Isle of Wight NHS Trust

Community-based mental health services for adults of working age

Quality Report

St Mary's Hospital
Parkhurst Road
Newport
Isle of Wight
PO30 5TG
Tel: 03000 616161
Website: www.iow.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1FAV		St Mary's Hospital (Mental Health Management)	PO30 5TG

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

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

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

Summary of findings

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We undertook an unannounced, focused inspection of community-based mental health services for adults of working age following concerns identified at our last inspection in May 2019. During that inspection, we found the provider was not fully meeting the required standards of care and issued a warning notice under section 29a of the Health and Social Care Act 2008. We undertook this inspection to check whether the provider had made the required improvements to the safety of the service. This inspection was a focussed inspection so therefore did not provide a change to the existing rating.

The provider had made the following improvements:

- Staff caseloads were a safe size. The overall team caseloads had significantly reduced. Waiting lists had reduced and patients' risk was reviewed regularly. The number of patients with an up to date risk assessment had increased significantly. The trust had an agreed timeframe for staff to complete risk assessments and team leaders monitored this.
- The trust had agreed two clinical care pathways and staff used identified tools to review patients' needs to ensure they were discharged to alternative services when ready. Team leaders were reviewing staff members caseloads to agree with staff when patients were ready for discharge.
- The waiting time for psychological therapies had reduced.

However:

- There was no set timeline for additional care pathways to be introduced.
- Staff morale remained low.

Summary of findings

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

Are services safe?
We were satisfied that the service had met the improvements detailed in the Section 29A warning notice served in May 2019 because:

- Staff members caseloads were of a safe size and patients on staff case loads were reviewed regularly and discharged when ready. The overall service caseload had significantly reduced.
- The waiting lists held by the community teams had reduced and staff regularly contacted patients to make sure their needs had not changed and recorded this.
- The number of patients with a risk assessment both on Care Programme Approach (CPA) and not on CPA had increased. There was an agreed time frame for staff to complete risk assessments. The completion of risk assessments was monitored and reviewed. Risk assessments could be easily located in the care record.

Are services effective?
We were satisfied that the service had met the improvement detailed in the Section 29A warning notice served in May 2019 because:

- The trust was about to introduce two care pathways. Staff were using outcome measures and the trust RAG rating system to review patients and identify if they were ready for discharge.

However:

- There was no date for future care pathways to be introduced.

Are services caring?
We did not inspect this key question at this time.

Are services responsive to people's needs?
We did not inspect this key question at this time.

Are services well-led?
We were satisfied that the service had met the improvement detailed in the Section 29A warning notice served in May 2019 because:

- Staff felt supported by the local team leaders within the service.

However:

Summary of findings

- Staff morale remained low and staff did not feel the trust understood the pressure they were under to reduce the waiting lists and caseloads. Staff told us that communication from senior leaders in the trust had not been good and the level of engagement from senior leaders was not sufficient. The trust had not sufficiently communicated the vision and the strategy to the of the service to the team which was further impacting on staff morale.

Summary of findings

Information about the service

The community mental health service offers a specialist multi-disciplinary service for individuals suffering from mental ill health. The community adult mental health service offers assessment and treatment for people aged 18 – 65, and for people over 65 years who do not require treatment for organic disorders such as dementia. There is an Early Intervention in Psychosis (EIP) team for patients experiencing a first episode of psychosis, which works with patients from 14 – 65. There is also a Single Point of Access team (SPA) that assesses patients referred to mental health services.

The service was last inspected in May 2019 when we rated the core service as inadequate overall. We rated the key questions, are services safe, are services effective, are services responsive and are services well led as inadequate. We rated the key question, are services caring as good. Following our inspection in May 2019 we issued the trust with a warning notice under section 29a of the Health and Social Care Act 2008. The reasons for the warning notice were as follows:

Patients in the community-based mental health services for adults of working age were not receiving a safe service because:

- patients were not receiving safe care and treatment due to risks not being considered and managed appropriately.
- staff did not make regular contact with patients who were awaiting allocation to assess their risk level regularly and determine if their risk level had changed.
- patients were experiencing long waiting times for all interventions and on average, two years to see a clinical psychologist.
- care and treatment was not provided to patients following an evidence-based care pathway that ensures patients receive the care and treatment needed in a timely manner including planning for their discharge back to primary health care.

We told the provider they needed to make significant improvements by 24 November 2019.

Our inspection team

The team that inspected the service comprised one CQC inspector and an inspection manager.

Why we carried out this inspection

We carried out an unannounced focused inspection to find out whether the provider had made significant improvements to the safety of the service since we issued a section 29a warning notice (requiring the provider to make improvements to the safety of the services) in May 2019.

How we carried out this inspection

As this was not a comprehensive inspection, we did not pursue all key lines of enquiry. We only focused on the issues identified in the Section 29A warning notice served following the last inspection. We concentrated on looking at the key questions, are services safe, are services effective and are services well led.

During the inspection visit, the inspection team:

- spoke with two community team leaders;
- spoke with 15 other staff members; including nurses, assistant psychologists, nursing assistants, care coordinators, peer support workers, social worker and a student nurse;
- looked at 10 care and treatment records of patients;
- reviewed the team waiting lists;

Summary of findings

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

As this was a focused inspection we focused on the issues identified in the Section 29A warning notice served following the last inspection we did not seek the views of people wo use the service.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that caseloads remain at a safe size and the overall team caseload reduces as appropriate.
- The provider should ensure that waiting time continue to reduce.
- The provider should ensure that staff continue to complete risk assessments for patients and within the agreed time.
- The provider should ensure that patients continue to be discharged in a timely manner.
- The provider should ensure that that they introduced all necessary care pathways.
- The provider should ensure staff are engaged in developing the vision and strategy for the future of the service.

Isle of Wight NHS Trust

Community-based mental health services for adults of working age

Detailed findings

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

Are services safe?

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

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

Our findings

Safe staffing

At our inspection in May 2019 we reviewed staff members caseloads and saw that they had more patients than were agreed by the trust on their caseloads. The trust standard during the May 2019 inspection was 35. However, we saw examples of caseloads that exceeded the standard. The overall caseload was approximately 1700 and patients remained on staff caseloads after they were ready for discharge. At this inspection we saw that staff caseloads had been reduced and that they were within the size agreed by the trust, 25 patients. The trust used a rating scale to review patients' needs and identify when they were ready for discharge. Staff caseloads were reviewed regularly, using the rating scale, and staff now discharged patients when they no longer needed a secondary care service. At this inspection the overall caseload was 925 and the changes the service had made would reduce this further.

During our inspection in May 2019 there was a waiting list of 180 patients across the three community mental health teams. There was also 204 patients waiting for psychological therapy and group work. At the time of this inspection there was 13 patients on the community teams waiting lists. There were 90 patients on waiting lists for psychological therapies and group work. The average waiting time for psychological therapies had reduced from two years to one year, although team members did tell us that some patients had still been waiting two years.

Assessing and managing risk to patients and staff

During our inspection in May 2019 we found that there were 1700 patient on the teams' clinical caseload and 180 patients on the waiting list. The trusts data told us that 53% of patients on Care Programme Approach (CPA) or on the waiting list to be on a CPA had a risk assessment completed. At this inspection we saw that 83% of patients on a CPA or waiting to be on a CPA had a risk assessment in place. This figure changed regularly as the number of patients on or waiting for a CPA changed. For example, in November 2019 the figure was 91%. At our inspection in May 2019 we saw that 23% of patients not on a CPA or waiting for a CPA had a risk assessment. At this inspection we saw that 91% of patients not on a CPA or waiting for a CPA had a risk assessment. We discussed the patients without a risk assessment with a team manager and business manager who explained that staff had four weeks to complete the risk assessment. The community teams were sent weekly risk assessment completion rates and reviewed risk assessment completion during their weekly team meetings. Senior manager meet weekly to discuss risk assessment completion. During our inspection in May 2019 we saw that staff could not always find risk assessments easily for non-CPA patients. At this inspection we reviewed 10 sets of patients records and saw that they all had a risk assessment in place. Staff were able to find risk assessments easily as entries or letters that included risk assessments were clearly labelled.

At our inspection in May 2019 we saw that staff did not make regular contact with patients who were awaiting allocation to assess their risk level regularly and determine if their risk level had changed and responded to appropriately. At the previous inspection we were told that patients on the psychological therapies and group work waiting lists were reviewed regularly. However, the trust could not demonstrate this was happening. At this inspection we saw that patients on the waiting list were given a risk rating and the team contacted all patients with the highest rating every week. We checked the notes of the care records of the three patients on the waiting list that needed weekly contact and saw that they had been contacted as agreed. Patients that did not need weekly contact were given advice on who to contact if they needed support. We reviewed three care records of patients awaiting psychological therapies and group work and saw that they were either open to other members of the team who had regular contact with them or staff contacted them regularly to make sure their needs had not changed.

Are services effective?

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

Our findings

Best practice in treatment and care

During our inspection in May 2019 we were told that there were draft care pathways, but they had not been ratified and none were in use. At this inspection we were told that two care pathways had been agreed, eating disorders and mood disorders, and were due to be in use from the week commencing 16 December 2019. There were other care pathways being developed but they did not have a date when they would be introduced yet. However, staff could explain how they were using outcome measures and the patient rating system to map patients progress and identify when they were ready for discharge.

Are services caring?

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

Our findings

We did not inspect this key question at this time.

Are services responsive to people's needs?

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

Our findings

We did not inspect this key question at this time.

Are services well-led?

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

Our findings

Leadership, morale and staff engagement

At the time of our inspection in May 2019 morale was low in the adult community team. At this inspection we spoke with 16 members of staff and morale remained low. Staff told us there was very little flexibility in the team which meant if someone left or was off sick they had to pick up additional work that prevented them meeting their own targets. Although caseload size had reduced, the level of acuity of patients had increased. Staff did not feel that senior managers in the trust understood the pressure they were under and had not engaged with them about how the service was being redesigned. However, they did tell us that local leaders were supportive and that they felt able to raise concerns with them.