

**Inadequate**

Isle of Wight NHS Trust

# Community-based mental health services for adults of working age

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
R1FAV	St Mary's Hospital (Mental Health Management)	Community-based mental health services for adults of working age	PO30 5TG

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Inadequate



Are services safe?

Inadequate



Are services effective?

Inadequate



Are services caring?

Requires improvement



Are services responsive?

Inadequate



Are services well-led?

Inadequate



### Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated community-based mental health services for adults of working age inadequate because:

- We identified a number of serious concerns in relation to patient safety. We served and urgent requirement notice letter and issued a section 31 notice of decision to urgently impose conditions on the trust as we had reasonable cause to believe a person would or may be exposed to the risk of harm unless we did so.
- An action plan developed by the community clinical quality, risk and patient safety committee identified some of the key issues around caseload management, care pathways and care records, in July 2016. In addition to continued non-compliance, the variation in performance and quality and gaps in critical aspects of service provision, demonstrated to us that the governance of community-based mental health services for adults was not sufficiently robust or effective. The executive team of the trust were unable to demonstrate that they had sufficient understanding of the risks in community mental health services. There had been no additional resources and/or senior managerial oversight to support the operational manager in reviewing the service, or the teams in reviewing their caseloads. This meant that the service was not able to implement required changes effectively, or in a timely manner whilst operating a safe service.
- The operational manager implemented a business continuity plan (a plan developed to respond to significant risks facing a service) in September 2016 as the service was identified as having serious challenges and was unable to safely meet the needs of service users. The business continuity plan (BCP) was required to address the risk of caseload management and staff capacity. This plan covered the West, Central and South Wight team localities. The North locality had informal arrangements of reduced service capacity. Board meeting minutes reflected that this had been noted and therefore the executive team were aware of this plan. We found that governance arrangements were not effective in design and operation to plan, monitor and provide assurance that community mental health services were managing

risks to patients. There were no governance arrangements in place, or executive input that provided oversight or assurance about the use of the BCP. The plan was not on the corporate risk register.

- There was limited capacity to deliver and to access essential psychological therapies. There was no psychologist in either team which meant the service could not consistently provide a full range of support and therapies in response to people's needs. There were no evidence based care pathways in place and patients were not allocated appropriately or consistently to the care programme approach framework. We reviewed 23 care records and all lacked detail, had gaps and omissions in the core assessment, care plans and/or risk assessments. The majority of the care records we viewed were not person-centred, and very few of the records we viewed contained evidence of people's involvement in planning their own care.
- The electronic care records system was not fit for purpose and there were concerns with lack of guidance in relation to how staff should complete the records. The system was time consuming to use, requiring staff to constantly come out of one part of the system to access information and updates from other teams. There was no contemporaneous flow of information and there were clear risks that important patient information was not easily available to staff.

However:

- Patients we spoke with were very complimentary about the treatment they received from the staff. They described staff as being kind, caring, considerate, thoughtful, hardworking and extremely dedicated. Patients and carers acknowledged that staff were dedicated to delivering this level of care and service despite persistent staff shortages and lack of funding within the team.
- Staff at the West, Central and South Wight team had notably better morale than the North East locality. Staff at the West, Central and South Wight team told us that they felt well supported by their team manager and that they had a good understanding of the challenges they faced. They reported they generally

# Summary of findings

worked well as a team. Staff also highlighted that they felt well supported by the operational manager and they frequently met with the staff and attended the offices.

January 2017:

- We returned to the trust in January 2017 to seek assurance that these urgent risks were being addressed effectively. We found there was limited appreciation of the current risks and needs in the community teams. The trust demonstrated limited

understanding of the service demand, capacity and working with other services. It was our view that the trust required significant support in understanding the issues, prioritising and implementing effective change at pace - in addition to the much larger, challenging piece of work around creating a sustainable model of community mental health services. We met with partner agencies, including NHS Improvement, NSH England and the clinical commissioning group, to ensure an effective plan of support and change was established.

# Summary of findings

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

### Are services safe?

We rated safe as inadequate because

- There were not robust systems in place to assess, escalate and effectively manage risk.
- Allocation and management of caseloads was not effective. The teams did not have the right numbers of staff or skill mix to safely meet all the requirements of the service.
- We identified safety concerns in relation to the standard of assessment, care planning and risk assessment and management. In addition, the electronic records system was not fit for purpose, requiring staff to constantly come out of one part of the system to access information and updates from other teams. There was no contemporaneous flow of information and there were clear risks that important patient information not easily available to staff, or was not put on the system. For example, it was not possible to accurately track safeguarding issues and actions. Staff confirmed that the electronic care records system made reviewing records following incidents very difficult and time consuming. This had been highlighted in serious incident and coroner`s investigations.
- The implementation of the business continuity plan (BCP) had resulted in letters being sent to some patients currently on caseloads, advising that the service can only work with people with the “most complex and urgent needs”. There was no oversight about the number of people affected, and there was not a clear plan to monitor the risks or any deterioration in a person`s condition who was not receiving a service.
- The north locality team base at St Mary`s hospital was an administrative office, for staff use only. The staff toilets and kitchen facilities were cramped and unclean.
- The West, Central and South Wight team building had put the lack of working personal safety alarms in the building on the risk register in June 2016 and this was still not resolved at the time of inspection.

However, we also found:

- Most staff were up to date with their mandatory training. This training included areas of learning essential for safe practice such as safeguarding vulnerable adults and basic life support.

Inadequate



# Summary of findings

- Staff demonstrated good understanding of safeguarding processes and were able to give examples of when they had acted effectively to protect people in their care. Teams had lone working procedures, which helped to ensure staff safety when out in the community.

## Are services effective?

We rated effective as inadequate because

- Patients did not always have a full, documented assessment of their needs and risks. We reviewed 23 care records and all lacked detail, had gaps and omissions in the core assessment and care plans. The majority of the care records we viewed were not person-centred, and very few of the records we viewed contained evidence of people's involvement in planning their own care.
- The Care Programme Approach (CPA) ensures services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The criteria for CPA was not being appropriately applied. For example, some patients who met the criteria had not been put under a CPA, or some did not have any CPA level recorded at all (whether they met the criteria or not). This meant the trust was unable to ensure all patient needs were assessed and met effectively.
- The availability of different professional disciplines varied and staffing shortfalls impacted on the effective running of those services. There was limited capacity to deliver and to access essential psychological therapies. There was no psychologist in either team which meant the service could not consistently provide a full range of support and therapies in response to people's needs
- Staff in the community mental health team were not receiving regular, effective supervision or support to review their caseloads. This was particularly evident in the north locality team.
- The electronic care records system was not fit for purpose and there were concerns with lack of guidance in relation to how staff completed it. The system was time consuming to use, requiring staff to constantly come out of one part of the system to access information and updates from other teams. There was no contemporaneous flow of information and there were clear risks that important patient information not easily available to staff.

Inadequate



# Summary of findings

However, we also found:

- The service had established recovery and wellbeing clinics to monitor physical health of patients. In addition, all patients attending the clozapine and depot clinics had their basic physical health monitored.
- The service had established emotional management workshops.

## Are services caring?

We rated caring as requires improvement because

- Care plans and patient records did not reflect that people were always fully involved in the planning of their own care.
- Although all patients we spoke with had regular contact and care from the community mental health services, some had recently received letters to say that contact was temporarily to cease due to a business continuity plan being in put place for this service. Patients said they had been very upset by the letter, however when they complained to their mental health practitioners, contact had been resumed.

However, we also found:

- Staff had a good understanding of the needs of their patients and were patient centred. Staff were committed and conscientious in the delivery of their care. However, at times staff had to make difficult decisions to prioritise patients' needs and risks because of poor staffing levels and capacity within the service.
- During our inspection we observed one home visit appointment with a senior mental health practitioner and attended one group therapy session. At all times staff were observed treating patients with dignity, respect, courtesy and a real interest in recovery.
- We spoke with 14 patients who all had regular contact and care with mental health community services. The feedback from these patients about the care and treatment they received from staff was consistently positive.

**Requires improvement**



## Are services responsive to people's needs?

We rated responsive as inadequate because

- The service was identified as having serious challenges and was unable to safely meet the needs of patients. This meant that the service was unable to respond consistently and effectively.

**Inadequate**





# Summary of findings

- The trust was unable to describe the demands and capacity of the service, and the impact on patient referrals into, and discharges out of, the service.
- We identified widespread delays from assessment to treatment and long waiting times for people requiring essential psychological therapies as part of their treatment.

However:

- Despite the pressures in the service, staff were flexible and re-prioritised appointments when an urgent issue arose. They also worked hard to support patients who may find it difficult to get public transport or attend appointments at clinics.

## Are services well-led?

We rated well-led as inadequate because

- Most staff said that they did not feel supported by the trust or engaged in the vision and values. Staff perceived that there had been a long-term lack of oversight and effective resourcing in mental health services.
- During our inspection, we identified that none of the actions required of the community mental health services following the comprehensive inspection in June 2014 had been completed, despite the trust stating that they had completed these actions in May 2016. The executive team of the trust were unable to demonstrate that they had sufficient understanding of the risks and concerns in community mental health services and there had been no additional resources and/or managerial oversight to support the operational manager in reviewing the service, or the teams in reviewing their caseloads
- There were staffing pressures at the operational, team leader and clinical levels. There was one team leader and one operational manager in post at the time of inspection. The head of operations post was vacant, the head of quality and nursing and one team leader were on sick leave and there was no contingency to cover this absent leadership support.
- Staff told us that at times they had to make difficult decisions to prioritise patients' needs and risks because of poor staffing levels. Staff we spoke with described feeling constantly worried about patient safety and often feeling hopeless and helpless in delivering the required level of care to patients.

**Inadequate**



## Summary of findings

- Despite the best efforts of many of the staff, there was a risk that low staff morale was affecting the care and support that patients received. Staff morale was notably much worse in the north locality.

# Summary of findings

## Information about the service

The community mental health service offer a specialist multi-disciplinary service for individuals suffering from mental ill health. It is open to patients age 18 and above, with no upper age limit. The community mental health service offers assessment and treatment for people aged over 65 years, who do not require treatment for organic disorders such as dementia.

The trust introduced a new care model in the community mental health service, effective from April 2016. This meant that two teams worked across three localities. In addition there is a team that specialise in early interventions in psychosis, for people between 14 and 65 years of age. The trust had introduced a community mental health services action plan in July 2016 to review the new model of locality care. The plan was implemented by the newly appointed operational manager. At the time of inspection there were three teams, each had a different consultant psychiatrist covering North East, West/Central and South localities.

The trust had a comprehensive inspection June 2014. A warning notice was served following the inspection for a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010 (assessing and

monitoring the quality of service provision). Outcomes for people were not monitored in all areas to improve the effectiveness and quality of services and the risk register had not been reviewed since July 2012.

The trust also received compliance actions for breach of regulation 23 1(a) 3(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 for the inspection as found that staff in the community mental health services team had high caseloads without the appropriate levels of supervision to manage these, staff did not have regular supervision meetings and staff had not attended mandatory training; regulation (1) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as people did not have timely review of their care planning approach (CPA) at least within the last 12 months in community mental health services. Overall, there was a concern that community teams did not focus on people presenting with the highest clinical risk who had severe and enduring mental health issues.

During our inspection, November and December 2016, we identified that none of the above actions required following the comprehensive inspection in June 2014 had been completed.

## Our inspection team

The team that inspected the service comprised: a CQC inspection manager (inspection lead), one inspector and a specialist advisor who has experience in community mental health.

## Why we carried out this inspection

We inspected this core service as part to a short notice inspection to follow up on some areas that we had

previously identified as requiring improvement or were we had questions and concerns that we had identified from our ongoing monitoring of the service or if we had not inspected the service previously.

# Summary of findings

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?
- During the announced inspection visit, the inspection team:
- visited all three community service bases, two of which Chantry house, in Newport and the health and wellbeing centre at Ryde were used for patient appointments and South block within St Mary's hospital site which was for staff use only
- attended group session with patients and went on one home visit

- spoke with 14 patients who were using the service and six carers
- collected feedback from nine patients using comment cards
- looked at 23 individual patient care records
- spoke with 25 other staff members; including consultant psychiatrists, senior mental health practitioners, mental health practitioners, registered nurses, support workers, administrators, a local authority social work manager and a peer support volunteer
- interviewed the clinical director and operational manager with responsibility for these services
- attended and observed one hand-over meeting and two multi-disciplinary meetings
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the provider's services say

- Overall patients were satisfied with the care and service provision and gave very positive feedback about the staff that cared for them. Patients found staff to be kind, polite, respectful, supportive, caring and encouraging. Patients described staff as going above and beyond that which was expected despite being so busy with constant staff shortages within the team. One patient said their nurse was 'outstanding in their personal commitment, empathy and hard work' and another said that staff went 'the extra mile' to deliver care.
- With regards to their involvement in the care, patients reported that they are consulted on care planning with their comments and wishes being taken on board as far as practical. However, the planning rarely followed the care plan format and only one that we spoke with had received a copy of their care plan.
- Carers told us that they usually felt supported by this service and found that staff were responsive, kind and dedicated. Carers said they were involved in care discussions as appropriate.
- Patients and carers commented that they were able to speak to their care coordinator about any issues at appointments however some were unsure how to make a complaint otherwise.
- Patients and carers had a list of emergency contact numbers if required. However, some carers commented that it was often difficult to make direct contact with their assigned staff as a matter of urgency that would be more helpful.

## Good practice

# Summary of findings

## Areas for improvement

### Action the provider **MUST** take to improve

#### Action the provider **MUST** take to improve

- The trust must agree a comprehensive community mental health services improvement plan. There should be the necessary external advice and agreement for this improvement plan. The plan should ensure demands on the service are appropriately escalated, assessed and managed.
- The trust must operate an effective escalation protocol in community mental health services. This escalation protocol will need to ensure patients are prioritised appropriately in response to service demands and pressures.
- The trust must review capacity and capability of staff and ensure there are sufficient resources and support to the service, and implement the necessary changes
- The trust must ensure there are sufficient skilled staff to undertake psychological therapies
- The trust must ensure staff have access to safe work equipment they need.
- The trust must ensure there are effective governance and senior leadership arrangements in place to support the local and operational leadership in implementing the required changes.
- The trust must ensure that every patient who has received a letter, as part of the current action taken under the business continuity plan, is risk assessed and appropriately managed. Each patient must have a documented risk assessment and a clear date for review.
- The trust must complete the review of the current caseload of each clinician, psychologist and psychiatrist. Each patient must be identified, have a full assessment of their needs and patients should be allocated for CPA according to the set criteria and guidelines.
- The trust must ensure better consistency in relation to the quality and detail of risk assessments and crisis/ contingency plans across the community mental health service
- The trust must ensure that all staff receive regular, effective supervision and this includes caseload management and clinical reviews.

- The trust must ensure care records incorporate detailed core assessments, care plans and risk assessments and are regularly updated to reflect changes in individual's situation or treatment. Records must include a clear assessment of people's risks and needs or a plan of how to manage these safely and effectively agreed with the person. Patient outcome measures should also be used.
- The trust must establish and maintain care plans which are person centred, holistic and include sufficient detail to enable staff to understand individual needs and monitor progress.
- The trust must establish effective systems and processes that enables the trust to assess, monitor and improve the quality and safety of the services
- The trust must review the electronic care records system and ensure it is fit for purpose. Staff must be provided with clear guidance and training in relation to how staff should complete the records.

### Action the provider **SHOULD** take to improve

- The trust should engage staff, patients and carers, ensuring they consult them on the changes and design of the service.
- The trust should ensure they implement processes to monitor health and wellbeing of staff.
- The trust should continue to monitor and work with partners to resolve the lack of availability of a second doctor to undertake Mental Health Act assessments in a timely manner.
- The trust should ensure they record and monitor all concerns and informal complaints to monitor potential trends and concerns
- The trust should ensure that consent to treatment and capacity assessments are clearly documented.
- The trust should ensure that requests for environmental and maintenance works are undertaken promptly and systems to track requests are effective
- The trust should record clinic room and refrigerator temperatures

## Summary of findings

- The trust should ensure that IT issues are responded to in a timely manner and requests tracked and monitored

Isle of Wight NHS Trust

# Community-based mental health services for adults of working age

## Detailed findings

### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North East Wight Locality	St Mary's Hospital (Mental Health Management)
West, Central and South Wight Locality	St Mary's Hospital (Mental Health Management)

### Mental Health Act responsibilities

The trust told us there were occasions that the duty approved mental health practitioners were unable to get hold of a second medical practitioner despite numerous attempts. This has resulted in the use of Section 4 of the Mental Health Act. Section 4 is used for a person to be admitted to hospital for assessment, but undertaken with only one doctor. It is used where the admission is “of urgently necessity” and where waiting to gather two doctors together would cause “undue delay”. Use of section 4 should only be considered as an exception. From information provided by the trust section 4 has been used 15 times between June 2015 and November 2016, with eight occasions in 2016, the most recent in December 2016. The trust had recorded the reasons for use of section 4 and it was always due to the lack of availability of a second doctor.

Medical staff told us that the geography of the island and retirement of GPs had contributed to the difficulty in accessing a second doctor. They felt that the situation had improved slightly since more trust doctors had agreed to undertake responsibilities of a second doctor. However, this remains an issue that the trust should continue to monitor and work with partners to resolve.

Staff told us they were confident in their understanding of their responsibilities under the Mental Health Act. There were also approved mental health practitioners within the community mental health teams.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff assumed patients had capacity unless there was an indication that this was impaired in some way. For example, staff supported people who, through illness, disorder or substance misuse, lacked mental capacity to consent to or make decisions about their own treatment or medication. In these circumstances, they described how they would discuss capacity with the patient and other members of the team. However, it was difficult to find where mental capacity assessments and best interest decisions recorded due to the care records system.

Consent to sharing information was not always clearly documented, although we saw some examples that this had been detailed in assessment letters. The trust could not provide accurate information about how many staff had received training in this area, although acknowledged that overall staff knowledge of this legislation was poor. MCA training did not form part of the trust's mandatory training program.



# Are services safe?

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

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

## Our findings

### Safe and clean environment

- Staff conducted the majority of their appointments at patients' homes or other suitable venues in the community. Although as part of the business continuity plan, staff were now asking patients to attend appointments at the community mental health team bases where possible. One team base was in the centre of Newport and the other was within the Ryde Health and Wellbeing centre, where a number of community health services were provided. Staff had access to rooms to see people.
- The West, Centraland South Wight team building had put the lack of working personal safety alarms in the building on the risk register in June 2016 and this was still not resolved at the time of inspection. The most recent update to the risk register was in August 2016. The building was clean, although some of the fixtures and fittings were old. We were told by staff that estates and maintenance requests were not acted on in a timely manner. When we reviewed the environmental risks on the risk register, the dates that risks had been identified and requests made showed a lack of action taken.
- The north locality team base at St Mary's hospital was an administrative office, for staff use only. The staff toilets and kitchen facilities were cramped and unclean. The bins in the toilet were overflowing and there was a strong smell in the toilet area. Staff told us that they have raised concerns about these facilities and there had been no action taken. Some of the north locality team continued to base themselves at the Ryde site in response to the facilities.
- We reviewed two of the clinic rooms used by the community teams. These were clean and had required equipment, although West, Centraland South Wight team clinic room was quite small and cluttered. There was no on-site defibrillator on site at West, Centraland South Wight team base, staff would use the emergency services if required. The service had just been successful in their business case to have an electrocardiogram machine to check clients' heart rhythm and electrical activity. The clinic rooms were used to administer depot injections to

patients. Personal protective equipment, such as gloves and aprons, were available. Clinical waste was disposed in clearly labelled plastic bags. Plastic bins for the disposal of syringes and needles were not over-filled and there was a system in place for collection. Neither of the teams recorded refrigerator or clinic room temperatures. We raised this at the time of inspection.

- The teams confirmed that they received pharmacy support and we were shown the process for sending prescription charts to the pharmacy for checking and sending the prescribed depot medication. No medication was stored in stock, although some patient medication was stored – for, example clozapine. Clozapine should only be dispensed under strict adherence to physical checks and blood tests. This was overseen by the clozapine clinic, managed by one of the community mental health nurses. We were told by staff that the blood analyser machine used in the clinic to enable a patient's blood to be tested on-site to be checked in order to dispense the Clozapine at the same time, this reduced the number of trips a patient had to make. We were told it was unreliable and not working properly. This had been reported multiple times in the past six months and no action had been taken.

### Safe staffing

- At the time of inspection, there were three whole time equivalent and six vacancies in the West, Centraland South Wight team. This had a significant impact on the quality and continuity of care offered to patients. Some staff acknowledged that caseload pressures were contributing to care records not being completed and updated. The service had completed interviews and hoped that this would result in the recruitment of at least one member of staff. However, the overall open caseload of the whole community mental health team was 1798 at the time of inspection and therefore it would not be possible to arrange 18 care co-ordinators to oversee the safe and effective care of so many patients.
- Allocation and management of caseloads varied between teams, and this meant that some staff held high caseloads. The teams did not have the right numbers of staff or skill mix to safely meet all the requirements of the service. We reviewed the caseload information for all 18 clinicians, six had more than 35 people on their caseloads, with the

# Are services safe?

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highest caseload being 54 people. Caseloads were not effectively monitored or discussed in supervision at the north locality, and systems in place at the West, Central and South Wight team required embedding. Adjustments were not made to caseloads that accounted for patient complexity, although they did reflect the clinician's working hours. The service could not identify how many patients haven't been seen for over a year.

- Caseload audit and review was identified as a key requirement of the service redesign in September 2016. Staff had not been effectively supported to review their caseloads in line with the service model in addition to the pressures on the service. Some staff told us that they were not allocated their caseload in accordance with their experience, skills, availability and complexity of need. Three of the service consultant psychiatrists had very high caseloads at 443, 537 and 321 respectively. The trust did not have a good understanding of these caseloads, for example, they did not know how many people had not been seen for over a year, or if there were people who may not require input from a psychiatrist. There were psychiatrists attached to the teams and staff told us they could usually access them for advice when required.
- There were not consistent cover arrangements for staff sickness and vacancies. In the West, Central and South Wight team, one agency nurse was employed long term to assist the team with managing their duty system. The whole service was struggling with the number of referrals coming in and difficulty recruiting into existing staff vacancies, the number of staff who were long term sick or on leave had made it very difficult for the service to meet the demands of its caseload. There had not been a review of the service capacity and demand to understand if it was effectively resourced. As a result, the service had implemented a business continuity plan that is discussed later in the report.
- At local level the clinical team leader has acknowledged the heavy caseloads of staff due to the difficulty in recruiting mental health practitioners and the additional pressure the role of duty cover, running depot and clozapine clinics as well as group facilitator roles puts on them. As such, they have created two new roles of group work facilitator and a full time duty role to separate out these additional duties.
- The trust provided all staff with mandatory training. This included basic resuscitation, safeguarding adults and

children, information governance, and infection control. Information provided by the trust showed that the mandatory training across the community mental health service compliance rate was 84% overall against the trust target of 95%. Adult resuscitation rates were the lowest at 56%.

## Assessing and managing risk to patients and staff

- During our inspection, we found the trust had implemented a business continuity plan (BCP) due to the pressures on the service. The BCP for community mental health services was being used inappropriately to respond to service demand and pressures. This had resulted in letters being sent to some patients currently on caseloads, advising that the service can only work with people with the "most complex and urgent needs". Patients were advised to contact the office, if required, in the meantime. The service was unable to identify, to the inspection team, the number of patients who had now received letters under the BCP, or if it was appropriate for these patients to have received these letters. The process was reliant on individual clinicians keeping a record. This meant there was no oversight about the number of people affected, and there was not a clear plan to monitor the risks or any deterioration in a person's condition who was not receiving a service.
- The electronic records system was not fit for purpose, requiring staff to constantly come out of one part of the system to access information and updates from other teams. There was no contemporaneous flow of information and there were clear risks that important patient information not easily available to staff, or was not put on the system. For example, it was not possible to accurately track safeguarding issues and actions.
- We reviewed 23 care records and all lacked detail, had gaps and omissions in the core assessment, care plans and risk assessments. The detail and quality of the crisis/contingency plans reviewed was poor or absent. Risk assessments were incomplete and lacked detail. This meant there was not a clear assessment of people's risks and needs or plan how to manage these clearly agreed with the person and did not always clearly reflect known risks to patients or their carers.
- Over 50% of patients receiving clozapine or depot medication via the dedicated depot and clozapine clinics did not have an allocated care co-ordinator. This meant if

# Are services safe?

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

there were any concerns or additional needs identified as part of the treatment provided at the clinic, the clinic lead was required to manage this in addition to their workload. The lead for the depot clinic at the West, Centraland South Wight team did not have additional care coordinator responsibilities, the leads for the north locality depot clinic and the clozapine clinic did this in addition to their existing care co-ordinator and caseload responsibilities. We were concerned that this system was overly reliant on the staff with key responsibility for running the clinic and there was no clear back up plan if they were unable to fulfil this role. For example, if a patient did not attend their appointment as planned, it was the clinic responsibility to follow this up. We saw an example of a patient who had not attended their depot appointment. We reviewed their records and noted that they had been seen in the emergency department a few days previously in mental health crisis. There was no clear plan to check on the whereabouts and wellbeing of the patient. We asked this to be followed up at the time of inspection.

- There was a lone working policy in place and staff followed this. A member of the administration team each day ensured all staff was safe if they had been on a visit and were not scheduled to return to base before going off duty.
- We observed both team multi-disciplinary meetings, which were held weekly. The West, Centraland South Wight team locality meeting was well attended and chaired by the team leader. The north locality meeting appeared less well attended and less structured, the team leader was off sick at the time of inspection. Risk and safeguarding were not discussed in detail as separate agenda items in the meetings, although we observed that the teams spent time highlighting some individuals they saw as being at risk.
- Staff demonstrated good understanding of safeguarding processes. Staff were able to give examples of when they had acted effectively to protect people in their care. However, the teams did not have an overall log of safeguarding referrals, which would allow them to monitor actions and potentially identify trends across the teams. The care records system made it very difficult to track if appropriate action was taken to safeguard people. Staff advised that communication between teams could be

disjointed. We observed poor communication between the in-patient team and the community team in relation to an unplanned discharge from the ward of a patient where a number of serious safeguarding concerns had been identified.

## Track record on safety

There were 23 incidents of unexpected death recorded for the community mental health service between November 2015 and November 2016. Of these, eight were reported as suicide or awaiting coroner`s hearing but suicide suspected.

## Reporting incidents and learning from when things go wrong

- The trust incident management policy highlighted what events staff should report. Staff reported incidents through the trusts electronic reporting system. Staff we spoke with knew how to report incidents and explained how managers reviewed them. There were 138 reported incidents between November 2015 and November 2016 for the community mental health services, with the highest incidents reported relating to verbal abuse, information governance and computer issues. The teams did not hold information about complaints or incidents at a local level and there had been no analysis of trends. Serious incidents were discussed at the business unit managers meeting to be cascaded to the teams, meeting minutes reflected this happened.
- Staff confirmed that the electronic care records system made reviewing records following incidents very difficult and time consuming. This had been highlighted in serious incident and coroner`s investigations.

## Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff we spoke with described the need to be open and honest with clients. In the sample of investigation reports we reviewed, it was noted if duty of candour had been applied and how the patient and/or family had been contacted.

# Are services effective?

Inadequate 

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

## Our findings

### Assessment of needs and planning of care

- Patients did not always have a full, documented assessment of their needs and risks. Of the current caseloads, we found that only two clinician's caseloads had complete care records by way of all patients allocated to the CPA framework and dates of the next CPA review. We identified that 123 (20%) patients on the current caseload of the care co-ordinators within the community mental health service that there had been no core assessment of needs recorded for these patients. We saw some examples of comprehensive assessment letters attached to the records following initial assessment by the single point of access team.
- We reviewed 23 care records and all lacked detail, had gaps and omissions in the core assessment, care plans and/or risk assessments. The majority of the care records we viewed were not person-centred, and very few of the records we viewed contained evidence of people's involvement in planning their own care. We saw examples where care records had not been reviewed, or updated to reflect changes in individual's situation or treatment. However, we found that staff had recorded appointment outcomes in daily progress notes on the electronic records.
- Evidence of physical health checks were not consistently documented, although where patients attended depot or clozapine clinics we saw that physical observations were recorded, blood results were recorded on a different record system. The clinical commissioning group had given the trust a quality target to ensure patients received physical health checks. The service had recently established physical health clinics to meet this target. The West, Central and South Wight team already started to run these and they were in the process of being established in the north locality.

### Best practice in treatment and care

- There was limited capacity to deliver and to access essential psychological therapies. There was no psychologist in either team which meant the service could not consistently provide a full range of support and therapies in response to people's needs. We reviewed psychological therapy caseload information provided by the trust, and this showed that 124 people were waiting for psychological therapy, with an additional 90 people waiting

for an initial screening to assess their therapy needs. Staff told us that they advised patients that they were likely to be waiting for at least a year. The amount of psychological therapies staff were able to provide was limited due to either caseload pressures or lack of appropriately trained staff in the team. As such a group work facilitator had recently been employed to initially provide self-esteem and emotional coping skill courses, which although based at Chantry house were available to all patients. To enhance these group discussions two volunteer peers had also been asked to attend. In addition, the operational manager was keen to build a capable staff team and had secured funding to support staff to access additional training.

- The Care Programme Approach (CPA) ensures services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The criteria for CPA was not being appropriately applied. For example, some patients who met the criteria had not been put under a CPA, or some did not have any CPA level recorded at all (whether they met the criteria or not). This meant the trust was unable to ensure all patient needs were assessed and met effectively. The operational manager and team leader had a good understanding of the longstanding issues in relation to the CPA process. An action plan had been developed, although this lacked detail and clear timelines. The executive team of the trust were unable to demonstrate that they had sufficient understanding of the risks in community mental health services beyond staffing issues and there had been no additional resources and/or managerial oversight to support the teams in reviewing their caseloads. This meant that the required changes within the service could not be implemented effectively and in a timely manner.
- At the time of inspection, there were not clear, evidence based treatment pathways in place within the service, nor had the service received confirmation in relation to commissioning requirements. Treatment pathways were in the early stages of being developed through the clinical pathways working group. We were shown some initial planning that had taken place. The operational manager, local management team and staff were keen to move this work forward, although recognised there were a number of other areas that required substantial work alongside this (for example, reviewing caseloads and applying the CPA framework). Staff shared concerns about the absence and/



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Inadequate 

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or withdrawal of ring-fenced funding by the CCG for investing in new services, and how this will impact on the trust plans to improve patient care as outlined in the NHS five year forward view.

- At our comprehensive inspection in 2014, we found that patient outcome measures were not routinely used in the community mental health service. We found that this was still the case during this inspection. There was a lack of consistent good quality information in relation to the mental health services overall, including the community mental health service. The clinical business unit for mental health and learning disabilities told us they had updated the executive team that they do not have the information required as set out in the mental health minimum data set (MHMDS). The MHSDS is a patient level, output based data set which delivers nationally consistent and comparable person-based information for children, young people and adults who are in contact with Mental Health Services.
- The electronic care records system was not fit for purpose and there was a lack of guidance in relation to how staff completed it, with staff storing information in different parts of the system. There was an electronic records working group to look at some of the key issues and staff told us that they had repeatedly raised concerns about the care records system. We were told that a business case had been presented for a new core assessment that was in the process of being developed. Some consultants did not use it all and used written patient records, this meant other staff could not review actions taken. The outcome of an audit undertaken by the patient safety, experience and clinical effectiveness team highlighted that auditing the electronic notes system is very time consuming and information may be stored in different parts of the system.
- No audits were taking place to monitor safety and/or quality. There were limited mental health specific audits included on the trust wide audit calendar. The medical director was unable to confirm that NICE guidance was adhered to, or identify how the trust monitors this.

## Skilled staff to deliver care

- The teams were made up of nursing staff, psychiatrists, social workers, occupational therapists, support workers and administrative staff. Staff shortfalls impacted the effective running of the service. For example, staff told us that a lack of clinical staff was placing greater strain on the existing clinical staff, or meant that support workers

worked with people at greater risk than they felt was appropriate. The service had supportive administration staff. They demonstrated understanding and commitment to the service and the clients.

- At our comprehensive inspection in 2014, we found that caseload supervision was infrequent and unstructured and caseloads were not reviewed regularly to ensure that service users were being supported towards recovery and planned discharge. During this inspection we found that staff were not receiving supervision or structured caseload management at the North locality community team. Staff in West, Central and South Wight team had some supervision and caseload management but this was not fully embedded.

## Multi-disciplinary and inter-agency team work

- On the Isle of Wight, a new way of working across health and social care was underway. The 'my life a full life' programme focusses on working in partnership with local people, voluntary organisations and the private sector to deliver a more co-ordinated approach to the delivery of health and social care services for older people and people with long term conditions. We were told about good examples of multi-disciplinary and interagency work. However, the care records system made it very difficult to follow how staff were working well with other teams in support of people who used services.
- The community mental health service was part of an integrated 'whole systems' approach, where all the mental health services worked together to provide care. The teams worked with improving access to psychological therapies, in-patient services, crisis and home treatment team, single point of access team, memory service, drug and alcohol service (IRIS). Some staff told us that there were communication problems between teams. For example, when patients were being referred between in-patient teams and community teams. Communication has also been identified as a consistent learning point from incidents.

- Both teams we went to had regular weekly MDT meetings, a service wide meeting had been established and took place once a month. The West, Central and South Wight team had implemented a daily morning meeting to review

# Are services effective?

Inadequate 

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the activities of each clinician to try to prioritise workloads more effectively and efficiently. A monthly business units managers meeting took place with all the team managers, operational manager and clinical director.

- The trust was working in collaboration to develop the recovery partnership model, with the council, police and other voluntary sector partners in a range of discussion

forums, workshops and groups. With the aim that they can work together to promote a public/third sector integrated mental health pathway. An example of this was the Safe Haven project, discussed at the end of the report.

## **Adherence to the MHA and the MHA Code of Practice**

Please see previous part of report

## **Good practice in applying the MCA**

Please see previous part of report

# Are services caring?

Requires improvement 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

## Our findings

### Kindness, dignity, respect and support

- During our inspection we observed one home visit appointment with a senior mental health practitioner and attended one group therapy session. At all times staff were observed treating patients with dignity, respect, courtesy and a real interest in recovery.
- We spoke with 14 patients who all had regular contact and care with mental health community services. The feedback from these patients about the care and treatment they received from staff was consistently positive. Patients described community staff as caring, compassionate, kind, respectful, understanding, supportive, helpful and encouraging. Patients also said staff listened to them and they felt safe when they had regular contact and care.
- Staff had a good understanding of the needs of their patients and were patient centred. Staff were committed and conscientious in the delivery of their care with one carer describing staff as genuinely interested. However, at times staff had to make difficult decisions to prioritise patients' needs and risks because of poor staffing levels.
- Patients spoke of their confidentiality being maintained by staff at all times

### The involvement of people in the care they receive

- Although all patients we spoke with had regular contact and care from the community mental health services, some had recently received letters to say that contact was temporarily to cease due to a business continuity plan being in put place for this service. Patients said they had been very upset by the letter, however when they complained to their mental health practitioners, contact had been resumed.
- Care plans were not a key part of the treatment planning process. We asked 10 patients about care plans, six said they didn't have a care plan and although four said they did, only one confirmed this had been completed in the last six months. Most patients thought it had been much longer since they had discussed theirs. Only one patient had a copy of their care plan.

- The care plan that could be printed from the electronic records system was not user friendly or written in an understandable format. Staff told us that they did not think it was always helpful to leave them with patients as they were not written an understandable way. For example, describing a person`s experience as a mental health diagnosis and then care plans were triggered relating to what boxes had been ticked rather than how it impacts them.
- Patients confirmed that carers and family members were involved in meetings and decisions about their care when appropriate. However, of the four carers we asked about care plans only two were able to confirm that there was a care plan in place and only one of these took place in the last 6 months and a paper copy of this had been given to the patient. Carers also told us that they had varying success with being able to access relevant staff when required and some had taken initiative to obtain direct email addresses to improve the situation.
- Patients, staff and carers we spoke with were not aware of any surveys or community meetings and all said they would give feedback directly to the staff member with whom they had regular contact. There was a service user & carer forum established by the trust to get feedback from service users, carers and representatives to help shape mental health community and inpatient services. However, this forum was not consulted on the issues faced by the community mental health teams and the implementation of the locality model or business continuity plan.
- The trust works with Carers IW, a small charity on the Isle of Wight that offers support to all adult carers generally caring for other adults with severe mental ill health. This support can be in a variety of different ways from general information and advice to one to one emotional support for carers, as well as a range of activities and respite facilities. A drop-in is run jointly by staff from Carers IW and members of staff from the trust mental health teams. Formal carer's assessments were undertaken by the local authority.

# Are services responsive to people's needs?

Inadequate 

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

## Our findings

### Access and discharge

- The service was open to patients age 18 and above, there was no upper age limit. The community mental health service offers assessment and treatment for people aged over 65 years, who do not require treatment for organic disorders such as dementia. The patients meeting the criteria attended the memory service that was not inspected as part of this inspection. The trust provided an early Intervention in psychosis service that worked with patients that met the criteria between the ages of 14 and 65, this service was not inspected as part of this inspection. Staff could usually access an inpatient bed when required and had access to respite beds for up to two weeks, these were provided by a third sector organisation.
- The community mental health services were going through significant changes to the community pathway with the introduction of a new care model in April 2016. This meant that three teams worked across three localities. Referrals to the CMHS were from the single point of access team. The single point of access team was the main point of all referrals into the secondary mental health service. They offered signposting or mental health assessments for both urgent and routine referrals. If the single point of access team felt that the person met the criteria for the community mental health service, referrals would then be allocated electronically via the duty desk system on the electronic care records system. Staff told us that often they did not agree to these referrals and sometimes felt they were inappropriate, or they did not have capacity to take on any more patients. This meant that while the waiting lists may be low (at the time of inspection seven people were on the waiting list for allocation of a care co-ordinator the north locality and none were waiting West, Central and South Wight team), staff highlighted that people were allocated to `wait` on a caseload.
- New referrals were triaged and assessed by the single point of access team, they then referred to the community mental health teams (CMHT). The referrals to the CMHT were assessed by the clinical team leader within 48 hours of receipt and allocated to the relevant member of staff or group treatment as appropriate. Staff told us that they felt that they received inappropriate referrals, that many patients did not meet the criteria for their service. There was not a plan in place to monitor numbers and assess the

appropriateness of referrals at the time of inspection. Trust data showed that there had been 603 referrals to the service from April 2016 to January 2017 and 177 discharges for the same timeframe. At the time of inspection, there were 1798 open cases to the community mental health service.

- Response times for the patient being contacted following the referral process was not monitored. We had requested actual figures from the trust, including for waiting times from assessment to treatment, but the trust were unable to provide this information. Therefore, we could not identify how long people waited to commence treatment after their initial assessment.
- We identified long waiting times for people requiring essential psychological therapies as part of their treatment. From information provided by the trust, 124 people were waiting for therapy, 46 had been waiting between three and six months and 42 between six and 12 months. Staff confirmed that they advised patients they would be waiting for at least a year from referral for therapy to commence. In addition, 90 people were awaiting their initial screening appointment to ascertain what their therapy requirements were.
- There were procedures in place to support staff in transfer and discharge processes, although these were recently introduced by the operational manager and will form part of the on-going caseload review. The service was currently unable to identify how many patients had not been seen by a member of the community team for more than a year and most likely did not meet the criteria for the service. While this had also been identified on the trust community mental health action plan there was not a clear action plan in place to address the significant impact of poorly defined referral and treatment criteria, large caseloads and demand outstripping capacity.
- We looked at the duty systems in place. A member of the team were allocated to undertake the duty role and a second person was `back up`. Duty slots were divided into morning and afternoons and were allocated via a roster on a monthly basis to allow staff to try and manage their work accordingly. Staff told us the duty worker role increased their overall workload. We were told by some staff that there had been an increase in contacts to the duty worker from patients who did have an allocated care co-ordinator but had been sent a letter advising that there was reduced capacity for the team and as such, focus was on those



# Are services responsive to people's needs?

Inadequate 

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

presenting with the most complex needs. One of the consultants also highlighted that they had seen patients as an urgent appointment, in their view, due to the reduced contact and monitoring from a care co-ordinator. The West, Central and South Wight team had employed an agency worker to fulfil this role fulltime to support staff to focus on their core work, due to on-going impact of lack of sufficient staff.

- Despite the pressures in the service, staff were flexible and re-prioritised appointments when an urgent issue arose. They also worked hard to support patients who may find it difficult to get public transport or attend appointments at clinics.
- The locality bases had reception and administrative staff who took all calls into the service to direct callers to the most suitable part of the CMHS, or other teams, depending on their need. The service was available Monday to Friday between 9 and 5, outside of these hours patients would be redirected to the crisis service. Overnight the crisis worker was based on the acute mental health ward. The crisis and home treatment team were not inspected as part of this visit.

## **The facilities promote recovery, comfort, dignity and confidentiality**

- The size and layout of the premises varied at the sites we visited. Both of the sites where patients attended had reception and client waiting areas, areas for the sole use of staff, interview rooms and clinic rooms. The reception area at Ryde was very busy when we visited, as a range of community health services were provided from this location. For example, physiotherapy and podiatry.

## **Meeting the needs of all people who use the service**

- At the Ryde health and wellbeing centre, there was good accessibility for disabled people. The West, Central and South Wight team were based in an old building that had limited access for disabled people, although there was wheelchair access at the back of the building and to the clinic room if required. Staff could access a telephone interpreting service when required.

## **Listening to and learning from concerns and complaints**

- Staff were able to describe how they would manage a concern or complaint, where possible seeking to resolve this at a local level. Patients and carers we spoke to told us they felt able to complain although most people we spoke with were unaware how to make a complaint and would prefer to speak with their known member of staff. Staff told us that if any complaints or issues were raised by patients and carers directly they would try to resolve them. If resolved these would not be reported on any centralised system, therefore the information was lost without establishing trends or possible learning points to share with others. An example of this is those patients who received a letter informing them that the team was operating under a business continuity plan due to low staff numbers and their current contact with staff had been suspended. By raising this issue with their key worker contact for several patients had been re-established. There was no local team information held for the number of complaints or informal concerns as part of the business continuity plan.
- The trust recorded concerns and complaints, although information we received was inconsistent and we were not clear how many complaints and/or concerns had been received. In the July 2016 complaints board report, the community mental health service was in the top ten areas receiving the highest number of complaints, with eleven logged; the information provided by the trust gave details of 10 recorded complaints November 2015 to September 2016. There was a second system of recording informal complaints for the community mental health service which had a total of 17 logged in the 12 months up to October 2016. The issues recorded were patient's lack of support, including cover for staff when on leave, lack of contact with the team and poor quality communication.

# Are services well-led?

Inadequate 

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

## Our findings

### Vision and values

- Most staff said that they did not feel supported by the trust or engaged in the vision and values. Staff perceived that there had been a long-term lack of oversight and effective resourcing in mental health services. Staff told us that the trust prioritised the physical health services over the mental health services.
- During our inspection, we identified the executive team of the trust were unable to demonstrate that they had sufficient understanding of the risks in community and inpatient mental health services beyond staffing issues. Mental health representation on the trust board was missing. The staff we met felt disconnected from the wider trust and none of the executive team had visited the teams.

### Good governance

- During our inspection, November and December 2016, we identified that none of the actions required following the comprehensive inspection in June 2014 had been completed, despite the trust stating that they had completed these actions in May 2016. In addition to continued non-compliance, the variation in performance and quality and gaps in critical aspects of service provision, demonstrated to us that the governance of community-based mental health services for adults of working age was not sufficiently robust or effective.
- The trust did not collect and collate centrally all key data in relation to waiting times, such as from assessment to treatment for each team. In addition, the trust did not routinely use patient outcomes measurements in the community mental health services. This meant it would not be able to monitor easily or effectively the performance and workloads of teams separately or in comparison with each other.
- Governance arrangements were not effective in design and operation to plan, monitor and provide assurance that community mental health services were managing risks to patients. There was no governance oversight or project management of the business continuity plan (BCP) to ensure its implementation was appropriate or effective. The plan was not on the corporate risk register. The executive team, responsible for the leadership, implementation and development of business continuity,

did not have any oversight of the BCP in community mental health services. They had not requested or received any assurance reports had not ensured that adequate time and resources were made available to the service.

### Leadership, morale and staff Engagement

- The community mental health services were going through significant changes to the community pathway with the introduction of a new care model in April 2016. There were staffing pressures at the operational, team leader and clinical levels. There was one team leader and one operational manager in post at the time of inspection. The head of operations post was vacant, the head of nursing and quality and one team leader were on sick leave and there was no contingency to cover this absent leadership support. The team leader on site during inspection was undertaking clinical work, due to lack of staff capacity within the team, and also undertaking management requirements, as well as overseeing the changes to the locality community model and business continuity plan (BCP).
- Despite the best efforts of staff, there was a risk that low staff morale could affect the care and support that patients received. Staff we spoke with identified lack of consultation and support from the trust with the changes to the community model. They also highlighted ongoing problems with their capacity to take on new patients and provide safe and effective care to existing patients on their caseload. Staff described frustration and felt overwhelmed. This had resulted in low morale and stressed staff across all areas, although this was more notable in the north locality team. The north locality staff had very poor morale, they felt stressed and frustrated. The team leader for the north locality was off sick at the time of inspection and the operational manager was trying to provide interim support in addition to their role. Staff at the West, Central and South Wight team had notably better morale than the North locality. These staff also told us that they felt well supported by their team manager and that they had a good understanding of the challenges they faced. They reported they generally worked well as a team.
- We asked for information from the trust in relation to plans to support staff and monitor the impact of this process on staff health and wellbeing. There was not an identified strategy to monitor impact on staff. There had been little consultation with patients or staff in relation to the change in model and future of services.

# Are services well-led?

Inadequate 

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

- Most staff told us that the team leader and operational manager were supportive, approachable and would listen to concerns. However, they did not feel able to raise concerns with the executive or senior management team – or that if concerns were raised, little action was perceived to have been taken. We were told about a number of issues that impacted patient care that were not addressed. For example, fixing the blood test machine for the clozapine clinic and inadequate staffing levels.
- Some staff told us that they did not believe the trust investigated and managed concerns around staff performance effectively and that when they raised concerns little or no action was taken. We also identified concerns about performance management and asked the trust to follow this up at the time of inspection.

## **Commitment to quality improvement and innovation**

- The trust had produced a quality improvement plan following the comprehensive inspection in 2014 with 102 actions across the trust. In May 2016, the trust produced the quality improvement framework which draws together all initiatives across the trust to deliver quality improvement. None of the quality measures in the quality improvement framework were specific to the mental health needs of the population and/or mental health services provided by the trust.

- The Serenity project, run by Hampshire Constabulary, the Isle of Wight NHS Trust, and Wessex Academic Health Science Network, is aimed at improving the care of patients in complex mental health situations. As part of the project mental health nurses have worked alongside police officers responding to calls that may involve mental health issues. The Serenity Integrated Mentoring (SIM) project on the Isle of Wight was the winner of the Prince of Wales Award for integrated approaches to care in 2016.
- The trust were working in collaboration with the council and voluntary sector to provide alternative places of support and safety during times of crisis for those with mental health needs. The initial vision of the `safe haven` is to give people a safe place to turn if they need mental health support out of hours, in addition to the existing out of hours and crisis provision. To offer police and ambulance staff a `first port of call` for any person in crisis as an alternative to s136 and use of the mental health inpatient unit or emergency department as a place of safety. The timeline indicated that the first part of the model will be in place by February 2017.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p><b>Regulation 9 of the HSCA 2008 (RA) Regulations 2014 Person centred care</b></p> <p>Community mental health care plans were not person centred or holistic and lacked any detail to enable staff to understand individual needs and monitor progress.</p> <p>There was no psychologist in either team which meant the service could not consistently provide a full range of support and therapies in response to people's needs.</p> <p>There were no evidence based care pathways in place and patients were not allocated appropriately or consistently to the care programme approach framework.</p> <p><b>This is a breach of Regulation 9 (1)(a)(b) (c); 3(a) (b)</b></p>
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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>Regulation 12 of the HSCA 2008 (RA) Regulations 2014 Safe care and treatment</b></p> <p>Community mental health care records lacked detail and had gaps and omissions in the core assessment, care plans and risk assessments. Patient outcome measures were not used.</p> <p>Care records had not been reviewed or updated to reflect changes in individual's situation or treatment. This meant there was not a clear assessment of people's risks and needs or plan of how to manage these safely and effectively agreed with the person.</p> <p>The trust must ensure staff have access to safe, working equipment they need.</p>

This section is primarily information for the provider

## Requirement notices

**This is a breach of Regulation 12(1)  
(2)(a)(b)(c)(d)(e)(g)**

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**Regulation 17 of the HSCA 2008 (RA)**

**Regulations 2014 Good governance**

Community mental health teams lacked detailed information of the caseload and risks being managed and the measurement of outcomes for patients.

The service did not undertake effective reviews and regular audits.

The electronic care records system was not fit for purpose and there were concerns with lack of guidance in relation to how staff should complete the records. The system was time consuming to use, requiring staff to constantly come out of one part of the system to access information and updates from other teams. There was no contemporaneous flow of information and there were clear risks that important patient information was not easily available to staff.

The service did not have effective systems and processes that enabled the provider to assess, monitor and improve the quality and safety of the services.

There was a lack of governance regarding the implementation of the business continuity plan. All patients who received letters were not risk assessed, appropriately managed and regularly reviewed.

All complaints were not being logged within the community team therefore opportunities are being missed to highlight trends and learning opportunities to continue to improve in service delivery.

A local risk register was not easily accessible within the community mental health team.

**This is a breach of Regulation 17(1) (2)(a)(b)(c)(e)(f)**

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing  
**Regulation 18 of the HSCA 2008 (RA)**

#### **Regulations 2014 Staffing**

Staff in the community mental health team were not receiving regular, effective supervision or support to review their caseloads.

Staffing and leadership levels were not adequate to fulfil all the functions of the service safely and effectively.

There were insufficient skilled staff to undertake psychological therapies.

**This is a breach of Regulation 18(1)(2)(a)**

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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

Regulated activity	Regulation
	<p>Section 31 HSCA Urgent procedure for suspension, variation etc.</p> <p>Section 31 HSCA Urgent procedure for suspension, variation etc.</p>
	<p>We issued a Section 31 Notice of decision to urgently impose conditions on the registered provider as we had reasonable cause to believe a person would or may be exposed to the risk of harm unless we did so. The notice of decision was in respect of Isle of Wight NHS trust.</p>
	<p>The Registered Provider must operate an effective escalation protocol in community mental health services. This escalation protocol will need to ensure patients are prioritised appropriately in response to service demands and pressures. There should be appropriate governance and leadership arrangements, and appropriate resources and support to the service and staff. The use of the escalation protocol should be on the corporate risk register and there should be clear mitigation and monitoring arrangements. The trust should ensure the escalation procedures are adhered to. The trust must provide the Commission with a report on the escalation protocol.</p>
	<p>B. The Registered Provider must ensure that every patient who has received a letter, as part of the current action taken under the business continuity plan, is risk assessed and appropriately managed. Each patient must have a documented risk assessment and a clear date for review. The trust must provide the Commission with a report of actions taken.</p>
	<p>C. The Registered Provider must complete the review of the current caseload of each clinician. Each patient must</p>



This section is primarily information for the provider

## Enforcement actions

be identified, have a full assessment of their needs and patients should be allocated for CPA according to the set criteria and guidelines. The trust must provide a report to the Commission on this work.

D. The Registered Provider should agree a comprehensive community mental health services improvement plan. There should be the necessary external advice and agreement for this improvement plan. The plan should ensure demands on the service are appropriately escalated, assessed and managed. There should be structures that ensure national guidance and best practice is followed; that promote effective leadership, and review capacity and capability of staff; there should be sufficient resources and support to the service. Staff must be effectively supervised and supported to review their caseloads. The improvement plan should be adhered to and the necessary changes must be implemented at the appropriate pace and urgency. The trust must provide the Commission with a report on the improvement plan and the action taken in response.

E. The Registered Provider must ensure that the Commission receives the following information every two weeks.

- o Number of patients known to the service
- o Numbers of patients who have risk assessment
- o Numbers of patients appropriately identified as requiring CPA
- o Number of patients who are on CPA
- o Number of patients who have CPA review date
- o Numbers of patients identified on the BCP
- o Management outcomes for patients on the BCP
- o Actual and expected caseloads numbers for clinical teams
- o Any complaints about the service or incidents involving staff and/or patients of the community mental health service