicants and potential start dates of successful candidates. 4 (b) The Trusts Seclusion policy will be reviewed to better incorporate privacy and dignity for female service users. This will be monitored and agreed by the Directorate Management Group.	
Who is responsible?	See above
What resources (if any) are needed to implement the change(s) and are these resources available?	
4 a) Dependant upon the availability and calibre of people applying for posts.	
Date actions will be completed:	See above
How will not meeting this regulation until this date affect people who use the service(s)?	
There is a possibility that female patients may need to access seclusion on Haven Ward. On these occasions every effort will be made to safeguard the dignity and respect of the patient.	
Completed by (please print name(s) in full)	James Barton
Position(s)	Director, Mental Health Services
Date	3rd July 2013

APPENDIX C

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St Ann's Hospital

69 Haven Road, Canford Cliffs, Poole, BH13 7LN

Date of Inspections: 26 April 2013
25 April 2013

Date of Publication: June 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Standard		Outcome
Respecting and involving people who use services	✗	Action needed
Staffing	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard
Records	✓	Met this standard

Details about this location

Registered Provider	Dorset Healthcare University NHS Foundation Trust
Overview of the service	St Ann's Hospital provides assessment and treatment to adults with mental health needs. The hospital can accommodate up to 94 people. It has an acute admission ward for all newly admitted people and two wards (one male, one female) for people who need in-patient treatment. There is a ward for older people with functional mental health problems, a small intensive care unit and a low secure forensic unit.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	5
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Action we have told the provider to take	16
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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 25 April 2013 and 26 April 2013, checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with staff.

What people told us and what we found

We carried out our inspection of the hospital because anonymous information of concern had been posted on the Care Quality Commission's website.

We visited four of the hospital's six wards, two separate treatment wards for male and female patients, a mixed acute admission ward and a male low secure forensic ward.

We observed some of the day to day activities on the treatment wards.

We spoke with nine patients in order to hear what they thought about the service they received and a range of staff in order to obtain their views about the service the hospital provided. They told us staff were polite and treated them with respect. They told us they could make suggestions at ward meetings about how things could be improved.

Information about the hospital's services and facilities was readily available and accessible to patients.

Arrangements were in place that helped to promote patients dignity and privacy but sometimes this had been compromised.

The provider took steps that ensured as far as reasonably possible at all times there were sufficient numbers of suitably qualified, skilled and experienced persons on duty to meet patients' needs.

There were systems in place to monitor the quality of the service provided at the hospital and identify and manage risk to patients, visitors and staff.

Records we looked at were accurate and up to date which ensured patients were protected from unsafe care and treatment.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 09 July 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's rights,privacy, values and choices were respected but their dignity had sometimes been compromised.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People who used the service understood and were given appropriate information and support regarding their care or treatment.

The provider (Dorset Healthcare University NHS Foundation Trust) had a website with information about the hospital and a copy of the hospital's "Service User Information Booklet" which could be downloaded. The booklet set out what patients could expect at and from the hospital and included the following statement.

"We want to provide you with as much choice as possible throughout your care and treatment. By making different choices available, we hope your care is more designed to meet your needs and take account of your personal preferences. There may be dietary requirements, dress codes and cultural practices that are important to you and your family. Your key nurse will discuss your needs with you and will ensure the ward team are aware of your preferences and will aim to respect these …".

One patient we spoke with told us that they had looked at the website before they were admitted and consequently knew about all the facilities that were available to them before they had arrived.

We saw the information booklet was displayed throughout the hospital on wards. We also noted other important information on display throughout the hospital included details of the provider's complaints procedures and the patient advice and liaison service (PALS). We also noted that information was readily accessible about advocacy and advice services such as Independent Mental Health Act Advocates (IMHA), the Citizens Advice Bureau, Independent Mental Capacity Advocates (IMCA), Dorset Race Equality Council and the

Dorset Mental Health Forum. This meant that patients could obtain advice and help with upholding their rights.

Patients we spoke with told us they were treated with respect and their dignity was promoted. They said hospital routines, facilities and their legal rights were explained to them and their care and treatment was discussed with them.

This all showed that the hospital was committed to promoting patient's needs, choices and rights and their views and experiences were taken into account in the way the service was provided.

We saw that the hospital had some wards specifically for patients of the same gender and also wards that accommodate both male and female patients. On the latter wards facilities such as bedrooms and toilets and bathrooms were segregated and there were also lounge areas reserved for the use of female patients only.

On some wards there was mix of single and shared bedrooms. Patients who were accommodated in shared bedrooms told us that they had curtains around their beds that provided them with some privacy. Our observations on the wards confirmed this.

We were told by staff that when patients required assistance with their physical care that either staff of the same sex provided that help or a same sex chaperone was present.

One patient said, "The staff are polite. If I am doing something wrong they may not be quite so polite … They have explained my rights to me recently because my section was reviewed … At a ward round today they discussed my medication with me and I can discuss any concerns I have about my treatment at a ward round.

Another patient said, "I am getting all the help I need … we had a ward round yesterday and they told me that I could go home".

A third patient told us their belief system was very important to them. They said, "I am a Christian and I have been told about the multi-faith room they have here and that I can see a priest".

A concern was raised with CQC that a partially clothed female patient had been moved through the hospital to be cared for in the seclusion room on Twynham ward. This is the hospital's low secure forensic unit for male patients.

This was confirmed by staff we spoke with. They told us that if patients became agitated or were highly disturbed and were a high risk they sometimes had to be moved to the low stimulus unit or seclusion room on Twynham ward. This meant that on occasions female patients had to be taken through the hospital to that ward. We were told when this happened Twynham ward was normally informed but that this did not always happen. Consequently there had been an occasion when a partially clothed female patient had been taken to the ward.

We saw audits that had been carried out about the use of the low stimulus unit and seclusion room on Twynham ward between 23 September 2012 and 28 April 2013. These audits showed that on 21 occasions female patients were cared for in either the low stimulus unit or seclusion room on the ward.

This all showed that although generally patients' diversity, values and human rights were respected there were occasions when patients' dignity had been compromised.

Staffing

✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

Steps had been taken to ensure that at all times there were enough qualified, skilled and experienced staff employed to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

We spoke with the hospital manager, two consultant psychiatrists, seven registered nurses, two mental heath support workers and nine patients in order to obtain their respective views about staffing levels.

All the patients we spoke with thought that there were usually enough staff on duty although several commented that cigarette breaks could be curtailed if there were not enough staff available to provide the supervision needed.

Documents that we looked at included correspondence about and the outcome of a review of staffing levels at the hospital carried out in Autumn 2012. We noted that one of Dorset Healthcare University Foundation Trust's (the trust) directors stated a commitment to holding regular reviews of staffing levels and making a registered nurse avaialable on every shift on every ward at the hospital.

The outcome of the review set out the minimum number of registered nurses and mental health support workers on each shift and ward as agreed with consultant psychiatrists and ward mangers. It also showed that the number of registered nurses and mental health support workers had been increased on some shifts on some wards.

We saw that a senior member of the hospital's staff visited the wards each day. They recorded details about the numbers of staff on duty and information about any matters that could adversely affect staffing levels. A "nurse in charge" on duty each day was responsible for re-allocating staff among wards when there were absences that could not be covered by the hospital's own bank staff.

We noted a member of staff on each ward carried a pager so they could respond and attend emergencies on other wards. This meant that on occasions the staffing levels on every ward apart from the ward with the emergency could temporarily be below the agreed minimum.

There was evidence that there had been recent problems with maintaining staffing levels but these had been resolved.

For example we saw records that showed for three days in April (16, 17 and 18) the staffing level on one ward on the afternoon/late shifts had been below the agreed minimum. The ward manager said they had subsequently been told by one of the trust's directors that if bank staff were unavailable they could use agency staff to cover staff absences.

Staff we spoke with told us that the hospital's own bank of staff covered the vast majority of staff absences or vacancies. They said that agency staff were only used to cover absences of mental health support workers. No member of staff we spoke with could recall agency staff being used to cover the absence of a registered nurse. This showed that people with the relevant skills and knowledge provided cover in the absence of permanent staff.

Documents we looked at showed that from 5 January 2013 to 21 April 2013 on the specialist low secure forensic ward there had been staff shortages. We saw that on 107 occasions for periods of time ranging from one hour to complete shifts staff numbers fell below the agreed minimum level. This was because the ward provided staff to cover shortages elsewhere for tasks that included, monitoring patients in a seclusion unit on the hospital's psychiatric intensive care ward, monitoring patients brought to the low stimulus unit or seclusion room on the ward from other wards in the hospital or responding to emergencies in other parts of the hospital. They also included assisting with the admission of patients on the hospital's acute admission ward.

We also saw documentary evidence that on 9 March 2013 the re-allocation of two staff from the ward to other wards resulted in a patient's rights being denied. Planned escorted section 17 leave under the Mental Health Act 1983 was cancelled for one patient. It also resulted in the curtailment of activities important for the treatment of other patients.

On 29 April 2013 the modern matron responsible for Twynham ward told us the provider had agreed that in future no staff would routinely respond to emergencies on other wards. Staff would not be reallocated to other wards without the express permission of an associate director or an on-call out of hours manager. They said it had been agreed that the seclusion room on the ward would not be used as a resource for other wards without the express permission of the on-call consultant. This meant that it was less likely that the ward's agreed minimum staffing level would be reduced and patient's rights compromised.

At the time of our inspection there were five vacancies for nursing and support staff at the hospital. They comprised one clinical team leader, two registered nurses, two mental health support workers and one occupational therapist. They represented 6.25%, 11.86%, 5.06 and 16.66% of their respective complements. The vacancies had all been advertised.

We saw that an "Early Warning Trigger Tool" had been used to produce monthly reports for the trust's "quality, clinical governance and risk assurance committee. This was to alert senior managers to potential risks that could result in patient care being compromised and enable remedial action to be taken. Indicators included staff vacancy rates, unfilled shifts and staff sickness rates. A committee report of 2 April 2013 stated that for the three month period from December 2012 to February 2013 no wards reported a score that exceeded

the trigger threshold.

We also saw a copy of a report to the trust's quality directorate's "in-patient safety" meeting for April 2013. We noted there was comprehensive information about staffing levels including reasons for staffing shortages.

This all showed the provider had systems in place to enable steps to be taken if necessary that would ensure proper staffing levels and skill mixes were maintained.

Assessing and monitoring the quality of service provision

✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to regularly check and monitor the quality of the service and identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

We saw that patients' views about what they thought of the care they received were obtained in a number of ways. They included the use of questionnaires, regular community meetings held on the wards and the use of suggestion boxes located on every ward.

We looked a a copy of the report of the "St Ann's Hospital Experience Survey" carried out for the the third quarter of the year 2012/2013. Patients had been asked for their views about their hospital stays. Questionnaires or a hand-held device that was kept on each ward had been used to collect information. The report showed that 67 patients had taken part in the survey and several areas for improvement been identified as a result of the responses received from patients. They included improved privacy around bed spaces and more activities during the day and at weekends. We saw that an action plan had been implemented. It included the introduction of new activities on all the wards and the ordering of new furniture for one ward that would improve the security of patients personal items.

The hospital manager told us that a copy of the report was discussed at a monthly Inpatient Safety Group and by the Public and Patient Experience and Engagement Committee. This showed that suggestions and concerns raised by patients were acted on.

Patients we spoke with told us they went to community meetings and could raise issues. One patient said, "We have meetings most mornings and you can mention what you want".

Another patient said, "Every morning there is a meeting to talk about what we are going to do and to talk about things that worry us".

On all the wards we visited we saw notice boards with the outcomes of the discussions that took place in these meetings. For example on Dudsbury ward we saw the following statements. "You asked for more pamper nights. We provided one more pamper night a week with home made face masks".

On Branksome ward a member of staff told us therapeutic activities that were arranged were based on the interests of the group of patients and a recent suggestion had resulted in starting a movie club. They said that people who attended watched a film and then critiqued it. During our visit to the ward we saw this activity taking place.

This all showed that there was a commitment to obtaining the views of patients and wherever possible acting on them.

We saw that arrangements were in place to check the provider's procedures were followed and identify where if necessary improvements could be made.

We looked at records that showed the following procedures, practices and equipment were regularly checked: infection control procedures, care plans and patient records, obtaining consent to treatment, medical devices, medication administration records and the management of medication.

We also saw a report from an audit had been carried out at the end of 2012 on Merley ward the hospital's acute assessment unit. The audit was of the completion of initial physical examinations carried out on patients on admission to the ward. It showed that improvements had been made since a previous audit in February 2011. We also saw that recommendations had been made that would lead to further improvements to the standards of physical assessments of patients admitted to the ward.

Other documents we looked at showed the provider had systems in place to check that standards were maintained and identify where improvement may be needed. They included a clinical audit programme for 2012/13, a provider compliance assessments implementation plan dated January 2013 and recent copies of the "Mental Health Services Directorate Governance Reports".

There was evidence that learning from incidents/investigations took place and appropriate changes were implemented.

Documents that we looked at included one about lessons learnt. The hospital manager told us that it was produced annually and was compiled from records about complaints and incidents. The manager also said that as a result of incidents around the use of rapid tranquilisation new guidance about the use of restraint had been implemented. We saw this guidance was readily available on the wards we visited.

There was a system in place (Ulysses) for recording incidents. We were told that the information was collated and incidents were categorised and rated according to risk. One clinical team leader told us that certain incidents routinely required a root cause analysis to be carried out to see what lessons could be learnt from them. They also said that they often received requests from the head of patient safety and risk to do such analysis of other incidents.

At our last inspection of St Ann's Hospital in February 2013 we looked at the provider's complaints procedures. We found that the provider took account of complaints and comments in order to improve the service.

Records

✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because information about them was kept securely and was complete and accurate.

Reasons for our judgement

We spoke with people who used the service but what they told us did not relate to this standard.

The provider's website included a number of their policies concerned with the management of information they held about people. They included the following.

Data Protection Act 1998: Access to Health and Social Care Records; Freedom of Information Act (2000): Trust Protocol; Guidance For Staff In Sharing Information With Carers: and Information Governance.

The information governance policy referred to among other things, staff training, the Common Law on confidentiality, password access protections and the Caldicott Committee recommendations on patient identifiable information.

This showed the provider was committed to managing sensitive information in accordance with the law.

People's personal records, including medical records, were accurate and fit for purpose.

With the assistance of staff we looked at the electronic records of the nine patients we spoke with during our inspection. We also looked at some paper records about patients that were held on wards. We saw that people's preferences and cultural needs were recorded. For example we saw that one patient's potential requirement for a Halal diet was recorded.

Records we looked at showed that patients' needs were identified and care plans were developed based on those assessments. We saw that care plans were routinely reviewed at least weekly in order to see what progress patients made with their treatment. Potential risk to patients were identified including self harm, harm to others, self neglect and accidents.

All the records that we looked at were up to date and accurate

Records were kept securely and could be located promptly when needed.

We saw that information about patients was accessed in staff offices on the wards that were locked when they were not occupied by staff. Records were kept in electronic and paper formats. We noted that access to electronic records was controlled by identity cards held by staff and passwords. Paper records were held in filing cabinets that could be locked.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

<table>
<tr><td>Regulated activity</td><td>Regulation</td></tr>
<tr><td rowspan="2">Treatment of disease, disorder or injury</td><td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010

Respecting and involving people who use services</td></tr>
<tr><td>How the regulation was not being met:

Regulation 17(1)(a)
The dignity of female patients was sometimes compromised when they were cared for on a ward that was meant to accommodate male patients.</td></tr>
</table>

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 09 July 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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APPENDIX D

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RDY
Our reference	INS1-574574123
Location name	St Ann's Hospital
Provider name	Dorset Healthcare University NHS Foundation Trust

Regulated Activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **How the regulation was not being met:** People's rights, privacy, values and choices were respected but their dignity had sometimes been compromised.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. **The dignity of female patients was sometimes compromised, when placed in seclusion/low stimulus**

   a) Staff have been reminded that the dignity of all patients, particularly women, needs to be considered during the inter-ward transfers.

   Responsible: **Associate Director Inpatient Services/Service & Operational Managers**
   Progress: **Completed**

Who is responsible for the action?	See Above

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?

1. **The dignity of female patients was sometimes compromised, when placed in seclusion/low stimulus**

(a) This forms part of ongoing Prevention and Management of Violence and Aggression training for all staff.

Responsible: **Associate Director of Mental Health**
Progress: **Completed**

(b) All incidents of restraint and seclusion will be monitored via the Directorate Management Group initially on a monthly basis.

Responsible: **Business Manager**
By: **August 2013**
Progress: **Complete**

(c) Where applicable, incidents are reviewed by the Matron/Operational & Ward Managers.

Responsible: **Matron, Forensic Services/Operational & Ward Managers**
Progress: **Completed**

Who is responsible?	See above

What resources (if any) are needed to implement the change(s) and are these resources available?

Date actions will be completed:	See above
How will not meeting this regulation until this date affect people who use the service(s)?	
N/A- The actions are achievable.	

Completed by (please print name(s) in full)	James Barton
Position(s)	Director of Mental Health
Date	3rd July 2013

Appendix 5

HSC54.13 OUTCOME OF CARE QUALITY COMMISSION INSPECTION – ST ANN'S HOSPITAL

The Director of St Ann's Hospital referred to a similar presentation made to the Committee previously regarding Safeguarding Mental Health and provided an update on the two inspection visits made by the Care Quality Commission (CQC) and subsequent follow-up visits. The Director stressed the desire to achieve a fully compliant inspection outcome.

Key points and comments were highlighted as follows:

- The Chairman enquired if the term 'Met this standard' is to be changed to mean something more meaningful?
  The Strategic Director (People Theme) confirmed the intention to move to a rating scale similar to School inspections i.e. 'outstanding, good, requires improvement and inadequate'.
- Referring to Appendix B Page 6, a Member questioned if it was feasible or achievable for all patients detained under the Mental Health Act 1983 and held in seclusion to be observed at all times?
  The Director explained that seclusion was an intervention rather than a treatment and provisions had now been put in place to achieve this objective.
- A Member asked if it was possible to be provided with a copy of the Inspection Report?
  The Director stated that the details were available via the CQC's website at www.cqc.org.uk.
- It was questioned if staff recruitment was a problem?
  The Director advised that the staff performed to an excellent standard and persons were keen to join the establishment.
- A Member queried if the new facilities were operational?
  The Director confirmed that the two brand new wards were now open and explained that the standard was of high quality, with patients having their own access to outdoor space.
  It was suggested that a visit be arranged for Members wishing to view the new facilities and it agreed that this be arranged to coincide with a site visit to the Mental Health Team on 29 January 2014.
- Referring to Appendix A Page 4, a Member sought clarification of the finding that limited leisure activities meant that people's individual needs were not always met?
  The Director explained that the provision physical health and interventions provided at weekends and evenings was a national issue. Examples of the type of provision included; pool sessions, film nights and outdoor activities.
- Concern was expressed at the finding of 'action needed' regarding dignity and respect.
  The Director provided a detailed explanation of the circumstances surrounding the case in question and the provisions put in place since the inspection.

The Director in advising the Committee that he was leaving the post, thanked the Chairman and Members for their support and reported that his successor was Jane Elson.

RESOLVED:

i) **That the Committee note the Report detailing the outcomes of the Care Quality Commission inspection of St Ann's Hospital.**

Voting: For – Unanimous

Appendix 6

DORSET HEALTHCARE UNIVERSITY FOUNDATION TRUST – IMPROVEMENT PLAN

The Interim Chief Executive of Dorset Healthcare University Foundation Trust gave an oral presentation to the Committee.

It was reported that recent developments within the Trust had highlighted three main areas for the Trust to improve upon:

- The leadership and governance
- Quality assurance
- Failure to deliver potential from bringing together community services

The Interim Chief Executive explained that there had recently been big changes within the Trust at leadership level, including the departure of two Directors and 3 non-executive Chairmen. It was explained that there were two non-executive vacancies to be filled; it was stated that these would be filled by end of January 2014. It was highlighted that there was a need to keep stability at the top level of management.

Another area for improvement was quality assurance, and the quality of services. It was explained that there had been moderate concerns raised by the regulator, the Care Quality Commission (CQC). These concerns were raised over administrative services around record keeping and mistakes being made. It was stated that the internal audit of services needed to be better regulated.

The other key area for improvement was down to the failure to deliver the potential from various services and organisations under the Trust. It was stated that given the size of the Trust, Dorset Healthcare must be at the forefront of bringing services together and simplifying services for patients. For example, patients being referred multiple times back and forth from GP surgeries to the Hospital. Different services needing to have better communication and be better linked up; integration of services was key.

Comments and discussions included:

- In response to a question about the issues highlighted, it was explained that the concerns named 'moderate' were treated very seriously; if any concerns had been branded 'serious' then those services would be closed. It was highlighted that no patients had been harmed in any way through the failings reported.
- It was commented that the timescale of changes would take effect over a long period of time, however the primary focus currently was the delivery of the 'integrated care' to be put into effect. This would be in place by February 2014.

- It was explained that the management structures would be reviewed. Services would be grouped together, such as primary care services, and local authority services. It was hoped that within 6 months the new structures would be in place.
- In response to a question, the Interim Chief Executive agreed that there was a high number of senior management. It was suggested that this could be an area of potential savings.
- The importance of integrating services was reiterated, due to there being approximately 70 different services across Dorset. Many patients required more than one service, e.g. having mental health problems as well as physical problems, therefore smoothing the process for patients was crucial.
- The Strategic Director (People Theme) commented that further discussions would take place with Bournemouth and Dorset to review the establishment of a Pan Dorset Joint Scrutiny Committee.
- In response to a question, the Interim Chief Executive stated that if the CQC had not flagged concerns then the Trust would not have been alerted to them.

RESOLVED that that verbal report be noted and further discussions with neighbouring authorities be held on the establishment of a Pan Dorset Joint Scrutiny Committee.