

Isle of Wight NHS Trust

Quality Report

Parkhurst Road
Newport
Isle of Wight
PO30 5TG
Tel: 01983 524081
Website: www.iow.nhs.uk

Date of inspection visit: 10-11 May 2017
Date of publication: 28/07/2017

Core services inspected	CQC registered location	CQC location ID
Community-based mental health services for adults of working age	St Mary's Hospital (Mental Health Management)	R1FAV
Wards for older people with mental health problems	St Mary's Hospital, Shackleton ward St Mary's Hospital, Afton ward	R1FX8
Long stay/rehabilitation mental health wards for working age adults	Woodlands	R1F33
Acute wards for adults of working age and psychiatric intensive care units (PICU)	St Mary's Hospital, Sevenacres (inpatient wards) Seagrove and Osbourne wards	R1FX7

This report describes our judgement of the quality of care at this provider. It 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.

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

Contents

Summary of this inspection

	Page
Overall summary	3
The five questions we ask about the services and what we found	4
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	7
Information about the provider	7

Detailed findings from this inspection

Findings by main service	8
Action we have told the provider to take	15

Summary of findings

Overall summary

We undertook this inspection to find out whether the Isle of Wight NHS Trust had made improvements to the inpatient and community mental health services following the comprehensive inspection of the trust in late November/early December 2016. At that inspection we rated the trust 'inadequate' overall and 'inadequate' overall for mental health services.

Following that inspection, we served a Section 31 Notice of Decision that imposed conditions on the trust's registration. This required the trust to take action to address safety concerns at both its community and inpatient mental health services.

At this inspection (May 2017), we found that there remained a significant amount of work still to do for the conditions of the Notice to be fully met including:

- further work on the ward environments to ensure they are fit for purpose
- addressing staffing levels and the size of consultant caseloads
- addressing the quality of patient records
- providing staff with access to supervision
- ensuring decisions are made about the future of some services, and
- implementing good governance systems to ensure the board can effectively assure itself that the required improvements are being made in a timely manner.

However, there had been some progress on a number of conditions in the Notice, most notably:

- work had been carried out and was progressing on the physical ward environments, in order to make them more safe

- there was positivity and enthusiasm from the staff on the Sevenacres site at being fully involved in planned improvements to their wards
- there was an increased awareness of staff about the potential risks on the inpatient wards.

At the time of this inspection (May 2017), a new Chief Executive Officer had been in post just over a week and there had been a number of major changes to the senior leadership team and the way the trust was organised. In addition, the trust was also receiving input and support from a number of external organisations, including NHS Improvement.

Despite there still being much to do, we were assured that the new Chief Executive Officer had a good understanding of what was required to make the required improvements. The addition to the executive and senior leadership team, of experienced mental health and quality improvement specialists, should, given time, enable the trust to clearly progress the required improvements..

Following this inspection, we agreed with the trust to make some minor amendments to a number of conditions detailed in the Section 31 Notice of Decision. These amendments were related specifically to how and what information the trust would submit to us to allow us to continue to monitor the trust closely.

We will continue to closely monitor the trust's progress in meeting the conditions detailed in the Section 31 Notice and we will inspect the trust again in the near future. The Section 31 conditions on the trust's registration remain in place at this time and will remain so until we are assured those conditions have been met. We will not hesitate to take further action should we find that patients, staff and the general public are at risk of harm.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services safe?

As this was a focused inspection specifically to follow up on action taken in relation to the requirements in the Section 31 Notice, we did not look at all aspects of this key question.

We found that:

- A significant amount of work remained to be completed for essential improvements to the safety and fitness for purpose of ward environments
- Staffing pressures remained across the community-based mental health services for adults of working age
- Consultant caseloads remained very high and continued to provide a significant risk for patients and the trust
- The quality of care records continued to vary, with gaps in key information and poor evidence of appropriate assessment and management of risk in some records.

However:

- Improvements to the ward environments had started, including the removal of a number of clear and more immediate risks
- Staff on Sevenacres had been fully involved in planning the improvements on the ward
- Staff awareness of risks had improved
- A new matron in post at the single point of access team and crisis/home treatment had made some positive changes in relation to how referrals were managed, but more work was needed to ensure all referrals were managed appropriately.

Are services effective?

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at all aspects of this key question.

We found that:

- Caseload management and the supervision of staff was still not being undertaken effectively.

However:

- There was an understanding that there needed to be a clear, comprehensive system in place, with training and tools to help staff identify acuity and for team leaders to be able to undertake supervision effectively.

Summary of findings

Are services caring?

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at any aspects of this key question.

Are services responsive to people's needs?

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at any aspects of this key question.

Are services well-led?

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at all aspects of this key question.

We found that:

- Governance and assurance by the board of all mental health services remained limited and processes were still in transition and development. The board were not able to have a clear understanding of issues as data was unreliable.
- Decisions were needed about the future of the rehabilitation service, Woodlands, and the trust's dementia service, incorporating Shackleton ward.

However:

- We were assured that the new Chief Executive Officer had a good understanding of what was required to make the required improvements; and the additions to the executive and senior leadership team, of experienced mental health and quality improvement specialists, should, given time, enable the trust to clearly assess what needs to be put in place to support further improvement.
- Work was being undertaken to review consultant caseloads and put appropriate plans in place for all community patients.
- The structure for the community mental health team was due to change, imminently, to include two new team leaders and a matron. This change would be vital to begin to address the issues with consultant caseloads.

Summary of findings

Our inspection team

Our inspection team was led by:

Karen Bennett-Wilson, Head of Hospital Inspection, Care Quality Commission

The team included CQC managers, inspectors, and a variety of specialists including a senior mental health nurse and a governance specialist.

Why we carried out this inspection

We undertook this inspection to find out whether the Isle of Wight NHS Trust had made improvements to the inpatient and community mental health services following the comprehensive inspection of the trust in late November/early December 2016. At that inspection we rated the trust 'inadequate' overall and 'inadequate' overall for mental health services.

Following that inspection, we served a Section 31 Notice of Decision that imposed conditions on the trust's registration. This required the trust to take action to address safety concerns at both its community and inpatient mental health services.

For **Community-based mental health services for adults of working age**, we told the trust that it must:

- Operate an effective risk escalation process that includes clear monitoring and senior oversight. We asked the trust to provide us with a copy of the protocol by 28 December 2016.
- Ensure every patient who had received a letter, as part of the action it had taken under its business continuity plan, is risk assessed and appropriately managed. Each patient must have a documented risk assessment and a clear date for review. We asked the trust to provide us with a report of actions taken by Wednesday 28 December 2016.
- Complete a review of the current caseload of each clinician. Each patient must be identified and have a full assessment of their needs. Patients should be allocated for CPA according to the set criteria and guidelines. We asked the trust to provide us with a report on this work by Wednesday 11 January 2017.
- Agree a comprehensive community mental health services improvement plan, which should be implemented as a matter of urgency. The plan should

detail how national guidance and best practice will be followed; describe how effective leadership will be provided that promote effective leadership and ensure sufficient resources, capacity and capability to enable staff to manage their caseloads effectively. Staff must be effectively supervised and supported to review their caseloads. We asked the trust to provide us with us with a report on the improvement plan and the action taken in response by February 2017.

In addition, we asked the trust to provide us with a range of information, every two weeks, that would allow us to monitor its progress in making improvements in these services.

Mental Health Inpatient Services

This included: wards for older people with mental health problems; long stay/rehabilitation mental health wards for working age adults; and, acute wards for adults of working age and psychiatric intensive care unit (PICU).

We told the trust that it must:

- Carry out an urgent assessment of the physical environment on the inpatient mental health wards at St Mary's Hospital. The trust must ensure there is a comprehensive ligature assessment and an action plan to mitigate the risks; and the plan must include a stated time for completion. We asked the trust to provide us with an action plan by 28 December 2016.
- Immediately review its policy and procedures, and governance arrangements, to ensure there is appropriate assurance to identify, assess, manage, mitigate and monitor all environmental risks to patients' care and safety across all inpatient mental health services. We asked the trust to provide us with a copy of the revised governance arrangements by 11 January 2017.

Summary of findings

In addition, we asked the trust to provide us with a range of information, every two weeks, that would allow us to monitor its progress in making improvements in these services.

Since serving the Section 31 Notice we have spoken with the trust and NHS Improvement regularly. The trust provided us with the required documents and information on time.

However, we were not assured that the trust was making appropriate, sufficient, timely progress to address the requirements of the Section 31 Notice of Decision. Therefore, on 10 and 11 May 2017 we undertook a short notice, focused inspection to follow up on progress with the requirements of the Section 31 Notice.

How we carried out this inspection

We carried out a short notice, focused inspection on 10 and 11 May 2017 to follow up the Section 31 Notice of Decision that we had served on 9 December 2016, following our comprehensive inspection that took place in late November and early December 2016. The purpose of the Section 31 Notice of Decision was to impose conditions on the trust's registration in respect of the regulated activity of Treatment of disease, disorder or injury. We served this Notice, which required the trust to make improvements, because the issues we identified at the inspection were serious and we believed that patients and other persons may have been exposed to the risk of harm if the conditions of the Notice were not urgently met.

Because this visit was to follow up issues identified in the Section 31 Notice of Decision, it focused primarily on the safe, effective and well-led key questions.

Before the inspection, we reviewed a range of information that we hold about the trust.

During the inspection visit we:

- looked in detail at the trust's governance and assurance systems and processes
- spoke with members of the senior team, including the new Chief Executive Officer, an Improvement Director, a senior mental health director from another trust who was supporting the improvement process, Heads of Service, and local service managers across a range of inpatient and community mental health services
- reviewed 49 patient care records across the community mental health teams and a number of mental health inpatient wards
- visited the older people's mental health wards, Shackleton and Afton
- visited Osbourne Ward, the acute mental health ward
- visited Seagrove psychiatric intensive care unit (PICU)
- visited the Woodlands rehabilitation service, and
- spoke with front-line staff at each of the inpatient services visited.

Information about the provider

The Isle of Wight NHS Trust is an integrated trust that provides acute, ambulance, community and mental health services. Services are provided to a population of approximately 140,000 people living on the island. The population increases to over 230,000 during the summer holiday and festival seasons. St Mary's Hospital in Newport

is the trust's main base for delivering acute services for the island's population. Ambulance, community and mental health teams work from this base, and at locations across the island. The trust also provides a GP led urgent care walk in centre and NHS 111 services.

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

Summary of findings

As this was a focused inspection specifically to follow up on action taken in relation to the requirements in the Section 31 Notice, we did not look at all aspects of this key question.

We found that:

- A significant amount of work remained to be completed for essential improvements to the safety and fitness for purpose of ward environments
- Staffing pressures remained across the community-based mental health services for adults of working age
- Consultant caseloads remained very high and continued to provide a significant risk for patients and the trust
- The quality of care records continued to vary, with gaps in key information and poor evidence of appropriate assessment and management of risk in some records.

However:

- Improvements to the ward environments had started, including the removal of a number of clear and more immediate risks
- Staff on Sevenacres had been fully involved in planning the improvements on the ward
- Staff awareness of risks had improved
- A new matron in post at the single point of access team and crisis/home treatment had made some positive changes in relation to how referrals were managed, but more work was needed to ensure all referrals were managed appropriately.

Our findings

As this was a focused inspection specifically to follow up on action taken in relation to the requirements in the Section 31 Notice, we did not look at all aspects of this key question.

Safe and clean environment

At the November/December 2016 comprehensive inspection we identified serious concerns in relation to the safety of the physical environment at a number of the mental health inpatient wards. The concerns included unidentified ligature points, and ligature risks which were identified but not mitigated; these were in areas that cared for high risk patients. On Afton, Shackleton and Woodlands wards, there were a number of serious environmental risks. These included broken window catches, an unsafe bed, and broken electrical switches which presented a clear risk of harm to patients. In the garden space on Afton ward there were significant risks to patients posed by broken steps and unlocked gates leading from the garden to a car park. All of these risks had the potential to cause significant harm to extremely vulnerable patients.

On Shackleton Ward, there were no coverings for the windows for six out of seven bedrooms. This resulted in the public being able to see directly into patient bedrooms, where some patients were bed bound and received all their personal care. Rooms were also not able to be darkened to allow for proper sleep of patients. These risks to patient's privacy and dignity were not being mitigated.

We identified multiple issues with the design, layout and usage of Shackleton wards seclusion room. The room did not comply with legislation and national best practice guidance, the environment was unfit for the purpose of seclusion and it posed a serious risk to patient safety. During the November/December 2016 inspection, we identified serious risks to patient safety and observed a service that was not adequately protecting patients.

At the May 2017 inspection we found that the environmental work on the mental health wards had progressed and immediate safety concerns had been

Are services safe?

addressed, although there was still a significant amount of work to do. There was an increased awareness of risks posed by the environment both by staff at ward level and by the service managers and the executive team. We found there was positivity and enthusiasm from the staff on the Sevenacres site at being fully involved in planned improvements to their wards, and they expressed the belief that assurance from the senior team would ensure that these changes would now take place as planned.

Safe staffing

At the November/December 2016 comprehensive inspection, we identified serious concerns in relation to patient safety in community mental health services and observed a service which was unable to respond effectively to the needs of patients. There were significant staffing pressures at all levels of the service, and staff described ongoing problems with the capacity to take on new patients and provide safe and effective care to existing patients on their caseload.

At the May 2017 inspection, we found that staffing pressures continued and the consultant caseloads continued to be a significant risk for the trust. However, we were advised that the structure for the community mental health team was due to change imminently, to include two new team leaders and a matron. This change would be vital to begin to address the situation.

Assessing and managing risk to patients

At the November/December 2016 comprehensive inspection, we found care records lacked detail and had gaps and omissions in the core assessment, risk assessments and care plans. Overall, crisis/contingency plans reviewed contained significant gaps in information or were of poor quality. Risk assessments were incomplete

and lacked detail. This meant there was not a clear assessment of people's risks and needs, or plan of how to manage these clearly agreed with the person. Risk assessments did not always clearly reflect known risks to patients.

At the May 2017 inspection, we found the quality of care records continued to vary, with gaps in key information and poor evidence of appropriate assessment and management of risk in some records. Audits of care records had commenced, but the sample size was too small and it was unclear how findings from audits would be evaluated or used to identify development and training needs of staff. The care records system remained a significant risk. It was not possible to have a contemporaneous overview of the risks and subsequent care and treatment of a patient. We found it confusing and difficult to track the risks and what actions had been taken in records. The records system was time consuming for staff to use and there remained the risk that important information could be lost or overlooked. In addition, the wards were not using the PARIS electronic system for risk assessments and only using hand written documents. This meant there was a risk that vital information might not always be uploaded in a timely manner and be available to other teams. Some of the handwritten risk assessments were difficult to read, and were sometimes scanned upside down which meant they could not then be easily read by staff in other teams.

The new matron in post at the single point of access team and crisis/home treatment had made some positive changes in relation to how referrals were managed. However, some poor working processes remained across the different teams that were affecting referral management between teams and external agencies. There was the potential for people to slip through the net.

Are services effective?

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.

Summary of findings

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at all aspects of this key question.

We found that:

- Caseload management and the supervision of staff was still not being undertaken effectively.

However:

- There was an understanding that there needed to be a clear, comprehensive system in place, with training and tools to help staff identify acuity and for team leaders to be able to undertake supervision effectively.

Our findings

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements we did not look at all aspects of this key question.

Skilled staff to deliver care

At the November/December 2016 comprehensive inspection we found that some staff were not receiving supervision or structured caseload management. Some did receive supervision and caseload management, but this was not fully embedded and the quality and quantity of supervision varied.

In the May 2017 inspection we found that caseload management and supervision had not been undertaken effectively with the community clinicians; and approximately half of the community service staff had still not had this support at all. There was an understanding that there needed to be a clear, comprehensive system in place, with training and tools to help staff identify acuity and for team leaders to be able to undertake supervision effectively; however, this had not yet been established.

Are services caring?

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

Summary of findings

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at any aspects of this key question.

Our findings

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at any aspects of this key question.

Are services responsive to people's needs?

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

Summary of findings

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at any aspects of this key question.

Our findings

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at any aspects of this key question.

Are services well-led?

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.

Summary of findings

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at all aspects of this key question.

We found that:

- Governance and assurance by the board of all mental health services remained limited and processes were still in transition and development. The board were not able to have a clear understanding of issues as data was unreliable.
- Decisions were needed about the future of the rehabilitation service, Woodlands, and the trust's dementia service, incorporating Shackleton ward.

However:

- We were assured that the new Chief Executive Officer had a good understanding of what was required to make the required improvements; and the additions to the executive and senior leadership team, of experienced mental health and quality improvement specialists, should, given time, enable the trust to clearly assess what needs to be put in place to support further improvement.
- Work was being undertaken to review consultant caseloads and put appropriate plans in place for all community patients.
- The structure for the community mental health team was due to change, imminently, to include two new team leaders and a matron. This change would be vital to begin to address the issues with consultant caseloads.

Our findings

As this was a focused inspection specifically to follow up on action taken in relation to the Section 31 requirements, we did not look at all aspects of this key question.

Good governance

At the November/December 2016 comprehensive inspection, we identified that the the trust's executive team were unable to demonstrate that they had sufficient understanding of the risks in community and inpatient mental health services beyond the staffing issues.

The leadership team, including the board lead for mental health services, had been unable to identify any concerns or demonstrate oversight of the mental health services. A business continuity plan had been developed by the trust because the service was unable to meet the needs of people requiring the service. However, we did not receive appropriate assurance that the plan was safe for patients, or would be able to deliver the significant change required at a pace that would be expected.

In relation to inpatient services, the governance arrangements for environmental risks were not effective in identifying risks, or mitigating identified risks. Where risks had been identified, the trust had not addressed these serious issues with appropriate pace and urgency. We did not receive appropriate assurance at that time that the trust was able to take steps to ensure patients would be safe from avoidable harm at a pace that would be expected.

At the May 2017 inspection, we found that governance and assurance by the board of all mental health services remained limited and processes were still in transition and development. Senior executives and service delivery leads were unable to adequately describe the current mental health governance arrangements. There was no evidence at inspection of reported assurance to the board with clear and appropriate metrics. We were advised that it was anticipated that these would be in place by the beginning of June 2017. Data continued to be unreliable, which would affect planning and have an impact on the speed and

Are services well-led?

effectiveness of essential improvements to services. In addition, the continued lack of clarity about referral criteria to the community mental health services and thresholds needed to be addressed.

Decisions were needed about the future of the rehabilitation service, Woodlands. We had continuing concerns about the safety of the environment at Woodlands and the lack of clear direction in relation to actions that had not been taken because of its proposed closure. Similarly, the trust still needed to make a decision about the future shape and delivery of its dementia service, incorporating Shackleton ward. Staff had not been effectively involved in discussions about the future of these services.

Leadership, morale and staff engagement

At the November/December 2016 comprehensive inspection, there was no defined leadership of the mental health services. Staff morale in all mental health teams was low; but particularly in community mental health services, where staff described ongoing problems with the capacity to take on new patients and provide safe and effective care to existing patients on their caseload. The service did not have appropriate executive level leadership and

governance to support the local team leader and operational manager. A business continuity plan had been developed by the trust because the service was unable to meet the needs of people requiring the service. However, we did not receive appropriate assurance at that time that the plan was safe for patients, or would be able to deliver the significant change required at a pace that would be expected.

At the May 2017 inspection, we found that there remained culture and engagement issues across all disciplines that would need to be worked on to support staff in the community mental health teams to fully engage in caseload reviews and management. However, staff told us that they felt hopeful that change was now starting to happen, and they were fully and positively engaging with external support.

We were assured that the new Chief Executive Officer had a good understanding of what was required to make the required improvements; and the additions to the executive and senior leadership team, of experienced mental health and quality improvement specialists, should, given time, enable the trust to clearly assess what needs to be put in place to support further improvement.

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
--------------------	------------

	Regulation 17 HSCA (RA) Regulations 2014 Good governance
--	----------------------------------------------------------

	The Section 31 Notice of Decision remains in place (details below).
--	---------------------------------------------------------------------

	See the individual core service reports (from the comprehensive inspection – November 2016) for full details of all Requirement Notices, which all remain in place.
--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Section 31 HSCA Urgent procedure for suspension, variation etc.
Diagnostic and screening procedures	After our inspection in November and December 2016, we issued a Notice of Decision to urgently impose conditions on the registered provider (under section 31 HSCA 2008) as we had reasonable cause to believe a person would, or may be, exposed to the risk of harm unless we did so.
Treatment of disease, disorder or injury	<p>Following our follow-up visit in May 2017, we judged that the Section 31 Notice of Decision should remain in place. However, we amended conditions E, F, I and J as set out in the Section 31 Notice. These amendments are purely in relation to the submissions of the information set out in each of those conditions. We agreed with the the trust that they cease sending fortnightly reports and instead submit a monthly overall update report to us on each of the matters set out in these conditions.</p> <p>Accordingly, under the s31 notice the following conditions remain in place for the regulated activity Treatment of disease, disorder or injury:</p> <p>Community Mental Health Service</p> <p>A.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</p>

Enforcement actions

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.

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.

C. The Registered Provider must complete the review of the current caseload of each clinician. 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 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 (now monthly).

- o Number of patients known to the service

This section is primarily information for the provider

Enforcement actions

- 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.

F.The first report should be received on 28 December 2016 and every two weeks thereafter (now monthly).

Mental Health Inpatient Services

G. The registered provider must carry out an urgent assessment of the physical environment on the inpatient mental health wards at St Mary's Hospital. The trust must ensure there is a comprehensive ligature assessment and an action plan to mitigate the risks. The action plan must include a stated time for completion. The assessment must cover all inpatient mental health wards and environments. There should be effective leadership, and the necessary resources and support to ensure changes have appropriate governance, are appropriately supported and are implemented with the necessary pace and urgency. The action plan must be produced by Wednesday 28 December 2016.

H. The registered provider must immediately review its policy and procedures and governance arrangements to ensure there is appropriate assurance to identify, assess, manage, mitigate and monitor all environmental risks to patients' care and safety across all inpatient mental health services. This includes where patient privacy and dignity may be compromised. The governance arrangements need to identify where additional

This section is primarily information for the provider

Enforcement actions

resources and support are required and how staff will be supported to understand what actions need to occur to effectively manage all environmental risks. The trust must provide a copy of the revised governance arrangements by Wednesday 11 January 2017.

I. The Registered Provider must ensure that the Commission receives the following information every two weeks (now monthly):

- A risk register that includes all environment risks in inpatient mental health services
- The action(s) taken to mitigate the risks
- Risks mitigated through individual patient assessment
- The controls that are in place
- The ongoing dated review and specified actions of how these risks are being managed.

J. The first report should be received on 28 December 2016 and every two weeks thereafter (now monthly).