Isle of Wight NHS Trust

Isle of Wight NHS Trust

Quality Report

St Mary's Hospital
Parkhurst Road
Newport
Isle of Wight
PO30 5TG
Tel: 01983 524081
Website: www.iow.nhs.uk

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

Summary of findings

Ratings

Overall rating for this service	**Good**
Acute, psychiatric intensive care units and health-based places of safety	Good
Child and adolescent mental health services	Good
Services for older people	Good
Services for people with learning disabilities or autism	Good
Community-based crisis services	Good
Rehabilitation services	Good
Primary mental health	Good
Drug and alcohol services	Good
Community mental health team	Requires Improvement

Summary of findings

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Summary of findings

Overall summary

The Isle of Wight NHS Trust is an integrated trust providing acute, ambulance and mental health services, and community services. Mental health services are provided to a population of approximately 140,000 people living on the Island. Services include community mental health services, which includes Early Intervention in Psychosis, inpatient acute and rehabilitation services, community child and adolescent mental health services (CAMHS), a tier 3 drug and alcohol service, a memory service, a community learning disability service and an intensive outreach service for residential and nursing care homes.

We carried out this comprehensive inspection because the Isle of Wight NHS Trust is an aspirant Foundation Trust, prioritised by Monitor for inspection. We inspected this core service as part of our second phase of the new comprehensive inspection programme introduced for mental health services.

The announced inspection took place between 4 and 6 June 2014, with an unannounced visit on 21 June between 4pm and 11pm.

Overall, we rated the Isle of Wight NHS Trust mental health services as 'good'. The trust was good for providing safe, effective, caring and responsive services. Leadership at a service level was good, but the overall trust leadership of services 'requires improvement'.

All services were rated as "good" with the exception of community mental health services which were rated as "requires improvement".

Key findings related to the following:

- People told us that they were involved in their care, and that staff were caring and working within their capacity, and treated them with dignity and respect. However, people being treated by community mental health services had less involvement in their care, and little information about the services available to them.
- We received 26 comment cards from people who use the mental health service. All were negative and people felt staff were oppressive and controlling.
- Staff were aware of the safeguarding processes and most had received safeguarding training.
- The majority of people who used the services, and were treated by staff, said they felt safe; however, there were examples of people stating that, at times, low staffing numbers affected people's care and treatment.
- Staffing levels were considered to be adequate in most areas, but there were concerns about capacity on Shackleton Ward and in community mental health services. Staff reported that no action around recruitment had been taken for some time in these areas. A staffing review had just been completed by the trust, and a recruitment plan had been produced and signed off by the executive board.
- Incidents were reported, and lessons were learned and shared across services, to minimise risks and prevent reoccurrences. However, staff in community mental health services were under-reporting incidents because of limited staff capacity within the service.
- People were treated according to national guidelines, and had good access to psychological therapies and activities in inpatient settings.
- Outcomes of care were monitored and reported, both nationally and locally, to improve the effectiveness of services. However, this was not evident in community mental health services, where patients were not monitored or reviewed appropriately to assess their progress or recovery.
- There was effective multidisciplinary working, and innovative working in some services with social care, housing, employment, the police and GPs to co-ordinate people's recovery and support their independence and self-care.
- Staff told us that they received appropriate training; however, the uptake of this training required improvement in some areas.
- Clinical, managerial and caseload supervision was offered and taken up in most areas, with the notable exception of the Rehabilitation and recovery team in community mental health services , where improvements are required.
- People received care and treatment at the right time, although there were long waiting times for assessment and treatment in community mental health services.
- People had good access to advocacy services.
- The complaints procedure was clear, and understood by staff and people using the service.

Summary of findings

- Processes for staff to deal with incoming issues, concerns and complaints were understood, and trust-wide learning from complaints was cascaded in a variety of formats to all service areas.
- Staff generally felt supported by their line manager and peers, but felt isolated and disconnected from the trust in some services. The trust had governance structures in place, which included the mental health services, but it was observed that the flow of information did not always cascade to ward and community staff.
- Staff said they could approach their manager with any concerns, and said they thought any concerns would be addressed. Risks were appropriately managed, but in some services, risk issues were sometimes not addressed, or not always acted upon in a timely manner.
- Mental health services did not have an overall clinical strategy, and did not have appropriate representation on the trust board to reflect the workings of an integrated trust.

Mental Health Act Responsibilities

- The Mental Health Act records we reviewed were comprehensive and in order.
- People's mental health capacity was assessed at ward reviews, and recorded in the trust's electronic recording system.
- The Mental Health Act manager kept the ward staff up to date with any actions that may be required, such as adherence to the conditions of a Section 47/49, and the need to liaise with the Ministry of Justice (MOJ).
- Reminders were also fed into the ward round process, so that the multidisciplinary teams could review Mental Health Act sections, ensuring good governance processes, in line with the Code of Practice (CoP).
- There were posters displayed in the ward informing people of the Independent Mental Health Advocacy service (IMHA). We spoke with the ward manager, who told us that any person detained under a section of the Mental Health Act would automatically be referred for an Independent Mental Health Advocate.

We have identified areas of outstanding practice. However, there were also areas of poor practice, where the trust MUST make improvements, and other areas of practice where the trust SHOULD take action to improve. These are identified in this report.

Professor Sir Mike Richards

Chief Inspector of Hospitals

August 2014

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

Mental health services had effective procedures to provide safe care and treatment. The staff were aware of potential risks, and these were identified in risk registers. Incidents were reported and investigated, and lessons were learnt and shared to prevent reoccurrence. Safeguarding was well established, and people were protected from abuse. In some services, however, staffing levels were affecting incident reporting and risk management; staff had high caseloads and people did not have appropriate risk assessments.

Are services effective?

Good

People were treated according to national and best practice guidance. Staff worked effectively in multidisciplinary teams to centre care around people. People's care was individualised, and there were a range of treatment approaches available to meet people's needs. Staff were well trained, and had good access to training and development opportunities. Staff told us that they were well supported by their managers.

There were appropriate policies and procedures for people detained under the Mental Health Act. Some services were less well developed in providing effective care.

Are services caring?

Good

The mental health services were caring, and people were extremely positive about the quality of the care and treatment they were receiving, and the approach of the staff. Across all areas we observed staff treating patients with dignity and respect. People told us they were involved in their care, although this was not the case in community mental health teams, and care plans did not always have documented evidence of this. We did receive some negative feedback via comment cards collected post inspection, where people described oppressive and controlling services, and staff behaviour.

Are services responsive to people's needs?

Good

Services were developed according to the needs of people on the Island. People had good access to services across a number of different community sites, although some services, such as in community mental health, had long waiting times. People had good access to information about services and treatment, and access to advocacy services. Complaints were taken seriously, investigated and responded to promptly.

Summary of findings

Are services well-led?

Leadership at service level was good, but required improvement overall at trust level. There was not a clear strategy for mental health services. The trust is developing a Strategic Partnership with Hertfordshire Partnership University NHS Foundation Trust, but staff were not aware what this meant for services, and how services would develop in the future. Staff felt supported by their line manager and peers, and considered that senior managers in the trust were accessible, but they did, at times, feel disconnected from the wider trust. There was responsible governance in mental health services, and staff were using and learning from audit, incidents and complaints. However, risks were not appropriately managed in some services. Public engagement was good and many services had innovative practice.

Requires Improvement

Summary of findings

What we found about each of the main services at this location

Acute, psychiatric intensive care units and health-based places of safety

Good

The Acute, PICU (psychiatric intensive care unit) and Section 136 place of safety services provided by the Isle of Wight NHS Trust were safely delivered in a caring manner. Staff displayed their skills in working with people, and were supportive and kind. Incidents were reported through the trust incident systems, with regular feedback and debrief to staff to ensure that they were kept informed.

Staff demonstrated a good knowledge of the local safeguarding policy, and procedures for safeguarding vulnerable adults, and worked well with other trust teams and external agencies to provide care that best met the needs of people. We saw that the wards worked as part of a multidisciplinary system, with a wide range of skilled professionals. There was goal setting and regular audits of care plans, and the use of outcome measures of effectiveness.

There were systems in place for people to give feedback to the service, and action was taken to improve the service. Staff told us that they felt supported by their managers, but felt disconnected from the rest of the trust.

There were systems in place to monitor the quality of the service provided, and action was taken to improve performance. The service had had eight locum consultants in the past five years, and this was affecting the consistency of consultant cover, leadership for the ward and consistency of treatment for the people admitted to hospital.

Child and adolescent mental health services

Good

The CAMHS provided by the Isle of Wight NHS Trust were delivered in a safe and caring manner. We found that staff were kind, friendly and delivered care which demonstrated a responsive manner when working with children, young people and their families. We observed that children and young people received a good service.

The team was in the process of moving from hard copy records to electronic records, and this had created some difficulties regarding how some of the information was being transferred and recorded. Information about assessments and care could not be easily located. Incidents were reported and some lessons learnt, but not all information on reported incidents was fed back to teams.

Staff demonstrated a good understanding of how to follow the local safeguarding policy and procedures for safeguarding children, and worked well with other trust teams and external agencies, to provide care that best met the needs of children and young people. The team worked collaboratively as a multidisciplinary team with a varied skill mix. The use of outcome measures of effectiveness was routine, and information was shared nationally and locally.

Summary of findings

The CAMHS had an understanding of the specific needs of the population they served, and delivered care which was largely responsive to people's needs. Children did not have long waiting times for care and treatment, although some children who required inpatient services for a longer period of time were placed off the Island.

Children could provide feedback to the service and this was acted upon. Staff told us that they felt supported by their managers, and were proud of their team and to work for the trust. The quality of the service provided was monitored, and necessary measures were taken to improve performance.

Services for older people

Good

Inpatient services for older adults were rated as good, for being safe, effective, caring and responsive to people's needs. There were clear systems in place for reporting safeguarding issues, and incidents of concern within the team were clear, and staff understood their responsibilities. Comprehensive risk assessments were carried out on admission. Staffing levels were good and were flexible to meet any patient needs, such as increased observations. Mandatory training was not completed by all staff, but this process was being managed.

Staff reported an open culture with the management team for reporting concerns and issues, but supervision was not done through a formal system. We observed people being treated respectfully and with compassion throughout our visit, and this was attributed to the strong leadership on the wards.

Services for people with learning disabilities or autism

Good

The CLDT services provided by the Isle of Wight NHS Trust were delivered in a safe and caring manner. We found that staff were polite, and delivered care which demonstrated good skills when working with people with learning disabilities and their families. We observed that delays were experienced in receiving psychological therapies, but on the whole, people received a good service.

The team was in the process of moving from hard copy records to electronic records, and this had created some difficulties regarding how some of the information was being transferred and recorded. Information about assessments and care could not be easily located. Staff told us this was work in progress and it was taking a lot of their 'hands on' time.

Staff demonstrated a good understanding of how to follow the local safeguarding policy and procedures for safeguarding vulnerable adults, and they worked well with other trust teams and external agencies to provide care that best met the needs of people. The team worked as a robust multidisciplinary team with a diverse skill mix. The use of outcome measures of effectiveness was routine, and information was shared nationally and locally.

Summary of findings

There were systems in place for people to give feedback to the service, and this was acted upon. Staff told us that they felt supported by their managers, and were pleased to work for the trust. Quality was monitored, and the team took necessary measures to improve their performance.

Community-based crisis services

Good

The CRHT team provided care to people in a compassionate and kind manner. We spoke with staff who understood local needs, and described involvement of those important in people's lives as being central to their work. Carers told us that their needs were always considered when staff visited. They had information made available to them in a variety of formats to meet individual needs. People told us that they were given information to refer to throughout their care.

The team had effective systems to prioritise referrals, safeguard people and report incidents. There was a regular audit of prescribing and medicines, to ensure the safe management of medicines. There was a multidisciplinary approach to risk management, and people were treated according to nationally-recognised guidance, although there were no specific systems to monitor outcomes of care. Partnership working with community teams and inpatient wards meant that there were effective outcomes for people, such as around early discharge from hospital.

'Operation Serenity' (a joint venture with the police) was proven to have a positive impact upon people's experiences when they presented in the community with a mental health issue. The team had a good record of gatekeeping all admissions to inpatient beds, and people were given increased choice about the care they received and where this was provided.

Staff attended alongside the attending approved mental health professional (AMHP), to people being assessed under the Mental Health Act, to offer support from the team as an alternative to hospital admission where appropriate. Complaints were handled according to trust policy, and people had access and information on advocacy services.

The CRHT team were cohesive and felt well supported by management. Robust systems were in place to ensure effective supervision and appraisal of staff. Staff described managers as accessible to them, and regularly consulted with them via a variety of formats. The service was regularly audited to establish levels of performance and outcomes for people using the service. Feedback from people and carers was regularly sought and used to improve the service.

Rehabilitation services

Good

There were effective procedures for staff and people using the service, to report both low-level and serious incidents. These were reported to relevant agencies, investigated, and reviewed to prevent a reoccurrence. Staff had access to training to safeguard vulnerable adults, and some staff had received

Summary of findings

training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Health Act (1983) was applied appropriately, and all documentation was current and in line with the Mental Health Act Code of Practice.

People were assessed and treated according to nationally-recognised pathways of care, and their health needs were being addressed. People were provided with psychological therapy, such as cognitive behaviour therapy (CBT). Staff and managers had regular supervision and appraisal, and new and temporary staff had induction. Staff worked in multidisciplinary teams to co-ordinate care, and were involved in goal setting and regular audits of care plans, but the use of outcome measures of effectiveness was not routine.

People were involved in their care and treatment; there was information on independent mental capacity advocates, and independent mental health advocates were available should people wish to talk with them.

There was a clear vision and strategy for the service; however, the unit did not have a clear understanding of the trust's overall vision and strategies, and staff felt disconnected from the wider trust.

Primary mental health

Good

Primary care mental health services provided by Isle of Wight NHS were effective and responsive to people's needs. Systems for reporting safeguarding issues and incidents of concern within the team were clear, and staff understood their responsibilities in relation to the issues. Patients' progress was comprehensively recorded and evaluated, and discussed with the person. The service provided a range of evidence-based psychological therapies. We saw that staff were highly trained and skilled in the delivery of such interventions. The use of clinical measurements was routine, in order to measure the effectiveness of treatment provided and outcomes for people. This was shared nationally and locally.

People told us that they found staff to be skilful and caring in their interactions with them. Treatment aims and outcomes from interventions provided were reviewed with patients during treatment. People told us that they felt involved in making decisions about their care, and we saw that service delivery and staff training were tailored to meet the diverse needs of the local population.

The staff team were well established and worked in a cohesive manner to provide positive outcomes for patients. Monitoring and auditing of the team was routine, and staff displayed a collective sense of responsibility for team performance.

Drug and alcohol services

Good

We found that the Island Drug and Alcohol Services (IDAS), provided by Isle of Wight NHS Trust, were delivered in a safe and caring way. We found that staff

Summary of findings

were respectful, and delivered care which demonstrated good skills for working with people who misuse drugs and alcohol, and their families. We observed that care and treatment was delivered in a timely manner; there were no people on waiting lists.

We found that the team were concerned about the service going to tender in July 2014. This meant that staff were worried as to whether the Isle of Wight NHS Trust would continue to provide the service, or whether it might be given to another provider.

Staff demonstrated a good understanding of how to follow the local safeguarding policy and procedures for safeguarding vulnerable adults and children, and worked well with other teams, within the trust and outside organisations, to provide care that best met the needs of people. There was good use of national guidelines to treat patients, and outcomes were monitored routinely to improve the service.

People who used the service were able to provide feedback and also knew how to complain. The majority of staff told us that they felt well supported by their managers, and were pleased to work for the team and the trust. However, one staff member felt that the senior management did not listen to their concerns.

We found that the team had arrangements in place to monitor the quality of the service provided, and took necessary actions to improve performance.

Community mental health team

Requires Improvement

Community-based mental health services, provided by Isle of Wight NHS Trust, were delivered in a caring and compassionate way. People we spoke with told us that they found staff to be kind and skilful in their interactions with them. We observed staff in their work with people, and found them to be compassionate and respectful towards them.

People were safeguarded, but incidents were not always reported appropriately. People's records were not up to date, or reviewed regularly with regard to care and risk management. Staff were able to tell us verbally of the risks to people's health, and describe in detail the support they were providing, but the documentation was not reflective of people's current treatment, needs or risks.

Staff had high caseloads, and waiting lists for services were long. Staff were not receiving regular line management or caseload supervision within the Rehabilitation and Recovery Team. This meant that managers were unclear about the appropriateness of interventions being undertaken with people, the effectiveness of records management, or compliance of staff with mandatory training.

Summary of findings

Information leaflets were available, and complaints procedures were clear and understood, both by staff and by people using the service. Teams worked well together, but they did not have an up-to-date operational policy, which outlines the function and interventions they provide. The national guidance and outcomes to monitor the effectiveness of the service were not routine.

Summary of findings

What people who use the location say

People we spoke with, who were using the services, were positive about their experience of care at the trust. Most told us that they found staff to be very caring and supportive towards them. People told us that they felt involved in developments around their care.

Areas for improvement

Action the provider MUST take to improve

- Risk management and care planning in people's records by the community mental health team must be improved. Records were not reviewed consistently or updated in a timely manner.
- The caseload management and line management supervision of caseloads in the Rehabilitation and Recovery Team were not regularly undertaken. Staff had high caseloads, and managers were out of touch with issues within the teams that may impact on care delivery and quality. Improvements need to be made to these management issues.
- Staff within the Rehabilitation and Recovery Team must be compliant with the trust's mandatory training programme.
- Action needs to be taken to ensure that all areas monitor the effectiveness of services in terms of outcomes for people, and there is an appropriate response to risks reported by staff and external reviews. Risk registers need to be regularly reviewed and updated.

Action the provider SHOULD take to improve

- The trust needs to continue to ensure that the turnover of locum staff is minimised in specific areas, to ensure that people receive consistent care.
- The locks on doors on Shackleton Ward and PICU need to be fixed, to ensure that people feel safe, and their privacy and dignity is protected.
- People's access to Section 17 leave needs to be improved, when this is deemed appropriate. (Section 17 leave is often used to prepare longer-term mental health patients for discharge from hospital care, by allowing short periods of leave from the hospital environment.)
- The reasons for discharge delays for older adults with complex needs should be identified and procedures improved.
- People's involvement in their care planning and their preferences, wishes and needs, including what recovery means to them, should be documented in records.
- There should be a clear strategy for the development of mental health services, in particular the future of older adults services should be determined.
- There should be regular reviews of identified risks, and issues raised at board level on the trust's risk register, in the community mental health team.
- The community mental health team should have an up-to-date operational policy, or information available to people on how use the service, which describes its function and what people should expect from the service.
- Staff engagement with mental health teams should be improved, as many staff in mental health teams felt "disconnected" from senior managers and the leadership of the trust.
- Mental health services should be appropriately represented at the trust board to reflect the workings for an integrated trust.

Summary of findings

Good practice

- Primary mental health services teams provided and referred people for a range of evidence-based psychological therapies on a group and individual basis.
- The service had developed new and innovative services to protect vulnerable people and reduce the use of the Mental Health Act. One example of this was 'Operation Serenity', where there was joint working, with policy in place to treat people at home or the community. This had reduced the use of the Section 136 place of safety, and also decreased the number of people having to be detained under the Act.
- The learning disability service was innovative in its use of assistive technology, to help people with communication difficulties, to encourage their choices and preferences.
- The Child and Adolescent Mental Health Service had effective multidisciplinary team and inter-agency working, with a range of support networks with other agencies. There were a wide range of therapies available, and treatment outcomes were monitored to drive service improvement.
- The Island Drug and Alcohol Service had introduced a range of health promotion measures, and had integrated its work with GPs. Service outcome measures were used to improve the service.
- The outside garden space for older adults on Afton Ward was funded and developed by staff. The garden was gender-specific, and had a quiet and restful area, as well as areas that encouraged activity and learning. It was described as inspirational by people and their families.
- On the acute, PICU and rehabilitation wards (including Section 136 place of safety areas) there was effective debriefing for staff following incidents, and staff shared lessons learnt in team meetings. Reflective practice was provided to staff through a skilled psychologist.
- There was effective use of the wellness recovery action plan (WRAP) for patients on the acute, PICU and rehabilitation wards (including Section 136 place of safety areas). Discharge planning started on admission, and the discharge tree was used on PICU. The wards had excellent relationships with housing and employment services.

Isle of Wight NHS Trust

Detailed findings

Services we looked at:
Primary mental health services; Child and adolescent mental health services; rehabilitation services; Acute inpatients, Psychiatric intensive care units and health-based places of safety; Services for older people; Services for people with learning disabilities or autism; Community-based crisis services; Drug and alcohol services; Community mental health services

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, OBE, retired Consultant Clinical Oncologist and past president of the Royal College of Radiologist.

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team included CQC mental health inspectors, consultant psychiatrist, specialist advisor in patient advocacy, Mental Health Act Commissioner, specialist advisors in mental health nursing, specialist advisors in occupational therapy, specialist advisor in learning disability,

consultant psychiatrist in CAMHS. The team also included expert by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting.

Background to Isle of Wight NHS Trust

The Isle of Wight NHS Trust provides an integrated acute, community, mental health and ambulance health care service to the population of the Isle of Wight. It was established in April 2012, following the separation of the provider and commissioner functions within the Isle of Wight Primary Care Trust (PCT). The health services provided by the trust include community mental health services, inpatient acute and rehabilitation services, specialist Child and Adolescent Mental Health Services (CAMHS), a Tier 3 Drug and Alcohol Service, an Early Intervention in Psychosis and Memory Service, and an intensive outreach service for residential and nursing care homes.

Why we carried out this inspection

We carried out this comprehensive inspection because the Isle of Wight NHS Trust is an aspirant Foundation Trust, prioritised by Monitor for inspection. The Care Quality Commission's (CQC) latest Intelligent Monitoring tool identified the trust in Band 5 (Band 1 – highest priority for inspection, Band 6 – lowest priority). We inspected this core service as part of our second phase of the new comprehensive inspection programme introduced for mental health services.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, 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?

The inspection took place on the 4 and 6 June 2014 with an unannounced visit on 21 June between 4pm and 10pm.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCG); NHS Trust Development Authority; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); the Royal College of Psychiatrists; Parliamentary and Health Service Ombudsman; and the local Healthwatch.

We held a listening event in Newport on 3 June 2014 when people shared their views and experiences of Isle of Wight NHS Trust. Some people who were unable to attend the listening event shared their experiences with us via email or telephone.

We carried out an announced inspection visit on 4, 5 and 6 June 2014. We spoke with a range of staff in the hospital, including consultants, approved mental health practitioners, mental health nurses, junior doctors, therapy staff, administrative and clerical staff, and ambulance crews.

We talked with people and staff from the ward areas, and in community services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment provided by the mental health services at St Mary's Hospital.

Good

Acute, psychiatric intensive care units and health-based places of safety

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Osborne Ward is an 18 bedded ward, which primarily caters for people between the age of 18 and 65 requiring inpatient care. The ward provides care, treatment and assessment to people who have been admitted informally or under the Mental Health Act. Two beds are ring-fenced specifically, one for detoxification, and one for people with a learning disability. The service operates seven days a week, 24 hours a day.

Seagrove Ward is an eight bedded Psychiatric Intensive Care Unit (PICU), which cares for people who may need to be in a secure environment during their inpatient stay.

The place of safety is a unit where people arrested under Section 136 of the Mental Health Act by the police are taken for an assessment of their mental health. From that unit people may be admitted to the Acute ward or to the PICU. People not needing admission would be referred to an appropriate community team for support with their mental health difficulty.

Summary of findings

The Acute, PICU and Section 136 place of safety services provided by the Isle of Wight NHS Trust were safely delivered in a caring manner. Staff displayed their skills in working with people, and were supportive and kind. Incidents were reported through the trust incident systems, with regular feedback and debrief to staff to ensure they were informed.

Staff demonstrated a good knowledge of the local safeguarding policy and procedures for safeguarding vulnerable adults, and worked well with other trust teams and external agencies to provide care that best met the needs of people. We saw that the wards worked as part of a multidisciplinary system, with a wide range of skilled professionals. There was goal setting and regular audits of care plans, and the use of outcome measures of effectiveness.

There were systems in place for people to give feedback to the service, and action was taken to improve the service. Staff told us that they felt supported by their managers, but felt disconnected from the rest of the trust.

There were systems in place to monitor the quality of the service provided, and action was taken to improve their performance. The service had had eight locum consultants in the past five years, and this was affecting the consistency of consultant cover, leadership for the ward, and consistency of treatment for the people admitted to hospital.

Good

Acute, psychiatric intensive care units and health-based places of safety

Are acute and psychiatric intensive care units safe?

Good

Osborne Ward

Incidents

- Staff used the trust's electronic incident reporting system to report incidents, and following an incident there was a formal debrief and feedback to the ward team.
- There was an incident reporting, complaints and serious untoward incident reporting meeting held every Wednesday. One purpose of the meeting was to look for any trends that were coming through the reports, and ask for further details around incidents.
- The incident reporting and complaints meeting was a sub group of the trust-wide governance group. Where there were lessons to be learnt, we saw that they were cascaded back through the local governance forums.
- Ward managers and clinical leads attended an acute leads meeting, and all attendees were responsible for disseminating lessons learnt, via team meetings, handovers and one-to-one sessions.

Environment

- One person told us that they did not feel safe because they shared a bathroom with interconnecting doors. They felt vulnerable because the door lock did not lock properly when they went to use the bathroom. We raised their concerns with the ward staff who responded by moving the person to another bedroom where they felt comfortable and safe. An urgent request to have the lock repaired was submitted.

Safeguarding

- The trust had a clear observation policy, consisting of three levels of observation.
- Staff were carrying out the observations according to this policy, and all the staff we spoke to understood the system. Staff were able to tell us of their role in ensuring that people were safely observed, and that observations were recorded.
- Services were planned to meet the needs of people living on the wards, such as activity programmes that kept people engaged and increased their daily living skills.
- Training records showed that all staff had completed training in safeguarding vulnerable adults and safeguarding children. All the staff we spoke to were able to describe the different types of abuse, and the action they would take if they suspected that someone was being abused.

Consent, Mental Capacity Assessment and Deprivation of Liberty Safeguards (DoLS)

- People's mental capacity and capacity to consent to treatment were well documented by doctors and nurses in people's records.
- The electronic medication system now highlighted people's consent to treatment.

Environment

- There were regular and comprehensive risk assessments of the local environment, to check that they were providing care to people in a safe setting.
- The environmental risk assessments had identified windows and door closures as ligature risks. All risks identified in the environmental risk assessments were placed on the trust's risk register, and action plans to reduce risks were produced and acted upon. Following the identification of ligature points, capital bids had been submitted to replace windows and door closures and some had been replaced. A second capital bid was being submitted to replace the remaining ligature points. The ward was actively managing identified ligature points through the use of individual risk assessments of self harm and where specific risks were identified people were supported through increased observation and psychological therapy.

Medicines

- There was a pharmacist for the inpatient service, who monitored the use of medication and its administration.
- When information was needed by people, the pharmacist was able to provide leaflets that explained about medication being taken by them.
- There was a medication group running on the unit that enabled people to discuss their current medication with the pharmacist, and raise any concerns that they had.

Good

Acute, psychiatric intensive care units and health-based places of safety

Assessing and monitoring safety and risk

- All of the staff we spoke to demonstrated that they knew the needs of the people living on the ward, and how their care was planned to meet their needs.
- The ward had a robust handover meeting, which was attended by ward nurses, the specialty doctor, junior doctors, the occupational therapist, health care support workers, discharge co-ordinator, and the pharmacist. The handover discussed risk issues for people using the service, and issues related to staffing that may have affected people's care and treatment.

Understanding and management of foreseeable risks

- There has been a recent safe staffing level review that has resulted in the planned increase of one qualified nurse across all shifts. This would ensure that the ward is covered by sufficient qualified nurses at all times.
- The ward was supported by a middle grade doctor over eight sessions a week, who had worked on the ward for a long time, and provided consistent medical cover and support to the people and staff on the ward.
- The ward had a locum consultant. In the last five years, there have been eight locum consultant psychiatrists covering the ward. This was affecting the consistency of consultant cover, leadership for the ward, and consistency of treatment for the people admitted to the hospital.

Seagrove Ward (PICU)

Incidents

- Staff could explain the process they used to report incidents through the electronic reporting system.
- The manager reviewed all incidents, and identified potential learning and improvements. Appropriate changes were implemented to minimise the risk of incidents reoccurring. The trust maintained a risk register that was regularly updated as new risks were identified and current risks were eliminated. An example is the recent refurbishment of the seclusion area, where CCTV had been installed, and ensured that clear observation of people in seclusion could be maintained.
- There were learning points from incidents, and action taken to improve safety. The use of seclusion had been identified as a priority area to address on the ward. The ward had employed strategies to reduce aggressive incidents that may lead to people being secluded. An example of this was through the training of staff in de-escalation skills. We saw that the ward used a seclusion audit tool to review the practice and identify high risk areas. The seclusion area had been refurbished, and consisted of an 'extra care area', the seclusion room, and ensuite facilities. The area was outside, and inside the seclusion room was monitored by CCTV to ensure the safety of people.

Safeguarding

- Staff training was planned to ensure staff were skilled and trained to provide safe care and treatment. The training included safeguarding vulnerable adults.
- Staff we spoke with demonstrated that they had the knowledge to ensure people were protected from abuse and harm whilst they were on the ward.

Environment

- Regular health and safety checks of the ward were completed, and identified risks were corrected to ensure the safety of people using the service.
- Environmental risk assessments were completed and there were no ligature points identified on the unit.
- The ward had a blanket rule about smoking. People staying on the ward were allowed outside to smoke every two hours. One person we spoke to said they would prefer to be able to smoke when they wanted to.
- The ward was clean and tidy when we visited, and cleaning schedules were followed.

Medicines

- Medicines were being stored safely. Medicines were stored in a locked clinic room, and all medicine cupboards and refrigerators were locked. The keys were kept by a nurse.
- Clinic room and fridge temperatures were being monitored, and were within the guidelines for the dates we checked.
- The ward pharmacist told us that they regularly met with people, to talk to them about their medication, and discuss side-effects. This was done on a one-to-one basis, or through the regular medication group that they ran on the ward, so that people understood what medication they were taking, and to recognise any side-effects that they may experience.

Good

Acute, psychiatric intensive care units and health-based places of safety

Assessing and monitoring safety and risk

- The ward worked to an agreed seclusion policy, to ensure that staff had clear guidance on putting people into, and managing them whilst in, seclusion safely. The manager informed us that the policy was currently being reviewed to ensure that it met national standards.
- People had individualised care plans that had been signed by people to show that they agreed with them. Each person had a risk assessment, and where risks had been identified, they had care plans in place to minimise and manage that risk.

Understanding and management of foreseeable risks

- A staffing review had just taken place, and there was a commitment from senior managers that the recommendations of the review would be implemented. This meant that when staff were needed to carry out place of safety assessments, there would be sufficient staff to carry them out, and also leave the ward with sufficient qualified nursing staff. We were not given any timescales when the proposed changes to staffing would take place.

Section 136 Place of Safety

Safeguarding

- All the staff we spoke with had completed training in safeguarding vulnerable adults, and were able to describe the different types of abuse they may see. They were clear about the action they would take to report any abuse they saw.

Assessing and monitoring safety and risk

- The unit was always contacted by either the police or the 'Operation Serenity' team prior to bringing a patient into the unit. The 'Operation Serenity' scheme sees mental health practitioners accompany police officers to incidents where police believe people may need immediate mental health support.
- The units were not staffed in readiness for people to be brought in for assessment. Staff were taken from the PICU and acute wards to assess people brought to the unit.
- Staff told us that having to staff the units had impacted on the wards, because they would lose staff to carry out the assessment.
- There were good arrangements to transfer people to the units, and when staff were concerned about people, they were able to request support from the police.
- The units had good arrangements to contact an approved mental health professional (AMHP), doctors from Child and Adolescent Mental Health Services (CAMHS), and access to Section 12 approved doctors. (A **Section 12** approved **doctor** is a medically qualified professional with an expertise in mental disorder, **and** has been recognised under **Section 12(**2) of the Act.)
- Information was gathered from a variety of sources to inform the assessment of people admitted. If the person was known to services, their community team were contacted for details about their care and risk assessments. General practitioners were contacted for any relevant information relating to people's risk and care.

Are acute and psychiatric intensive care units effective?

(for example, treatment is effective)

Good

Osborne Ward

Assessment and delivery of care and treatment

- A comprehensive care plan was written within 72 hours for everyone admitted to the ward.
- We looked at five people's care notes, and found that comprehensive risk assessments had been completed. We saw that care plans had been signed by people to signify their agreement. Where people did not sign, staff had recorded that they had refused, and noted why they had declined to sign their care and risk management plan.
- Physical health care was actively assessed and monitored. We found evidence of regular health checks in people's files and we observed people having regular blood pressure, temperature and pulse checked whilst we were on the ward.
- People on Clozapine had their physical health monitored regularly, such as through regular blood testing and monitoring for side effects.

Good

Acute, psychiatric intensive care units and health-based places of safety

Outcomes for people using services

- The team used Health of the Nation Outcome Scales (HoNOS) to monitor outcomes. These outcomes showed positive results.
- Care plans were audited each week on the ward, and the outcome of the audits were discussed at the acute leads meeting. Ward managers ensured actions identified through the audits were completed.
- People had outcome goals which were assessed and monitored. All the documentation we looked at had appropriate assessments, reviews and responses to the person's changing circumstances.
- People did not have long stays for acute care on the ward.

Competent Staff

- Staff received supervision every 6-8 weeks, which they told us was supportive, and aided them in carrying out their roles successfully.
- Staff had sessions where they were able to reflect on their practice, with the support of a clinical psychologist.
- All staff on the ward were up to date with equality and diversity training.

Multidisciplinary working

- There was a robust multidisciplinary team on the ward. The team was made up of doctors, pharmacist, occupational therapist, and staff from the ward.
- The pharmacist was embedded within the ward team, participating in ward reviews, handover, and clinical evaluation.
- We attended a morning handover, and found a robust system for handover was held each morning, involving the multidisciplinary team. The handover ensured that any staff that had been away for a while were given plenty of information that ensured they kept up to date with new admissions and any incidents that had happened on the ward.

Mental Health Act (MHA)

- All mental health documentation that we looked at we found to be in order. People's files were well organised, with patient information. We saw that Sections 5/2 and 5/4 were adhered to, in line with the code of practice.

Seagrove Ward (PICU)

Assessment and delivery of care and treatment

- We followed the care and treatment of some of the people on ward at the time of our inspection. We found that people's care and treatment needs were discussed at the time of referral, and decisions about the types of interventions were made among professionals following a review of the person's needs.
- Care was delivered on the ward by a multidisciplinary team (MDT). In addition, there was input from specialist teams, such as physical healthcare, when required. We saw from a care plan that a range of appropriate options had been discussed for the person's discharge. Risks were identified and physical health checks had been carried out.
- There were a range of therapeutic activities being developed for people staying on the ward. People were encouraged to participate in activities, such as coffee mornings and community morning meetings.

Outcomes for people using services

- The team used Health of the Nation Outcome Scales (HoNOS) to monitor outcomes. These outcomes showed positive results.
- People had outcome goals which were assessed and monitored. All the documentation we looked at had appropriate assessments, reviews and responses to the person's changing circumstances
- People were staying on the ward longer than they needed to because there were no beds available for them to be transferred to. People were discharged directly to the community, to minimise the duration they were to remain on the ward.

Competent Staff

- All of the staff we spoke to had regular supervision, and told us they had had an appraisal. They told us they were well supported, and were able to access support when needed.
- Staff had appropriate skills to meet the needs of people on the ward. Whilst visiting the ward, we saw staff managing someone who had just been into seclusion for aggressive behaviour, and they managed that person's transition back into the ward community, ensuring the person was safe throughout the episode.

Good

Acute, psychiatric intensive care units and health-based places of safety

Multidisciplinary working

- Assessments on the ward were multidisciplinary in approach, with involvement from medical, nursing, and specialist teams. There were good links to the police through the 'Operation Serenity' programme.
- There was a good multidisciplinary (MDT) presence on the wards, and all staff worked together to provide the best outcome for people.
- We saw that there was an occupational therapist for the ward, and they work closely with staff and people to create programmes to facilitate recovery leading to discharge.

Mental Health Act (MHA)

- All records were in accordance with the Mental Health Act Code of Practice.
- People's mental health capacity was assessed at ward reviews and recorded in the trust's electronic recording system.

Section 136 Place of Safety

Assessment and delivery of care and treatment

- Assessments are undertaken by nursing staff, who perform a triage function in determining if the person needed admission, and if they did, where that admission should be.

Outcomes for people using the service

- The adult place of safety has good links to the 'Operation Serenity' project, and has seen a reduction in the number of people regularly brought to the unit.
- People brought to the units were quickly placed in the appropriate ward that would meet their needs.
- People who did not require admission, but needed community support, were referred to an appropriate community team that could support them at home.

Competent Staff

- The units do not have regular staff based there, and staff came from PICU and Osborne Ward when necessary. When someone is brought to the units, staff from both the PICU and Osborne Ward carry out a joint assessment, and decide the best place for the person to be cared in. This could be either the PICU or Osborne Ward.
- The management of the units was shared between the ward managers on the wards linked to the place of safety. The staff for the children's place of safety were not trained in mental health nursing, although when they did have an admission, there was access to a CAMHS consultant and mental health practitioners.

Multidisciplinary working

- The hospital-based place of safety units all had access to doctors, AMHPs, and Child and Adolescents Mental Health (CAMHS) psychiatrists.

Mental Health Act (MHA)

- Under the Mental Health Act people brought in to the hospital-based place of safety, under police powers, must be informed about their rights whilst they were there. By the nature of the police power, and the short time allowed to keep people in the place of safety, people's rights are limited.
- On this inspection, we saw that there were leaflets and pro-formas to record that these rights had been given. We heard that staff attempted to assist people to understand their rights.
- Staff worked in accordance with the MHA Code of Practice in relation to the place of safety. There were appropriate procedures to ensure staff worked within the MHA Code of Practice. For example, to record key demographic details, issues such as transfers between the police and the place of safety, and the outcome of the use of the place of safety.

Are acute and psychiatric intensive care units caring?

Good

Osborne Ward

Kindness, dignity and respect

- We observed that staff demonstrated kindness and consideration to people through the interaction that we saw.
- We observed that people were treated with respect and dignity on the ward.
- People's privacy and dignity was not always maintained, because we saw several people having their blood pressure and pulse being monitored in the middle of the ward, in full view of other people staying on the ward, or people visiting the ward.

Good

Acute, psychiatric intensive care units and health-based places of safety

- All the people we spoke to told us that staff treated them really well and with kindness. One person said, “love it here, staff are great”. We saw facilities like cool water machine for people to use when they wanted a cold drink.
- Single sex accommodation was maintained on all the wards, which was in line with national guidance.

People using services involvement

- Care plans were formulated jointly by staff and people using the service, and we found that people had a written care plan within 72 hours of their admission.
- People had signed to confirm that they had agreed with their care plans and risk assessments.
- Relatives were involved in the care planning of people living on the ward, and their information was used to develop people’s care plans.

Emotional support for care and treatment

- The staff demonstrated a high level of emotional support to patients on the ward at an individual level, and took time to explain and support patients in a sensitive manner.
- There were health and well-being, and recovery groups on the wards.
- We observed a daily discussion group session, and saw that the needs of people were considered, and that people were engaged and taking part in the group.
- One person said “when I have one to one the staff listen to me. They help me to express my feelings". Another person expressed feeling confident in how staff supported them, and felt they would do this whether it fell within their realm of health issues or outside of it.

Seagrove Ward (PICU)

Kindness, dignity and respect

- People on the ward were generally positive about the attitude of staff and the support they had received. Comments included ‘’staff are ok. They look after me and I feel confidence in them. Staff help me a lot and I like them’’ and ‘’I feel it’s a good ward with very good staff".
- We saw that the interaction between people who used the service and staff members was positive, and that staff responded to people with patience, kindness and ensured that they were treated with dignity.
- We observed examples of staff engaging with people in a kind and respectful manner on the ward. For example, we saw staff working with people, who appeared engaged and comfortable with the staff member. We also noted that people felt comfortable approaching the different staff, and we saw positive interactions between managers and people using the service.
- Seagrove Ward was a mixed sex ward, and always promoted physical and sexual safety for everyone using the ward. There was a female-only lounge and a male-only lounge, which meant that both genders could have quiet spaces to themselves.

People using services involvement

- All the people we spoke to discussed what and how they were supported by staff. One person said staff were friendly and accommodating, knowledgeable and caring. This was reflected in the interactions we observed on the ward between staff and people.
- We looked at a care plan and discussed this with a staff member. We saw that the person’s rights had been discussed, and information was detailed in respect of the psychological and physical sections. Staff were aware of the risks to the person. In addition, the recovery plan was written from the patient’s perspective. Staff discussed the issues they had to face to try to get patients to sign care plans, and how they employed strategies to overcome these.
- The ward operated a named nurse system to ensure consistency for people staying on the ward. One person told us about their named nurse, and described them as “excellent’’. They told us that together with their primary nurse, they had reviewed their care plan the previous day, and discussed their progress towards discharge.

Emotional support for care and treatment

- People using the service described the activities undertaken on the ward which helped their well-being. They said activities happened and were not usually cancelled. One expressed liking the "staff led activities"; another discussed "watching films and playing ball games".

Section 136 Place of Safety

Kindness, dignity and respect

- Access to the suite was through a private entrance that protected people’s privacy and dignity when being brought onto the suite by the police.

Good

Acute, psychiatric intensive care units and health-based places of safety

- There was a children's place of safety (POS) available for children up to 18 years old. Staff told us that the unit has rarely been used for POS, and therefore was used to sometimes support the paediatric ward; but if needed, it would be locked off with its own discrete entrance to ensure young people's privacy and dignity.

People using services involvement

- On the day of our inspection there were no people admitted to the units, so we did not see any interactions between staff and people.

Are acute and psychiatric intensive care units responsive to people's needs? (for example, to feedback?)

Good

Osborne Ward

Planning and delivering services

- People were admitted to the unit if they were in crisis, or needed to be detained under the Mental Health Act. Data available showed that 96% of all people admitted to an inpatient bed were assessed by the team known as 'gatekeeping', which was within the national target.

Right care at the right time

- Whether admissions were planned or unplanned people always received a full assessment, including using pre-admission information. This involved undertaking a range of mental and physical health checks. Where a risk was identified, plans were put in place to support the person. For instance, if there was previously identified safeguarding, staff would link in with staff in the community teams to look at the historical and present risks, which would then inform how a person was supported on the ward.
- Care was being delivered by a multidisciplinary team (MDT). In addition, there was input from specialist teams, such as physical healthcare, when required. We saw from a care plan that a range of appropriate options had been discussed for the person's discharge. Risks were identified and physical health checks had been carried out. We looked at notes for one person, and followed up on a discussion with them. They were clear that most of the areas discussed in their notes had been discussed during the MDT round.
- There was early discharge planning for everyone on the ward. The average length of stay for people was 10 days; however sometimes, due to a lack of accommodation, people remained in hospital when they were ready for discharge.
- In line with national standards, people who were discharged received a community follow-up within seven days.

Meeting people's individual needs

- The unit had one bed reserved for people requiring detoxification. This was well planned, and people told us that they had their treatment explained clearly, so they knew what to expect when they went into hospital.
- There was appropriate involvement of the Independent Mental Health Advocates (IMHAs) for people who had requested or needed support.

Learning from concerns and complaints

- People were aware of how to raise complaints, and some told us that they were aware of the Patient Advice and Liaison Services (PALS) and advocacy, if they wanted to raise a complaint.
- Staff made it clear to people that they would not disclose information about them to carers unless they gave their consent.
- The service regularly requested feedback from people who had used the service, and used that feedback to make changes to the service provided. One improvement was the recording of the community meeting once a week, as a result of people's comments.

Seagrove Ward (PICU)

Planning and delivering services

- People were admitted if they needed care in a secure environment for a period of their admission.
- Care planning was individualised, based on the person's own assessment and that of the clinical team. The delivery of care was sensitive and organised to support people in the least restrictive way.

- There was planning around early supported discharge from the unit. Liaison with community teams and the acute ward regularly took place, to ensure planning was in place to support the early discharge of people from the unit.

Right care at the right time

- Pre-admission information was obtained from the other wards or the community, in advance of an admission, to ensure that staff knew of the risk areas relevant to a person, and how they could best support them during their stay.
- Anyone being admitted always received a full assessment, including using pre-admission information. This involved undertaking a range of mental and physical health checks. Where a risk was identified, plans were put in place to support the person. For instance, if there were accommodation issues, staff would link in with staff in the community teams, to look at what input might be required. Whilst on the ward, we observed that staff discussed a range of areas pertinent to a person's care and welfare. This included what they had been up to during the day, appointments off the ward, referrals to community teams, and current issues, such as their drug related mood state, observation levels, discharge arrangements, family involvement, and behaviours.
- There was good liaison between the ward and community teams, so that planning for people's discharge was carefully co-ordinated, and people's accommodation was organised while they were on the ward.
- Discharge arrangements began at the point of admission, to limit the amount of time people spent on the ward. Care co-ordinators were brought in early to a patient's care, to help facilitate their arrangements for discharge.
- We found that people sometimes remained on the ward when they no longer needed PICU care, because of a lack of beds on other wards. People were granted unescorted Section 17 leave from the ward because they had sufficiently recovered, and were safe to leave the ward on their own. However, some people did not always get their escorted Section 17 leave due to issues with staffing levels.

Meeting people's individual needs

- The links to resources in the community, to support people when they were discharged, were good. An example of this were the links with the housing department.
- Care plans were informed by people's preferences and assessed needs.
- People had access to advocacy services.

Learning from concerns and complaints

- The ward held daily community meetings, where people were able to discuss issues that affected them during their stay on the ward. Activities and food were common issues that people often raised in the meetings. A fully equipped gym was now available for people to use with supervision.
- We saw that the unit used a service user's questionnaire to find out about people's experience of staying on the ward, and they used that information to change and improve the service and care given.

- **Section 136 Place of Safety**

Planning and delivering services

- All admissions to the place of safety were through the police or the 'Operation Serenity' project.
- Staff were always available to respond to people brought to the unit, and to undertake an assessment of their mental health needs.
- Facilities were in place for people to spend short periods of time on the unit having an assessment, and if there were no beds available on the admission wards, they were nursed there with experienced nursing staff, so that their care needs could be met.

- **Right care at the right time**
- There was evidence of good working relationships between the many parties involved in the place of safety, including Crisis Resolution and Home Treatment Teams, the approved mental health professionals (AMHPs), the doctors, the police service, and Accident and Emergency departments. This co-ordinated group of professionals' ensured that people were receiving the care they would need at the right time.
- The arrangements to ensure that people could be conveyed to a hospital-based place of safety were in place, including working arrangements for the police to phone the unit in advance, to ensure that the suite was

available, and to assist staff to co-ordinate a speedy assessment. We found that outside of core hours there could be a delay in accessing AMHPs to complete the Mental Health Act assessment.

- **Meeting people's individual needs**
- Information we saw showed that people were able to access an inpatient bed in the relevant acute psychiatric service when a decision was reached to admit them to hospital. Where people were not deemed to require hospital stays, they were offered follow up by the Crisis Resolution and Home Treatment Team, with the level of support determined by the levels of assessed and manageable risk.

Section 136 Place of Safety

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Are acute and psychiatric intensive care units well-led?

Good

Osborne Ward, Seagrove Ward and Section 136 Place of Safety

Vision and strategy

- The service did not have a clear vision or strategy.

Responsible governance, risk management and performance information

- There was a governance structure in place that supported the safe delivery of the service.
- Management staff on the ward attended a clinical leads meeting with the modern matron for updates, and disseminated this information, for instance, in team meetings.
- Team meetings discussed operational areas, such as consultant care arrangements, and there was feedback from the governance forums, as well as from incident reporting. Staff were also able to raise concerns.
- All staff we spoke with told us that they felt they would be able to raise concerns.
- The views of staff were also collected through supervision sessions.
- The trust's risk register included risks identified regarding the use of locum consultants, and action was being taken to mitigate these risks. However, staff expressed frustration with the support provided by the HR department, in delaying recruitment.

Good

Acute, psychiatric intensive care units and health-based places of safety

Leadership and culture

- Staff we spoke with told us they felt that the line management of their team was good, and that they felt supported by their team manager. They felt they had good access to training and development opportunities.
- Managers and staff we spoke with told us that they had a good interface with their line manager.

Engagement

- All the staff we spoke to felt disconnected from the trust. One person in a focus group, for example, expressed the views of several staff and said, "we are just attached to an acute trust".
- Lines of communication from the board and senior managers to the frontline services were not effective, and staff were not aware of key messages, initiatives, and the priorities of the trust.

Seagrove Ward (PICU)

Vision and strategy

- The service did not have a clear vision or strategy.

Responsible governance, risk management and performance information

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- All staff we spoke with told us that they felt they would be able to raise concerns.
- The views of staff were also collected through supervision sessions.
- The trust keeps a detailed record of risks that were found; once rectified they are then removed from the trust's risk register. An example was the identification of ligature points and the escalation of those risks, leading to capital bids to replace the door handles and closures identified.

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Public and Staff Engagement

- People's views and experiences of the services were collated via questionnaires, and were acted upon. The services were changed and improved as a result. An example was the increase in individual activities for people staying on the ward.
- All the staff we spoke to felt disconnected from the trust. One person in a focus group, for example, expressed the views of several staff and said, "we are just attached to an acute trust".

Good

Child and adolescent mental health services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The Child and Adolescent Mental Health Service (CAMHS) provides a service to children and young people aged 0–18yrs, and their families, who are experiencing emotional health and well-being difficulties. The community mental health clinic offers support, consultation and training to children's services, and provides primary and specialist mental health services in the community, and to inpatient treatment services as required. This is a community-based service only.

CAMHS offers an intervention to any 0-18 year old with an identified emotional-behavioural or mental health concern. Any professional, parent, carer or voluntary sector employee can refer a child or young person to CAMHS. Adolescents who feel that they have mental health difficulties are able to self-refer.

CAMHS is open 8:30am-5pm, Monday to Thursday, and 8:30am-4:30pm on Fridays. Outside of these hours, for an urgent mental health response, referrers can contact the appropriate GP, the Beacon Centre, or the Adult Crisis Resolution Team.

Summary of findings

The CAMHS services provided by the Isle of Wight NHS Trust were delivered in a safe and caring manner. We found that staff were kind, friendly and delivered care which demonstrated a responsive manner for working with children, young people and their families. We observed that children and young people received a good service.

The team was in the process of moving from hard copy records to electronic records, and this had created some difficulties in how some of the information was being transferred and recorded. Information about assessments and care could not be easily located. Incidents were reported and some lessons learnt, but not all information on reported incidents was fed back to teams.

Staff demonstrated a good understanding of how to follow the local safeguarding policy and procedures for safeguarding children, and worked well with other trust teams and external agencies to provide care that best met the needs of children and young people. The team worked collaboratively as a multidisciplinary team with a varied skill mix. The use of outcome measures of effectiveness was routine, and information was shared nationally and locally.

The CAMHS services had an understanding of the specific needs of the population they served, and delivered care which was largely responsive to people's

Good

Child and adolescent mental health services

needs. Children did not have long waiting times for care and treatment, although some children who required inpatient services for a longer period of time were placed off the Island.

Children could provide feedback to the service, and this was acted upon. Staff told us that they felt supported by their managers, and were proud of their team and to work for the trust. The quality of the service provided was monitored and necessary measures were taken to improve performance.

Are child and adolescent mental health services safe?

Good

Incident

- Incidents were reported, and all reported incidents were consistently shared with members of the team.
- The team leader had no access to incidents once they had been reported and sent online. The team did not keep a log of reported incidents on site. The team leader told us that all reported incidents went to the service manager and did not come back to the team. They told us that incidents had been investigated, actions completed and discussed with the team.
- Staff told us that they received feedback following incidents through meetings and group supervision, and those lessons learnt were recorded.
- Some learning from incidents was discussed, and specific changes to practice were circulated within the team. Some of the staff spoken with were able to give us examples of changes made to practice as a result of learning from such incidents. For example, a new alarm system and process for escorting children to and from therapy rooms was introduced.

Safeguarding

- All staff spoken with demonstrated that they knew how to identify and report any abuse, to ensure that people who used the service were safeguarded from harm.
- Training records indicated that all staff were trained in safeguarding children. All staff spoken with were able to name the designated lead for safeguarding within the trust, who was available to provide support and guidance. All people who used the service who we spoke with told us that they felt safe, and knew how to raise any concerns about abuse.
- Information was easily accessible in an easy-to-read format, to inform people who used the service, and staff, on how to report abuse.

Good

Child and adolescent mental health services

Consent , Mental Capacity Assessment and Deprivation of Liberty Safeguards (DoLS)

- All staff had received training in the Mental Capacity Act (MCA). The legislation and the assessment of Gillick competency had been used appropriately to ensure that young people's rights were respected and they exercised control over their lives.

Environment

- The environment was clean and staff practiced good infection control procedures.

Records

- The team was in the process of moving from hard copy records to electronic records, and this had created some difficulties in how some of the information was being transferred and recorded. Staff told us that this was work in progress and they were creating new documents that would fit in with the new system. This meant that the new system was not compatible with some of the previously-used documents, and information was not easily available or readily located.

Assessing and monitoring safety and risk

- There was a safety alarm system in all therapy rooms, to enable staff to summon assistance when needed. This ensured both the safety of people who used the service and that of staff.
- Risk assessments were carried out for all visits to people, to ensure that all staff were safe; where the risk was deemed high, two staff members were to visit together.
- People's needs were assessed prior to care and treatment starting, and these clearly identified people's needs. There were good examples of completed needs assessments; however, the care planning was not always detailed enough. The team leader showed us new care plans to be introduced, and explained the changes due to the recent moves to new electronic records. Work on robust risk assessment and management plans was also in progress, to fit it in with the new electronic records.
- The team conducted a risk meeting each morning, to discuss any risks to people who use the service or staff, and management plans were drawn up to minimise any risks.

Understanding and management of foreseeable risks

- The team leader told us that risks and near misses were recorded on the trust's electronic incident reporting system, and the investigations and outcomes were used to put in place management strategies for any risks identified.
- The risks which could be anticipated from insufficient medical, nursing and therapists cover, and the impact of this on meeting patients' needs, had been considered.

Staffing

- Staffing levels were appropriate, with a good skill mix. The team had an input from the wider multidisciplinary team, including consultant psychiatrists, clinical psychologists, mental health nurses, family therapists, occupational therapists and psycho-therapists.

Mandatory Training

- Staff received the training they needed, and where updates were required, this was monitored through a system that highlighted it. All staff spoken with told us that they received mandatory training and got reminders when their updates were due.

Are child and adolescent mental health services effective?

(for example, treatment is effective)

Good

Assessment and delivery of care and treatment

- Care plans were written following an assessment, and agreed by the person or family; those who we spoke with told us that a copy had been given to them.
- Records sampled showed that comprehensive assessments had been completed of the person's needs and risks. From this a care plan was developed that showed staff how to support the person to ensure their needs were safely met.
- People's needs were tailored to professionals with the right skills to meet their needs; for example, people with psychological needs were under the care of a psychologist; those with family issues would be under the family therapist. People with complex needs were

Good

Child and adolescent mental health services

able to receive care from a range of professionals. People spoken with told us that they were involved in their care plans, and that plans were reviewed and updated regularly.
- The team did not use a Care Programme Approach (CPA) framework for people who had severe mental health needs or a range of different needs; however, multi-agency working was clearly evidenced. CPA is a particular way of assessing, planning and reviewing people's mental health care needs. Work was in progress to formulate the CPA framework.
- People told us that a wide range of positive therapeutic activities were offered, such as anxiety group, self-esteem group, emotional group and family therapy. We saw that the team carried out surveys to get ideas on how they could improve the programmes, and maintained a close monitoring system on outcomes.

Outcomes for people using services

- The team used Health of the Nation Outcome Scales-Child and Adolescent (HoNOS-CA) to monitor outcomes. These outcomes showed positive results.
- There were a number of audits which were carried out in order to ensure improvements to the effectiveness of service delivery could be made. For example, peer support and self-help groups had been developed, staff and other professionals received training to recognise early warning signs of mental health.
- The trust worked with external bodies and participated in national clinical audits to improve quality.
- The CAMHS provision is a member of CAMHS (Child) Outcomes Research Consortium (CORC). CORC measures quality outcomes for children and young people on how they experienced therapy, so that any necessary changes can be made; it also compares services, so that they can learn from each other. The trust was doing well in areas such as access to psychological therapies, involvement of young people in their care, children reporting positive outcomes, and family therapy, compared to similar services. Where the trust was not performing well an action plan was devised to make necessary changes for improvement; for example, ensuring the prevention of relapse for children who had used the service.
- The team was awarded with Royal College of Psychiatry Award for CAMHS team of the year in 2013.

Staff, equipment and facilities

- Staff received the training they needed, and where updates were required, this was monitored.
- All staff spoken with told us that they received regular supervision and had an annual appraisal.
- Staff were appropriately qualified

Multidisciplinary working

- In records we sampled there was evidence that the multidisciplinary team worked together.
- There was evidence of working with others, including internal and external partnership working, such as multidisciplinary working with GPs, schools, paediatric unit, mental health crisis team, the independent sector and local authority. Staff explained to us the advantages of the electronic system, which enables all staff to document their care input on one system, and how easily the out of hours mental health team can access the records.

Mental Health Act (MHA)

- There were policies and procedures in place pertaining to Mental Health Act responsibilities. At the time of our inspection there were no persons subject to the MHA.

Are child and adolescent mental health services caring?

Good

Kindness, dignity and respect

- People told us that staff were helpful, and they had been treated with dignity and respect.
- We observed that the interactions between staff and people who used the service were good, and staff treated people with respect.

People using services involvement

- People who used the service, and their families, told us that they were involved in their care planning and reviews. People could invite their relatives and friends to be involved in their care planning if they wanted to.
- People told us, and we observed, that they attended their review meetings.

Good

Child and adolescent mental health services

- Children and their families were asked for their views about the care they received. All the people we spoke with were happy with the care they or their children received.
- People told us that their individual needs were met and they had access to services to meet their needs. People told us they had choices of treatment and care that met their preferences and needs.

Emotional support for care and treatment

- Children told us that staff talked to them like a person, and were not judgemental.
- Children attended treatment programmes with psychologists and family therapists to address their emotional needs.
- During our inspection we visited a school with staff from the team, and people spoken with told us that this helped them a lot, rather than going to the CAMHS clinic. People told us that this helped them to overcome anxieties associated with unfamiliar environments.

Are child and adolescent mental health services responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services

- Referrals to the service were allocated to the health professional whose specialty best fits the needs identified in the referral. Sometimes the allocated worker will change if it is thought that another professional can best meet that need.
- Staff worked with other community teams, such the transition team and external agencies, to ensure that people had the support they needed.
- The service did not operate out of hours, but staff told us that urgent referrals were picked up by the adult mental health crisis resolution team. Staff confirmed that this is followed by a handover on the next working day, and discussion within the team.

Right care at the right time

- There had been no waiting list for people to receive care for the past five years.
- There were good integrated pathways. Primary mental health workers visited schools regularly to provide support and carry out assessments. There was a link with the transition team, paediatric unit, adult mental health team and GPs, to ensure that they were aware of and up to date with the needs of people they work with. All parties involved were invited to meetings prior to discharge and care pathways were developed.
- The team worked closely with the paediatric unit at St Mary's Hospital, where one bed is reserved for any person who requires access to the short term inpatient service. The outreach and in reach nurses spent their time in the paediatric unit to support the person and staff.
- The average length of stay in the paediatric unit was one to two nights. The longest stay was for 47 nights for a child who had to be found a long stay bed off the Island. The outreach and in reach nurses continued to maintain contact with all children placed off the Island.
- We saw that people's discharge was well planned, and the service offered an additional period of 30 days for people to contact the team again if any problems arose before they were totally discharged from care.
- The transition team and education team were involved prior to discharge, and discharge was planned, and all agencies were prepared for the care and support required.

Meeting people's individual needs

- Each person who used the service was provided with an information pack from the CAMHS, which supplied details needed to contact the service, including what to do out of hours.
- People had access to advocacy services.

Learning from concerns and complaints

- All people spoken with told us that they could raise complaints when they wanted to, and they were listened to, and given feedback from these.
- Information on how to make a complaint was easily accessible and in a user-friendly format.
- All the staff we spoke with knew how to support people who used the service, and their relatives, to make a complaint.

Are child and adolescent mental health services well-led?

Good

Child and adolescent mental health services

Good

Vision and strategy

- Most of the staff spoken with showed a good understanding of the values, vision and objectives of the service. Staff told us that the team would provide care in an integrated way that children and their families would be proud of.
- They told us that the service would provide individualised care at the right time, and endeavour to provide that care within the Island wherever possible.
- Staff told us about the trust's ambitions to become a Foundation Trust, and how they were working with other outside agencies to improve ways of working.

Responsible governance, risk management and performance information

- Regular team meetings were held, with minutes of the meetings recorded. Discussions in the meetings included caseloads, incidents, learning and development, risk management and service updates.
- Staff spoken with told us that the trust's clinical governance team analysed the risks within the organisation, and this information was shared with all staff to reduce risks to safety.
- The CAMHS service carried out a variety of audits, which were monitored regularly, and actions were taken to improve quality.
- The trust's risk register included risks identified by the introduction of the electronic records systems. Action was being taken to mitigate these risks.
- Staff were aware of the whistleblowing policy, and said that they would feel confident to report and refer concerns if it was needed. The whistleblowing policy was available on the trust's intranet site for staff to refer to.

Leadership and culture

- The service was overseen by a service lead, and the team leader was responsible for day-to-day running of the service.
- Staff told us that they felt well supported by their managers and peers. Staff felt that managers were responsive to staff needs, they listened, and were approachable and open to new ideas.
- They felt the team was very committed to ensuring that they achieved high quality care, and there was very good information sharing within the team.
- Staff told us that the morale was high within the team, as they were all proud of what the service had achieved so far.

Public and Staff Engagement

- People who used the service, and their families, were asked for their views in satisfaction surveys and in meetings. An online survey was set up, which asked people for their views on the service. The completed evaluation results were then used to identify any themes or trends to the service which may require improvement.
- A newsletter was circulated during each school term, which gave people information to keep them up to date with what was happening within the CAMHS service, and included action taken following feedback.
- People spoken with told us that they were involved in how the service was run, and some changes had been made as a result of the trust listening to their views.
- Staff told us that they had weekly briefings, 'the Friday Flame' from the chief executive, and an e-bulletin. Staff told us that senior managers were accessible, approachable, encouraged openness and regularly visited the team.

Innovation, Improvement and Sustainability

- The service used outcomes, clinical audit and information from people's feedback to continually improve the service.

Good

Services for older people

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Afton Ward

Afton Ward is a 12e bed acute admission unit for older people that experience severe mental health problems. The ward takes admissions for people who have associated physical health problems.

Shackleton Ward

Shackleton Ward is a seven bed unit which provides specialist inpatient assessment and care for those living with dementia. The unit is able to offer assessment and advice to relatives, carers and residential homes on the management of people who present with challenging problems in the care that they require. The unit is also able to offer advice to and for individuals who are not receiving inpatient care.

Dementia Intensive Treatment Service (DITS)

The dementia intensive treatment service provides support and training for people usually living in nursing or residential care, but also occasionally for those living in their own home. The service is managed by the Shackleton Ward manager, with a team lead for the community service. DITS functions to prevent admission to hospital. The criteria for intervention is 'people with dementia and associated behaviours that challenge'.

Memory Service

The memory service team works along the spectrum from early intervention to continuing health care needs across acute and mental health services. The team supports people in their own homes and residential and nursing homes. Interventions are usually up to eight weeks but when people require more intensive support the length of intervention is more open ended. There is some overlap between the memory service and DITS and there are close working relationships between the teams.

Good

Services for older people

Summary of findings

Inpatient services for older adults were rated as good, for being safe, effective, caring and responsive to people's needs.

There were clear systems in place for reporting safeguarding issues, and incidents of concern within the team were clear, and staff understood their responsibilities Comprehensive risk assessments were carried out on admission. Staffing levels were good and were flexible to meet any patient needs, such as increased observations. Mandatory training had not been completed by all staff, but this process was being managed. Staff worked in multidisciplinary teams to co-ordinate care, and were involved in goal setting and regular audits of care plans, but the use of outcome measures of effectiveness was not routine.

Staff reported an open culture with the management team for reporting concerns and issues, but supervision was not done through a formal system. We observed people being treated respectfully and with compassion throughout our visit, and this was attributed to the strong leadership on the wards.

Are services for older people safe?

Good

Afton Ward

Incidents

- Information provided by the trust showed that over the previous six months five serious incidents (SIRI's) that required investigation were reported, which were attributable to mental health inpatient services, including Afton and Shackleton Wards. These included two slips/trips/falls; two unexpected deaths,.
- There was a clear process in place for reporting and learning from incidents. We observed that the ward used an electronic process for recording incidents. Staff completed the incident report online (and this was forwarded to the ward manager who reviewed the information). The ward manager then forwarded information to other relevant people according to the nature of the incident.
- Incidents were investigated, usually by the ward manager, and the results of the investigation would be sent to the modern matron. Occasionally, more information could be requested, which the ward manager would be expected to supply.
- The ward manager informed us that incidents were discussed at the modern matron's action group meeting, and also at the weekly acute leads meeting (which included ward managers). The ward held a daily meeting for qualified staff, and feedback from incidents was a standing agenda item at this meeting.
- A support worker told us that "incidents are reported electronically and these were audited by managers" and a staff nurse we spoke with told us "we complete the datix form and this goes to the ward manager. We get good feedback and this is shared on the ward".
- Incident reports were completed for any person found on the floor; this included observed and unobserved falls. The ward manager told us that a higher than expected level of falls had been reported and investigated. It was established that this often occurred when people were moving from their bed to the toilet, mostly during the night. It was not possible to permanently fit handrails as these were a ligature risk. However, research had identified that an easily removable handrail was available that could be used if

required in the person's room. When handrails were not required, or a ligature risk was identified, they could be removed and the fittings covered with a plate, so that they did not present as a ligature anchor risk.
- Risk assessments for suicide and falling were undertaken for each person admitted to the ward, and the rails used as appropriate. We saw rails fitted in bedrooms as explained by the ward manager, and this process had led to a reduction in the number of falls on the ward. This showed that action was taken following the review of reported incidents.

Safeguarding

- Occasionally, low level physical interventions needed to be used on the ward, and we saw records that demonstrated that physical intervention processes were regularly reviewed. All physical interventions, however minimal, were treated as an incident, and managed through that process. Individual record forms were also completed, which gave comprehensive information that was forwarded to the trust control and restraint lead for review. Nineteen forms were reviewed from November 2013, and all were appropriately completed.
- The trust mandatory training programme included safeguarding adults training, and trust information showed that 75% of staff on Afton Ward were up to date with this training. We spoke with a staff nurse who confirmed that they had received safeguarding adults training.
- Any safeguarding alerts were discussed with the consultant, and also reported to the trust adult safeguarding lead. The deputy manager informed us that the safeguarding lead in the trust was "well regarded".

Consent, Mental Capacity Assessment and Deprivation of Liberty Safeguards (DoLS)

- There was a weekly review of people's capacity at the regular case conference, but ward staff we spoke with had some lack of understanding regarding the Mental Capacity Act 2005, especially the use of Deprivation of Liberty authorisations.
- Staff we spoke with told us that if they had any concerns, they would seek advice from qualified staff or from the safeguarding adults lead. At the time of our visit, there were no Deprivation of Liberty authorisations in place, but five people were detained under a section of the Mental Health Act.

Medicines

- The pharmacist visited the ward most days (at least three days a week), and was also present at the ward round. A pharmacy technician visited five days a week. There was a central pharmacy with two mental health pharmacists working within the team, who advised on medicines prescribing.
- The team also received referrals if concerns had been identified regarding side effects. Advice offered to medical staff included side effects of medicines, use of antibiotics, and follow-up referrals from medical staff regarding confirmation or exclusion of possible side effects. Advice was also given to each new rotation of senior house officers, regarding the avoidance of anti-psychotic medicines in older person's treatment.
- A computer-based prescribing system has been used on Afton Ward for three years. Nursing staff administrating medicines, view what is prescribed, prepare the medicine and record after the person has taken it. If a medicine is not accounted for, the system will not reset for the next day until the entry is resolved.
- Procedures were in place if medicines needed to be obtained out of hours, and the system linked with general practitioner computer systems to view the person's diagnosis and medicines prescribed. Venous thromboembolism assessments and allergies were also linked to the system.
- The pharmacist advised us that a routine monthly audit was undertaken in the use of anti-psychotic medicines; audits were also undertaken in the use of rapid tranquilisation.
- Any serious drug errors were reported through the incident reporting system, and a weekly pharmacy meeting is held to review incidents reported. The pharmacist told us that they had "no concerns regarding the management of medicines and it was rare to have any problems on the ward".

Environment

- The environment was very clean, in good repair and well decorated; there was an immediate and positive impression of a caring environment.

- We observed a high standard of cleanliness on the ward, with information clearly stating when cleaning had taken place.
- The ward manager told us that they directly managed the household services staff working on the ward, which gave flexibility and ensured that high levels of cleanliness were maintained.
- We observed that the ward had limited storage space, and the accessible bathroom was small when hoists were required to be used. A support worker told us that manoeuvring a hoist in the room consequently made the work more difficult and increased risk.
- The ward manager noted that space on the unit was a problem, and some equipment, such as hoists, had to be stored in an open area that was not ideal. The ward manager also pointed out to us that a mattress had to be stored in the clinic room, and confirmed that the assisted bathroom/toilet was a little small for use with people with a wheelchair who required to be lifted using a hoist.
- Actions had been done to try to reduce the impact of the limited space, but the restrictions of the building limited the options available to ward staff. For example, we visited the ward on another day when there was a spare bedroom available and this had been used to temporarily store equipment that had previously had to remain in the ward area. This showed that staff were aware of risks and were taking action to try to minimise these risks.
- The ward had 12 single rooms with a shared bathroom between each two rooms; both doors to the bathroom were lockable to ensure privacy. There were male and female segregated areas, including lounges, and the layout of the ward gave some ability to be flexible around the male and female ratio with the use of corridor doors.
- There was a day room/dining room in the central area surrounded by male bedrooms, a sluice room and a clinic room. Concerns had been raised by the ward manager regarding the need to take commodes past the eating area to the sluice, but there were no other options.
- We observed pictures of staff on the walls, with a description of their role and the clothes they wore to help to identify their responsibilities, such as support worker, qualified nurse, and ward manager.
- There was easy and direct access to a garden that was laid out to include male and female areas, and designed to reflect male and female interests. The garden could also be used as a whole, unsegregated area. There was also a small orchard of apple and pear trees that had been planted beyond the garden. This was to improve the view from the garden and ward as the trees matured. The garden was very well maintained, and included good quality equipment. The garden was used to encourage people into the fresh air as part of their recovery.
- Both inside the ward, and outside in the garden, it was evident that a lot of thought had gone into thinking about the details of the environment, to make it as comfortable and appropriate to the needs of people as possible.

Assessing and monitoring safety and risks

- The seven case records we reviewed had comprehensive and current risk assessments, which included historical and current risk, and were regularly reviewed and updated. These assessments included risks such as risk of falling, nutrition, bed rails and Waterlow pressure sore risk assessments.
- Individual environmental risk assessments for each person admitted to the ward had been completed, including possible ligature points.
- The three staff we spoke with told us that they felt the staffing was adequate to care for the needs of people on the ward and to keep them safe. A support worker we spoke with thought “the ward was appropriately staffed, but if people were unsettled this could cause disruption especially when facilitating activities”. A staff nurse said they thought “staff numbers were about right, but sometimes additional staff had to be requested”. This was particularly the case when people had very complex needs, such as people who were admitted to the ward when no beds were available on the organic (dementia) ward.
- The ward manager confirmed that on occasions, people with more profound dementia may need to be admitted on to the ward, and this was not ideal. Additional staff may be required and this would be requested through the modern matron.

Understanding and management of foreseeable risks

- In the review of the case file of a person detained under Section 47/49 of the Mental Health Act (1983) we saw that the consultant had sent details of a risk assessment of the ward environment to the Ministry of Justice prior to the transfer of a person from prison to the ward.
- The ratio of staff to people cared for was felt to be appropriate, with usually two qualified and two support staff working morning and evening shift, with one qualified and two support staff working at night. There was also use of staff on overlapping shifts, such as from 8:30am to 4.30pm, and 9:00am to 5pm. The ward manager, who primarily works across the working day, also worked some shifts to maintain their clinical role. Occasionally staff would be increased if people with complex needs were admitted to the ward, and in this situation, a request for bank staff was made to the modern matron.
- There was access to an on-call consultant and senior house officer out of hours, and the ward manager and deputy manager informed us that the ward felt well supported by medical staff.

Shackleton Ward and the Dementia Intensive Treatment Service (DITS)

Incidents

- Information provided by the trust showed that over the previous six months five serious incidents (SIRI's) requiring investigation were reported, which were attributable to mental health inpatient services, including Afton and Shackleton Wards. These included two slips/trips/falls; two unexpected deaths.
- All incidents were recorded in the person's notes, and relatives were informed. Incidents were also recorded online in the incident reporting system. Any reported incident and learning was shared at handover meetings.
- There were examples of learning following incidents. The deputy manager told us that learning had occurred following an incident being incorrectly recorded as a slip fall, rather than as a push by another person, and as a consequence of this, recording had improved.
- The ward manager gave us an example of a person, detained under Section 3 of the Mental Health Act, who had sustained a fractured femur. Concerns were expressed that the person could not be admitted to the appropriate ward due to their Section status, and no internal transfer form had been completed at the time. As a result of this incident, there were changes to policies, and protocols had to enable people to be moved within the hospital very quickly if this was necessary. It had also been agreed that the emergency call would be used for any such incidents in the future.

Safeguarding

- Trust records showed that 85% of staff on Shackleton Ward were up to date with adult safeguarding training. A staff nurse told us that she had adult safeguarding training annually, and this is delivered face-to-face and via e-learning. The staff nurse had not made an alert, but explained to us that body maps were used to record any bruising that may have occurred through falling or due to hostile behaviour from others.
- Another staff nurse we spoke with said that they felt that "a very pro-active approach was taken towards safeguarding, and that there were effective safeguarding policies and procedures in place". She told us that she fully understood the processes and they were implemented in her practice. The staff nurse felt told us there was a clear provision of timely safety information from a range of sources.
- Another member of staff gave us an example of making a safeguarding alert when the safeguarding lead was not available.
- A support worker told us that they felt safe in the job that they did, and that the trust had provided good training on physical interventions, and as a team they kept each other safe.
- A staff nurse told us that de-escalation was used to try to diffuse difficult to manage behaviours, but sometimes physical interventions had to be used, such as holding a person to prevent the person harming themselves or others. Every time physical interventions were used it was recorded in the person's case notes. (The term physical intervention is used to cover the use of direct or indirect force, through bodily, physical or mechanical means, to limit another person's movement.)
- A support worker told us that physical interventions sometimes needed to be used when staff were undertaking personal care. The de-escalation room had to be used on occasions, but this was as a last resort, and the support worker told us that this is always recorded. They told us that they used distraction

techniques, such as having a cup of tea, a chat, going down to the garden or using art and craft activities. If this does not work, then the intervention would be escalated to using the de-escalation room.

Medicines

- The pharmacist visited the ward most days (at least three days a week), and was also present at the ward round. A pharmacy technician visited five days a week. There was a central pharmacy with two mental health pharmacists working within the team, who advised on medicines prescribing. The team also received referrals if concerns had been identified regarding side effects. Advice offered to medical staff included side effects of medicines, use of antibiotics, and follow-up referrals from medical staff regarding confirmation or exclusion of possible side effects. Advice was also given to each new rotation of senior house officers regarding the avoidance of anti-psychotic medicines in older person's treatment.
- A computer-based prescribing system had been used on Shackleton Ward for three years. Nursing staff administrating medicines viewed what was needed, prepared the medicine and recorded after the person had taken it. If a medicine was not accounted for, the system would not reset for the next day until the entry was resolved.
- Procedures were in place if medicines needed to be obtained out of hours, and the system linked with general practitioner computer systems to view the person's diagnosis and medicines prescribed. Venous thromboembolism assessments and allergies were also linked to the system.
- The pharmacist advised us that a routine monthly audit was undertaken in the use of anti-psychotic medicines; audits were also undertaken in the use of rapid tranquilisation.
- Any serious drug errors were reported through the incident reporting system, and a weekly pharmacy meeting was held to review incidents reported. The pharmacist told us that they had "no concerns regarding the management of medicines and it was rare to have any problems on the ward".

Records

- There were difficulties with recording information, with three systems currently being used; the electronic health system, which social care approved mental health practitioners were not able to access, the social care system that was read-only for health staff, and paper-based systems. This had caused problems in accessing and updating information.

Environment

- The ward was L shaped, and had three beds on one side and four beds on the other. Each bedroom was numbered and signed in large writing, which helped orientate people to their own bedrooms. Glass in the doors had sea scenes (such as a seahorse or a shell) in a frosted material to improve privacy. Pictures had been used by staff to try to improve the environment.
- The ward had access to a garden, but this was at some distance from the ward, and therefore not easily accessible. We were informed by a member of the team that it was hoped to erect a flag pole in the garden, so people could see this from the ward and it would remind them of the garden.
- One bathroom included a toilet with grab rails installed. The bath was very low and an over bath shower had been fitted, but no rails had been installed. We noticed that the alarm cord had been hooked behind the mirror, making it difficult to reach. We were advised by staff that this bathroom was not really used, as it was not suitable for people living on the ward.
- The bathroom in the centre of the ward had an accessible bath that had been serviced recently. The toilet in this bathroom was not appropriate, having been situated in front of a washbasin that caused a potential hazard when someone was leaning forward. The toilet roll holder was at a distance from the toilet that meant people would have to over reach; no rails had been fitted. We were advised by staff on the ward and the ward manager that these issues had been highlighted to the estates department, but action had not yet been taken to rectify these problems.
- We were advised by the ward manager that the de-escalation room needed replacement chairs, as they had recently been broken and replacements had been requested. At the time of our visit the only seating was a large foam slab in the room.
- A staff nurse told us that she thought that aggression had increased due to the ward environment. There was no access to the garden and people often paced up and down the ward as they had nowhere else to go. The staff

nurse told us that this had been reported to senior managers. Dignity was difficult to maintain due to lack of locks on doors. This issue had been raised with senior managers, but no action had yet been taken.

- A senior staff nurse stated that they felt the environment was not conducive to meeting people's needs, and especially highlighted that there was no easy access to the outdoor area and garden, and that this impacted on people's recovery. They stated that senior management had been informed and, as yet, no action had been taken. The ward manager felt that a good service was offered within limited resources, but the environment was not right.

Assessing and monitoring safety and risks

- Effective handovers took place between staff shifts, ensuring appropriate sharing of information to maintain continuity and safety of care.
- We reviewed files and saw that risk assessments, falls, nutrition, and antecedent, behaviour and consequence charts (ABC) had been completed to record behaviours that were difficult to manage. This showed that the ward were proactive in assessing risk.
- A member of the ward team told us that one person had had a fall, and we noted that this had been recorded on the trust's electronic clinical information system. Documentation showed that the family had been informed, and the incident report had been completed. We also noted that the incident had been discussed at the handover meeting.
- A member of the ward team told us of a recent incident that had occurred in a situation that had been risk assessed, and it had been deemed appropriate to encourage independence; the family had been informed and the incident logged correctly. There had been no injury as a consequence of the incident. This showed that following risk assessment, people were encouraged to be as independent as possible.
- We looked at two case files and saw that the documentation was thorough, and we saw evidence of on-going review, and that interventions changed as a result of changing needs and updated risk assessments. We saw care plans had been developed by working closely with the consultant and the person's family to ensure the person's needs were met effectively, and considered how the person's needs would be safely met when they were discharged.
- There were two housekeepers who worked on the ward and they were involved in handover meetings. Housekeepers had been trained in using physical interventions, and would occasionally "watch the floor" if nursing staff had to attend to an emergency.
- At night time there was one trained nurse and two support staff. When staff were caring for people with complex needs, a member of staff may be asked to work a twilight shift (from 4pm to 11pm) to help to reduce the pressure on afternoon staff. This was reported as working well.
- Staff we spoke with told us that effective handovers took place between staff shifts, and this ensured appropriate sharing of information to maintain continuity and safety of care.

Understanding and management of foreseeable risks

- On day time shifts the ward aimed to have a minimum of four staff, ideally two trained nurses and two support staff; and two staff working in the DITS team: one qualified nurse and one support worker. If there was a need on the ward, senior nurses would stop what they are doing and assist.
- The ward manager said "to an extent, the team feel better since moving to the St Mary's site as it is closer to other services although there were some problems with the environment. The skill mix has improved". The ward manager felt well supported by the modern matron. The regular support had meant that the team felt more able to deal with on-going challenges, particularly problems with resources and equipment for the ward. The ward manager said "the ward was set up on a temporary basis in June 2013 and it feels like that is still where we are".
- There was still a shared view amongst staff that staffing was limited, and this caused some concerns, especially when two people were required to help a person with their personal care. This had been reported to senior managers as a risk, but no action had yet been taken.

Good

Services for older people

Are services for older people effective?
(for example, treatment is effective)

Good

Afton Ward

Assessment and delivery of care and treatment

- We reviewed four case files and care plans (33% of people currently inpatients on Afton Ward) and saw that core assessments were fully completed, and these included a comprehensive summary of issues and identification of the person's needs. All people had completed and comprehensive health and medical assessments.
- Care plans were kept in the person's hard copy file; they were personalised and specific to the needs of individual people. All plans we looked at showed evidence of review, and there were daily entries in the progress notes, with good evidence of involvement of people in care planning.
- Care plans were based around a standard template. The management section included a mix of direction to staff to ascertain information and broad guidance. However, the section designated for detailing how staff should respond to needs was blank in all cases. For example, an anxiety care plan identified that staff should ascertain what causes the person to be anxious; however, no issues had been identified or plan of action stated.
- We tracked the admission, assessment and discharge process for one person who was on leave at the time of our inspection. We saw that documentation demonstrated appropriate assessments, reviews and responses to the person's changing circumstances.
- Although care plans we saw lacked some details, we saw that records were consistently kept up to date, and that staff had a good understanding and knowledge of the people they were working with.
- The ward manager informed us that the trust expected regular audits of care plans to be undertaken. We saw completed weekly care plan audits that the ward manager had undertaken, and the monthly audit completed by the modern matron. The outcomes of these audits were discussed at the acute leads meeting, and ward managers were responsible for ensuring any actions identified through the audits were completed.

Outcomes for people using services

- The team used Health of the Nation Outcome Scales (HoNOS) to monitor outcomes.
- We spoke with a support worker who told us "I enjoy working on this ward as it is nice to get people better and return home. Usually people remain on the ward for around three months but one person had been on the ward a year". We were told that this was due to some particular circumstances and medical issues.
- Data supplied by the trust showed that the average length of stay over the past two years was 20 weeks.

Competent Staff

- Data from the trust showed that 96% of staff had an appraisal between April 2013 and March 2014. The ward manager acknowledged this had been a struggle to achieve. As a consequence, a new structure had been agreed, with appraisals being delegated to other staff. For example, the ward manager would undertake appraisals with the two deputies, who would appraise the Band 6 qualified staff. Similarly the Band 6 staff would appraise the Band 5 staff, and so on. We were informed that relevant staff were currently undergoing training to prepare them for this role.
- Staff we spoke with told us that a clinical psychologist facilitated a reflective practice group on a weekly basis that all staff (with the exception of the ward manager) were invited to attend.
- There was not a formal supervision process in place, but qualified staff attended a daily meeting that provided an opportunity for these staff to share any concerns, and also to discuss people on the ward who may have particularly complex needs. Staff were encouraged to access supervision from a supervisor in another area if they should want to, and staff were currently being trained to take on supervisory roles.
- Staff we spoke with told us they felt very well supported. The ward manager told us that support staff can access supervision if required. A support worker told us "the manager was very supportive and approachable and staff knew they could ask for a one to one session if they felt this was needed".
- Staff told us they were supported to undertake specialist training identified at appraisals. The ward manager had recently been supported to undertake a prescribing course.

Good

Services for older people

Multidisciplinary working

- Our review of notes identified that there was a weekly multidisciplinary team meeting that included a review of people's care. All of the case records we looked at had notes of weekly reviews that had been completed following discussion with the person and presented at the weekly review meetings. These were personalised and reflected involvement of the person.
- A representative from the Home Treatment Team attended most weekly reviews. Referrals to other services, such as physiotherapy, speech and language therapy, clinical psychology and occupational therapists, to undertake home visit assessments prior to discharge, were responded to quickly. The deputy manager told us "the occupational therapy service is good and will take people home for assessment prior to discharge".
- Concerns were expressed that the ward used to have a designated occupational therapist, but this was no longer the case. Access to occupational therapists had been agreed, but the ward manager felt the arrangement was not working as well as it could, especially with regard to activities on the ward. The ward manager explained that support staff facilitated activities on the ward and we observed this happening during our inspection. Support staff also supported people to join groups facilitated by occupational therapists in other areas of the hospital. We were informed by senior staff on the ward that referrals to occupational therapists for home visit assessments were responded to quickly.
- All nursing staff we spoke with told us there is good support and involvement from medical colleagues , both during working hours and also out of hours.

Mental Health Act (MHA)

- We reviewed the records of three of the five people currently detained under a section of the Mental Health Act (1983). One person was on Section 17 leave at the time of our visit. (Section 17 leave is often used to prepare longer-term mental health patients for discharge from hospital care, by allowing short periods of leave from the hospital environment.) The three records we reviewed included two people detained under Section 2 of the Mental Health Act, and one person detained under Section 47(49).
- The records we reviewed were comprehensive and in order. We saw that the Mental Health Act manager had kept ward staff informed of any actions that were required. For example, after admission to the ward we saw a note to the primary nurse from the Mental Health Act manager that reminded the nurse of the conditions of the Section 47(49), and the need to inform the Mental Health Act office and the Ministry of Justice of any changes. The prison transfer documentation was all in place and correct. In another file we saw that the Mental Health Act manager had sent a reminder to the ward asking about plans to renew the person's section. This showed that there was good governance of the administration of the Mental Health Act.
- We saw posters displayed in the ward informing people of the Independent Mental Health Advocacy service (IMHA). We spoke with the ward manager who told us that any person detained under a section of the Mental Health Act would automatically be referred for an Independent Mental Health Advocate. The deputy ward manager was very positive about the IMHA service, and it could be accessed at weekends. If the person contacted at the weekend was unable to respond, they undertook to find an alternative. In one of the files we reviewed we saw that a comprehensive report had been completed by an IMHA.

Shackleton Ward and the Dementia Intensive Treatment Service (DITS)

Assessment and delivery of care and treatment

- Shackleton Ward had seven beds and there were five people staying on the ward during our inspection. Four people were detained under a section of the Mental Health Act; one person was on section 17 leave. We reviewed the case files of two people.
- Admission assessments for both people were generally thorough for physical and mental health needs. We did see some omissions in the assessments, such as weight, height and body mass index not being completed. For one person this was particularly significant, as the same assessment record stated that the person had very low weight. However, subsequent records showed clear responses to the person's needs, with programmed weight monitoring and the introduction of a nutrition care plan.
- When people were admitted to Shackleton Ward they were first orientated to the ward environment and assessed by a doctor. Notes were kept in the clinical

electronic information system, and care plans were formulated once staff had been able to properly assess the person's needs. Care plans were kept electronically and also as hard copies. Care plans were developed by working closely with the consultant and the person's family, to ensure that the person's needs were met effectively. Consideration was given regarding how the person's needs would be met when they were discharged.

- Case files demonstrated appropriate and consistent care and treatment. Documentation was thorough, and we saw evidence of on-going review and interventions changed as a result of changing needs. We saw that all records were consistently updated and details appropriately recorded.
- Care plans were comprehensive, appropriate, clear and regularly reviewed. We noted that the care plans had different initiation dates that reflected their development as the person's needs changed or developed.
- The care plans we reviewed were person-centred, and gave clear guidance to staff on how to meet people's needs. They included plans for caring for people in pain, and also covered issues such as confusion, communication, rapid tranquilisation, nutrition, relationship building, falls and personal care.
- The care plans used, were mostly of an older style, rather than newer pre-printed templates. The newer care plans gave more care plan development direction, and were personalised by inserting the patient's name. The older care plans provided for more free text in care plan development. The care plans examined on Shackleton Ward, old and new type, were comprehensive, clear and were very individual and personalised.

Outcomes for people using services

- The senior staff nurse told us about the admission and discharge pathway. She said there was a culture of collective responsibility between teams that worked well together and worked hard to ensure positive outcomes for people that used the service.
- People had outcome goals which were assessed and monitored. For example, in one person's file we saw that recording of daily activities, the person's progress, multidisciplinary working and progress towards discharge were very appropriate and consistent.
- We tracked another person from admission to discharge. There had been good processes and a short length of stay had been achieved. Ward staff had worked closely with the person to hasten their discharge due to their particular wishes.
- Information provided by the trust showed that the average length of stay in 2012/13 had been 61 weeks whilst in 2013/14 this had reduced to 38 weeks.

Competent Staff

- Staff did not receive regular supervision. One support worker thought this supervision was appraisal, and a staff nurse we spoke with told us they did not receive formal supervision, and this had been the case since moving to the new ward in June 2013. The senior staff nurse stated that the reason for this was a shortage of staff. Regular staff meetings had also not happened. The member of staff highlighted that they did not have any learning or improvement objectives. However, supervision was being introduced.
- A staff nurse told us that she had not received supervision since the new service was established. We spoke with the ward manager about this, who told us that supervision had been difficult to arrange, but staff were being trained to be supervisors.
- Information received from the trust showed that 53% of staff had had an appraisal between April 2013 and March 2014. The staff nurse told us that an annual appraisal had been carried out recently, and we saw that approximately half of the staff team had received an appraisal in the past six weeks.
- We spoke with a qualified nurse, who told us that she enjoyed working on the ward, and she was also working in the Dementia Intensive Treatment Service (DITS). She told us that her mandatory training was up to date, and this had included training in the use of physical interventions (which were sometimes necessary when carrying out physical care), conflict resolution, and other specialist training, such as dementia care.
- A support worker said "we are encouraged to undertake mandatory training and we are given opportunities to attend courses that we are interested in as long as it is useful for the service users. For example I found a course on ECG which I found useful. Some of these courses are linked with Southampton University".

Good

Services for older people

Multidisciplinary working

- There were weekly multidisciplinary case reviews, and these were well recorded in case files and the progress made by the person was noted. Independent mental capacity advocates were invited to case conferences.
- A senior staff nurse told us that referrals made to therapy services, such as occupational therapy, physiotherapy and dietetics, were responded to quickly. Access to social workers and consultants was also described as good. Ward staff told us that the ward used to have access to regular occupational therapy support to provide activities, but this had declined.
- We spoke to team members of the memory service. The team covers a wide range of needs, from people with early memory problems, to more severe memory problems at end of life. People had eight weeks intensive cognitive stimulation therapy, followed by 24 weeks of maintenance. The DITS work with people with more profound needs, but there is overlap between the memory team and DITS, which is supported by close working relationships. DITS responded when the person's placement was at risk. Members of the DITS team joined weekly meetings of the memory service, which ensured good communication and liaison between the teams.

Are services for older people caring?

Good

Afton Ward

Kindness, dignity and respect

- We observed people during the morning of our visit, and saw that staff treated people respectfully and with dignity.
- The ward was very calm and restful, and people we observed appeared relaxed and comfortable. We observed that staff were very involved and engaged with people; for example, one support worker was helping a person with a jigsaw, and another was reading the newspaper with a person. Another member of staff sat talking with two people.
- During the inspection we saw staff actively engaging with people. Following the community meeting, which is a weekly meeting that anyone on the ward can attend, we noted that there were a range of activities on the ward for people to be involved in, which included gentle exercise, quizzes and word games.
- We saw that an occupational therapist facilitated group activities on another ward that were available for people staying on Afton Ward to join. These groups were attended by people from different wards. We joined a music group on another ward that some people from Afton Ward attended, and saw that people of different ages mixed and worked well together.

People using services involvement

- We joined the community meeting that happened daily from 9.30 to 10.30am. This was an opportunity for people to raise any problems or concerns or queries they were experiencing. One person raised a concern about managing risk in relation to using the toilet. The problem was noted by staff, and it was evident that staff were listening to people and working hard to maintain a safe and well managed environment.
- All people had records of weekly reviews that had been completed following discussion with the person, and these were presented at the weekly review meetings. The records were personalised and reflected the involvement of the person. We looked at four care plans and saw good evidence of the involvement of people in their care planning.

Caring relationships

- We saw that staff were very passionate and committed to caring for the people on the ward. We observed people being treated respectfully and with compassion throughout our visit. One nurse told us that "a lot of what happens on the ward has filtered down from the ward manager. We try to be welcoming on the ward, we try to make the environment as comfortable as possible; for example we use nice china crockery at meal times".
- We observed people having lunch, and people we spoke with told us that they were given a choice at mealtimes, and that the quality of the food was good, both nutritionally and cooked well.
- People did not have to wait too long for meals, and members of staff were observed to be courteous and demonstrated respect for people on the ward. There was a strong emphasis on cleanliness, and aprons were worn by staff prior to serving meals. A choice of hot and

cold drinks were readily available. When meals were served, good quality crockery was used and napkins were provided; the tables were laid out very well, and it felt more like a restaurant than a ward environment.

Emotional support for care and treatment

- People were encouraged to maintain their independence as much as possible. The ward manager told us that a protocol has been developed that meant that people on the ward can access the ward kitchen, but it was difficult to implement this due to numbers of staff.
- Care plans we reviewed included consideration of people's emotional needs.

Shackleton Ward and the Dementia Intensive Treatment Service (DITS)

Kindness, dignity and respect

- During our inspection we observed well motivated, positive staff, showing respect for the people they were working with. We saw that one person dropped some food on the floor and observed that staff were very quick to clean up without any fuss or loss of the person's dignity.
- Individual toiletries could be brought in for people by their relatives and these were kept in lockers. This showed that that people had the opportunity to continue to use the things that they liked and preferred to use, and these choices were respected.
- The dignity of people was difficult to maintain as there were no locks on doors. This issue had been raised with senior managers, but no action had yet been taken.
- As we walked around the ward, we walked past a toilet and noticed that a gentleman who had been catheterised was sitting on the toilet unsupervised. We saw that a member of staff returned to the bathroom with another member of staff; the alarm bell was rung for more assistance and the staff responded rapidly. On another occasion, the alarm went off and we observed that 12 staff appeared in 15 seconds to support the team. This showed that there was an immediate response to situations that required additional staff support.

People using services involvement

- People and family carers were involved in care; some people would discuss their preferences, and other people's relatives would give information about choices, preferences and hobbies.
- There was a weekly case conference with additional meetings arranged in between if required. Relatives were asked if they wanted to attend these meetings. We spoke with a relative who told us that the family were very much involved in discussions regarding care planning and medicines.
- We saw that the section of the care plan for recording the person's involvement, comments and signature were either left blank or stated that "the patient lacked capacity". This may be seen as a blanket statement, and consideration of how information relating to the person's inability or unwillingness to be involved in their care could be recorded may be helpful.
- We spoke with one person who told us that they were very positive about their stay on the ward; they told us "I am treated well and had good food which I enjoy". People that are able to, can choose from a menu.
- We asked about communicating with people who were confused, and were told that a variety of techniques were used, including non-verbal communication, the use of pictures, and speaking clearly and slowly to help people understand what was being said. Staff were aware of the importance of adapting communication to suit the particular needs of the people being cared for.

Caring relationships

- We saw that very good personal care was being offered to people with challenging behaviour, delivered with care, respect and dignity. We observed that staff were very professional and warm in their approach to people, and were very passionate about the work they were doing.
- We observed a one-to-one activity in the quiet lounge. There was good engagement between the member of staff and the person. We heard lots of positive communication and appropriate prompting from the member of staff, who used scented modelling material as a catalyst for the intervention. The member of staff encouraged the use of visual, olfactory and tactile senses. We saw two people returning from the garden.

- Ward staff showed us the activities recording book, which was used to record factors such as the person's orientation, interaction, participation, concentration and relaxation. This demonstrated that activities were considered an important part of the person's treatment.

Emotional support for care and treatment

- We spoke with a relative who told us that the ward staff were very reassuring when the family telephoned.
- Two staff on the ward had just finished training in palliative care, following an experience of working with a person who had been on the ward for two years. We saw that staff had a passion for providing emotional support to people on the ward, and especially for creating the right environment for end of life care.

Are services for older people responsive to people's needs?

(for example, to feedback?)

Good

Afton Ward

Planning and delivering services

- Afton Ward was an acute admission unit for older people with severe mental health needs. To ensure that older people with additional health needs could also be cared for, staff were trained to give infusions and care for people with a wide range of additional physical care needs and chronic physical conditions. This meant that a range of complex needs of people could be cared for in the one environment.
- The Home Treatment Team managed admissions to the ward, and consultants were very much involved in this process during normal working hours. Occasionally, the ward would admit people with dementia, when there were no beds available on the organic ward. The skills and expertise on the ward also meant that occasionally younger people could be admitted due to other wards struggling to meet the person's needs appropriately.

Right care at the right time

- We reviewed 30% of case files, and saw that the clinical documentation was generally robust, with regular review of risk assessments and care plans. Core assessments were completed for all people, and demonstrated a comprehensive summary of issues and needs. All people had completed and comprehensive medical assessments in place. Care plans were personalised and specific to the needs of individual people.
- Individual and group activities to support people's recovery were facilitated on the ward, and people also had access to groups facilitated by an occupational therapist on other wards. During our inspection, we joined people in one of these groups on an adjacent ward.
- Staff we spoke with told us that referrals to other specialist services, such as physiotherapy, speech and language therapy, clinical psychology and occupational therapy, were responded to quickly. We saw good evidence of multidisciplinary working in the case notes we reviewed.
- Discharge was carefully planned, and home visits were undertaken by occupational therapy staff to assess the home environment prior to discharge. Ward staff informed us that usually the discharge process would start with people returning home for the day, and then an overnight stay prior to discharge. Measures were put in place to help to ensure that people discharged from the hospital were well supported.
- A staff nurse said "people are very much involved in planning their discharge. Referrals will be made to care managers who will ensure resources are put in place prior to the person's discharge". The deputy ward manager told us that a representative from the Home Treatment Team regularly attended discharge meetings, and physical health care after discharge was always well organised. A support worker we spoke with said "discharge is carefully planned and usually people will start with returning home for the day and then an overnight stay prior to discharge. Measures are put in place to help to ensure people are well supported when they leave the hospital".
- The ward manager informed us that that care managers used to be able to attend ward meetings and this enhanced the discharge process. Timely discharge was now sometimes frustratingly difficult to achieve, due to the delays in referrals for social services care managers being accepted. We spoke with the deputy manager who told us that "social care involvement can be problematic, it was better when a care manager attended regularly".

Good

Services for older people

Meeting People's individual needs

- We tracked the admission, assessment and discharge process for one person, who was on section 17 leave at the time of our inspection; documentation was comprehensive and demonstrated a planned process for their leave.
- We saw posters displayed on the ward, informing people of advocacy services, and one person we spoke with told us that they were aware of the advocacy service and had an advocate to support them.

Learning from concerns and complaints

- It was clear from our conversations with staff that there was a culture of listening to people and their carers, and responding to concerns raised. Staff worked hard to improve the quality of care that the ward was providing.
- On weekdays, there was a daily meeting for people on the ward to share any concerns or issues they had. We joined the meeting on the day of our inspection, and observed that people were encouraged to communicate any concerns, and that these were acknowledged, and actions agreed.
- Ward staff were encouraged to deal with complaints as locally and quickly as possible. Feedback about complaints was shared at the daily meeting. The manager gave us an example of how an incident led to improvements in the way that staff worked with families. A staff nurse we spoke with told us "we get really good feedback from families".

Shackleton Ward and the Dementia Intensive Treatment Service (DITS)

Planning and delivering services

- The Dementia Intensive Treatment Service (DITS) was originally conceived as one service, with staff working on Shackleton Ward and also providing support in the community to avoid the need for hospital admission. The Dementia Intensive Treatment Service usually provided support and training for people living in nursing or residential care, but occasionally for those living in their own home. The ward manager explained that Shackleton Ward and DITS were both managed by the ward manager, with a team lead for both the ward and the community service. DITS functioned to prevent admission to hospital, and the criteria for intervention was 'people with dementia and associated behaviours that challenged'.
- The ward provided specialist inpatient assessment and care for people suffering from dementia. It was situated on the first floor. Staff moved to the ward on a temporary basis in June 2013, and at this time the number of beds was reduced. The modern matron told us that prior to the move to the St Mary's Hospital site, the ward had gradually reduced from 24 beds to 12 beds and was situated at Ryde.
- The majority of people admitted to Shackleton Ward were detained under a section of the Mental Health Act. Some admissions came via the general practitioner, and in these situations the consultant would be involved and agree that the admission was appropriate. Discharge was sometimes delayed, and this was usually due to issues relating to family preferences and decisions about funding. Waiting for approval for continuing care funding was another factor that could also delay discharge.
- The DITS team work with people with more profound needs, but there is overlap with the memory service, and this was supported by close working relationships. DITS responded when the person's placement was at risk, and behaviour was challenging. Members of the DITS team joined weekly meetings of the memory service, which ensured good communication and liaison between the teams.
- A Band 5 staff nurse told us that the experience of working with people on the ward was invaluable when supporting people in the community. The DITS team provided a very skeletal service, and future focus aimed to mirror the service provided by the existing Home Treatment Team.

Right care at the right time

- We reviewed case files for two of the five people cared for on the ward at the time of our inspection. These files demonstrated appropriate and consistent care and treatment. Documentation was thorough, and we saw evidence of on-going review, and interventions changed as a result of changing needs.
- Two files were reviewed, which included one person being discharged on the day of our inspection; this enabled us to track the person's care from admission to discharge. This person had originally been admitted to Osborne Ward, which was considered to be an inappropriate environment to meet their needs. The notes showed that the admission to Osborne Ward was

due to lack of beds on Shackleton Ward. However, the person was transferred to the appropriate ward placement three days after admission, when a bed became available.

- People discharged from Shackleton Ward may return to their previous home, or require assessment by social services for an alternative arrangement. A senior staff nurse we spoke with told us that discharge was sometimes delayed, and this was usually due to issues relating to family preferences and decisions about funding. Approval for continuing care funding would also delay discharge.
- Progress reporting was thorough, and demonstrated responsiveness to people's needs. For example, we saw that the notes for one person recorded that the person had complained of pain, and it was not possible to offer paracetamol as this was contraindicated for the person's medical condition. Medical staff had been contacted to prescribe a suitable alternative.
- Band 5 staff nurses told us that a pool car needs to be arranged for staff and people to go out on DITS visits; this can take up to 20 minutes to organise, and on occasions, the car has been cancelled by the pool car service. We were given an example of the pool car being booked to take a person on Section 17 leave, when an attempt was made to cancel the car reservation, which nearly jeopardised the person's leave. The pool car process could have adverse consequences on patient care.

Meeting people's individual needs

- The 'This is Me' tools had been completed in case files. This is a tool that can be used by people with dementia to tell staff about their needs, preferences, likes, dislikes and interests, and helps staff to provide person-centred care.
- We observed notices for visitors that gave details of visiting hours and protected meal times which did appear a little restrictive. We spoke to the manager about this, who explained that it had been necessary to introduce this arrangement due to some disruption that had been caused to people particularly at meal times. She informed us that arrangements could be made for visitors to see their loved ones at other times if this was requested.
- There was a variety of information available on the wall rack in the foyer to the ward, including leaflets about confidentiality, advocacy, the Friends and Family Test, and the Butterfly Scheme. (The Butterfly Scheme aims to improve people's safety and well-being by teaching staff to offer a positive and appropriate response to people with memory impairment, and allows people with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.)
- Advocates had been used to support people on the ward.

Learning from concerns and complaints

- The ward manager informed us that a carers meeting had just been re-introduced for external carers to the ward, and the first meeting had recently been held. This first meeting focused on people getting to know each other, but it was hoped that the meeting would provide a forum for concerns to be raised, and help to ensure on-going improvement in care.

Are services for older people well-led?

Good

Afton Ward

Vision and strategy

- Staff we spoke with were very clear about the vision and culture of the ward. They told us that the manager set high standards, and the team worked hard to make the ward environment as comfortable and therapeutic as possible. Staff explained that there was a strong emphasis on providing activities as part of the recovery process, and the team worked hard to ensure that people were discharged as soon as they were ready.
- Staff we spoke with were less clear about the trust's vision and future strategy for mental health services.

Responsible governance, risk management and performance information

- The team had regular meetings, and there was evidence of learning from incidents, audit and complaints.
- Staff we spoke with were clear about their responsibilities in relation to raising concerns about quality of care. Staffing was generally felt to be adequate by the ward manager and the ward team, but areas for improvement had been highlighted, and these were being worked on.

- For example, the ward manager noted that they would like to have another member of staff to work a 'middle shift' on case conference days, as this would ensure that there was more time for staff to talk with people to ensure their understanding and involvement in their treatment.
- Staff raised concerns with us about the staffing levels not being sufficient to meet the needs of more complex people when they were admitted to the ward.
- We were given examples of concerns raised, such as limited space in the assisted bathroom and the location of the sluice room, but these were due to environmental factors and not possible to rectify within the current building. These items had not been identified on the trust's risk register.
- There was a trust audit programme in place, which included audits of care plans and infection control.
- Staff told us that they felt comfortable about raising any issues of concern with the ward manager and that he was approachable, and they felt their concerns would be listened to and addressed if possible.

Leadership and culture

- The ward was led by a well-motivated manager, who had set high standards and consequently had made a significant impact on providing a quality service. Nursing staff we spoke with told us that there was a strong sense of loyalty towards the manager within the team.
- One member of staff we spoke was very complimentary about the ward manager's leadership, and noted that he had been the "drive behind the garden and the personal items on the ward; he has high standards and expectations of staff". A support worker told us that they felt "supported by management and had good job satisfaction".
- Staff we spoke with told us that the team was very supportive, and there was good communication within the team. Handover meetings were held between shifts to promote good continuity of care. Qualified staff also met to receive trust information, discuss complex issues, and be a communication forum for concerns and issues.
- Ward staff told us they felt that the modern matron was supportive, and was readily available when he was needed.

Public and Staff Engagement

- Staff we spoke with on the ward had a very good understanding of people's needs, and what was required to care for them in the most appropriate way. People could provide feedback at regular daily community meetings. We saw that areas of concern with the local environment had been highlighted, and every attempt had been made to find a solution to the challenges of limited space for storage and some issues around ward layout.
- We spoke with ward staff about leadership at a higher level within the trust, and they told us that they had no contact with senior managers and did not know who they were. One staff nurse said "communication from the trust is not too good". However, we did see some posters on notice boards with information about trust values, and a picture of the chief executive officer.
- Senior staff on the ward told us of their frustrations with some of the bureaucratic processes they experienced, especially delays in the recruitment of staff.

Shackleton Ward and the Dementia Intensive Treatment Service (DITS)

Vision and strategy

- There was a new plan for people living with dementia that was published in draft form in May 2014: 'Living Well With Dementia On The Isle of Wight 2014 – 2019. A partnership approach to the development of services on the Isle of Wight for people living with Dementia.'
- The draft document stated: 'Shackleton Ward (the dementia inpatient unit) was moved on 3rd June 2013 from its premises in Ryde to a new interim ward on (the) St Mary's Hospital site. The new Shackleton Ward provides seven beds; modern well-appointed facilities and the principles of the dementia friendly environment have been followed when designing the ward.
- The Dementia Intensive Treatment Service (DITS) supports and educates residential homes, nursing homes, families and carers with people who have problematic symptoms of dementia, displaying challenging behaviour, or other complex presentations and whose placements are at risk. By supporting staff and carers at times when behaviour becomes challenging it is evidenced to prevent the escalation to crisis and reduce the number of placement breakdowns or hospital admissions.'

- The document also gave details about the intention of the Isle of Wight to become a dementia-friendly island. The document noted that 'in the Prime Minsters Challenge in 2012 key commitment 3 was an innovation challenge prize of £1 million pounds which the Isle of Wight NHS Trust was awarded with support from the Isle of Wight Clinical Commissioning Group, Isle of Wight Local Council and Care homes.'
- The project was a step towards a dementia-friendly island, by providing some of the most vulnerable people with dementia with an environment which is standardised and harmonised across different care settings, reducing the distress caused by transitions of care, and improving the quality of life and safety in each care environment.
- The staff we spoke with recognised that the move to Shackleton Ward in 2013 was a temporary move. The ward manager responsible for Shackleton Ward and DITS told us that the Dementia Intensive Treatment Service was originally conceived as one service, with staff working on the ward and also providing support in the community.
- Staffing shortages on the ward meant that staff were not able to maintain the level of resource expected to the DITS, and consequently, the clinical commissioning group (CCG) raised concerns about the contract not being fulfilled. The team had been providing the CCG with data, and we were informed that the service was currently being reviewed.
- The ward manager explained that the Shackleton Ward and DITS were both managed by the ward manager, with a team leader for the ward and the community service. She recognised that the review of the current services being undertaken by the CCG may mean that the service could be separated.
- Staff were less clear of the future strategic intentions of the trust.

Responsible governance, risk management and performance information

- The team had meetings to discuss incidents, audit and complaints, and there were examples of learning and improvement.
- Ward staff we spoke with were clear about their responsibilities in relation to raising concerns about the quality of care.
- We were given a number of examples by different team members of issues that had been escalated to a more senior level due to concerns about safety or delivery of care. These concerns included difficulties experienced in maintaining privacy and dignity due to a lack of locks on doors, concerns about risks in the assisted bathroom due to a lack of rails being installed, and staff shortages. However, no action had been taken to address these concerns.

Leadership and culture

- Staff told us that they felt well supported by the ward manager, and modern matron and peers.
- The ward was set up on a temporary basis in June 2013, and staff reported that it still felt temporary, but the support had helped them to cope with uncertainty.

Public and Staff Engagement

- Staff told us that they felt comfortable about raising any issues of concern with the ward manager, and that he was approachable, and they felt their concerns would be listened to and addressed if possible.
- When we visited the memory service we were told that members of the executive team had visited the service, and one senior manager had planned to go out for the day with the service. The chief executive officer attended the dementia awareness day that the team arranged.
- We spoke with senior managers and service leads, and they told us that they felt separate from the senior management team, but were very positive about the support they received from the modern matrons. Staff told us of issues of concern, which had been raised to senior managers, such as equipment problems, where no action had been taken.
- Concerns and frustrations were raised with us regarding human resource processes, particularly the lengthy procedures, and how they felt disempowered by the processes. One manager said “we are managing services but not allowed to make budget decisions”. Another manager told us that a member of their team had left, and when the recruitment process had started they were informed that the post no longer existed, and the establishment had been reduced. There was some shared pessimism about the future.

Good

Services for people with learning disabilities or autism

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The Community Learning Disability Team (CLDT) is based at the Arthur Webster Clinic. The team provides community services for adults of 18 years of age onwards, who have either been diagnosed as having a learning disability, autism, Asperger's syndrome, attention deficit hyperactivity disorder (ADHD). The team provides nursing assessments, interventions, medications for psychiatric conditions, and psychological approaches, including individual therapies and group therapies, speech therapies and behavioural analysis.

The service operates between 9am to 5pm, Monday and Friday, and out of hours and urgent referrals go through to 'Wight Care', which is a 24 hour service run by the local authority.

Summary of findings

The CLDT services provided by the Isle of Wight NHS Trust were delivered in a safe and caring manner. We found that staff were polite, and delivered care which demonstrated good skills for working with people with learning disabilities, and their families. We observed that delays were experienced in receiving psychological therapies, but on the whole, people received a good service.

The team was in the process of moving from hard copy records to electronic records, and this had created some difficulties in how some of the information was being transferred and recorded. Information about assessments and care could not be easily located. Staff told us that this was work in progress and it was taking a lot of their 'hands on' time.

Staff demonstrated a good understanding of how to follow the local safeguarding policy and procedures for safeguarding vulnerable adults, and worked well with other trust teams and external agencies to provide care that best met the needs of people. The team worked as a robust multidisciplinary team with a diverse skill mix. The use of outcome measures of effectiveness was routine, and information was shared nationally and locally.

There were systems in place for people to give feedback on the service, and this was acted upon. Staff told us that they felt supported by their managers and were pleased to work for the trust. Quality was monitored, and the team took necessary measures to improve their performance.

Good

Services for people with learning disabilities or autism

Are services for people with learning disabilities or autism safe?

Good

Incidents

- There was an effective system to record incidents, and near misses and 'never events'. (Never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)
- All the staff we spoke with clearly demonstrated how they would identify and report incidents.
- Incidents were reported, investigated and analysed. Staff were given feedback following incidents, so that lessons could be learnt as to how incidents were responded to.
- During our inspection we saw staff attending training, which had been recommended as a result of an incident that had happened.

Safeguarding

- All staff spoken with demonstrated that they knew how to identify and report any abuse, to ensure that people who used the service were safeguarded from harm.
- Training records indicated that all staff were trained in safeguarding vulnerable adults.
- All staff spoken with were able to name the designated lead for safeguarding, who was available to provide support and guidance.
- Information was easily accessible in an easy-to-read format, to inform people who used the service, and staff, on how to report abuse.

Consent, Mental Capacity Assessment and Deprivation of Liberty Safeguards (DoLS)

- All staff had received training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We saw an example of how this legislation had been used appropriately in a person's best interests to ensure their safety and welfare.
- On reviewing the notes of four people, we found inconsistent practice concerning the assessment of people's capacity to consent. We noted the assessment and good recording of two people's capacity to consent to their treatment undertaken by the multidisciplinary team, and an Independent Mental Capacity Advocate (IMCA) was involved. In the other two notes, there were no records to show that capacity to consent assessments had been carried out.

Environment

- The environment was clean and well maintained, and the security was monitored.

Records

- The team was in the process of moving from hard copy records to electronic records, and this had created some difficulties in how some of the information was being transferred and recorded.
- Staff told us that it was still work in progress and was taking up much of their 'hands on' time.

Assessing and monitoring safety and risk

- Risk assessments were carried out for all visits to people to ensure that all staff were safe; where the risk was deemed high, staff would go out in pairs.
- Care plans and risk assessments clearly identified how staff were to support patients when they behaved in a way that could cause harm to themselves or to others.
- People's needs were appropriately assessed. We saw good examples of completed needs assessment, followed by detailed care plans and behavioural management plans.

Understanding and management of foreseeable risks

- Staff told us that risks and near misses were recorded on the trust's electronic incident reporting system, and the investigation outcomes were used to put in place management strategies for any risks identified.
- The risks which could be anticipated from insufficient medical, nursing and therapists cover, and the impact of this on meeting patients' needs, had been considered.

Staffing

- The team consists of a consultant psychiatrist, learning disability nurses including nurse prescribers, psychologists and psychology assistants, occupational therapist and assistant, physiotherapist and assistant, speech therapist and community support workers.
- Staffing levels were appropriate, with a good skill mix. All staff told us that they had a caseload of 25-30, and felt this was manageable.

Good

Services for people with learning disabilities or autism

- The team was supported by administrative staff. It was these staff from administration who told us that they felt overloaded and stretched with work.

Are services for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment and delivery of care and treatment

- The team applied some evidence-based clinical guidelines from the National Institute for Health and Care Excellence (NICE) to underpin their practice.
- They also used commercial computer software to monitor and evidence safe and effective care.
- Records sampled showed that comprehensive assessments had been completed of people's needs and risks.
- Care plans were comprehensive, personalised and regularly reviewed. They showed that people and their families, where appropriate, had been involved in developing the care plans.
- Records we sampled showed that people had had a physical health check within the last 12 months. Specific care plans for people's physical health needs had been developed where appropriate. One person had complex physical health needs, and staff were working closely with the local general hospital to ensure that the person's needs were assessed and treated.
- People had an individual health action plan in a pictorial format.
- There were a number of audits which were carried out and were able to measure standards in terms of development and improvement within the service. These audits included, for example, an audit on autism clinic and on dementia services for people with Down's syndrome. The service used the information to drive improvement. For example, a dementia baseline assessment would be completed for all people over the age of 30 with Down's syndrome. An audit on autism clinic made improvements on people to get the right support tailored to their needs from other organisations.

Outcomes for people using services

- The provider carried out outcome satisfaction surveys, where people gave a summary of the care and treatment they had received. The results showed that most of the people were happy with the care they received.
- The team used some outcome measures to determine the effectiveness of the service which they provided. We saw that the team used Health of the Nation Outcome Scales-Learning Disabilities (HoNOS-LD), which is an outcome measure which decides the progress of therapeutic intervention. Assessments sampled showed some positive results in people's behaviours directed at others, eating and drinking, and activities of daily living.
- The team conducted an audit on the effectiveness of Dementia Baseline Assessment for people with learning disabilities. The assessment is aimed to make people and the team aware of any potential cognitive deterioration, which could indicate dementia onset. The team introduced a health check and dementia screening process that alerted people and staff to any potential loss in memory, which could indicate the early stages of dementia. This ensured that people at risk of developing dementia received the care they needed at an early stage.

Competent Staff

- Staff received the training they needed, and where updates were required, this was monitored.
- All staff spoken with told us that they received regular supervision and had an annual appraisal, and their personal and professional development goals were set.
- Staff told us that they received further training in different areas of their specialities. The team had nurses specialising in areas such as epilepsy, autism, mental health and challenging behaviour, dementia, complex health needs and transition. The team also included three nurse prescribers.

Multidisciplinary working

- In records we sampled we saw that people attended their reviews with the multidisciplinary team. We saw some well collaborated evidence of working as team following the Care Programme Approach (CPA) framework, where required.
- There was excellent evidence of working with other external agencies, such as district nurses, GPs, transition

Good

Services for people with learning disabilities or autism

team, hospital teams, mental health crisis team, the independent sector, and local authority. For example, staff told us that they also work closely with the mental health team in Osborne Ward, where if required, a person can be admitted. The team would co-ordinate the care with the ward, and staff from the ward had received training from the learning disabilities team to ensure that they were able to meet the needs of people admitted.

Mental Health Act (MHA)

- There were policies and procedures in place pertaining to Mental Health Act responsibilities. At the time of our inspection there were no people subject to the MHA.

Seven day services

- The service operated between 9am and 5pm, Monday and Friday, which meant that the team could not respond to any urgent referrals out of hours.
- However, staff told us that any urgent referrals would go through to 'Wight Care'. They told us that 'Wight Care' is a 24 hour service run by the local authority, and they would assess the needs of the person and signpost the person to the right service that would be able to meet their needs. For example, they can contact the mental health team, or medical team, depending on the needs. Staff told us that this will be followed by a handover on the next working day, and discussion within the team.

Are services for people with learning disabilities or autism caring?

Good

Kindness, dignity and respect

- All the staff we spoke with demonstrated a clear understanding of how to treat people with respect and dignity.
- The staff were polite, kind and passionate about their role in providing therapy to people.

People using services involvement

- People had a variety of care plans, which were individualised and showed evidence of risk assessments.
- Review meetings were used to involve people and their views within the care planning process. We found some evidence of people's views being included within the care planning process.
- People had access to an independent advocate and an Independent Mental Capacity Advocate (IMCA). There was information available on how to access this service.

Emotional support for care and treatment

- Staff were responsive to the individual needs that people had when they used the service. We found that staff had a very good understanding of people's particular needs. One staff member told us that visits and appointments were scheduled according to individual needs; for example, some people needed short notice for appointments to avoid anxiety. Staff told us that they try to stay as a key worker with an individual that they know very well, to ensure that there is an ongoing therapeutic relationship, to give reassurance to people. People's families and relatives were also encouraged to be involved.
- People had access to talking therapies on a one-to-one basis, to support them with their emotional well-being.
- Nurses facilitated some social interventions, such as activities in the community, in a structured manner, to ensure that social needs were met. People were given enough information to ensure that they received support from the services if needed.

Are services for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services

- Referrals to the service were accepted from people with a learning disability, their carers, GPs, and other health or social care professionals.
- The team worked closely with Osborne Ward at St Mary's Hospital, where one bed is reserved for any person who requires the short-term inpatient service. The community nurse will spend their time co-ordinating care, and support the person and staff.

Good

Services for people with learning disabilities or autism

- Where people's needs cannot be met within the local area, for example, people with forensic mental health needs requiring inpatient services, these people are placed out of area. The care co-ordinator continues to maintain contact with all people placed out of area until they are ready to be discharged.

Right care at the right time

- All referrals are seen within three working days. If they were viewed as urgent, a decision would be made to allocate the referral to an appropriate team member, who will contact the referrer. Other referrals would go to a referral meeting to be discussed. Referrers were contacted for inappropriate referrals with an explanation. Appropriate referrals were placed on a waiting list or allocated.
- There was a maximum waiting list of 12 weeks to receive psychological therapies. Staff told us that people were usually seen within nine to 10 weeks.
- We attended the referrals meeting that takes place every other Thursday morning, and we observed that people's needs were prioritised, and nurses were able to respond to people urgently or within three days. This ensured that there was some access for people who had the highest needs, and the service was able to respond accordingly to meet people's needs.
- People with complex needs had a contingency plan in place, which had details on what actions to take, and services to contact in case of an emergency. The trust had a learning disabilities liaison nurse, who people could contact to co-ordinate arrangements with the hospital. This meant that the hospital staff had all the information they needed to care for the person effectively.
- The team worked closely with both mental health and general inpatient services, to ensure that people who had been admitted to hospital as inpatients were identified and helped through their discharge. We saw that the team would maintain contact with the wards.
- We saw excellent integrated pathways. Nurses visited primary health care services regularly to provide support and carry out assessments. There was a strong link with the transition team, Osborne Ward, adult mental health team and the general hospital, to ensure they were aware and up to date with the needs of the people they work with. All agencies involved were invited to review meetings and care pathways developed. This meant that care was co-ordinated and all agencies prepared for the care and support required.

Meeting people's individual needs

- The team had a wide range of information available, which was adapted to meet the needs of people with communication difficulties. For example, all information leaflets were in an easy-to-read and pictorial format. Some of the care plans were in an easy-to-read format.
- Person-centred assistive communication technology was also used to help people with very limited communication skills, to enhance their choices and preferences. The staff team demonstrated a good understanding of the needs of the people they served, and worked closely with other external agencies, such as the general hospital, GPs, local authority and independent sector, to ensure that the identified needs of people who used the service were addressed. We saw that, where appropriate, staff from external agencies attended review meetings with the team to ensure that information was shared.
- People had access to an independent advocate and IMCA. There was information available on how to access this service.
- People were able to access interpreting services to meet their needs if they did not speak English well enough to express themselves.

Learning from concerns and complaints

- People were provided with information about the ways in which they could raise complaints and concerns regarding the service.
- Staff we spoke with were able to identify complaints which had been made regarding the service, and explain how the service had learnt from them. For example, how the team had made improvements to enhance communication with families and carers.

Good

Services for people with learning disabilities or autism

Are services for people with learning disabilities or autism well-led?

Good

Vision and strategy for this service

- All staff spoken with showed a good understanding of the values, vision and objectives of the service.
- The service did not have a written strategy, but staff told us that the aim of the service was to support people in the community, to deliver safe, high quality care, and to keep them out of hospital. The team had a focus on person-centred care, and would always try to improve the way in which they worked.
- Staff did not have knowledge about the trust strategy for mental health services.

Responsible governance, risk management and performance information

- Regular team meetings were held, with minutes of the meetings recorded. Areas of discussion included service updates, audits, incidents, complaints, caseloads and any issues of concern raised by staff.
- Most of the staff spoken with told us that the trust clinical governance team analysed the risks within the organisation, and this information was shared with all staff to reduce risks to safety.
- All new policies were identified and communicated to staff through staff meetings and emails.
- All the staff we spoke with confirmed to us that they received regular communication from the board and their managers, and were kept up to date with changes within the trust.
- The trust risk register included risks identified by the introduction of the electronic records systems. Action was being taken to mitigate these risks.
- Staff were aware of the whistleblowing policy, and said that they would feel confident to report and refer concerns if it became necessary. The whistleblowing policy was available on the trust's intranet site for staff to refer to.

Leadership and culture

- The service was led by a team manager. All staff spoken with told us they felt that the management of their team was good, and that they felt supported by their team manager.
- Staff told us that the manager was very approachable, had an open door policy, and encouraged openness.
- Staff felt that the unity within the team was very strong, and that it helped them with focusing on quality and achieving positive outcomes for people.

Public and Staff Engagement

- Peoples' views were gathered through feedback from questionnaires, and their views were taken into account. People and their families were routinely given questionnaires about different services provided by the team. The results were analysed to provide an overview of the service, and necessary changes were made to improve the service.
- Most of the staff we spoke with told us that they were pleased to work for the trust, but specifically working for the CLDT. All the staff we spoke with told us that they felt supported by their managers. All staff told us that they felt free to approach all the managers, including senior managers.
- All the staff we spoke with showed a good understanding of the values, vision and objectives of their team and the trust.
- Staff told us that they had weekly briefings, 'the Friday Flame' from the chief executive, and an e-bulletin. Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable, encouraged openness and regularly visited the team.

Good

Community-based crisis services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The Crisis Resolution and Home Treatment Team offers both ongoing home treatment and out of hours crisis assessments to people experiencing mental health problems on the Isle of Wight. The service includes the 'Operation Serenity' project, which is jointly undertaken with the police.

It provides a service to adults aged 18 years upwards (no upper age limit), who are in an acute mental health crisis, where symptoms and risks are of such severity, that without the involvement of the Home Treatment Service, the situation may result in a hospital admission. They act as 'gatekeeper' to mental health inpatient services, rapidly assessing individuals with acute mental health problems. They provide community-based treatment 24 hours a day, seven days a week.

Summary of findings

The CRHT team provided care to people in a compassionate and kind manner. We spoke with staff who understood local needs, and described involvement of those important in people's lives as being central to their work. Carers told us that their needs were always considered when staff visited. They had information made available to them in a variety of formats to meet individual needs. People told us that they were given information throughout their care to refer to.

The team had effective systems to prioritise referrals, safeguarding people and report incidents. There was regular audit of prescribing and medicines to ensure the safe management of medicines. There was a multidisciplinary approach to risk management, and people were treated according to nationally-recognised guidance, although there were not specific systems to monitor outcomes of care. Partnership working with community teams and inpatient wards meant there were effective outcomes for people, for example, around early discharge from hospital.

'Operation Serenity' (a joint venture with the police) was proven to have a positive impact upon people's experiences when they presented in the community with a mental health issue. The team had a good record of gatekeeping all admissions to inpatient beds, and people were given increased choice about the care they received and where this was provided.

Staff attended alongside the attending AMHP to people being assessed under the Mental Health Act, to offer

Good

Community-based crisis services

support from the team as an alternative to hospital admission, where appropriate. Complaints were handled according to trust policy, and people had access to, and information on, advocacy services.

The CRHT team were cohesive and felt well supported by management. Robust systems were in place to ensure effective supervision and appraisal of staff. Staff described managers as accessible to them and regularly consulted with them in a variety of formats. The service was regularly audited to establish levels of performance and outcomes for people using the service. Feedback from people and carers was regularly sought, and used to improve the service.

Are community-based crisis services safe?

Good

Incidents

- Staff were aware of the incident reporting system. They were able to provide evidence that they shared the learning from safety incidents and safeguarding reviews, internally and externally.
- One example given was following a serious untoward incident, when people using the service who were awaiting psychology were found to not be monitored or visited during this period. Following the investigation, the team changed the way they worked, to ensure monitoring and visits continued until psychology arrangements were in place.

Safeguarding

- Staff were knowledgeable about their responsibilities with regard to safeguarding children and adults.
- 93% of staff had received safeguarding training, and there were policies and procedures available to view, via the trust's intranet site.
- The service worked alongside the police, and developed the 'Operation Serenity' service in November 2012. This service was developed as issues were identified around the level of use of Section 136 place of safety, which may have been preventable, and which might not always be the most appropriate action to safeguard vulnerable people. 'Operation Serenity' involved a mental health practitioner working with the police to jointly attend people in the community who are in mental health crisis.

Consent, Mental Capacity Assessment and Deprivation of Liberty Safeguards (DoLS)

- Staff were able to discuss issues around consent and capacity, and how to undertake or organise an assessment for people as necessary. Mental Capacity Act and Deprivation of Liberty Safeguards were part of their mandatory training programme.

Good

Community-based crisis services

Medicines

- People we spoke with told us that they were given information about the medicines they received and their uses.
- Systems for prescribing and medicines management were robust. Storage and processes for administering medicines, including the related documentation on prescription cards we observed, were in line with best practice. A trust pharmacist attended weekly to audit medicines and prescribing practice.

Records

- Records management was using two electronic systems. Staff reported that working between the two systems was effective in accessing information, but was time consuming and cumbersome on occasions.
- Paper records were printed from electronic systems to share with people as part of their care and treatment. Records we were shown were comprehensive, concise and up to date.

Assessing and monitoring safety and risk

- At the point of referral, health and police staff would share risk information, prior to the visit, in relation to the referred person or address. Data was analysed so that the service was available at times of high volume. The use of Section 136 had reduced considerably as a result, and people were receiving the most effective response from services in times of crisis.
- There was a lone working policy and procedure, and staff were familiar with this.

Understanding and management of foreseeable risks

- Staff used multiple of sources of information when referrals to the team were taken to establish the risk history for people.
- We saw excellent examples of positive risk management adopted by staff. We observed some of these during case discussion at the handover, and the clinical lead gave examples of how the reflective weekly meeting focuses on an MDT approach to risk management. They showed high levels of risk management and decision-making skills in order to maintain both patient safety and that of others.
- The team is made up of 12 nurses, three social workers, seven support workers, one psychologist and one consultant psychiatrist.
- Each shift had an allocated co-ordinator, who arrived at least an hour early in order to plan work for the team. Clinical handovers were undertaken at the beginning of each shift. We observed a handover meeting in which staff discussed people referred to them, and prioritised responses according to risk. The meeting was comprehensive, detailed and informative for all in attendance about the needs of people being cared for. The team undertook two daily handovers of care between shifts.
- The senior house officers (SHOs) in the team were usually GP trainees, so there was good physical health monitoring. The team told us that part of their assessment may warrant referral to a variety of other services, including mobility or pain clinics. This meant that care was personalised and enabled people to maximise their health and well-being.

Mandatory training

- In the CRHT team, 74% of all mandatory training had been completed.

Are community-based crisis services effective?

(for example, treatment is effective)

Good

Assessment and delivery of care and treatment

- The team had participated in the Home Treatment Accreditation Scheme (HTAS), which is an initiative from the Royal College of Psychiatrists. They had submitted data for their accreditation in February 2014, and were positive about achieving the standards for this.
- The scheme engaged staff in a comprehensive review of the service involving service users. Documentation seen with regard to the scheme was comprehensive, with many positive aspects in regard to team performance and developments.
- 'Operation Serenity' was a joint venture with the police started in November 2012. This service had proven to have a positive impact upon people's experiences when

they presented in the community with a mental health issue. 'Operation Serenity' involved a mental health practitioner working with the police to jointly attend people in the community who are in mental health crisis.

- The clinical lead discussed their desire to use an unmarked police car to convey people using the 'Operation Serenity' project, and for police to be plain clothed in order to meet the Crisis Care Concordat 2014 guidance around best practice.
- Staff used evidence-based practice and positive risk management techniques in formulating their assessments. Consideration in regard to people's capacity and consent were demonstrated. This meant best practice was adopted in assessing and planning people's care.
- As part of the initial visits to people receiving home treatment input, the team undertook routine baseline bloods and physical observations. Physical health was considered within the assessment process and documentation.
- Audit was undertaken within the team, which included response times, outcomes, length of treatment and also audits of patient records.

Outcomes for people using services

- The Crisis Resolution and Home Treatment (CRHT) Team provide a liaison service to the Emergency Department at St Mary's Hospital, a crisis response and home treatment function. This included assessment, education regarding illness, self-management skills guidance, alongside signposting and medicines monitoring.
- The team undertook specific medication commencement, mainly Clozaril for people in the community, as an alternative to having this undertaken in hospital.
- A Wellness Recovery Action Plan (WRAP) was completed with people, which focused on people's strengths, self-awareness, sustainable resources and support systems. We did not collect or see data in regard to this.
- The 'Operation Serenity' project, which is jointly run with the police, had resulted in a 5% reduction in the use of Section 136. This meant that integrating services to meet the needs of vulnerable people had reduced the use of the Mental Health Act.

Competent Staff

- Staff told us that they were supported to undertake training outside of mandatory training. Staff attendance on training was monitored by managers and shared with staff.
- Staff told us that they received individual clinical and managerial supervision. They also undertook weekly reflective group supervision. There was a robust supervision process in place, and staff tended to have clinical supervision every four to eight weeks.
- Staff were provided with an annual appraisal by the clinical lead, and this informed their supervision sessions, by identifying staff progress towards their achievement throughout the year.
- There was also reflective practice provided once a week with the psychologist, this involved one person on the caseload being discussed in depth, and management strategies being developed with the multidisciplinary team (MDT).
- Managerial supervision tended to happen on an 'ad hoc' basis, as and when it was needed. This would be at least every eight weeks. Training needs, case reflection and improving performance were imbedded in this process.
- Staff told us that they were happy with the level of support and supervision they received. Newly appointed staff were provided with a comprehensive induction programme. Staff we spoke with could demonstrate their understanding of their role, objectives and communication processes, within the team and the wider trust.
- The GMC national training scheme survey (2013) identified general psychiatry as similar to expected when compared to other trusts for junior doctor training. Local teaching was better than expected.

Multidisciplinary working

- The team had established good working relationships with staff in other departments. It helped that the inpatient wards and Home Treatment Team were located in the same office. The team had discharge facilitators based on the wards. The CRHT had at least daily visits to the ward, and attended the ward handover every day.
- The CRHT did not work between the hours of 1am and 8.30am, when responsibility defaulted to the ward staff. The Home Treatment Team had funded staff on the

Good

Community-based crisis services

ward, who completed assessments during these hours. Data collated between the team and the wards showed that the length of stay on the ward had reduced since the CRHT team became involved.

Mental Health Act (MHA)

- Staff were familiar with their responsibilities in regard to the MHA. The clinical lead from the team regularly attended approved mental health professional (AMHP) meetings.
- Assessments that needed to be undertaken under the Mental Health Act, were initially discussed with the team by the AMHP undertaking the assessment, with regard to bed availability. Where possible, and capacity allowing, someone from the team would accompany the AMHP on the assessment.

Seven day Services

- The CRHT work seven days a week. During the hours of 1am and 8.30am the Home Treatment Team has funded staff on the inpatient wards, who complete assessments.
- The 'Operation Serenity' service runs with CRHT trained staff and a police officer in a police response vehicle, on Wednesday, Friday and Saturday, from 5pm to 1am. On all other days 'Operation Serenity' is manned from the CRHT office, from 5pm to 1am.

Are community-based crisis services caring?

Good

Kindness, dignity and respect

- We heard staff speaking compassionately and respectful towards people.
- We observed staff to be skilled, compassionate and highly motivated in the work they undertook. Language used by staff reflected a strong team approach and caring attitude.
- The team had devised a questionnaire in collaboration with staff and carers, to gain people's feedback. The questionnaire was given out at the end of each care episode, and there was a 60% return rate. Responses from these came directly back to the team. The service had improved in a number of areas in the light of the feedback received. One example of this was when patients responded that they were seen by too many different staff members. As a result of this feedback, the team devised 'core' teams of three staff assigned for each person.

People using services involvement

- People told us that staff involved them fully in their care and consulted with carers throughout the process. One carer told us, "they offered to speak to me on my own and were very supportive of my needs". One person told us, "they were very good people". We met with staff who were clearly positive about the work and outcomes for people using the service.
- Staff demonstrated a proactive approach to incoming referrals. Staff we met with told us that carers were involved in people's assessment with the person's permission.
- Carers were contacted as part of the teams accreditation work, and the comments we observed were extremely positive. One carer we spoke with told us that their needs, and those of the whole family, were considered throughout their relatives contact with the team.

Emotional support for care and treatment

- The people we spoke with told us that they felt supported in all aspects of their lives. Carers described the staff as having a genuinely caring attitude towards them and for their welfare.

Are community-based crisis services responsive to people's needs? (for example, to feedback?)

Good

Planning and delivering services

- The team's operational policy was available, and set out clear lines of responsibilities. Updates had been undertaken through the development of new ways of working, and also to include 'Operation Serenity'. 'Operation Serenity' was developed through identification of local needs. Data collected showed that

Good

Community-based crisis services

the Isle of Wight historically had a high Section 136 rate, although only 40% of those people detained went on to require a formal assessment by the Mental Health Act team.

- The clinical lead told us that historically, inpatient admission had been used to house vulnerable people, but not always appropriately, and not always based on mental health symptomology or associated risks. Statistics from the first year of 'Operation Serenity', over a Friday and Saturday night each week (identified as the busiest periods), found that there had been a 5% reduction in the use of Section 136. This meant that integrating services to meet the needs of vulnerable people had reduced the use of the Mental Health Act.
- Referrals to the team came from other teams within the trust, and through self-referral for crisis issues, or following triage by the filtering team at Chantry House.
- The average time period between referral and the first assessment was six hours in a mental health crisis. Staff told us that they worked closely with acute staff to ensure a more timely response.

Right care at the right time

- Data available showed that 96% of all people admitted to an inpatient bed were assessed by the team known as 'gatekeeping' which was within the national target.
- We conducted a number of focus groups, and staff told us that availability of beds was generally good, and they did not identify instances of delays due to lack of beds. This meant that bed availability was not impacting upon patient care and safety.
- The team developed weekly meetings between the ward, Home Treatment Team and CRHT staff. These were known as 'BUG meetings'. The BUG meeting was implemented to discuss any delays or issues. Staff told us that people would never just be discharged if there is a delay in transfer - they would be kept on by the CRHT team as an interim measure. This meant that the service operated with a degree of flexibility, to ensure safe transition between services to meet people's needs.

Meeting people's individual needs

- Staff provided information in written form for carers to access support. For people who required referral on to other services within the trust, staff would highlight any unmet needs of carers on the assessment document, or verbally at joint discharge visits. This meant that the needs of those involved in people's care were routinely given consideration.
- The team had the facility to get information for people in formats such as 'easy read' or Braille. The team liaised with the trusts communications department for written materials in other languages.
- Staff we spoke with described clearly how to access interpreters, and described having undertaken online learning in relation to black minority and ethnic people.
- Advocacy services available for people in the area, and previously accessed by the team, had now been amalgamated with social services. The service is now mainly for patients subject to the Mental Health Act, although the team can still request Independent Mental Health Advocates (IMHAs) through the service.
- Staff were aware how to access advocacy services for people, and leaflets given to people about the team also contained information about relevant local advocacy contacts.

Learning from concerns and complaints

- Staff were aware of the trust's complaints policy.
- Complaints were received from the Business and Performance Team. In the first instance, a phone call or meeting would be arranged before a complaint became formal. The clinical lead told us that informal complaints were routinely logged.
- Leaflets providing information about the team also contained complaints advice.
- People we spoke to had not had need to make a complaint, but felt sure of how to take forward any issues they had.
- Evidence of trust-wide learning from complaints and incidents was cascaded by the clinical lead, and shared with staff, and staff received information globally through updates via the trust email system. The information was discussed in regular team meetings.

Good

Community-based crisis services

Are community-based crisis services well-led?

Good

Vision and strategy

- Staff had a broad understanding of the behaviours and values they were expected to uphold by the trust, and received regular emails in regard to this. The team were clear about plans for development and strategic objectives; for example, improving the effectiveness of 'Operation Serenity' by staff being available, out in the patrol car, on more nights than they are currently. However, with regard to trust-level strategies for the services, staff were less clear.

Responsible governance, risk management and performance information

- Team meetings were held to discuss audit, complaints and incidents.
- Staff told us that team meetings were good for feedback and shared learning, with regard to audits undertaken within and outside of the team.
- Levels of activity and referrals into the service, and their source, were collated within the team. Feedback about performance was shared with managers.
- Staff confirmed that they had received governance training. Senior managers raised any issues that needed inclusion in the trust-wide risk register, and the manager told us that this was generally an effective tool for capturing ongoing concerns.
- The team told us that debriefing would occur after any major incident, with time and space set aside for this. Debriefing could be as a team or individually, depending on what was required. It would be run either by the team psychologist, or by an external person, if appropriate. This meant that mechanisms were in place to support staff and to promote their positive well-being.
- Staff told us that they were aware of the trust's whistleblowing policy, and that they felt able to report incidents and raise concerns, and that they would be listened to. Staff confirmed that their manager was supportive and acted upon any concerns raised.

Leadership and culture

- Staff we spoke with told us that they were well supported by their managers. We saw, and staff confirmed, that the team was cohesive with high staff morale.
- They all spoke positively about their role, and demonstrated their dedication to providing quality patient care.

Public and Staff Engagement

- The team were proactive in their approach to seeking a range of feedback from people using the service. People were engaged using questionnaires and comments. The questionnaire had been designed in consultation with carers. Feedback and comments were acted upon, and the results were collated annually, and shared with the team and the wider trust. At the time of our visit, the team had since been asked to adopt the trusts more generic 'We Care. Getting it Right' questionnaire, which goes directly to the clinical governance team. The team felt that this was less effective, and were planning to seek permission to reinstate their original questionnaire.
- People using the service were also included on staff interview panels.
- Staff told us that senior managers had engaged them, provided information, and regularly consulted with them, in a variety of formats.

Good

Rehabilitation services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Woodlands is a 10 bedded rehabilitation unit located within a local community. It offers longer-term rehabilitation approaches for people who need to learn or re-learn the skills required to live independently. The service operates 24 hours a day, seven days a week.

Summary of findings

There were effective procedures for staff and people using the service, to report both low level and serious incidents. These were reported to relevant agencies, investigated, and reviewed to prevent a reoccurrence. Staff had access to training to safeguard vulnerable adults, and some staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Health Act (1983) was applied appropriately, and all documentation was current, and in line with the Mental Health Act Code of Practice.

People were assessed and treated according to nationally-recognised pathways of care, and their health needs were being addressed. People were provided with psychological therapy, such as cognitive behaviour therapy (CBT). Staff and the manager had regular supervision and appraisal, and new and temporary staff had induction. Staff worked in multidisciplinary teams to co-ordinate care, and were involved in goal setting and regular audits of care plans, but the use of outcome measures of effectiveness was not routine.

People were involved in their care and treatment, and there was information on independent mental capacity advocates and independent mental health advocates (IMHA) available, should people wish to talk with them.

There was a clear vision and strategy for the service; however, the unit did not have a clear understanding of the trust's overall vision and strategies, and staff felt disconnected from the wider trust.

Good

Rehabilitation services

Are rehabilitation services safe?

Good

Incidents

- There were procedures in place for staff and people, using the service, to report both low level and serious incidents.
- Incidents were reported to relevant agencies, investigated and reviewed, to prevent a reoccurrence.
- On Woodlands Unit, we saw that incidents were recorded onto an electronic recording system. Staff told us they received regular feedback about incidents that they had reported, and following an incident, there was a formal debrief and feedback to the ward team.
- Staff told us there was learning from incidents for their service. They were kept informed through team meetings and action plans that were produced by the team.
- There was an incident reporting, complaints and serious untoward incident reporting meeting held every Wednesday. The meeting looked at the incidents, the likelihood of them happening in the different units, and actions that could be taken to prevent them happening again.

Safeguarding

- Staff we spoke with had access to training to safeguard vulnerable adults.

Consent, Mental Capacity Assessment and Deprivation of Liberty Safeguards (DoLS)

- Information from staff and records indicated that some staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This knowledge is relevant when working with people who lack capacity, and who are not subject to the Mental Health Act 1983.
- Assessments of people's mental capacity to make decisions regarding care, treatment and best interest meetings, took place for specific treatment issues.
- Whether a person had consented to care or treatment was being recorded in the person's notes. We saw this was being completed appropriately. An example of this was that consent for medication was completed.

Equipment and environment

- Records showed that emergency equipment was checked regularly, to ensure it was fit for purpose and staff had training for this. Emergency equipment was easily accessible.
- The ward area was clean, and cleaning schedules were used.
- Staff observed infection prevention and control procedures.
- Systems for the Control of Substances Hazardous to Health (COSHH) were in place, and were followed to keep people safe.

Medicines

- Medicines were stored appropriately, and safely in locked cupboards.
- Safety checks on the management of medicines were performed regularly.

Assessing and monitoring safety and risk

- There were procedures in place to identify and manage risks to people. We observed that staff discussed risks related to patients at the handover between shifts, and in the multidisciplinary ward round. Patient safety was taken into account in the way care and treatment was planned, and links to community teams were discussed.

Understanding and management of foreseeable risks

- The service had systems to deal with foreseeable emergencies. Most staff were trained in intermediate life support techniques, and dates were booked in for staff who had yet to complete this.
- Training records confirmed this, and staff told us that they felt confident in dealing with medical emergencies. There was an accident and emergencies department close by to the ward.

Are rehabilitation services effective?
(for example, treatment is effective)

Good

Assessment and delivery of care and treatment

- There were clear and comprehensive care assessments for people, and these were implemented and monitored

monthly, to ensure people's changing needs were being met. The service used the WRAP approach, to help decrease people's symptoms, and increase their personal responsibility.
- Physical healthcare checks were being completed and regularly reviewed if people's health care needs changed. Where appropriate, referrals were made to specialist teams. For example, staff told us that the liaison and links with the physical healthcare teams were excellent and responsive. This was felt to enhance care for people using the service, and support the team by ensuring best practice was in place with regard to treatment plans.
- The service supported people back into the community, by initially providing direct support once they were in their new homes.
- People were provided with psychological therapy that was tailored by a psychologist, such as cognitive behaviour therapy (CBT).

Outcomes for people using services

- There was good, comprehensive use of the WRAP approach, to ensure that people took responsibility for their recovery, and helped with the management of their mental illness.
- People received CBT as part of their treatment plans. One person said, "I understand now how to manage myself and that will stop me going back to hospital".
- We spoke to people who were engaging with housing services, to ensure their accommodation was organised before discharge.

Competent staff

- Staff and the manager received regular supervision and appraisal. However, there was documented evidence of appraisal, but no evidence that staff supervision was completed.
- The manager supported his team towards personal and group development.
- Staff told us about the group supervision that was facilitated by the clinical psychologist every two weeks. This allowed them to discuss challenges and issues that arose from their day-to-day work.
- New and temporary staff were given a robust induction programme that introduced them to the unit and its way of working.

Multidisciplinary working

- There was good evidence of multidisciplinary working within the unit; for example, occupational therapists worked to keep people motivated, and were involved in their rehabilitation plans.
- The unit had good connections with the employment services and local colleges that supported people to do different courses to assist their rehabilitation.

Mental Health Act (MHA)

- We reviewed three people's files, and found that all processes and documentation were in line with the Mental Health Act Code of Practice.

Are rehabilitation services caring?

Good

Kindness, dignity and respect

- People using the service were generally positive about the attitude of staff, and the support they had received. One person said, "so lovely here, all the staff here are great". Another person told us, "my primary nurse gives me real confidence that I will recover".
- We observed that the interaction between people who used the service and staff was positive, and that staff responded to people with patience, kindness and ensured that they were treated with dignity and respect.
- We observed many examples of staff engaging with people on the unit. For example, we saw that there was a community group taking place on the day of the inspection. People were engaged and contributing to the discussion.
- The rehabilitation inpatient ward had gender specific areas and there had not been any mixed sex breaches with the accommodation.

People using services involvement

- When we spoke with people, they told us that they had a high level of involvement in their care, and had had issues clearly explained to them. For example, when we spoke with one person they told us that their care and treatment was clearly explained to them, both individually with their primary nurse, and within their review meetings.

Good

Rehabilitation services

- There was information on independent mental capacity advocates and independent mental health advocates (IMHA) available, should people wish to talk with them. We saw that advocates had been involved in some decisions, where appropriate.
- Meetings took place on wards to gather the views of people. For example, people told us that they felt the morning meeting gave them a good opportunity to raise any concerns they have, and to discuss issues. On the day of our inspection, we observed that the meeting talked about eating healthily, and also discussed people who were leaving the unit soon.
- The unit had wellness recovery action plans (WRAP). These were individualised patient statements about how people wanted to be treated. These included statements about self-management and domestic planning.

Emotional support for care and treatment

- We saw that staff demonstrated a high level of emotional support to people on the unit at an individual level, and took time to explain and support them in a sensitive manner.

Are rehabilitation services responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services

- There was a strong emphasis on rehabilitation relating to the planning and delivery of care.
- Clear policies and protocols were in place in terms of the assessment process and care pathways. Issues and targets were incorporated, and local practices were being implemented to create a successful rehabilitation pathway.

Right care at the right time

- Good discharge planning enabled the service to plan for new people coming into the unit.
- There was good evidence of people's care needs being met through their care plans and daily records.
- People using the service received therapy in different ways, such as Cognitive Behavioural Therapy (CBT).
- People told us, "we are all allowed to make our own decisions within reason".
- We saw that there was robust discharge planning that people had been involved with, and in many cases, the goals were all set by the person themselves.

Meeting people's individual needs

- Care planning followed set assessments that included a person's individual equality characteristics, such as their cultural background. For example, supporting people to meet their spiritual needs.
- Information booklets had been developed for Woodlands. This included information on the service provided on the unit, including details of what to expect from the service.
- There was information on independent mental capacity advocates and independent mental health advocates (IMHA) available, should people wish to talk with them. We saw that advocates had been involved in some decisions, where appropriate.

Learning from concerns and complaints

- Information leaflets were available regarding the Patient Advice and Liaison Service (PALS), and how to complain should people wish to. Feedback was also being collected from people who were using the service, via feedback forms.
- When a complaint was received, the teams were aware of the process for investigating it and identifying learning.
- People were supported to make complaints whenever they had issues, but were encouraged to discuss those concerns first with their named nurse, or with the nurse in charge.
- People's complaints and feedback were used to improve the service that was being provided. An example is the WRAP programme that saw people leading on what they wanted in their care planning.

Good

Rehabilitation services

Are rehabilitation services well-led?

Good

Vision and strategy

- There was a clear vision for the service. The unit worked with people who needed to relearn the skills for living independently. All the staff we spoke to were clear about the role and function of the unit; however, they were not clear about the trust's overall vision or strategy for mental health services.

Responsible governance, risk management and performance information

- Staff meetings took place regularly, to ensure that staff were up to date with issues on the unit, and discussed how to continue improving the service provided. The meetings also provided feedback to staff from incidents and accidents.
- The manager attended the local clinical leads meeting, chaired by the modern matron, where governance issues were discussed, and fed through to the governance forum, and to staff via the line manager.

Leadership and culture

- The unit was led by a unit clinical manager who reported to the modern matron.
- Staff told us that they were well supported by their managers, and were able to raise issues of concern to them.
- This was supported by the positive and strong teamwork that we observed during our inspection.

Public and staff engagement

- People provided feedback about the service via questionnaires, and through complaints and concerns.
- The unit also had 'a feedback tree', where people posted their experience and views of the service.
- Staff in the unit felt isolated from other parts of the trust, and this was partly due to the unit's location. Staff told us that they felt disconnected from the rest of the trust, at times. All staff had access to the trust's intranet system, where further information was posted.

Good

Primary mental health services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The Isle of Wight NHS Trust provides primary care mental health services as part of their community mental health services. The team is based at the Gables, within the grounds of the Earl Mountbatten Hospice. Therapy is provided at this location, and at GP surgeries and clinics across the Island, in order to offer accessible appointments to meet the needs of local people. The service is staffed by trained psychological wellbeing practitioners and therapists, and offers a wide range of skills and therapies to people experiencing common mental health problems.

Summary of findings

Primary care mental health services provided by the Isle of Wight NHS Trust were effective and responsive to people's needs. Systems for reporting safeguarding issues and incidents of concern within the team were clear, and staff understood their responsibilities in relation to the issues. People's progress was comprehensively recorded and evaluated, and discussed with the person before each appointment. The service provided a range of evidence-based psychological therapies. We saw that staff were highly trained and skilled in the delivery of such interventions. The use of clinical measurements was routine, in order to measure effectiveness of treatment provided and outcomes for people. This was shared nationally and locally.

People told us that they found staff to be skilful and caring in their interactions with them. Treatment aims, and outcomes from interventions provided, were reviewed with people during treatment. People told us that they felt involved in making decisions about their care, and we saw that service delivery and staff training were tailored to meet the diverse needs of the local population.

The staff team were well established and worked in a cohesive manner to provide positive outcomes for people. Monitoring and auditing of the team was routine, and staff displayed a collective sense of responsibility for team performance.

Good

Primary mental health services

Are primary mental health services safe?

Good

Incidents

- Staff told us about the mechanisms and processes for incident reporting through the trust's electronic system. They were clear about their role and accountability for reporting incidents, concerns and near misses.
- When incidents were reported, staff told us that any feedback provided was shared in team meetings. Lessons learnt from incidents relating to the wider trust were distributed by email.
- The manager of the service met with other service managers and heads of service weekly. Issues discussed include risk registers and incident reporting.

Safeguarding

- Staff were trained in safeguarding vulnerable adults and children.
- Staff were knowledgeable about their responsibilities in regard to safeguarding. Policies and procedures were available to view via the trust's intranet site.
- Safeguarding concerns were referred to the local authority, who then allocated a social worker to lead in organising investigations. Staff felt that this made the process less confusing and provided clarity for them.
- Staff were responding appropriately to any signs or allegations of abuse
- The trust had a safeguarding lead, whom staff said they could contact with any concerns for advice.

Records

- Records management was effective. An electronic system was mainly used.
- The team also inputted data alongside this, into the national Improving Access to Psychological Therapies (IAPT) database. The national system was not compatible with the trust system, so processes for reporting were lengthy and often duplicated effort to fulfil the necessary level of data entry required.

Assessing and monitoring safety and risk

- There was a lone working policy and procedure in place. Systems observed within the service were clearly defined in regard to staff working in community settings, remote locations, and working out of hours.
- Electronic records showed that comprehensive assessments, outlining treatment plans and person-centred outcomes, had been agreed with the person. One person using the service told us, "my involvement in the process was paramount and guidance from staff with recommendations for treatment was helpful".

Understanding and management of foreseeable risks

- Service development was monitored for its impact on people. The manager provided monthly audits of performance and safety, to both the trust, and externally to the National Service Centre Central Information Centre (NSCIC). These included quality outcome measures in regard to referrals and activity levels. Staff and service user opinion was also sought throughout the journey through therapy.
- The manager told us how risks to the service that were identified due to capacity or staffing levels were mitigated, and there was a business case for emerging risks which may directly affect people's ability to access the service in a timely manner. Senior managers were described as receptive to concerns raised.
- Any disruption to staffing levels incurred due to staff sickness was dealt with through cross cover within the team in the long term, to reduce the impact on people using services.

Are primary mental health services effective?

(for example, treatment is effective)

Good

Assessment and delivery of care and treatment

- We looked at records and saw that care plans were structured and outcome-based, with people's involvement documented. We saw updates of plans that

reflected people's progress in achieving their treatment aims. Progress notes were reflective of the therapy being delivered. Treatment was evaluated before and after most therapy sessions to determine progress.

- Staff we spoke with had a good understanding of the current, relevant National Institute for Health and Care Excellence (NICE) guidance relating specifically to the variety of conditions that people who were referred to the service were experiencing.
- The manager used team meetings, supervision and emails to ensure that up-to-date clinical information and research was disseminated to the staff team. The manager told us that the team worked together to ensure that they were aware of the most recent clinical information, and that this was how they ensured that best practice was maintained.
- People's physical health needs were considered. Due to the specific therapy-based nature of the service, if issues were identified, signposting to the appropriate service was provided.

Outcomes for people using services

- The service was developed around an outcome-based framework. The service used a number of outcome measures to determine the effectiveness of the care delivered, and shared these with the Health and Social Care Information Centre (HSCIC).
- The team were part of the Health of the Nation Outcome Scales (HoNOS) two year pilot in the trust. HoNOS is the mostly widely-used routine clinical outcome measure recommended by the National Service Framework for Mental Health. The scale aids the assessment process, and can determine through its evaluation the progress of therapeutic intervention. These were completed by practitioners who had received training in how to undertake this.
- The team also used national IAPT tools and locally-approved questionnaires to measure progress and outcomes for patients receiving therapy.
- Outcomes were audited regularly, and shared with staff and senior managers. Data was seen on a sample of 50 people's feedback about the service from April 2014: Of the responses to the question "did you get the help that mattered to you?" 86% said all the time, 12% most of the time, and 2% sometimes.

Competent Staff

- The manager told us that they did an annual forecast of staff training needs, including updates required by practitioners, numbers of newly recruited staff, training places required at the University on the mainland, and training for new therapies to address local needs.
- Staff were skilled in a variety of therapies, including Cognitive Behavioural Therapy (CBT), Transactional Analysis (TA), and Eye Movement Desensitisation and Reprocessing (EMDR).
- Staff described managers as supportive in respect of such training and updates, enabling them to continue to be accredited in their sphere of expertise.
- There was a robust supervision process in place. Psychological Well Being Workers received weekly caseload management, and High Intensity Therapists had weekly CBT supervision. EMDR and TA therapists received external professional supervision.
- Performance and caseload capacity were imbedded in the supervision process. The team also had a weekly team business meeting to discuss general team issues and trust updates.
- Staff received an annual appraisal, which staff told us was referred to throughout the year during supervision, to evaluate progress towards their professional and personal development objectives.

Multidisciplinary working

- The team consisted of trained psychological wellbeing practitioners, therapists and psychologists. The team adopted a multidisciplinary approach to care and treatment when addressing people's needs.
- There were good links with other services within the trust, which ensured that information was shared. Clinical leads within the team aimed to meet with community team staff on a weekly basis.
- Staff also told us that they have built good working relationships with many GPs in the area in which they work. This included educational evenings, specifically aimed at engaging and promoting the service to GPs, which we were told had been well received.
- There were excellent links to the employment advisory service, which holds a full time contract with the trust. Staff in the employment service spoke positively about the staff in the primary mental health services, and told us that they worked in partnership to achieve positive outcomes for people.

Good

Primary mental health services

- Requests for social worker input for people were accessed via a contact centre within the local authority. Staff told that the system was effective.

Seven day services

- Services ran from Monday to Friday, 9am-7pm Monday, Wednesday and Thursday and 9am to 5pm Tuesday and Friday.
- Staff were keen to provide treatment that suited individual needs, and the service operated three late nights each week in order to provide an accessible service for people who worked during the day.

Are primary mental health services caring?

Good

Kindness, dignity and respect

- People who used the service spoke very positively about the primary care mental health service. Feedback from one person included, "staff don't give up on you". Another told us, "I felt listened to and that in itself was helpful". One person said, "I was very impressed and could not fault the service".
- The staff we spoke with were passionate about their role in providing therapy to people.
- The service regularly sought feedback, from people who used the service, throughout their therapy journey, with the use of questionnaires. Some of the comments we saw were, "a very professional and caring service", "would like more one to one and would be prepared to pay for it", and "I had someone impartial to speak to, it was a good help".

People using services involvement

- Staff told us that the philosophy of care provision was one of self-care, promoting independence and facilitating continuity for people in the activities of daily living. People we spoke with were clear about this philosophy, and gave examples of how they had been enabled to achieve these.
- People told us that throughout the process staff checked they had a clear understanding of their treatment. They felt fully involved in the assessment process and empowered to achieve personal goals. One person told us, "I was given clear expectations about my commitment in the process along with how they could support me". This meant that people were supported to make choices about their care by gaining informed consent to commence therapy.
- We observed people being given a choice of appointments in their preferred location by administrative staff.
- In care records we saw that consideration was given to those things which were important to people in their life; the possibility of their involvement if they so wished was clearly documented. This meant that people's individual circumstances were identified and respected.

Emotional support for care and treatment

- Staff promotion of self-care was routine. People we spoke with told us about the "tools" they had been provided with through therapy that have enabled them to self-manage their condition.
- The service also provided couples counselling for depression.

Are primary mental health services responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services

- People could access the service by self-referral, mainly following consultation with their GP.
- The primary care mental health services were able to identify and deliver services in the wider community.
- Staff showed good understanding of the local communities, and the team had an understanding of the diverse needs of the people who used the service. All aspects of people's health and well-being were considered, and the team worked closely with GPs and secondary care mental health services to ensure that the identified needs were met.
- People were also signposted to a variety of services, including employment services.

Right care at the right time

- People accessing the service were usually offered an appointment within 28 days. The appointment would

be based, at the initial stage, on providing a timely response for assessment. People would not always be able to choose the location for the first appointment due to capacity issues. This meant that a longer waiting time may be experienced, as people often preferred to wait until they could be given an appointment at a location nearer to their home.

- Between January to June 2014 the average waiting time for assessment was approximately 26 days, and the time from assessment to treatment was 26 days. The service did not respond to urgent needs, so the waiting list was not managed with regard to risk.
- The team had developed ways to reduce waiting times for therapy, by offering more disorder-specific group work, rather than individual sessions for people appropriate to the individual's needs. If people assessed or already in receipt of the service presented with more urgent needs, then staff referred to the appropriate team within the trust for them to provide more focused support.
- Groups and individual therapy were delivered according to the individual's needs.
- The service provided out-of-hours appointments three times per week; alongside this satellite clinics were provided around the Island for people to access care near to their home. Telephone support and evidence-based, computer-based treatments to meet people's individual needs were also offered. This meant that the service was flexible enough to fit in with people's lives where possible.
- We observed people being given a choice of appointments in their preferred location by administration staff. The times, location and length of appointments were established according to people's needs, and to support people to maintain work and education.
- Staff collaborated with other agencies and across services to promote safety. Staff told us that they had well established links with local drug and alcohol services and community mental health teams. For example, clinical leads aimed to meet weekly with community mental health teams.

Meeting people's individual needs

- Staff we spoke with described clearly how to access interpreters, and had undertaken training and additional online learning in relation to meeting people's diverse needs.
- The team had established good links with community mental health services, and met regularly with them. Staff were not aware of any delays in people's transition to other services. Staff described transfer arrangements to other teams as effective and straightforward.
- The service had the highest level of people over the age of 65 in the country receiving an Improving Access to Psychological Therapies (IAPT) service. We saw that staff had undertaken specific training in relation to how to adapt therapies for older adults. This demonstrated that the service looked at the needs of individuals and adapted their service.
- The service provided a variety of information leaflets which were specific to the services they provided. These were available as necessary, in a variety of accessible formats. This meant that people who used the service had relevant information, and were able to access additional information which was useful to them.

Learning from concerns and complaints

- Staff were aware of the trust's complaints policy and how to access it, and were confident on how to advise people with concerns and complaints.
- In the waiting areas we saw that there were leaflets and information available about how to make a complaint.
- People were provided with information about the ways in which they could raise complaints and concerns regarding the service.
- There was evidence of trust-wide learning from complaints and incidents, and this information was cascaded in team meetings, or through updates via the trust email system and intranet site.

Good

Primary mental health services

Are primary mental health services well-led?

Good

Vision and strategy

- The service strategy was based on the national Improving Access to Psychological Therapies (IAPT) service. This enabled the team to have a clear understanding with regard to the current and future needs of the service.
- The service had a set of minimum quality standards; these were in line with the national IAPT service audits for improving quality. In February 2014, the service had evaluated their compliance with these standards, and were able to provide evidence for compliance in all aspects, alongside the future needs of the service identified.
- Staff did not have a clear understanding of the trust's strategy for mental health services.

Responsible governance

- Regular team meetings were used to discuss developments for the team, their objectives and managing risks to the service.
- Monthly audits, with regard to performance and outcomes measures, were submitted to the national HSCIC database in the trust's governance department.
- The manager received regular reports and updates monitoring the team's performance. During our visit, the manager was in the process of formulating a business case for additional staff, to secure staff to meet given team targets and performance measures. This meant that barriers to the delivery of high quality care were regularly analysed and could be mitigated systematically.
- Service developments were being monitored for risk, both nationally and locally
- Staff received regular caseload, professional and peer group supervision. We saw that staff attendance at training was monitored by managers and shared with staff. Staff told us business meetings were seen as an arena for feedback with regard to performance audits undertaken for the team. Staff had received governance training.
- Staff were aware of the internal and external whistleblowing processes. They told us that they would feel comfortable raising concerns with their manager.

Leadership and culture

- The interim service lead has been in post for 9 months and also continues to undertake some clinical work and that the previous service lead was Band 8b who did not undertake clinical work.
- We observed a supportive and cohesive team that benefited from a strong sense of purpose and clarity about the service objectives, including regular performance information and updates.
- There was a sense of collective responsibility for team performance.
- Staff could demonstrate a clear understanding of their role, objectives and the communication processes within the team and the wider trust.
- Staff confirmed that the team was cohesive with high staff morale, and was well supported by their manager.

Public and Staff Engagement

- The team provided every person using the service, with the opportunity to share their views during and at the end of their involvement with the service. People could give their views openly, or anonymously, through questionnaires provided, and feedback was being used to improve the service.
- Staff we spoke with told us that they felt proud working for the trust, but in particular, they felt proud working for the primary care mental health services within the trust. They spoke positively about their role, and demonstrated their dedication to providing quality patient care.
- Staff had a broad understanding of board level leadership and were able to identify the trust values through the information dispersed at team meetings or via email. Business meetings were undertaken on a weekly basis and one member of staff told us, "we are kept well informed about trust issues".

Innovation, improvement and Sustainability

- The service was keen to introduce innovative therapies to meet the needs of people. For example, some of the staff within the team were shortly undertaking training in interpersonal therapy, as recommended by the National Institute for Health and Care Excellence (NICE), for working with people with depression.

Good

Primary mental health services

- The service had used alternative systems for managing new referrals to reduce people's waiting times for therapy.

Good

Drug and alcohol services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The Island Drug and Alcohol Service (IDAS) offers assessment and recovery-focused treatment for people who misuse drugs and alcohol. In addition, it also provides support for families and carers of drug and alcohol misusers. It provides assessment for detoxification, and residential rehabilitation for people who have a drug dependency. Referrals into the service can be made by any person, professional or service.

The drug team provides substitute prescribing for primary heroin users (who may also use other drugs, including alcohol), drug detoxification (subject to assessment), one-to-one assistance, and group support. It offers advice and information alongside needle exchange, safer injecting practices, acupuncture, Hepatitis C and HIV testing, and Hepatitis B vaccination.

The alcohol team offers full assessment for harmful and dependent alcohol users; the team also provides one-to-one work and signposting, as well as access for alcohol detoxification (subject to meeting criteria). A range of alcohol assessments and other useful information are also available.

The family and carer service offers information and support to anyone affected by someone else's drug or alcohol use, by way of one-to-one support, and the drug and alcohol carers' forum. Service user support is also available.

The service operates Monday to Friday from 9am to 5pm, and runs a Thursday evening clinic until 7.30pm.

Summary of findings

We found that IDAS services provided by the Isle of Wight NHS Trust were delivered in a safe and caring way. We found that staff were respectful and delivered care which demonstrated good skills for working with people who misuse drugs and alcohol, and their families. We observed that care and treatment was delivered in a timely manner; there were no people on waiting lists.

We found that the team were concerned about the service going to tender in July 2014. This meant that staff were worried as to whether the Isle of Wight NHS Trust would continue to provide the service, or if it might be given to another provider.

Staff demonstrated a good understanding of how to follow the local safeguarding policy and procedures for safeguarding vulnerable adults and children, and worked well with other teams, within the trust and outside organisations, to provide care that best met the needs of people. There was good use of national guidelines to treat patients, and outcomes were monitored routinely to improve the service.

People who used the service were able to provide feedback, and also knew how to complain. The majority of staff told us that they felt well supported by their managers, and were pleased to work for the team and the trust. However, one staff member felt that the senior management did not listen to their concerns.

We found that the team had arrangements in place to monitor the quality of the service provided, and took necessary actions to improve their performance.

Good

Drug and alcohol services

Are drug and alcohol services safe?

Good

Incidents

- Incidents were reported and investigated. Staff told us that they received feedback, following incidents, through meetings, and information was circulated within the team.
- Learning from incidents took place, and specific changes to practice were made as a result of incidents and investigation.

Safeguarding

- All staff spoken with had a good understanding of how to identify and report any abuse, to ensure that people who used the service were safeguarded from harm.
- Training records showed that all staff were trained in safeguarding vulnerable adults and children.
- All staff spoken with knew the designated lead for safeguarding, who was available to provide support and guidance.
- All people who used the service that we spoke with told us that they felt safe, and knew how to raise any concerns about abuse.
- We saw that information was readily available, to inform people who used the service, and staff, on how to report abuse.

Consent, Mental Capacity Assessment and Deprivation of Liberty Safeguards (DoLS)

- Capacity to consent to care and treatment was addressed as part of the assessment routine, and this was documented.

Records

- Records within the team were managed using the electronic system. Staff explained to us the advantages of the electronic system, which easily linked different teams, and enabled them to access people's records when needed.

Environment

- The environment was clean, and staff practiced good infection control procedures.
- Security procedures were followed.

Assessing and monitoring safety and risk

- Risk assessments were carried out for all visits to people, to ensure that all staff were safe; where the risk was deemed high, staff saw people in pairs.
- All staff were aware of the lone working policy, and told us that they followed it.
- People's needs were clearly assessed prior to care and treatment starting. There were good examples of completed needs assessment, and detailed care plans that matched the identified needs. There were risk assessment and management plans in place that expressed how staff should support people safely.

Understanding and management of foreseeable risks

- There were two nursing vacancies to staffing levels that were not filled after two nurses had left. The manager told us that these vacancies had been put on hold until they knew about the outcome of the service which was currently under tender.
- The majority of staff told us that they were coping with their caseloads, and continued to meet their targets. One staff member raised concerns that they would not be able to cope when staff went on annual leave during the summer holidays. We saw that the team did not have any waiting list, and attended to people on time.
- The manager told us that risks and near misses were recorded on the electronic incident reporting system, and the investigation outcomes were used to put in place management strategies for any risks identified.
- The risks, which could be anticipated from insufficient medical, nursing and therapists cover, and the impact of this on meeting patients' needs, had been considered.

Mandatory training

- Staff had received the mandatory training they needed, and where updates were required, this was monitored through a system that highlighted ongoing needs. All staff spoken with told us that they received mandatory training and got reminders when their updates were due.

Are drug and alcohol services effective?
(for example, treatment is effective)

Good

Drug and alcohol services

Good

Assessment and delivery of care and treatment

- Staff were aware of the most recent, relevant National Institute for Health and Care Excellence (NICE) guidance. Information about up-to-date clinical research and policy was shared amongst the team.
- The physical health needs of people were routinely assessed and monitored, and the team worked closely with GPs and secondary health care services, to ensure that the identified needs were met during people's care with the team. Physical health needs were assessed, to ensure that people were not put at risk of receiving treatment that was not suitable for their health conditions, and some people were unable to access detoxification as a result of failing to meet the criteria.

Outcomes for people using services

- The IDAS team carried out outcome satisfaction surveys, where people gave a feedback on the care and treatment they had received. The results showed that most of the people treated were happy with the care they had received.
- The IDAS team used audits to evaluate service provision against relevant NICE and National Treatment Agency (NTA) guidelines, to monitor outcomes for people. The service was good at maintenance doses being discussed with people, dosage increased or decreased in consultation with the patient and methadone prescribed as first choice.
- The service identified that all people needed to be offered motivational interviewing as part of an assessment, and harm reduction advice and information, and relapse prevention following assessment in maintenance. The service drew up an action plan to address these areas, which included updating policies, reviewing caseloads, and training for staff.

Competent Staff

- Staff received the training they needed, and had opportunities for continuing professional development in areas that benefit and address the needs of people who use the service. For example, some of the staff had attended training in Cognitive Behavioural Therapy (CBT) and the Birmingham Treatment Effectiveness Initiative Programme.
- All staff spoken with told us that they received regular supervision, and had an annual appraisal where their personal and professional development goals were set.
- Staff we spoke with were appropriately qualified, and competent in their job role. Staff were trained in CBT, detoxification, motivational interviewing, and nurse prescribing.

Multidisciplinary working

- In records we sampled there was evidence that the multidisciplinary team worked together. People told us, and we saw, that they attended their review meetings.
- There was evidence of effective multidisciplinary working with others, including internal and external partnership working, working with GPs, the mental health crisis team, adult mental health team, the independent sector and local authority. However, staff told us that problems existed between IDAS and the adult mental health team, with dual diagnosis issues, as there was open debate about which service took overall responsibility for the person's care. The manager told us that work was in progress to develop a working protocol between the two services.
- Staff explained to us the advantages of the electronic system, which easily linked different teams together, and enabled them to access people's records when needed.

Mental Health Act (MHA)

- There were no Mental Health Act responsibilities at the time of our inspection.

Seven day Services

- The service ran from Monday to Friday, 9am to 5pm. There was an extra clinic on Thursday evenings to support people who needed to attend out of normal working hours.

Good

Drug and alcohol services

Are drug and alcohol services caring?

Good

Kindness, dignity and respect

- All the people we spoke with, who used the service, were very positive about IDAS. People were very complimentary about the support they received from the whole team, and felt they could come for help anytime, despite potentially failing to follow their care plans.
- People told us that they had been treated with respect and dignity, and commented that staff were polite, friendly and willing to help.
- Questionnaires on what people felt about the care provided, were readily available for people who used the service, and their families, to complete. The staff told us that they had an open culture for people to feedback how they felt about the service provided.

People using services involvement

- People spoken with told us that they were involved in their care reviews, and were free to air their views.
- Records we sampled showed that people's, and their family members', views were taken into account, and they were supported to make informed choices.

Emotional support for care and treatment

- There was effective joint working by staff across a number of services, to promote the safety and well-being of people. We saw that there were strong links with the GPs, Criminal Justice System (CJS) and social services.
- We observed that the service provided psycho-social interventions that helped people to reduce drug related harm, enhancing motivation to change, and maintaining abstinence from illicit drugs.

Are drug and alcohol services responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services

- People had self-referred via open access services, or were referred by their GP, or other partnership agencies, to these services. Some publicity about other locally-available services was seen around each service that we visited.
- The service had an understanding of specific needs of the people it served, and the geographic areas of people with high use of drugs and alcohol. The service used this information to distribute its resources and health promotion materials effectively, in areas where it was most needed.
- The service is mostly community-based, but where people's needs require inpatient beds for detoxification, the two beds at Real World Trust and one at Osborne Ward can be used.

Right care at the right time

- Most of the referrals were seen on the first day of contact, or within three working days. If they were viewed as urgent, a decision would be made to allocate the referral to an appropriate team member, who would contact the referrer. The care co-ordinator would discuss treatment options with the person; and conduct a risk assessment and initial care plan. The team had no waiting list.
- Depending on the needs of each individual, the treatment schedule was a 15 day programme, and 12 weeks is the timeframe for successful completion.
- The team operated community detoxification in people's homes, and there is a dedicated team to support alcohol withdrawal. If people need admission, they are admitted to Osborne Ward, where there is one bed for supported detoxification.
- The team worked closely with mental health inpatient services, to ensure that people who had been admitted to hospital as inpatients would get the support they needed.

Good

Drug and alcohol services

- We saw good co-ordinated work between services. There was a strong link with the community mental health team, Osborne Ward, GPs, CJS and the Multi-Agency Public Protection Arrangements (MAPPA), to ensure that they were aware and up to date with the needs of people they work with. All agencies involved were invited to review meetings, where appropriate. This meant that care was co-ordinated with all agencies, to ensure that people received the right care and support required.

Meeting people's individual needs

- The IDAS team provided people with information leaflets, which were specific to the services which they provided. This meant that people who used the service had important information, and any useful additional relevant information was also available to them.
- Care plans identified goals, and followed needs highlighted in assessments that included a person's individual cultural background, spiritual needs and wishes.

Learning from concerns and complaints

- All the people we spoke with told us they could raise complaints when they wanted to, and they were listened to, and given feedback from these discussions.
- Information on how to make a complaint was easily accessible, and in a user-friendly format.
- All staff spoken to knew how to support people who used the service, and their relatives, to make a complaint.

Are drug and alcohol services well-led?

Good

Vision and strategy

- All staff spoken with showed a good understanding of the values, vision and objectives of their team and the trust. Staff told us that the service would provide safe, quality care, and cheerful experience to people, all the time. They told us that they would always work with other teams within the trust and external agencies to ensure that people received the best care they needed within the Island.
- We found that the team was concerned about the service going to tender in July 2014, and this was a decision from the commissioners. The manager felt that they do not have a good shared vision with the commissioners. Staff were worried whether the Isle of Wight NHS Trust would continue to provide the service, or if it might be given to another provider.

Responsible governance, risk management and performance information

- Regular team meetings were held, with minutes of the meetings recorded. Discussions included incidents, service performance, and updates on service, risk management and training.
- The team had a trust-wide risk register, and the manager told us that this was used to monitor risks within the trust, and provided insight on issues of concern that needed attention.
- All staff were able to describe how they would raise incidents, concerns, safeguarding and whistleblowing. They all felt that the trust's governance system was robust.
- Staff were aware of the whistleblowing policy, and said that they would feel confident to report and refer concerns if it was needed. The whistleblowing policy was available on the trust intranet site for staff to refer to.
- We saw that there were a number of audits which were carried out, which were able to measure standards in terms of development and improvement within the service. For example, all people were on supervised daily consumption of methadone for at the first three months.

Leadership and culture

- The team was led by a clinical team leader, who was responsible for day-to-day running of the service. All staff spoken with were very proud to be working for the IDAS team. All the staff we spoke with told us that they felt supported by their line managers, and worked as a united team.
- Staff told us that they felt well supported by their managers, and they worked as a solid team that shared the same goals and ambitions. Staff spoke highly of how they worked as a team, supported each other, and how they enjoyed their roles.

Good

Drug and alcohol services

- Staff took pride in what they do, and how they were supported to develop their skills to competently carry out their duties.

Public and Staff Engagement

- Peoples' views were gathered through feedback from questionnaires, and comments from the feedback were positive.
- Most of the staff we spoke with told us that they were pleased to work for the trust, but specifically to be working for the IDAS team.
- Staff told us that they had weekly briefings, 'the Friday Flame' from the chief executive, and an e-bulletin.
- Staff felt that they had been supported, and kept updated by the senior management, as a team, about the period of uncertainty on the future of the service.
- Most of the staff told us that they felt free to approach their manager. They said that senior managers were accessible, approachable, encouraged openness, and visited the team to support and update them with regard to the proposed service tender. One deputy manager felt that the senior managers were not addressing the staffing concerns.

Requires improvement

Community mental health team services

Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Information about the service

This Rehabilitation and Recovery Team (RRT) service provides mental health services across the Isle of Wight for people experiencing serious and/or enduring mental health problems (Clusters 11-17). The office is situated at South Block in St Mary's Hospital, but provides access to care within clinics around the Island and in people's own homes. The service is for people aged 18 upwards, and provides care to people aged over 65 years who are experiencing a functional illness.

The Acute and Recovery Team (ART) service works with people experiencing non-psychosis mental health issues (Clusters 4-8). Staff offer assessment, support and treatment alongside referral for psychological therapies as necessary. The Couple and Family Consultation (CFC) service member of staff is part of the ART. Thisoffers couple and family assessment and treatment to Isle of Wight adults who are experiencing mental health problems, by working with referred patients, together with their partners or family members. A single point of access for referrals was operated within ART. The office is situated at the Chantry House in Newport. These services have not previously been inspected by CQC.

The Early Intervention in Psychosis (EIP) Team which was not part of the inspection.

Summary of findings

Community-based mental health services provided by the Isle of Wight NHS Trust were delivered in a caring and compassionate way. People we spoke with told us that they found staff to be kind and skilful in their interactions with them. We observed staff in their work with people and found them to be compassionate and respectful towards them. However, people did not have appropriate information and were not always involved in their plans of care.

People were safeguarded, but incidents were not always reported appropriately. People's records were not up to date, or reviewed regularly with regard to care and risk management. Staff were able to tell us verbally about the risks to people's health, and describe in detail the support they were providing, but the document was not reflective of people's current treatment, needs or risks.

Staff had high caseloads, and waiting lists for services were lengthy. Staff were not receiving regular line management or caseload supervision within the Rehabilitation and Recovery Team. This meant that managers were unclear about the appropriateness of interventions being undertaken with people, the effectiveness of records management, or compliance of staff with mandatory training.

Information leaflets about the service were not available as these had not been updated. Complaints procedures were clear and understood by staff and people using the service. Teams worked well together, but they did not

Requires improvement

Community mental health team services

have an up-to-date operational policy, which outlines the function and interventions they provide. The national guidance and outcomes to monitor the effectiveness of the service was not routine.

Are community mental health team services safe?

Requires improvement

Incidents

- Staff told us that they used the trust's electronic incident reporting system for reporting any incidents, concerns or near misses.
- The learning from incidents was shared at monthly team meetings, to minimise risk and prevent reoccurrences.
- Staff told us that they also received regular updates, by email and bulletins, containing feedback.
- Staff gave examples of incidents reported, but these tended to be more serious incidents. Risks associated with the delivery of patient care, for example, high caseload numbers, or staff shortages, were not routinely reported. Staff told us that there was possibly a tendency to under-report incidents due to their limited capacity to complete the form online. Therefore, risk issues were not clearly understood within the wider trust, which may prevent improvement to systems and team practice being implemented.

Safeguarding

- Staff were trained in safeguarding vulnerable adults. In the Acute and Recovery Team, 93%, and in the Rehabilitation and Recovery Team, 78%, were up to date with training in regard to safeguarding adults.
- Staff explained to us the process they used to report incidents, and knew their responsibilities with regard to safeguarding. They told us concerns were discussed with line managers, where appropriate, in the first instance.
- There were detailed policies and procedures in place in respect of safeguarding, to support staff to respond appropriately to concerns.
- A single point of access for referrals was provided by the local authority.
- The trust had a safeguarding lead, whom staff could identify, and knew they could seek further advice from, as necessary.

Requires improvement

Community mental health team services

Consent, Mental Capacity Assessment and Deprivation of Liberty Safeguards (DoLS)

- Staff were able to discuss issues around consent and capacity, and how to undertake or organise an assessment for people as necessary. Mental Capacity Act and Deprivation of Liberty Safeguards were part of the mandatory training programme. Records we looked in did not relate to anyone with any documented issues in regard to mental capacity.

Medicines

- Medicines were not stored in the clinics we visited; a central depot clinic was undertaken at a satellite clinic and this where medicines were stored.

Records

- Records management was, in the main, using an electronic system. In the Rehabilitation and Recovery Team (RRT) we reviewed eight electronic records within the team. The records we saw contained a risk assessment, which had been completed when the person had initially been accepted onto the caseload. Risks assessments and updates had not been regularly completed following this initial assessment.

Assessing and monitoring safety and risk

- There was a lone working policy and procedure in place.
- Within the electronic records system, there was a facility to highlight where people presented identified risks to staff safety.
- Staff had established systems for ensuring staff whereabouts were known and logged, and a system was in place for ensuring staff had returned safely following community visits.

Understanding and management of foreseeable risks

- All records in the Rehabilitation and Recovery Team (RRT) lacked a recent review of risk assessments, with little reference to how identified risks should be managed. Staff were unable to clearly identify any regime or timeframe for review.
- The risk assessments we saw lacked any person-centred content with regard to risk management.
- The manager of the team told us that they ensured appropriate review of risk had taken place within monthly caseload supervision. However, the records we saw in relation to caseload supervision were not monthly, but in some instances had not been undertaken for between 6-12 months. There was no pattern of any regular supervision with regard to staff caseload which was seen from 2011.
- Risk assessments we saw within the Acute and Recovery Team (ART) were up to date, and had been appropriately reviewed. The manager within the team undertook monthly caseload management, and timely reviews of risk were identified and actioned.
- Within the ART team, there was a filtering system for all referrals to the community mental health teams. This system was supported by a qualified nurse and a support worker. The systems used in regard to assessing and prioritising incoming referrals were evidence-based tools. GP referrals, sent by fax or letter and not marked as urgent, would be passed to the team manager by the administration staff, for later review and allocation, without a review of the details of the referral by a qualified member of staff. As a result, it is possible that an unmarked urgent action required may be delayed.
- Managers told us that risks to the service, that were identified due to capacity or staffing levels, were mitigated through formulating a business case. Senior managers were described as receptive to concerns raised. Any disruption to staffing levels incurred due to staff sickness was dealt with through cross cover amongst teams, to fill any gaps, and limiting any impact upon people using services. There had been three Band 5 nurse vacancies for an extended period of time, which had recently been recruited. It was anticipated that they would be joining the team within the next few weeks.
- The RRT manager told us that issues in regard to vacant posts within the team, which had been impacting upon caseload numbers and capacity, were reported and reviewed within the trust's risk register. This was rated 'red' within the register, and that the manager had last updated this in December 2013, with the risk remaining current. There was no evidence that this had been reviewed by the trust since July 2012. This meant that systems and processes for monitoring foreseeable risks, with regard to the impact on the delivery of patient care, as a result of staffing in community teams, were not evident.

Mandatory Training

- Staff told us that they were supported to undertake training outside of mandatory training.

Requires improvement

Community mental health team services

- In the ART, 91%, and in the RRT, 73%, of staff were up to date with mandatory training. Staff attendance on training was monitored by managers. A training grid was available, and this was updated and shared with staff. Within the RRT, at least two members of staff had only completed 50% of their mandatory training, and we found monitoring of attendance was infrequent and unstructured, and did not identify staff falling behind on essential training.

Are community mental health team services effective?

(for example, treatment is effective)

Requires improvement

Assessment and delivery of care and treatment

- There was comprehensive assessment of people's needs on initial contact, which covered all aspects of care as part of a holistic assessment. However, care plans lacked regular updates to reflect progress in achieving aims.
- There was very little evidence of physical health monitoring in records. Staff told us that no physical health checks were undertaken. We saw that physical health was discussed initially, but no further assessment of these needs had been offered. This meant that patients' physical health and well-being, as part of a holistic approach, was not considered.
- NICE guidance was referred to in respect of competencies for staff in delivering psychological therapies. Teams were establishing a more therapeutic base for interventions. Managers showed us plans for numbers of staff to attend a variety of workshops in the coming months, which included Cognitive Behavioural Therapy (CBT). Some staff were already trained in some aspects of CBT and Dialectical Behavioural Therapy (DBT). The nature of the issues which people presented with, often led to referral on for psychological therapies following assessment.
- Information on patients who were subject to the Care Programme Approach (CPA) was shared on the electronic system, which both health and social work staff can access. Documentation, in regard to the Care Programme Approach (CPA), was seen, but lacked timely review or involvement of people in the process. Staff told us that they had failed to undertake CPA reviews in a timely manner due to the fact that capacity to meet demand was "challenging". This meant that the assessing and co-ordinating of care, for people who had complex needs, lacked a consistent approach.

Outcomes for people using services

- No information was routinely collected to demonstrate people's outcomes of care.

Competent staff

- Staff we met with understood their aims and objectives, in regard to performance and learning, through their annual appraisal. However, within the RRT, these objectives were not being revisited and reviewed on a regular basis throughout the year, due to infrequent meaningful supervision.
- Staff told us that no regular caseload or line management supervision had been taking place within the RRT, and records we saw, dating back as far as 2011, confirm this. Out of six records we looked at, the regularity of caseload supervision was, on average, twice year.
- Trust Guidelines for Caseload Management described an external caseload review that had been undertaken in August 2011, which indicated that community teams did not focus on people presenting with the highest clinical risk and who had severe and enduring mental health issues. The recommendation was that a structure for undertaking caseload management should be developed and maintained. Caseload management guidelines outlined that individual meetings with staff should take place every four weeks, for at least an hour, discussing all cases on a three monthly cycle. This meant that within the RRT, the trust's own guidelines were not being adhered to.
- There was effective monthly caseload and line management supervision for all staff in the ART. Incorporated into this was a review of each staff member's objectives and aims, as part of their own professional development.

Multidisciplinary working

- Multidisciplinary teams were made up of, or had input from, occupational therapists, nurses, social workers

Requires improvement

Community mental health team services

and medical staff. In all teams we visited, staff described positive relationships with other services, and the multidisciplinary approach to care and treatment was optimal.

- Staff spoke of good relationships with other teams, and transfer between teams involved working in partnership, and where possible, undertaking joint visits. Other teams we met with during our visit described effective collaborative working with ART and RRT staff.
- One of the Senior CCO's in ART has established a weekly clinical risk meeting as part of their appraisal objectives. This was due to commence in the week following our inspection, and would have a multidisciplinary approach to risk management, and developing strategies to deal with complex cases.
- Transfer of care between teams, and shared care within teams, was effectively managed. This enabled smooth transition between teams for the patient as part of their ongoing recovery. Staff were clear about the lines of accountability and who to escalate any concerns to.

Mental Health Act (MHA)

- Staff received training and updates with regard to the Mental Health Act.
- We saw records for people subject to a Community Treatment Order (CTO); these were reviewed and updated appropriately.
- Staff told us that social workers and approved mental health professionals (AMHP) in the teams provided guidance on the Mental Health Act to support compliance. One record we were shown for a person subject to a CTO was comprehensive, but did not contain any reference to the persons own wants and needs.

Seven day services

- The service operates 9am to 5pm, Monday to Friday. Out of working hours, in a crisis, people had the contact numbers for the Crisis Team, or were advised to contact the out of hours GP.

Are community mental health team services caring?

Requires improvement

Kindness, dignity and respect

- We spoke with five people using the services. People were very complimentary about the care and treatment they received. One person told us, "can't fault it". Another person told us, "they are amazing". People told us that they felt listened to and included in each stage of the care they received.
- We observed interactions between staff and people using the service, both over the phone, and also face-to-face. The language used was empathetic, clear and simple, without the use of jargon.
- Staff demonstrated clear compassion and warmth, and positive engagement with people was seen.

People using services involvement

- Some of the people we spoke with were clear about their care plan, and told us that they felt involved in it. Others knew verbally what their plan of care was, but had not had this formalised or documented for them. This meant that people were making choices about their care, but this information was not readily available to them in a written format.
- People we spoke with told us that they had not received any information about the service.
- We spoke with people who told us that they had a basic understanding of their medication and condition. One person told us they had received information some years before, but nothing recently.
- We reviewed some records and found no evidence of involvement of the people signing or being part of the development of their own care plan. One person we spoke with told us, "I have no care plan; they just visit and help me". We raised the issue with managers during our visit, who clarified that there was no formal structure to review the contents of care plans. This meant that people were unable to see and contribute to any progress being made towards their recovery.
- Staff told us that people's carers were involved in their assessment and care planning, where appropriate. One person told us, "they asked if my partner wished to be involved in my care from the outset".

Requires improvement

Community mental health team services

Emotional Support for care and treatment

- We spoke with people who used the service, and received many positive comments about the support from staff.

Are community mental health team services responsive to people's needs? (for example, to feedback?)

Requires improvement

Planning and delivering services

- Options and pathways for the care available were not clearly outlined in the records we reviewed. Staff told us that the team reconfiguration, and lack of an operational policy since the reorganisation in 2008, meant that clarity about team direction and service provision was unclear. Managers told us that the operational policy for both teams had not been rewritten to reflect the reconfiguration.

Right care at the right time

- The Acute and Recovery Team operated a duty filtering system from 9am to 5pm. The referrals coming in were prioritised with regard to need, and appointments were available for people to be booked into the system in the coming days or weeks.
- Referrals on to other services were forwarded following initial collection of referral information. Staff told us that they prioritised incoming referrals according to risk and identified need. During our visit we were unable to observe staff dealing with incoming referrals.
- Managers told us that caseloads were high, and they currently had long waiting lists. In the RRT, staff had up to 60 people per member of staff. In the ART, they dealt with up to 40 people per member of staff.
- Caseload supervision within the RRT was infrequent and unstructured. This meant that caseloads were not reviewed regularly to ensure that people were being supported towards recovery and planned discharge.
- Pathways for care and discharge were not flexible to ensure that services worked together to meet people's changing needs, and this was minimising choice. Some of the people on existing caseloads could be discharged, but their needs could not be met in primary care. Some people, for example, needed an administration of an intramuscular injection, but many had been stable for some months and years in relation to their mental health. GPs on the Island were said to be reluctant to administer such injections, and so people were kept on the caseload due to this restriction. Managers told us that they planned to work more closely in an educative and supportive role with GP staff, in order to move people back to primary care, but with the assurance of swift access to care from mental health services as part of their discharge plan, as required.
- Care and treatment provided was only cancelled when absolutely necessary, and any need for cancellation explained to the person directly, with alternatives offered to access support. Staff sickness issues were mitigated using cross cover within the team as required.
- People using the service told us that they were in receipt of the numbers to call if they needed a response to an immediate crisis. People had access to services to meet their immediate needs, either through services provided by the trust, or from a variety of local or national support services.
- The member of staff who offers the Couple and Family Consultation (CFC) service forms part of the Acute and Recovery Team (ART), and staff can refer people to this clinician when therapy is an identified need. At the time of our visit there were 28 referrals on the waiting list which had been screened and accepted. The oldest referral on the list dated back to October 2013, which meant that the waiting time for this referral was approximately 7.5 months. Staff told us that these waiting times were "pretty typical".
- There was also another waiting list for Psychological Therapies: the 'Screening List' contained the referrals that still had to be scrutinised. At the time of our visit, the list contained 59 referrals. We were advised that waiting times for these referrals would be considerable. One person told us, "I waited nine months for therapy but now things are happening I am feeling hopeful it will be helpful". This meant that recognised evidence-based therapeutic interventions were available within the service, but people may have a lengthy wait for treatment following referral.

Meeting people's individual needs

- We spoke with managers from both teams who told us that no information leaflets had been developed in recent years, since the team was reconfigured in 2008.

Requires improvement

Community mental health team services

This meant that there was lack of a consistent approach to information about the service, as well as to people's involvement in their care, and education about their treatment.

- We asked staff about access to advocacy services for people, and they were clear as to local procedures for this. Leaflets were seen in reception areas detailing how to access advocacy services.

Learning from concerns and complaints

- Staff were aware of the trust's complaints policy.
- Complaints were received directly and forwarded to the team manager. In the first instance, a phone call or meeting would be arranged before a complaint became formal. Informal complaints were routinely logged.
- Managers told us that complaints went to, and came through, the Business and Performance Team.
- No leaflets or information were routinely provided by the teams with regard to complaints. In the waiting area at Chantry House (the base of the ART) we saw a number of leaflets, in the reception area used by people, regarding how to make a complaint. People we spoke to had not needed to make a complaint, but felt sure of how to take forward any issues they had.
- The team manager shared the learning from complaints via updates from the trust's email system. This information was included and discussed at team meetings.

Are community mental health team services well-led?

Requires improvement

Vision and strategy

- Staff had a broad understanding of the current and future needs of the organisation, but expressed their thoughts on values and attitudes much more than specific strategies. The team had been involved in the plans to develop the team into a Flexible Assertive Community Treatment (FACT) team. This involves an amalgamation of the team, with other teams such as Assertive Outreach and Early Intervention Teams, to form one larger generic team. An away day had been well attended by staff to roll out plans and strategies for undertaking this in the coming months. However, in regard to trust-level strategies for the services, staff were less clear.

Responsible governance, risk management and performance information

- Staff in the Rehabilitation and Recovery Team (RRT) and Acute and Recovery Team (ART) had regular weekly or bi weekly business meetings with their team. This covered a range of issues, including clinical, team and more trust-wide matters.
- Information and learning from incidents and complaints was discussed at team meetings.
- Systems to monitor and review the quality of care were under-developed. Caseload supervision within the RRT was infrequent and unstructured. This meant that caseloads were not reviewed regularly to ensure that people were being supported towards recovery and planned discharge. For example, structures for monitoring the caseload, supervision and documentation, were not in line with best practice or trust policy.
- Managers provided regular audit information to the governance department regarding team performance on a range of issues. These included staff training, and health and safety. Systems seen in RRT lacked accuracy, with regard to outcomes for people, or staff performance within the team.
- A trust-wide risk register was in place, and managers told us that this was an effective tool for capturing ongoing concerns but the register was not regularly updated. However, issues and risks reported, as a result of inadequate staffing levels in the community teams, had not been reviewed at board level for almost two years. This meant that key risks and actions to mitigate any impact upon effective care delivery were not prioritised.
- Staff told us they received governance training.
- Staff we spoke with were aware of internal and external whistleblowing policies, and where to find them. All the staff we spoke with told us that they would feel comfortable raising concerns with their managers.

Leadership and culture

- There was a clinical lead who covered the day-to-day running of each team. Above them, a service lead

managed and supported the team leaders. The current service lead held overall responsibility for both services, but this was performed alongside another role that involved regular visits to the mainland.
- Staff in the ART told us that they were well supported by their line manager.
- Staff in the RRT were not as well supported. Interviews for senior posts had only recently been completed so there were delays in effective management of team issues at a senior level. This was impacting upon staff's caseloads, which were up to 60 in most cases.
- Staff in the RRT told us that they were encouraged to access clinical and professional supervision outside the team, but found it difficult to have protected time to complete this due to competing demands.
- The occupational therapists and psychological therapist within the teams received regular professional supervision outside of the team.
- We saw a supportive culture within teams. Staff told us that all members of the team were valued and respected, regardless of discipline, or level of seniority. We were able to observe teams working in collaboration, and saw documentation of positive working relationships.
- Staff we met with in focus groups talked positively about their work, although many admitted capacity was an issue for them. They communicated clearly to us that staff supported each other within teams.
- We saw that staff were passionate about their work, and showed a genuine compassion for people.

Public and Staff Engagement

- People were engaged through the 'We Care. Getting it Right' questionnaires which were provided to people using the service. These were offered to people as they arrive or leave at reception, and were also available in the waiting room. Staff also gave these to people on discharge from the service.
- At Chantry House (the base of the ART) there was a service user forum, which was set up around five years ago. This ran monthly, and feedback was given to the team, and also passed to the service user link co-ordinator and the lead nurse for mental health, who facilitated other service user groups.
- Staff told us that team meetings focused on team objectives, and direction and sharing of plans for the implementation of new ways of working. This meant that staff had an arena to share concerns or team issues arising.
- Focus groups were undertaken during our inspection. Staff attending these told us that senior management communicated regularly with them. Key messages about the trust were communicated to all managers at monthly senior management meetings, and shared with the team. Staff told us that senior managers and the board provided information, and consulted with them mainly through emails.
- Managers told us that they felt detached and disconnected from the board, but did feel supported by direct managers and their colleagues.
- Staff told us that the board did provide information to them about developments, and gained their opinion through the annual staff survey.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 Health and Social Care Act 2008 (Regulated Activities) (Regulated Activities) Regulations 2010: Care and Welfare How the regulation was not being met: People who use services were not protected against risks of receiving care or treatment that is inappropriate or unsafe. - There was little evidence of physical health checks for people in community mental health services. - Care plans were not regularly reviewed to reflect people's progress in community mental health services. - People did not have timely review of their care planning approach (CPA) at least within the last 12 months in community mental health services. Regulation 9- (1) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 Health and Social Care Act 2008 (Regulated Activities) (Regulated Activities) Regulations 2010: Care and Welfare How the regulation was not being met: People who use services were not protected against risks of receiving care or treatment that is inappropriate or unsafe. - There was little evidence of physical health checks for people in community mental health services. - Care plans were not regularly reviewed to reflect people's progress in community mental health services.

This section is primarily information for the provider

Compliance actions

- People did not have timely review of their care planning approach (CPA) at least within the last 12 months in community mental health services.

Regulation 9- (1) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting workers How the regulation was not being met: The registered person did not have suitable arrangements in place to ensure that staff were appropriately supported to enable them to deliver care and treatment to service users and to an appropriate standard by receiving appropriate training, professional development and supervision. - Staff had high caseload and did not have the appropriate levels of supervision to manage these. - Staff did not have regular supervision meetings. - Staff had not attended mandatory training. Regulation 23- 1(a) 3(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
	Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting workers How the regulation was not being met: The registered person did not have suitable arrangements in place to ensure that staff were appropriately supported to enable them to deliver care and treatment to service users and to an appropriate standard by receiving appropriate training, professional development and supervision.

This section is primarily information for the provider

Compliance actions

- Staff had high caseload and did not have the appropriate levels of supervision to manage these.

- Staff did not have regular supervision meetings.

- Staff had not attended mandatory training.

Regulation 23- 1(a) 3(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the Quality of Service Provision Patients could not be assured that they are protected against the risk of in appropriate or unsafe care and treatment by means of effective operation of systems designed to enable the person to regular assess and monitor the quality of services and identify and manage risk to the health , welfare and safety of service user and others. How the regulation was not being met: - Outcomes for people were not monitored in all areas to improve the effectiveness and quality of services. - No action was taken in response to an external review of caseload management in August 2011. The review identified that community teams did not focus on people presenting with the highest clinical risk who had severe and enduring mental health issues. The recommendation was that a structure for undertaking caseload management should be developed and maintained. Caseload management guidelines outlined that individual meetings with staff should take place 4 weekly for at least an hour, discussing all cases on a three monthly cycle. Staff did not have regular supervision meetings and this meant that within the RRT the Trust's own guidelines were not being adhered to. - No action was taken in response to staff reported concerns about the locks and lack of rails in the assisted bathroom on Shackleton Ward. - The risk register in the community mental health team had not been reviewed since July 2012. Regulation 10- 1 (a) (b) 2 (c) (i) (ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the Quality of Service Provision Patients could not be assured that they are protected against the risk of in appropriate or unsafe care and treatment by means of effective operation of systems designed to enable the person to regular assess and monitor the quality of services and identify and manage risk to the health , welfare and safety of service user and others. How the regulation was not being met: - Outcomes for people were not monitored in all areas to improve the effectiveness and quality of services. - No action was taken in response to an external review of caseload management in August 2011. The review identified that community teams did not focus on people presenting with the highest clinical risk who had severe and enduring mental health issues. The recommendation was that a structure for undertaking caseload management should be developed and maintained. Caseload management guidelines outlined that individual meetings with staff should take place 4 weekly for at least an hour, discussing all cases on a three monthly cycle. Staff did not have regular supervision meetings and this meant that within the RRT the Trust's own guidelines were not being adhered to. - No action was taken in response to staff reported concerns about the locks and lack of rails in the assisted bathroom on Shackleton Ward. - The risk register in the community mental health team had not been reviewed since July 2012. Regulation 10- 1 (a) (b) 2 (c) (i) (ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010