DHSC – CQC External Quality Regulation Programme

# Mental Health Services

## Assessment Report

Reayrt Noa
Noble's Hospital
Braddan
Isle of Man
IM4 4RJ

Date of visit: 1 - 4 August 2022 to 31 January - 2 February 2023

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# Our Findings

## Overall summary

We carried out this announced assessment on 1 to 4 August 2022 and 31 January to 2 February 2023. The assessment was completed by a team of Care Quality Commission (CQC) inspectors, inspection managers and specialist advisors.

This assessment is one of a programme of assessments that the CQC is completing at the invitation of the Isle of Man Government's Department of Health and Social Care (IOMDHSC) in order to develop an ongoing approach to providing an independent regime of assessments of health and social care providers delivered or commissioned by IOMDHSC and Manx Care.

The CQC does not have statutory powers with regard to improvement action for services on the Isle of Man, and providers on the island are not subject to CQC's enforcement powers. The assessment is unrated and areas for improvement we have told the provider to take can be found in the recommendations section in this report.

The Isle of Man is a self-governing British Crown dependency in the Irish Sea between England and Ireland. The Isle of Man has a population of approximately 86,000 people, however visitors to the island increase the population, particularly during the island's Tourist Trophy (TT) motorcycle racing event. Manx Care was established in April 2021 by Tynwald, the Government of the Isle of Man as an arm's length organisation, to focus on delivery of health and social care on the island.

We looked at infection prevention and control measures under the Safe key question. We look at this in all assessments even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

**Services were divided into the following areas:**

- Drug and alcohol team
- Crisis team
- Child and adolescent mental health service
- Community mental health service for adults
- Community-based mental health services for older people and memory service
- Mental health acute and older people's ward

**People's experience of using this service and what we found:**

To get to the heart of people's experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the assessment.

You can find information about how we carry out our assessments on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-assessment

**We found areas where the service could make improvements. CQC recommends that the service:**

- **Service-wide:**
    - Takes action to ensure all areas of the environment are clean and fit for purpose and ensure calibration of healthcare equipment in line with manufacturers' guidelines.
    - Implements processes to ensure it is clear who holds responsibility for the cleaning of equipment.
    - Improves staffing levels to ensure there are sufficient numbers of staff to ensure safe care and effective management of patients.
    - Takes action to ensure the service can work to its operating model, with enough staff deployed to be able to meet the needs of patients safely and effectively.
    - Takes action to ensure staff complete all relevant aspects of the patient care record, to maintain a contemporaneous record system.
    - Implements processes to make it easier to carry out routine and regular prescribing audits.
    - Implements an effective system to ensure the oversight of all mandatory training requirements for all staff.
    - Improves safeguarding training to ensure all staff have undertaken the correct level

of safeguarding vulnerable adults and children training for their role and have routinely participated in formal safeguarding supervision.

- Takes action to improve access to out of hours at home crisis support for patients and their families and carers.
- Ensures staff routinely offer a copy of the care plan to patients and their families and carers, recording that they have done so.
- Implements a robust and regular audit programme including patient care records, medicines, and prescribing.
- Implements processes to ensure medicines and first aid supplies held on the premises remain within expiry dates.
- Considers supporting patients to develop personalised advance decisions and crisis plans.
- Takes action to ensure patients' physical health is assessed in line with best practice guidelines, particularly for those with psychosis or schizophrenia, and that records clearly identify which team or service is responsible for supporting patients with their physical healthcare.

- **Drug and Alcohol Team:**
  - Continues to work with primary care to encourage them to provide physical healthcare monitoring and support for the clients of the drug and alcohol team.
  - Considers implementing a specific care plan designed for people with addiction needs to enhance care planning and client involvement further.

- **Crisis Team:**
  - Implements a programme of regular staff team meetings.
  - Reviews the workload of leaders to ensure they have capacity to drive forward improvements across the service.

- **Child and Adolescent Mental Health Service:**
  - Takes action to monitor waiting lists effectively.
  - Implements a system to evidence how any learning following an Isle of Man Safeguarding Board Serious Case Management Review (SCMR) is actioned.
  - Ensures staff have easy access to review a patient's up to date prescribed list of medicines.
  - Ensures that staff routinely record capacity and consent to care and treatment.

- **Community Mental Health Service for Adults:**
  - Takes action to ensure the effect of medicines on patients' mental and physical health is monitored in line with best practice guidelines.
  - Takes action to ensure patients are given information about their medicines and ensure records identify that patients have been involved in decisions about their

medicines.

- Takes action to ensure the safe and effective storage of patient information, in line the General Data Protection Regulation and the Isle of Man Data Protection Act 2018.
- Takes action to ensure all patient complaints are managed within Manx Care publicised timeframes.
- Considers how best to enable families and carers to feel supported and engaged with the service.
- Considers if patient risk assessments should be updated in line with risk management plans, to better evidence the rationale for changes in risk management plans.
- Continues to strive to fill locum psychiatry posts with permanent post holders.

- **Community-Based Mental Health Services for Older People and Memory Service:**
  - Improves supervision recording and oversight.
  - Considers improving lone working staff protection/provision.
  - Provides access to patient advocacy services.
- **Mental health acute and older peoples ward**
  - Takes action to ensure staff receive restrictive intervention training.
  - Ensures clear arrangements are put in place to manage the risk posed by gender mix within bedroom areas.
  - Ensures that all restrictive intervention is recognised, minimised, and ceased as soon as it is safe to do so.
  - Ensures that staff complete and update risk assessments and care plans and that they routinely offer a copy of the care plan to patients and their families and carers, recording that they have done so.
  - Ensures a clear operating model is in place to manage the wide range of needs and high acuity that patients present and ensure that the patient mix on the wards does not limit the level of care some patients received.
  - Reviews the workload of leaders to ensure they have capacity to drive forward improvements across the service.
  - Ensures that governance and assurance processes are effective and lead to service improvement.

**We have also identified areas we have escalated to the IOMDHSC:**

- Several concerns around medicines were found, including the safe storage and appropriate use of medicines. There was a risk of staff working outside of their scope of practice, and a lack of oversight of prescriptions, including the process for storage and retrieval, meant that it was not always possible for prescribers to have full understanding of what a patient had already been prescribed, so patients could potentially receive their medicines both from the

service and their GP.

- Governance concerns identified included limited succession planning for key roles, the workload of service leaders, and demand and capacity issues which meant that waiting times for assessment and treatment in some services were too long. Home treatment was not always available, particularly at night.
- Communication between services and families and carers was not always effective, and there was inconsistency in how patients' consent to treatment was captured and recorded.
- There was a lack of an effective system for identifying, assessing, and mitigating risks such as lone working, oversight of cleaning schedules and equipment maintenance, ligature risks, and the secure storage of confidential patient records.
- The process for reporting and reviewing performance, themes and trends was not robust. There was a lack of key performance indicators for services to measure themselves against.
- The process for staff recruitment, induction and training was not robust.
- Consideration needed to be given to matters of diversity to ensure that services were accessible and welcoming to all. There were no accessibility standards or translation services available, and no promotion of specific support for people from diverse backgrounds or communities.

# Community Substance Misuse Service

## Overall summary

The Drug and Alcohol Team (DAT), based at Noble's Hospital in Braddan, is a specialist community substance misuse service providing support to people at the team's base or in the community. The Drug and Alcohol Team is a multi-disciplinary team that works within a harm minimisation framework to provide a comprehensive, evidence-based assessment, treatment and support service to people who are presenting with alcohol and/or drug dependency. The multi-disciplinary team delivers an Island-wide specialist service including dedicated provision for young people under 18 years of age. The service works in partnership with third sector organisations and criminal justice agencies.

Staff in the Drug and Alcohol Team included a psychiatrist, non-medical prescribers, mental health nurses, general nurses, therapists, drug and alcohol workers, a young person's substance misuse worker, recovery workers, support workers, social workers and administrators.

**Our key findings**

- The service provided safe care. The premises where clients were seen were safe and clean. The number of clients on the case load of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-orientated care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with guidance and best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the clients under their care. Managers ensured that these staff received training, supervision and attended team meetings.
- Staff treated clients with compassion, kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

## The assessment

**About the service**

The Drug and Alcohol Team, based at Noble's Hospital in Braddan, is a specialist community substance misuse service providing multi-disciplinary support to people with substance misuse needs. People are supported at the team's base or in the community as required with an assessment, care plan and treatment for their substance misuse needs.

**During the assessment**

We looked at the environment used by clients and staff.

We spoke with 2 clients and observed interactions between staff and 2 people who telephoned the service. We met with several carers who kindly invited us to their carers' group.

We spoke with 9 members of staff including the service manager, the deputy service manager, the psychiatrist, a nurse, recovery workers, support workers and administration staff. We also spoke with senior leaders of the service.

We observed a multidisciplinary team meeting, which also included partner agencies.

We reviewed a range of records. This included 6 clients care records and 10 medication records.

We reviewed a variety of records relating to the management of the service, including audits, policies and procedures.

## Is the service safe?

We found that this service was safe in accordance with CQC's assessment framework.

**Safe and clean environment**

**All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.**

All areas were visibly clean, well maintained, well-furnished and fit for purpose. The general environment was visibly clean and well ordered. The service had a dedicated housekeeper, and cleaning schedules and records were available. The service manager confirmed that maintenance and additional cleaning requests were actioned in a timely way.

The service controlled infection risk well. Staff used equipment and control measures to protect clients, themselves and others from infection. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Infection prevention audits were undertaken. A risk assessment was in place and appropriate systems based on guidance had been put into place to manage the risks associated with COVID-19. This included the accessibility and use of personal protective equipment (PPE), COVID-19 testing and safe distancing measures.

The clinic room was clean and had equipment for clients to have physical examinations. Equipment was clean and in working order. We found there were no records to show that the weighing scales and blood pressure machine had been suitably calibrated in line with manufacturers' guidelines. We also found that some dressings and the pads for the electrocardiogram (ECG) machine had expired. In addition, the sharps bin was found to be undated. These items were removed and replaced immediately by the service manager.

**Safe staffing**

**The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.**

The service had enough staff to keep clients safe. The clinical team totalled 22 people and

consisted of medical, nursing, therapy, social work, recovery workers, support workers and administration staff. The service had very low turnover rates and there was just one vacancy at the time of the assessment. This was for an additional community support worker. Recruitment was ongoing at the time of the assessment.

The service did not use bank or agency staff at the time we visited. Sickness levels were usually low at the team however, there had been a recent spike in sickness due to COVID-19. The team had managed this through staff working from home if they were asymptomatic and other staff covering duties. Managers supported staff who needed time off for ill health. Staff told us that managers were supportive of flexible working patterns and promoted a healthy work life balance.

Managers monitored referrals, staff caseloads and activity in the team and adjusted staffing levels to take account of increasing referrals into the service. At the time of this review, caseloads averaged 30 client's pro rata.

The service had enough medical staff and clients could get support from a psychiatrist quickly when they needed to. Psychiatrists provided regular clinics, with reserved slots for urgent consultations. In addition, the team employed non-medical prescribers.

### Mandatory training

**Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of clients and staff. At the time of the assessment, overall compliance averaged 80%.**

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept spreadsheets of information identifying when staff were due to complete or had completed their mandatory training. The organisation hoped to introduce a new electronic training notification system to improve training oversight.

### Assessing and managing risk to clients and staff

**Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans. Assessment and management of client risk**

A duty worker was available each working day to review all referrals and to provide advice to those being referred to the service. This role was ring fenced to ensure adequate response to referrals.

Staff completed risk assessments for each client on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff developed harm reduction plans with clients and ensured clients had copies of these. In all cases we reviewed we found that a risk assessment and risk management plan was in place, were thorough and addressed all known risks including physical health, mental health and safeguarding concerns.

Staff continually monitored clients on waiting lists for changes in their level of risk and responded when risk increased. The team operated a process to ensure that clients on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment.

Staff could recognise when to develop and use crisis plans according to client need. Crisis plans were in place and where a known client contacted the team during working hours in crisis, the

team responded swiftly. Plans also set out arrangements to contact the crisis team out of hours.

During the assessment, we observed a multidisciplinary team meeting. Discussion included individual client risks including safeguarding concerns, and the team recorded any actions for staff to complete.

Staff followed clear personal safety protocols, including for lone working. Staff had access to personal alarms and staff were available to respond if necessary. Interview rooms were located near to the reception area and staff could respond easily if needed. Lone working practices were in place including arrangements for logging which staff were in or out of the building.

### Safeguarding

**Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training on how to recognise and report abuse, appropriate for their role. Staff understood their responsibilities and the organisation had appointed a safeguarding lead who supported staff through training and advice.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The team demonstrated an understanding of safeguarding principles and practice and had made safeguarding referrals in the previous year. Safeguarding concerns were discussed at multidisciplinary team meetings and reported as required.

Staff kept up to date with their safeguarding training. Safeguarding training was mandatory for staff, with 91% having completed safeguarding adults and 95% safeguarding children training as appropriate to their role. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

### Staff access to essential information

**Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

The team had access to an electronic record system which was shared across Manx Care's mental health service. This system facilitated effective information sharing across the mental health services. Electronic records were stored securely, and we observed staff using good information governance protocols, such as locking their computer screens when leaving their desks. Any paper records were scanned on to the system to ensure easy access and safe storage.

Client care records were comprehensive, and all staff could access them easily. When clients transferred to a new team, there were no delays in staff accessing their records because the organisation used the same electronic service user care record system.

### Medicines management

**The service used systems and processes to safely prescribe and record medicines. Staff recorded that they regularly reviewed the effects of medicines on each client's mental and physical health.**

Staff followed systems and processes to prescribe medicines safely. Staff completed medicines records accurately and kept them up to date. Staff stored and managed all prescribing documents safely. Medicines were not stored within the clinic.

Staff followed the UK Department of Health and Social Care's drug misuse and dependence guidelines on clinical management to manage substitute prescribing and alcohol withdrawal.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. The team had access to a pharmacist to consult for advice. Manx Care had plans in place to update the electronic prescribing system in future.

The team worked with Public Health to provide clients with Naloxone as part of the national Naloxone programme. Naloxone is a medication used in an emergency to treat an overdose of narcotics. Staff had trained to support clients in the use of naloxone kits and were rolling this training out to relevant professionals including paramedics and the police. Appropriate protocols were in place for the safe management of this.

Staff had procedures and equipment to undertake random urine testing to identify if clients had used any illicit substances, where this occurred, arrangements were in place with a local pharmacy to carry out supervised consumption of client's medication.

The team had a safety alert system which is shared with and via partnership agencies, police and public health to ensure shared learning.

**Track record on safety**

The service had a good track record on safety.

**Reporting incidents and learning from when things go wrong**

**The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.**

The service had no serious incidents under investigation at the time of the assessment. However, an Isle of Man Safeguarding Board Serious Case Management Review had been published in August 2021. The report stated that "the Young Person's worker will be placed within the CAMHS service which will strengthen the dual diagnosis focus of the role". At the time our assessment, the young person's specialist worker was placed in the Drug and Alcohol team, not within the Child and Adolescent Mental Health service. Managers of neither service could not explain why the placing of this specialist role was not in line with the Isle of Man Safeguarding Board Serious Case Management Review report of August 2021.

Staff knew what incidents to report and how to report them. Managers were able to review incident information.

Staff raised concerns and reported incidents and near misses in line with Manx Care's policy.

Manx Care had a duty of candour policy. Staff understood the duty of candour. They understood to be open and transparent and gave clients and families a full explanation when things went wrong.

Managers debriefed and supported staff after incidents. Managers investigated incidents

thoroughly. Staff received feedback from investigation of incidents, both internal and external to the service.

Managers shared learning with their staff about serious incidents that happened elsewhere in Manx Care and across the wider national healthcare landscape. Staff also had access to a regular safety bulletin. Staff used team meetings to discuss the feedback and look at improvements to client care.

## Is the service effective?

We found this service was effective in accordance with CQC's assessment framework.

**Assessment of needs and planning of care**

**Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.**

Staff completed a comprehensive assessment of each client's needs and developed care plans to meet these. Care plans were personalised, holistic and were recovery orientated. These fully considered substance misuse, wider addiction, safeguarding concerns including social needs, risks, mental health care needs, physical health needs and sexual health needs. Care and treatment records showed that staff met regularly with clients for individual key working sessions and regularly reviewed and updated care plans when client's needs changed.

Staff supported clients to safely reduce and stop their alcohol and drug use through the appropriate use of withdrawal assessment tools and by following national guidance on detoxification.

**Best practice in treatment and care**

**Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.**

Staff provided a range of care and treatment suitable for their clients as recommended by national guidance. The service followed Public Health Isle of Man guidance on working with substance misuse clients and provided interventions for stabilisation, reduction, withdrawal, community detoxification and relapse prevention. This included medication and psycho-social interventions, therapies, alternative therapies such as acupuncture, activities, training and work opportunities.

GPs took the lead for physical healthcare on the island however the team described challenges clients sometimes had in accessing these services. The team therefore made sure that clients had a full physical health assessment and addressed any physical health problems with appropriate services. The team employed physical healthcare nurses to undertake full health screening and intervention. The team also undertook blood borne virus (BBV) testing and vaccinations and linked with the Hepatitis C nursing service and sexual health service. The team was also working hard to encourage primary care services to provide support to their clients and developing shared care agreements.

Staff supported clients to live healthier lives by supporting them to take part in programmes such

psychoeducation, exercise and activity and giving advice.

Staff used recognised rating scales to assess and record the severity of client conditions and care and treatment outcomes. These included the Christo Inventory for substance misuse services, Patient Health Questionnaire-9 (PHQ-9) and the Generalised Anxiety Disorder 7-item (GAD-7).

Staff took part in clinical audits and quality improvement initiatives and managers used results from audits to make improvements. Managers carried out client care record audits, to see if care plans were recovery focussed and had been developed collaboratively between clients, carers and staff.

**Skilled staff to deliver care**

**The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.**

The service had a full range of specialists to meet the needs of each client. This included medical, nursing, therapy, social work, recovery and support staff.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care.

Managers gave each new member of staff a full induction to the service before they started work. Induction covered mandatory training, familiarisation to the building and to the service. Newly appointed staff were supported to develop their skills and knowledge in the service.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff gave examples of opportunities that were available to them for career development. Manx Care was supportive of funded learning and development opportunities for staff. Several team members were undertaking additional training in therapeutic interventions and leadership.

Managers supported staff through regular, constructive appraisals of their work. Staff had regular case management supervision with managers in the service. Medical staff had access to medical appraisals.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Staff were encouraged to engage in the meetings and to provide feedback.

The corporate capability policy pre-dated the establishment of Manx Care. However, managers recognised poor performance, could identify the reasons and dealt with these. Staff were supported to improve.

**Multidisciplinary and interagency teamwork**

**Staff from different disciplines worked together as a team to benefit clients. They**

**supported each other to make sure clients had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held regular multidisciplinary meetings to discuss clients and improve their care. We a attended a multidisciplinary meeting and observed that it was well attended and provided a holistic approach to meeting client need. Staff appeared confident and empowered to engage in the meeting.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. GP letters were clear and effective.

The service followed good practice for transfers of care. Staff had effective working relationships with other teams in the organisation including the community adult, child and adolescent and crisis teams, and the inpatient unit. Protocols to support clients transfer between services were being developed by managers across the integrated mental health service.

Staff had effective working relationships with external teams and organisations, including third sector agencies, the criminal justice teams, prison and police services, housing, social care and education.

### Good practice in understanding mental capacity

**Staff supported clients to make decisions on their care for themselves but did not routinely assess and record capacity clearly for clients who might have impaired mental capacity.**

The Isle of Man did not have a legislative framework to assess and determine mental capacity. These decisions were made in line with common law. The Isle of Man government was in the process of developing this legislative framework and the Mental Capacity Bill was moving through parliament. Once enacted, the Bill would support practitioners to determine a person's mental capacity and would include safeguards with respect to care and treatment when they might be deprived of their liberty.

## Is the service caring?

We found this service was caring in accordance with CQC's assessment framework.

### Kindness, privacy, dignity, respect, compassion and support

**Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.**

Staff were discreet, respectful, and responsive when caring for clients. We observed staff gave clients time to express themselves.

Staff gave clients help, emotional support and advice when they needed it. Clients told us they were able to get help and support from staff when they needed it.

Staff supported clients to understand and manage their own care treatment or condition. Staff directed clients to other services and supported them to access those services if they needed help. This included supporting clients to engage with third sector organisations and mutual aid groups and to engage in a range of therapeutic interventions, which were also accessible online.

Staff understood and respected the individual needs of each client. Staff knew their client well and spoke knowledgably about their needs and the support being provided.

Staff followed policy to keep client information confidential.

**Involvement in care**

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

**Involvement of clients**

Staff involved clients and gave them access to their care plans. Records showed that staff had engaged clients in their care plans.

Staff made sure clients understood their care and treatment (and found ways to communicate with clients who had communication difficulties). The clients understood their care plans and what their support looked like.

Staff involved clients in decisions about the service, when appropriate. The team was working hard to engage clients, former clients, their carers and third sector partners in the development and delivery of the service. This had included supporting the development of mutual aid groups for support with alcohol, drug and gambling addictions.

Clients could give feedback on the service and their treatment and staff supported them to do this. They were encouraged to complete feedback forms and to complete a questionnaire when they were discharged from the service. Clients had given very positive feedback regarding the service. The team was developing a client engagement initiative at the time of the assessment.

The clients care records we reviewed were recovery focused and addressed all client's wider needs. However, staff told us that the template used for care planning was designed for mental health services and that a specific care plan designed for people with addiction needs would enhance care planning and client involvement further.

**Involvement of families and carers**

Staff supported, informed and involved families or carers where appropriate and with client consent.

There was no legal entitlement to a carer's assessment on the Isle of Man. Families and carers told us they found it difficult getting support from health and social care services.

The Drug and Alcohol service had links with an organisation wide carers' group and staff put carers in touch with the group.

## Is the service responsive?

We found this service was responsive in accordance with CQC's assessment framework.

**Access and waiting times**

**The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not**

**meet.**

The service had clear criteria to describe which clients they would offer services to and offered clients a place on waiting lists. The service accepted self-referrals and referrals from GPs and other health and third sector services. Clients and their carers confirmed thar the service was responsive when they made contact and that they did not have to wait too long for treatment.

At the time of the assessment the team was working with 390 people. Demand for the service was increasing significantly, the services caseload had increased from 338 in August 2021.

Despite increasing referrals, the service met Manx Care's target times for seeing clients from referral to assessment and assessment to treatment. Staff saw clients who were urgently referred quickly and those with non-urgent needs within the service's target time. The average waiting time for people to receive a comprehensive assessment was 4 weeks from referral. Waiting times for initial assessments for specific psychological therapies such as dialectical behaviour therapy was longer, however these had reduced significantly in line with additional staff having trained to deliver these interventions.

The service used systems to prioritise clients according to their risk and to help them monitor clients while they were on the waiting list. Managers reviewed this regularly and adjusted priorities if client's needs changed. Waiting lists were not too high, with 29 people waiting at the time of our review. The longest wait for treatment at the time was 50 days however clients were generally seen much sooner.

Staff tried to engage with people who found it difficult or were reluctant to seek support from drug and alcohol services. We saw the team worked with other professionals and services who knew the person well if that would help to promote their engagement. Staff also helped clients to access mental health care and support services as appropriate and when they transferred between services or needed physical health care. Staff saw clients who were urgently referred quickly. Staff risk assessed each referred client to determine the urgency of support required. Consultant psychiatrists held regular clinics, with spaces allocated to see clients who had been referred as needing urgent support. The duty worker was able to target interventions based on clients' need.

Where a client needed urgent inpatient detoxification, the team worked with specialist services in England and Wales and if required could access a bed at the acute inpatient ward at Noble's Hospital.

Records showed when clients did not attend a planned appointment the staff tried to contact people to find out why. We observed the duty worker contact individuals who had not attended appointments that day.

Clients had some flexibility and choice in the appointment times available. We observed staff changing appointments in response to client requests. Staff would also work outside core hours to meet client's needs.

Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible.

**The facilities promote comfort, dignity and privacy**

**The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.**

The service had a full range of rooms and equipment to support treatment and care. These included group spaces and individual interview rooms.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

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

**The service met the needs of all clients, including those with a protected characteristic or with communication support needs.**

The service could support and make adjustments for disabled people, people with communication needs or people with other specific needs. The building was accessible for people with restricted mobility. Corridors and doorways were wide enough to accommodate wheelchairs and there were accessible toilets for staff and clients to use. The building was easily accessible for people using public transport.

Staff made sure clients could access information on treatment, local services, their rights and how to complain. The information was readily available in the client areas and on the Manx Care website.

The service had information leaflets available in English and in Manx.

Managers made sure staff and clients could get hold of interpreters or signers when needed. Clients could access an interpreter in British Sign Language and in other languages if they need to.

### Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

We found that clients, relatives and carers knew how to complain or raise concerns. Clients told us they had a good response from staff when they raised issues.

Manx Care had recently concluded a pilot service called MCALS (Manx Care Advice and Liaison Service). The service took calls and emails from clients, families, carers and members of the public who wanted a response to an enquiry. Manx Care concluded that MCALS would be a permanent service. For the first time this gave members of the public a direct helpline spanning both health and social care services. MCALS also supported people to raise a formal complaint about services if they wished to.

Staff understood the policy on complaints and knew how to handle them. There had been no formal complaints for this service since April 2022. The manager confirmed that were any concerns were raised by clients or their carers they would proactively meet with the person to ensure an effective solution and learning.

Managers of Manx Care investigated complaints made across the services and identified themes. The care, quality and safety team tracked all registered complaints and discussed these with managers in the relevant service.

The service used compliments to learn, celebrate success and improve the quality of care. We saw several compliments that clients had submitted in relation to the support staff had provided for them.

## Is the service well-led?

We found this service was well-led in accordance with CQC's assessment framework.

### Leadership

**Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.**

We found a clear and effective management structure in place. Leaders worked well together and demonstrated high levels of experience, capability and resourcefulness to deliver safe and effective care to clients. Leaders had a thorough understanding of the services they managed. They could clearly explain how the team was working together to provide high quality care. Staff were aware of who the senior leaders were and told us they felt confident in speaking to them if they had concerns.

### Vision and strategy

**Staff knew and understood the service's vision and values and how they applied to the work of their team.**

Staff knew and understood the vision and values of the team and wider organisation and their role in achieving them. Staff were clear regarding their manager's and their own roles and responsibilities. Clear job plans, objectives and expectations were in place for the team in line with the organisation and services values and strategy.

### Culture

**Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.**

Morale was good at the service. Staff said that they felt part of a cohesive team and that they were engaged in the development of the service. Staff were positive about the leadership team, confirming leaders were approachable and supportive of their work. Staff stated a high level of satisfaction with their work and the functioning of the team.

We observed an open culture and staff told us they would feel confident raising concerns without fear of victimisation or recriminations. A whistleblowing process was in place that allowed staff to go outside of their line management should they need to raise any concerns. Staff knew about the whistleblowing processes and stated they would feel confident to use these should they need to. There had been no formal reported cases of whistleblowing or bullying at the team in the previous year. Where required, staff performance issues had been managed appropriately.

Staff had access to regular professional development, clinical supervision and management supervision appropriate to their role. All staff had undertaken an appraisal in the previous year.

Staff attended team meetings and weekly multidisciplinary meetings. Staff told us that service developments were discussed at these meetings, and they were offered the opportunity to give feedback on the service and input into service development. Staff told us that the managers also

led on team building and wellbeing activities within the team meetings.

Staff gave examples of opportunities that were available to them for career development. Manx Care was supportive of funded learning and development opportunities for staff. Several team members were undertaking additional training in therapeutic interventions and leadership.

### Governance

**Our findings from the other key questions demonstrated that governance processes operated effectively at service level and that performance and risk were managed well.**

The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. The team held governance meeting which all staff attended and took an active role in. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. In addition, multidisciplinary meetings considered areas of governance and practice. Minutes for these meetings showed the service had effective governance and administration procedures in place.

Our findings from the other key questions demonstrated that governance processes operated effectively, and that performance and risk were managed well. Managers had effective oversight of systems and processes to ensure that the service was safe.

Effective systems and processes were in place to capture governance and performance information. Local processes had been developed, including complaints procedures, training and supervision logs and local procedures for managing referrals, waiting lists, risk and safeguarding. The management team had access to detailed information about performance against targets and outcomes. The service manager had good oversight of performance and of mandatory training, staff supervision and appraisals. The provider had up to date policies and procedures to support staff to carry out their duties.

Staff completed regular clinical and non-clinical audits. The service manager had oversight of the audits and action plans and used the findings of these to drive improvement.

The service had an up to date risk register which senior staff reviewed regularly. Staff were able to escalate concerns to the manager who could then include them on the risk register if necessary. Potential risks that we found had been captured within the risk register.

### Information management

**Staff collected analysed data about outcomes and performance.**

Managers in the service regularly reviewed data which was relevant to the safe and effective running of the service. This data was monitored by senior leaders and presented to the Board of Manx Care.

### Learning, continuous improvement and innovation

**Staff were committed to learning and improving how they delivered the service. They had identified areas for improvement and initiatives were underway, such as:**

The service was Drugs and Alcohol National Occupational Standards (DANOS) accredited. This sets out a framework for substance misuse workforce development.

The team had established very positive working relationships with third sector organisations and the strategic partnership, which had enhanced the opportunities and support available to their clients. This included attendance at the multidisciplinary team meetings to ensure holistic and coordinated support to clients.

The team was working hard to engage clients, former clients, their carers and third sector partners in the development and delivery of the service. This had included supporting the development of mutual aid groups for support with alcohol, drug and gambling addictions. The team was also developing a client engagement initiative at the time of the assessment.

The team worked with Public Health to provide clients with Naloxone as part of the national Naloxone programme. Naloxone is a medication used in an emergency to treat an overdose of narcotics. Staff had trained to support clients in the use of naloxone kits and were rolling this training out to relevant professionals including paramedics and the police. Appropriate protocols were in place for the safe management of this.

At the time of the assessment the team was trialling a shared care pilot scheme for 2 medications (Acamprosate and Disulfiram) to allow for ongoing transfer of a small number of clients who do not require specialist services.

# Crisis Services

## Overall summary

We carried out this announced assessment on 3 August 2022. The assessment of the mental health services was completed by 2 Care Quality Commission (CQC) assessment managers, 2 inspectors and 2 specialist advisors.

We looked at infection prevention and control measures under the Safe key question. We look at this in all assessments even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively**.**

**Service and service type**

The crisis response and home treatment team (CRHTT), based at Noble's Hospital in Douglas, provides an island wide crisis response service for people who are experiencing significant deterioration in their mental health and require an urgent response to facilitate a resolution of their crisis. The CRHTT operates 7 days a week for 24 hours a day and provides multi-disciplinary assessments and, if appropriate, offers home treatment as an alternative to hospital admission. Interventions are intensive and short term and are designed to return the individual to a state of positive mental health.

**Our key findings**

- All premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service did not always have enough staff to keep patients safe from avoidable harm and the service was reliant on bank and agency staff. Staff could not always provide a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Managers supported staff with training, appraisals, supervision and opportunities to update and further develop their skills, however, staff had limited capacity to fully participate in this. The service was easy to access, and staff planned and managed discharge well. However, the team had limited capacity which impacted on the level of treatment the team could offer.
- A shift coordinator was available each working day to review all referrals and staff continually monitored patients for changes in their level of risk and responded when risk increased. While known risks were recorded in patients' clinical notes staff did not always complete or update a risk assessment tool or risk management plan. Staff kept records of patients' care and treatment however records were not always up-to-date and or easily available to all staff providing care. Staff completed assessments with patients on accessing the service however, they did not always work with patients to develop individual care plans or update them as needed. Care plans, where present, reflected most assessed needs but were not always personalised, holistic and recovery oriented.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had kept up to date with training on how to recognise and report abuse. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff

apologised and gave patients honest information and suitable support.

- The teams included or had access to the range of specialists required to meet the needs of patients under their care and staff from different disciplines worked together as a team to benefit patients. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness and supported patients to understand and manage their care and treatment. Staff involved patients in decisions about their care, but staff did not always make sure that patients received copies of their care plans and risk assessments.
- Leaders had the skills, knowledge, and experience to perform their roles and were visible in the service however there was a recognised need to dedicated leadership at the team. Staff felt respected and supported however the demands on the service impacted on their ability to access professional development.
- Our findings from the other key questions demonstrated that governance processes required further development to ensure that the service operated effectively, and that performance and risk were managed safely.

## The assessment

**About the service**

The crisis response and home treatment team (CRHTT), based at Noble's Hospital in Douglas, provides an island-wide crisis response service for people who are experiencing significant deterioration in their mental health and require an urgent response to facilitate a resolution of their crisis. The CRHTT operates 7 days a week for 24 hours a day and provides multi-disciplinary assessments and, if appropriate, offers home treatment as an alternative to hospital admission.

**During the assessment**

We looked at the environment used by patients and staff.

We spoke with 2 patients who had used the service.

We spoke with 4 members of staff including the service manager, a nurse, a social worker and administration staff. We also spoke with senior leaders of the service.

We reviewed a range of records. This included 7 patients' care records and 7 medication records.

We reviewed a variety of records relating to the management of the service, including audits, policies, and procedures.

## Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

**Safe and clean environment**

**All premises where patients received care were safe, clean, well equipped, well furnished,**

**well maintained and fit for purpose.**

All areas were visibly clean, well maintained and fit for purpose. The general environment was visibly clean and well ordered. The service manager confirmed that maintenance and additional cleaning requests were actioned in a timely way.

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Appropriate systems based on guidance had been put into place to manage the risks associated with COVID-19. This included the accessibility and use of personal protective equipment (PPE), COVID-19 testing and safe distancing measures.

There was no clinic room or private area for patients to receive a physical examination and the team did not have direct access to medical equipment. The team was co-located with the acute service so could access the ward based facilities where required. However, the team did have access to a medicine's cabinet used to store individual patients' medication.

### Safe staffing

**The service did not always have enough staff to keep patients safe from avoidable harm. The number of patients on the caseload of the team was too high to ensure that staff could give each patient the time or treatment that they needed. Staff did receive basic training but staffing levels did impact on completion and induction and additional training.**

The service did not always have enough staff to keep patients safe or ensure that staff could give each patient the time or treatment that they needed. The clinical team totalled 19 people and consisted of medical, nursing, social work, support workers and administration staff. During the day shift there were usually 3 members of staff however there was not enough staff to ensure there was more than one staff member available during all night shifts. This meant the team was not always able to offer home treatment and support where required at night.

The service used bank or agency staff at the time we visited. Most bank staff had previously been permanent staff at the service, so knew the team and its procedures well. The team offered induction training to new and non-permanent staff however, staff told us that this was not always effective, and they had limited time to complete the training.

Sickness levels were reported as low within the team, however there had been a recent rise in sickness due to Covid. The team had managed this by working additional hours. Managers supported staff who needed time off for ill health. Staff told us that managers were supportive of flexible working patterns.

The service had enough medical staff and patients could get support from a psychiatrist quickly when they needed to. The team employed 1 consultant, 1 staff grade doctor and could get additional support from the medical staff within the acute service. Psychiatrists provided regular clinics, with reserved slots for urgent consultations.

### Mandatory training

**Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept spreadsheets of information identifying when staff were due to**

**complete or had completed their mandatory training. The organisation hoped to introduce an electronic training notification system for staff.**

The mandatory training programme was comprehensive. Staff told us that they had limited time to keep up to date with their mandatory training. At the time of the assessment overall compliance averaged 64% across the crisis and acute service.

### Assessing and managing risk to patients and staff

**A shift coordinator was available each working day to review all referrals and to provide advice to those being referred to the service. Staff continually monitored patients for changes in their level of risk and responded when risk increased.**

We found that known risks were recorded in patients' clinical notes, however staff did not always complete a risk assessment tool or risk management plan for each patient on admission to the service, and where available these were not always reviewed regularly, including after any incident.

Staff could recognise when to develop and use crisis plans according to patient need. Crisis plans were in place and where a known patient contacted the team in crisis, the team responded swiftly.

Staff followed clear personal safety protocols, including for lone working. Lone working practices were in place including arrangements for logging which staff were in or out of the building and the location of staff within the community.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had kept up to date with training on how to recognise and report abuse.**

Staff understood their responsibilities to protect patients from abuse and the organisation had appointed a safeguarding lead. The team also had a safeguarding lead who supported staff through training and advice. Training on how to recognise and report abuse was available to staff as appropriate for their role but not all staff had kept up to date with the training. Across crisis and acute services 57% of staff were up to date with adult safeguarding training however 87% of staff were up to date with children's safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The team demonstrated an understanding of safeguarding principles and practice and had made safeguarding referrals in the previous year. Safeguarding concerns were discussed at multidisciplinary team meetings.

### Staff access to essential information

**Staff kept records of patients' care and treatment however records were not always up-to-date and or easily available to all staff providing care.**

The team had access to an electronic record system which was shared across Manx Care however we found that staff also used a range of paper records. Paper records had not always been scanned on to the system to ensure easy access and safe storage. We also found that staff had recorded information in different areas of the electronic system meaning it was not always

easy to locate important information.

Electronic records were stored securely, and we observed staff using good information governance protocols, such as locking their computer screens when leaving their desks.

**Medicines management**

**The service used systems and processes to safely prescribe medicines. Staff recorded that they regularly reviewed the effects of medicines on each patient's mental and physical health.**

There was no clinic room at the team base, however the team was co-located with the acute service so could access the ward-based facilities where required. The team had access to a medicine's cabinet used to store individual patients' medication. We found that there was an individual patients' medication within the cabinet that had been due for issue 6 months previously.

The staff team told us that there was minimal involvement from pharmacy services to the team and it was unclear if any prescribing audits had been undertaken.

**Reporting incidents and learning from when things go wrong**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

The service had 2 serious incidents under investigation at the time of the assessment. The crisis service had not been subject to any specific Isle of Man Safeguarding Adult Board Serious Case Management Review recommendations. Following a recent Safeguarding Adult Board Serious Case Management Review that made recommendations across agencies Manx Care had shared information with staff about how to recognise and respond to self-neglect.

Staff knew what incidents to report and how to report them through DATIX system. Managers debriefed and supported staff after incidents. Managers investigated incidents thoroughly. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff raised concerns and reported incidents and near misses in line with Manx Care's policy.

Manx Care had a duty of candour policy. Staff understood the duty of candour. They understood to be open and transparent and gave patients and families a full explanation when things went wrong.

Managers shared learning with their staff about serious incidents that happened elsewhere in Manx Care and across the wider national healthcare landscape. Staff also had access to a regular safety bulletin. Staff used team meetings to discuss the feedback and look at improvements to patient care.

## Is the service effective?

We found this service was not always effective in accordance with CQC's assessment framework.

**Assessment of needs and planning of care**

**Staff completed assessments with patients on accessing the service however they did not always work with patients to develop individual care plans or update them as needed. Care plans where present reflected most assessed needs but were not always personalised, holistic and recovery oriented.**

Staff completed an assessment of each patient's needs however they did not always work with patients to develop individual care plans or update them as needed. Care plans did not fully consider all patient needs particularly physical health and wider social needs.

Care records did show that staff met regularly with patients and responded when patient's risks or needs changed.

### Best practice in treatment and care

**Staff could not always provide a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Staff did not ensure that patients had good access to physical healthcare or support patients to live healthier lives.**

Staff provided a range of care and treatment for their patients as recommended by guidance. Due to staffing they were not always able to provide home treatment as required by patients. In addition, we found limited evidence that staff had considered best practice guidance to assist their decision making about best available treatments.

GPs took the lead for physical healthcare on the island. The team described challenges patients had in accessing these services. We found the team did not ensure that patients had a full physical health assessment at referral or undertake ongoing physical health monitoring.

### Skilled staff to deliver care

**The teams included or had access to the range of specialists required to meet the needs of patients under their care. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills however staff had limited capacity to fully participate in this.**

The service had a range of specialists to meet the needs of each patient. This included medical, nursing and social work professionals.

Staff told us they had case management supervision with managers in the service. Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Team meetings took place, but staff described these as ad hoc.

The corporate capability policy pre-dated the establishment of Manx Care. Managers recognised poor performance, could identify the reasons and dealt with these. Staff were supported to improve.

### Multidisciplinary and interagency teamwork

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff had effective working relationships with other teams in the organisation including the emergency department, community adult, older people, drug and alcohol teams, and the inpatient unit. Protocols to support patients transfer between services were being developed by managers across the integrated mental health service.

Staff described effective working relationships with external teams and organisations, including third sector agencies, the criminal justice teams, prison and police services, housing, social care and education.

### Adherence to the Mental Health Act and the Mental Health Act Code of Practice

**Staff understood their roles and responsibilities under the Mental Health Act 1998 and the Mental Health Act Code of Practice.**

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. The social worker in the team was an Approved Social Worker and supported colleagues with advice on the Mental Health Act.

Access to a free independent mental health advocacy service was not available on the Isle of Man. Manx Care's Mental Health Act Legislation Committee hoped to develop and introduce an independent advocacy service. Patients could instruct independent legal advice to support them with mental health matters such as Mental Health Review Tribunals and apply for legal aid to help with the costs.

We were not able to review if staff applied the Mental Health Act correctly as there was no specific formal audit of the Mental Health Act undertaken for the Crisis Team.

### Good practice in understanding mental capacity

**Staff supported patients to make decisions on their care for themselves but did not routinely assess and record capacity clearly for patients who might have impaired mental capacity.**

The Isle of Man did not have a legislative framework to assess and determine mental capacity. These decisions were made in line with common law. The Isle of Man government was in the process of developing this legislative framework and the Mental Capacity Bill was moving through parliament. Once enacted, the Bill would support practitioners to determine a person's mental capacity and would include safeguards with respect to care and treatment when they might be deprived of their liberty. Manx Care introduced a capacity, best interest decisions and deprivation of liberty policy in June 2022. The policy included a formal assessment tool for staff to use.

## Is the service caring?

We found this service was caring in accordance with CQC's assessment framework.

### Kindness, privacy, dignity, respect, compassion and support

**Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care and treatment.**

Staff were discreet, respectful, and responsive when caring for patients. Patients told us that staff gave them time to express themselves.

Staff understood and respected the individual needs of each patient. Staff gave patients help, emotional support and advice when they needed it. Patients told us they were able to get help and support from staff when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Staff directed patients to other services and supported them to access those services if they needed help. This included supporting patients to engage with third sector organisations and in a range of therapeutic interventions, which were also accessible online.

Staff understood and respected the individual needs of each patient.

Staff followed policy to keep patient information confidential.

### Involvement in care

Staff involved patients in decisions about their care, but staff did not always make sure that patients received copies of their care plans and risk assessments. They ensured that patients had easy access to additional support.

### Involvement of patients

Staff involved patients in decisions about their care and made sure that they understood their care needs and treatment plans. However, we were unable to identify if staff gave them access to their care plans. The patients we spoke with understood what their support looked like, but patient care records did not always show that staff had engaged patients in developing their care plans or that they had been given a copy.

Staff involved patients in decisions about the service, when appropriate. The team was working hard to engage patients, former patients, their carers and third sector partners in the development and delivery of the service. Patients could give feedback on the service and their treatment and staff supported them to do this. They were encouraged to complete feedback forms and to complete a questionnaire when they were discharged from the service.

## Is the service responsive?

We found this service was responsive in accordance with CQC's assessment framework.

### Access and waiting times

**The service was easy to access, and staff planned and managed discharge well however the team had limited capacity, which impacted on the level of treatment they could offer.**

The service provided a single point of access to individuals experiencing significant deterioration in their mental health or an increase in their psychological distress which required an urgent response. Interventions were intensive and short term and designed to return the individual to a state of positive mental health. Referrals were accepted from a variety of sources including other health care providers, primary care and self-referrals.

The service operated 7 days a week for 24 hours a day and was designed to provide multi-

disciplinary assessments and, if appropriate, offer home treatment as an alternative to hospital admission. In addition, the service acted a psychiatric liaison service and worked with the police to undertake Mental Health Act assessment and street triage.

Leaders told us that the service has seen an increase in demand which has impacted on the ability to offer home treatment. Staff told us that the service is very stretched which has led to a reactive and unclear operating model. The senior team recognised an inconsistent application of eligibility for the service and that capacity is very limited.

The team operated its own risk rating process to respond to patients following referral. Patients assessed as red, the highest risk, would be seen within one day. Those whose risk were rated as amber would be seen within 72 hours. Those rated green would be seen within one week however the team would monitor for changes to the risk the patient presented.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from the service. We saw the team worked with other professionals and services who knew the person well if that would help to promote their engagement. Staff also helped patients to access other mental healthcare and support services when appropriate and when they transferred between services. When patients were referred for urgent support, staff saw them quickly. Staff risk assessed each referred patient to determine the urgency of support required. Psychiatrists held regular clinics, with spaces allocated to see patients who had been referred as needing urgent support. The shift coordinator was able to target interventions based on patients' need.

Records showed when patients did not attend a planned appointment the staff tried to contact people to find out why. We observed the shift coordinator contact individuals who had not attended appointments that day.

**The facilities promote comfort, dignity and privacy**

**The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.**

The service had a full range of rooms to support treatment and care. These included individual interview rooms had sound proofing to protect privacy and confidentiality. The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity

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

**The service met the needs of all patients, including those with a protected characteristic or with communication support needs.**

The service could make adjustments for disabled people, people with communication needs or people with other specific needs. The building was accessible for people with restricted mobility. Corridors and doorways were wide enough to accommodate wheelchairs and there were accessible toilets for staff and patients to use. The building was easily accessible for people using public transport.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information was readily available in the patient areas and on the Manx Care website.

The service had information leaflets available in English and in Manx.

### Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

We found that patients, relatives and carers knew how to complain or raise concerns. Patients told us they had a good response from staff when they raised issues.

Manx Care had recently concluded a pilot service called MCALS – Manx Care Advice and Liaison Service. The service took calls and emails from patients, families, carers and members of the public who wanted a response to an enquiry. Manx Care concluded that MCALS would be a permanent service. For the first time this gave members of the public a direct helpline spanning both health and social care services. MCALS also supported people to raise a formal complaint about services if they wished to.

Staff understood the policy on complaints and knew how to handle them. Staff had also received a bulletin including a reminder on how to recognise and manage complaints in July 2022. There had been 4 formal complaints for this service since February 2022. Each had been fully investigated and 3 of these had been upheld. Learning had been shared with the team.

Managers of Manx Care investigated complaints made across the services and identified themes. The care, quality and safety team tracked all registered complaints and discussed these with managers in the relevant service.

## Is the service well-led?

We found this service was not always well-led in accordance with CQC's assessment framework.

### Leadership

**Leaders had the skills, knowledge and experience to perform their roles and were visible in the service. However, there was a recognised need to provide dedicated leadership in the team.**

We found that while there was not a clear management structure in place and there was limited managerial capacity managers worked hard to provide support and supervision to the service. Overall management was undertaken by an operational manager who also oversaw the acute wards and the community mental health team. The lead nurse also worked across the acute services. The Manx Care senior mental health leadership team recognised this issue and was considering how the service could be managed in the future. Staff were aware of who the leaders were and told us they felt confident in speaking to them if they had concerns however recognised the need for dedicated leadership of the service.

### Vision and strategy

**Staff knew and understood the service's vision and values and how they applied to the work of their team.**

Staff knew and understood the vision and values of the team and their role in achieving them. They felt that there needed to be a clearer strategy for the service and its role in wider mental health services. Staff were clear regarding their manager’s and their own roles and responsibilities

but considered that there needed to be a clearer operating model setting out what the service could and could not do, and their individual role in achieving this.

### Culture

**Staff felt respected and supported however the demands on the service impacted on their ability to access professional development. They felt able to raise concerns without fear of retribution but did not feel able to influence the development of the service.**

Morale was described as good at the service, staff said that they felt part of a cohesive team and that the team worked well together. Staff confirmed leaders were approachable and supportive of their work but recognised that they had minimal capacity to lead on the development of the service.

All the staff told us they were extremely busy with their workload but were committed and passionate about delivering the best care they could.

Staff told us there was no bullying in the service. They demonstrated that they were respectful of each other and worked well together as a multidisciplinary team to meet patients' needs. Staff told us they would feel confident raising concerns without fear of victimisation or recriminations. A whistleblowing process was in place that allowed staff to go outside of their line management should they need to raise any concerns. Staff knew about the whistleblowing processes and stated they would feel confident to use these should they need to. There had been no formal reported cases of whistleblowing or bullying at the team in the previous year. Where required, staff performance issues had been managed appropriately.

Staff had access to professional development, clinical supervision and management supervision appropriate to their role however, their ability to access this was hampered by demand on the service. Manx Care was supportive of funded learning and development opportunities for staff. Staff gave examples of opportunities that were available to them for career development, and some had undertaken additional training in therapeutic interventions.

Staff attended weekly multidisciplinary meetings however team meetings were described as ad hoc and focused on operational issues rather than service developments.

### Governance

**Our findings from the other key questions demonstrated that governance processes required further development to ensure that the service operated effectively, and that performance and risk were managed safely.**

The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning however this required further development. The acute service held governance meetings which included oversight of the crisis team and staff stated they had limited capacity to engage in this.

Systems and processes were in place to capture governance and performance information and local processes had been developed, including complaints procedures, training and supervision logs and local procedures for managing referrals, risk and safeguarding. The management team had access to information about performance against targets and outcomes. The service manager had good oversight of performance, staff supervision and appraisals. The provider had up to date

policies and procedures to support staff to carry out their duties. However, our findings from the other key questions demonstrated that governance processes did not always operate effectively, and that performance and risk were not always managed well.

**Information management**

**Staff collected analysed data about outcomes and performance.**

Managers in the service reviewed data which was relevant to the safe and effective running of the service. This data was monitored by senior leaders and presented to the Board of Manx Care.

**Learning, continuous improvement and innovation**

Due to limited capacity within the team, there was little opportunity for leaders and staff to engage in improvement and innovation activities.

# Child and Adolescent Mental Health Service

## Overall summary

The child and adolescent mental health service are a multi-disciplinary service providing specialist community based mental health support for children and young people. Patients and their families and carers are supported in their own homes with an assessment, care plan and treatment for their mental health needs. The service provides a range of help and support for children and young people, such as cognitive and dialectical behaviour therapies and family therapy.

Staff in the child and adolescent mental health service included mental health and neurodevelopmental nurses, support workers, social workers, psychiatrists, therapists, and administrators. Managers told us a part time dietitian and pharmacist had also been recruited since we carried out our assessment of the service.

**Our key findings**

- The service did not always provide safe care. Clinical premises where patients were seen were not always safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists but could not ensure that patients who required urgent care were seen promptly. Staff were not always able to assess risk in a timely way and few staff participated in safeguarding supervision.
- Staff developed care plans informed by a comprehensive assessment, but they were not always holistic or recovery-oriented and did not demonstrate that they had been developed in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people but did not always effectively record it.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. However, the environment meant they could not always ensure the privacy and dignity of patients. Staff actively involved patients and families and carers in care decisions but did not routinely give them a copy of the care plan.
- The service was not easy to access. Staff could not always assess and treat patients who required urgent care promptly and those who did not require urgent care had to wait too long to start treatment. However, the criteria for referral to the service did not exclude children and young people who would have benefitted from care.
- The service had not been well led but was improving with a new manager. The governance processes ensured that procedures relating to the work of the service were beginning to run more smoothly.

## The assessment

**About the service**

The Child and Adolescent Mental Health Service (CAMHS) provides a mental health assessment and treatment service for children and young people from birth to 18 years of age, along with support for their families and carers. The service operates between the hours of 9am and 5pm, Monday to Friday.

**During the assessment**

We observed interactions between staff and patients who attended in person or by telephone. We reviewed 6 patient care records and 10 medication records, including prescriptions.

We spoke with 14 members of staff including the manager of the service. We also spoke with the senior leadership team responsible for the service. We reviewed written feedback from one member of staff.

We reviewed a range of records relating to the running of the service. This included a variety of records relating to the management of the service, including reports, policies and protocols.

We asked the service to provide us with contact details so we could speak with patients and their families or carers about their experience of using the service. We spoke with parents of 2 patients who were using or had recently used the service.

## Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

**Safe and clean environment**

**Not all clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.**

Consultation rooms did not have alarms and they layout of the building meant staff might not be able to respond quickly in an emergency. We were not made aware of any instances when staff had needed help in an emergency and not received it.

There was no clinic room or private area for patients to receive a physical examination. Equipment to measure height and weight was located on a corridor, off an open staff kitchen area. We found vacutainer blood collection tubes that had expiry dates of January and February 2022. We raised this with staff who disposed of them immediately.

Not all areas were clean, well maintained, well-furnished or fit for purpose. The building was old and in a poor state of repair. Patient toilet facilities were located out of sight from the reception window and contained items which patients could use to harm themselves. However, there had been no reports of patients doing this. One patient toilet had a baby changing mat but there was nowhere to place it other than the toilet floor. Not all portable electrical appliances showed an up-to-date safety check.

Furnishings were worn and some consultation rooms were not well cleaned. Many consultation

rooms were re-purposed and to a poor standard. One consultation room had previously been a play therapy room so contained a sink and many toys. The sink was dirty and there was no cleaning schedule to ensure the toys were cleaned between use.

Staff told us there were numerous aspects of the workplace built environment which were problematic, including pest control issues, this meant it was not always a nice place to work. The Team/Service are relocating to new purpose built accommodation in early 2023. The building was made of a series of temporary structures, bonded together, which meant there were lots of corridors and corners preventing staff from having clear visibility. The service had a timetable to move into more suitable premises elsewhere on the hospital site.

Cleaning of the building was carried out by a third party. Some areas of the building were clean but others, including areas where patients and families attended for consultations, were dirty and showed evidence of poor cleaning standards.

We observed staff following infection prevention and control guidelines, such as hand washing. Hand gel dispensers were available in the reception area and there were various locations in the building where staff and visitors could wash their hands. Staff managed their own clinical equipment, such as sphygmomanometers to measure blood pressure, and there were no cleaning records to show these were cleaned in between use.

Staff did not make sure equipment was well maintained, clean and in working order. There were no records to show clinical equipment had been cleaned between use or calibrated in line with manufacturer' guidelines. Some fire extinguishers and portable appliances showed they were overdue for testing.

### Safe staffing

**The service did not have enough staff, who knew the patients to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was too high to prevent staff from giving each patient the time they needed. Staff did receive basic training.**

### Mental Health Practitioners

The service did not have enough mental health practitioners and support staff to keep patients safe. The number and grade of staff required to meet the needs of the service was being reviewed to enable the service to meet the significant increase in demand. The service manager had developed a business case to increase staff numbers and roles, but this was waiting to be reviewed and approved by the Isle of Man government.

The business case was to request an additional 6 band 7 mental health practitioners, 2 band 4 outreach workers and additional administrators.

Staffing the needs of the service had been an issue for some considerable time, due to a significant increase in referrals, during and since the COVID-19 pandemic. Referrals had increased by 42% since March 2020.

The staffing plan was complicated, with funding from higher grade vacant posts being used to fund lower grade posts, posts being filled using a mixture of redeployed staff, a preceptorship nurse and temporary funding arrangements. This meant there was little long-term security in the staffing arrangements, which managers hoped would improve if the business case was approved.

Some vacancies had recently been filled but staff told us there were not enough therapists to ensure all those who needed family therapy could receive it in a timely way, with patients waiting several weeks for urgent and up to 8 months for routine therapy.

The service had low rates of bank and agency mental health professionals, with 1.2 bank and 2 agency staff working in the team, all of which had been working in the service for some time and were familiar with the service. The service had no bank or agency outreach staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, not all staff felt the induction was as clear or effective as it could have been.

The service had low turnover rates and levels of sickness were not high. Staff working in temporary roles were positive about taking up permanent roles.

Staff held high numbers of patients on their caseloads and even the manager of the service was carrying a caseload. Some staff told us that caseloads were too high, with some standing at over 100 at the time of this review. One told us they were “asked to do too much”. However, other staff told us their caseloads were manageable and they had enough time to ensure their patients got the time they needed when they needed it.

**Medical staff**

The service did not have enough medical staff. Particularly, there were not enough medical staff to support the numbers of patients with neurodevelopment disorder needs. Staff told us there was not always a medic available who was able to assess and manage the needs of these patients, which meant patients waited longer than they needed to for the right help.

Managers could use locums when they needed additional support or to cover staff sickness or absence. However, the service could not always get support from a psychiatrist quickly when they needed to. At the time of this review, one psychiatrist was on leave, another was on extended absence and a locum had just started work that week so was still in their induction phase. This left just one accessible psychiatrist working in the service. Even without this leave, staff told us urgent cases could wait a week to see a doctor and it could be longer for those with neurodevelopmental disorders.

**Mandatory training**

**Staff had completed and kept up to date with their mandatory training. All but one of the staff said they were up to date with their mandatory training.**

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept spreadsheets of information identifying when staff were due to complete or had completed their mandatory training. The organisation hoped to introduce an electronic training notification system for staff.

**Assessing and managing risk to patients and staff**

**Staff assessed and managed risks to patients and themselves but not always in a timely way. They were not always able to respond promptly to sudden deterioration in a patient’s health. Crisis plans were not routinely developed with patients and their families and**

**carers. Staff followed good personal safety protocols but there was no clear system to support this.**

**Assessment of patient risk**

Staff completed a risk assessment for each patient, using a recognised tool, but were not always able to do this in a timely manner. There were 32 unscreened referrals when we carried out this review, 98 patients waiting for an initial assessment and 151 patients waiting for a neurodevelopment disorder screening assessment. This meant that it was not always possible for the service to have a full appraisal of patient risk. Managers hoped the business case they submitted would be successful so they could recruit more staff and address the capacity and demand issue which had led to these waiting lists.

Staff used a recognised risk assessment tool which was part of a standardised electronic patient record system.

Staff did not routinely develop crisis plans and advanced decisions with patients and their families or carers. So, there was no record of what the patient's wishes might be on how they would like to be supported during a mental health crisis. Staff told us that patients reported finding it difficult to get support outside of normal office hours. Care plans identified which team or service a patient might use but did not identify what a crisis might be for individual patients or how the patient and their family or carer might wish to manage it according to their experience and preferences. Patients in crisis often used the local accident and emergency department because they were unable to access support in their own homes.

The service had a lone working policy and staff followed good safety protocols such as using the electric patient record system and a physical white board to show where they were. However, staff told us that if they were late returning from a home visit, there was no system in place to check on their welfare.

**Management of patient risk**

Staff were not always able to respond promptly to any sudden deterioration in a patient's health. Staff told us that patients and families found it difficult to get support outside of office hours and there were not enough staff working in the service to be able to respond to the increased number of referrals they were receiving. When patients or their families and carers contacted the service to let staff know that a patient had deteriorated, staff would review the urgency of their needs and if necessary, an urgent assessment by the duty worker could be arranged but this did not always happen in a timely way due to the workload pressures, especially as there was only one member of staff running the duty system.

Staff could not routinely monitor patients on waiting lists for changes in their level of risk and were not always able to respond. Some patients were checked regularly based upon known risks or regular contact with the service. However, others were only checked when they contacted the service to enquire how long they would be waiting on the waiting list. A whole system review of all patients waiting to be seen had been carried out when the new manager came into post, where each patient record had been reviewed. However, this was a "point in time" review and because of the high numbers of patients waiting to be seen, the service was struggling to monitor waiting lists effectively. Patients and their families were directed to use a digital mental health and wellbeing service while they were waiting for their assessment and for their treatment to begin.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding.**

Staff received training on how to recognise and report abuse, appropriate for their role. However, one member of staff told us that when they started working in the service, nobody had explained the local safeguarding process to them, but they assured us they would nonetheless report any safeguarding concerns. The service had a member of staff whose role was specifically designated to support “Looked After Children” who were referred into the team.

Staff kept up to date with their safeguarding training. However, one member of staff told us they were recently out of date with level III safeguarding training, but they had booked the relevant training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff told us they had good links with social care and education services. When necessary, staff liaised with colleagues in Manx Care’s Safeguarding Team and attended multiagency child protection conferences. Some of the mental health practitioners in the service were social workers, who would provide advice and support to colleagues if required. The Intercollegiate Document “Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff”, Fourth edition: January 2019 advises that staff should participate in safeguarding supervision, relevant to their role, “…to strengthen the protection of children and young people by actively promoting a safe standard and excellence of practice...”. We found low numbers of staff routinely engaged in safeguarding supervision, but the manager told us they would discuss safeguarding in their management supervision.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff understood their responsibilities and Manx Care had a designated doctor and designated nurse for safeguarding. Mental health services had appointed a safeguarding lead. Information about how to make a referral was available for staff on the provider’s intranet.

The service had no serious incidents under investigation at the time of the inspection. However, an Isle of Man Safeguarding Board Serious Case Management Review had been published in August 2021. The report stated that “The Young Person’s worker will be placed within the CAMHS service which will strengthen the dual diagnosis focus of the role.” At the time our assessment, the young person’s specialist worker was placed in the Drug and Alcohol team, not within the Child and Adolescent Mental Health service. Managers of neither service could explain why the placing of this specialist role was not in line with the Isle of Man Safeguarding Board Serious Case Management Review report of August 2021.

### Staff access to essential information

**Staff working for the child and adolescent mental health service kept records of patients’ care and treatment, but these were not always detailed. Records were clear, mostly up-to-date and were easily available to all staff providing care.**

We reviewed 6 randomly selected patient care records. Patient notes for those who were regularly seen by a member of the staff team were clear, comprehensive and up to date. Records for those patients who had been placed on a waiting list were less detailed, containing a brief initial

assessment and noting the waiting list the patient had been placed on. The recording of new information relating to changes in risk could be stored in more than one place, for example it might be in a generic record or might in the risk assessment.

All staff providing care could access patient care records easily when they needed to. Electronic records were stored securely, and we observed staff using good information governance protocols, such as locking their computer screens when leaving their desks.

When patients transferred to a new team, there were no delays in staff accessing their records because the organisation used the same electronic patient record system. We observed that the electronic patient record system caused some delays for staff when it "crashed", which staff told us happened a lot.

**Medicines management**

**The service used systems and processes to safely prescribe medicines, but staff did not have easy access to review an up-to-date list of medicines prescribed to patients. Staff did not always record if they regularly reviewed the effects of medications on each patient's mental and physical health.**

No medicines were administered or stored in the service. Staff followed systems and processes to prescribe medicines safely, but they did not have easy access to review an up-to-date list of medicines prescribed to patients. We reviewed 10 patient records at random, to look at prescribing in the service. Three of the records we reviewed had no medicines information because the patients had not yet been assessed and 3 contained no information about medicines, but only one of those clearly showed there was no medicines prescribed. Three contained clear up-to-date information about which medicines had been prescribed but one record was not clear, so we could not establish what medicine was being prescribed at the time of our review.

The service did not include a pharmacist but had access to one. We did not see that any regular routine audits of medicines management were carried out. There was limited access for staff to consult directly with the pharmacist and no routine access for patients and their families to discuss their medicines with one. Since we carried out our assessment, managers have told us that the service has now employed a part time pharmacist to support the work of the team.

We could not see that staff regularly reviewed the effects of patients' medicines on their mental and physical health. Some staff told us their high caseloads prevented them from doing this in a timely way.

Staff stored and managed all prescribing documents safely. Paper copies of prescriptions were individually scanned and stored in each patient record, which meant it was difficult to carry out audits to ascertain prescribing themes across the service. We found the service was working towards adopting electronic prescribing, which would enable timely and accessible oversight of prescribing.

We saw that the process for patients to obtain repeat prescriptions was straightforward and worked well. There were no medicines related incidents recorded for the service.

Staff learned from safety alerts and incidents to improve practice. Manx Care provided electronic safety bulletin updates for staff. There was a process in place to make sure local and national safety alerts were shared with staff in the service.

Staff did not have the facilities, such a clinical treatment room, to carry out physical health assessments for their patients. Equipment for staff to measure patients' height and weight was located in an open corridor. Some patient care records we reviewed clearly showed that the service had carried out some physical health checks and that this information was shared with the patient's family and the GP, but other records were not clear who would carry out these checks, whether it would be the service or the patient's GP. The service manager had identified that the effects of each patient's medicines on their physical health should be monitored, according to best practice guidance such as the National Institute for Health and Care Excellence, and the service was piloting a new "shared care" protocol and process with local GPs to ensure this took place. There had previously been shared care arrangements, but these had broken down. Staff were hopeful the new pilot would improve how patients' physical healthcare was assessed and monitored.

**Reporting incidents and learning from when things go wrong**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with Manx Care policy.

Staff reported serious incidents clearly and in line with policy. The service had no "never events". Never Events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

Manx Care had a duty of candour policy. Staff understood the duty of candour. They understood to be open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. We did not see if patients and their families and carers were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Managers shared learning with their staff about incidents that had happened elsewhere in Manx Care and across the wider healthcare landscape. Staff also had access to a regular "Safety and Learning Bulletin". Staff used team meetings to discuss feedback and look at improvements to patient care. Recent changes and proposed changes to the service were regularly discussed and they all linked to improving the service for patients and their families and carers.

## Is the service effective?

We found this service was not always effective in accordance with CQC's assessment framework.

**Assessment of needs and planning of care**

**Staff assessed the mental health needs of all patients, but not always in a timely way. They**

**worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, but were not always personalised, holistic or recovery oriented.**

Staff completed a comprehensive mental health assessment of each patient once they had been allocated to a mental health practitioner. However, there were waiting lists for all aspects of the service, which meant these were not carried out in a timely way so there were long waits for patients' needs to be assessed and for them to get the support they needed. Staff told us there were not enough family therapists in service so waiting times were in excess of 7 months.

Staff did not make sure that patients had a full physical health assessment and knew about any physical health problems. The service carried out an audit in May 2022, to see how well they managed the physical healthcare of patients prescribed antipsychotic medication and / or mood stabilisers. The audit looked at 20 patient care records to see if checks were carried out before commencement of medication and at regular intervals during treatment. These checks are recommended in best practice guidelines and in the Manx Care "Physical Healthcare Policy". The audit found that none of the care records recorded physical healthcare in the Care Programme Approach (CPA) documentation. Only 15% showed that, prior to commencing prescribing medication, routine blood tests had been carried out and only 10% showed that an electrocardiogram (ECG) had been done. Of these, none had follow-up blood tests or ECGs at the 4 week or 3 month review point. Less than 50% of the sample received basic baseline checks such as blood pressure, pulse, height and weight before commencing their medication and the number of patients who received these basic checks at the 4 week and 3 month review point varied from 35-67%. The audit also confirmed our findings that there were inconsistencies with respect to the recording of physical healthcare information in the patient record system – some information was documents in the dedicated "physical healthcare" section, and some were documented in the general notes section. The service had implemented an action plan to improve the physical healthcare monitoring for patients.

Where patients had an allocated community mental health professional, staff developed a comprehensive care plan for each patient, that met their mental health needs. We found staff did not routinely develop a comprehensive care plan for each patient's physical healthcare needs.

For those patients with an allocated community mental health professional, staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were not personalised, holistic or recovery orientated. The service carried out an audit of care plans between March and April 2022. The audit found that less than 15% of care plans were personalised and showed that the views of patients and their families and carers had been included. Of the 6 randomly selected patient care records we reviewed, we found they were functional but not personalised or recovery oriented.

### Best practice in treatment and care

**Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. They did not ensure that patients had good access to physical healthcare but did support them to live healthier lives. Staff participated in clinical audit, benchmarking and quality improvement initiatives.**

Staff provided a range of care and treatment suitable for the patients in the service. Despite long waiting lists, the service provided patients with a variety of treatments and therapies to meet their assessed needs such as cognitive behaviour therapy, dialectical behaviour therapy and family therapy.

Staff delivered care in line with best practice and guidance. Where audit findings showed there was room for improvement, such as with physical healthcare checks, there were clear action plans in place to drive improvement.

Staff supported patients to live healthier lives by supporting them to take part in local programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes such as Generalised Anxiety Disorder Assessment (GAD-7), Systemic Clinical Outcome and Routine Evaluation (SCORE-15) and Patient Health Questionnaire (PHQ-9). However, we did not see that staff used side effect rating scales when prescribing medicines.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff were invested in developing the service to make improvements to the way they did things. They engaged with service providers locally, and in England, to incorporate innovative, evidence-based developments so the service could improve access and outcomes for patients and their families and carers.

Managers used results from audits to make improvements. The new service manager had implemented several audits to gather a baseline of the work undertaken, which were being used to improve the way staff delivered the service. These included the physical healthcare audit and the care plan audit.

**Skilled staff to deliver care**

**The team included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.**

The service had access to a full range of specialists to meet the needs of children and young people. Staff told us there were not enough family therapists for all the patients who would benefit. There had been some long-standing vacancies, for example in psychology, but the service was trying to recruit to the post. While the post was vacant, managers used the available funding to support temporary recruitment to other relevant roles. The service had a paediatric nurse and neurodevelopmental disorder nurses. Specialist roles such as dietetics could be accessed within the wider integrated mental health service.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. However, some staff felt the induction programme could be better structured.

Managers supported staff through regular, constructive appraisals of their work. We did not review

figures for appraisals, but staff told us they received an appraisal each year and some showed us their most recent appraisal document. All but one member of staff told us they had regular caseload supervision. We were told staff were not routinely given the opportunity to participate in reflective practice or peer supervision sessions, which some felt would be useful. Managers told us that staff could access regular clinical supervision, which was hosted virtually by an external senior CAMHS clinician in an NHS trust.

Manx Care supported staff to secure and pay for external specialist professional supervision if access on the island was limited.

Managers supported medical staff through regular, constructive clinical supervision of their work. Non-medical prescribing was monitored by the medical director and senior members of staff in the team.

We reviewed team meeting minutes for 2022 and saw that managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service supported staff to undertake specialised training, for example in cognitive or dialectical behaviour therapy, nurse prescribing and leadership. Additional training in risk assessment and “route cause analysis” was also available to staff.

Managers recognised poor performance, could identify the reasons and dealt with these. Manx Care had a human resources department to support staff and managers with performance issues.

**Multi-disciplinary and interagency teamwork**

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff told us these meetings had become more focussed and fewer professionals attended the meetings than had previously attended. Some staff felt this was not a positive move, because even if they were not directly involved with the patient being discussed, they might be able to offer useful insight. Other staff felt the more focussed meetings were more effective and a better use of their time.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. The GP letters we reviewed in patient care records were clear and effective.

Staff had effective working relationships with other teams in the organisation. We noted there were some delays for patients waiting to be transferred out of the service and into the adult community mental health service. Protocols to support patient transfer between services were being developed by managers across the integrated mental health service. The team had effective links with inpatient mental health and acute hospital wards.

Staff had effective working relationships with external teams and organisations. Managers of the service had developed good links with external agencies such as the local social services department, schools, GPs and third sector mental health organisations.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**

**None of the records we reviewed were for patients subject to the Mental Health Act.**

Staff understood their roles and responsibilities under the Mental Health Act 1998 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice.

Access to a free independent mental health advocacy service was not available on the Isle of Man. Manx Care's Mental Health Act Legislation Committee hoped to develop and introduce an independent advocacy service. Patients could instruct independent legal advice to support them with mental health matters such as Mental Health Review Tribunals and apply for legal aid to help with the costs.

We were not able to review if staff completed regular audits to make sure they applied the Mental Health Act correctly or if managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

**Good practice in understanding mental capacity**

**Staff supported patients to make decisions on their care for themselves but did not routinely record consent and capacity or competence clearly for patients who might have impaired mental capacity or competence. They understood the principles of Gillick competence as they applied to people under 16.**

Staff did not routinely record capacity to consent clearly each time a patient needed to make an important decision. We saw no record of consent to treatment in any of the 6 patient records we reviewed. All records contained an "consent to share information" form but nothing was recorded to show any other aspect of capacity or consent. Staff told us they recorded consent in the generic daily note section of the patient care record, which could make it difficult to find.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Staff told us medical colleagues would support them if they needed it, for example to be sure young people understood the prescribing of their medicines.

The Isle of Man did not have a legislative framework to assess and determine mental capacity. These decisions were made in line with common law. The Isle of Man government was in the process of developing this legislative framework and the Metal Capacity Bill was moving through parliament. Once enacted, the Bill would support practitioners to determine a patient's mental capacity and would include safeguards with respect to care and treatment when they might be deprived of their liberty.

## Is the service caring?

We found this service was caring in accordance with CQC's assessment framework.

**Kindness, privacy, dignity, respect, compassion and support**

**Staff treated patients with compassion and kindness. They understood the individual needs**

**of patients and supported patients to understand and manage their care, treatment or condition.**

Staff were discreet, respectful, and responsive when caring for patients. We observed staff holding kind, compassionate and supportive telephone conversations with patients and families.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

### Involvement in care

Records did not show that staff involved patients in care planning and risk assessment or that the service actively sought their feedback on the quality of care provided. Staff informed and involved families and carers appropriately but did not record this well. The provision of free advocacy services was not available on the Isle of Man, so community patients did not have access to free independent mental health advocates.

### Involvement of patients

Staff involved patients in their assessment and care planning but did not routinely give them access to a copy of their care plans. The service's recent care plan audit confirmed our findings. The audit was carried out between March and April 2022 and found that less than 20% of care plans were recorded as having been offered to patients and their families and carers. Both parents we spoke with had not received a copy of their child's care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). In response to feedback, the service ran an attention deficit disorder hyperactivity disorder (ADHD) education group for parents.

We saw no evidence to suggest that the service had involved patients and their families or carers in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment, and staff supported them to do this. Administrators routinely sent feedback forms to families for them to complete. However, we could not see that staff used this information when planning changes or improvements to the way the service was run and delivered. We looked at the information the service provided to us for this review, but we did not find evidence to show that staff carried out any regular analysis of patient and family carer feedback.

The concept of supporting patients to make advanced decisions on their care was not embedded across mental health services on the Isle of Man.

The provision of free advocacy services was not available on the Isle of Man, so community patients did not have access to free independent mental health advocates.

**Involvement of families and carers**

Staff supported, informed and involved families or carers. The service provided education groups and family therapy. We were told some support groups has been cancelled because of the COVID-19 pandemic and had never restarted, which they thought was understandable but disappointing because the groups had been really helpful for their child.

There was no legal entitlement to a carer's assessment for carers on the Isle of Man. A parent told us staff in the service were very supportive to them.

## Is the service responsive?

We found this service was not always responsive in accordance with CQC's assessment framework.

**Access and waiting times**

**The service was not easy to access. Staff could not always assess and treat patients who required urgent care promptly and patients who did not require urgent care waited a long time to start treatment. Staff could not ensure that transitions to adult mental health services took place without any disruption to the patient's care. Its referral criteria did not exclude patients who would have benefitted from care. Staff followed up patients who missed appointments.**

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. We found referrals into the service came in several different formats, such as letters, standardised referral forms and partially completed forms which made it difficult to process them. Patients could only access the service if they were referred by a professional, such as their GP or their school.

The service did not meet Manx Care's target times for seeing patients from referral to assessment and assessment to treatment. Parents told us the waiting time from referral to assessment was too long and they had waited between 6 and 24 months for help. The target time to screen a referral was 7 days. There were 32 patients waiting for their referral to be screened, 27 of which had exceeded the target time. The target time for psychology was 135 days. There were 140 patients waiting for psychology, 74 of which had exceeded the target time. At the time of our review, the longest wait for psychology was over 4 years.

Staff could not always see urgent referrals quickly and non-urgent referrals could be waiting many months before receiving an initial assessment.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact people who did not attend appointments and offer support to encourage them to engage if they were reluctant.

Patients had some flexibility and choice in the appointment times available.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. However, we were told staff had cancelled appointments with little notice, on the day they were due to take place. Managers could run reports to see how many appointments had been cancelled or rescheduled.

Appointments generally ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists/support patients. However, these were in the early stage development. Waiting lists had not been effectively managed in the past but the new service manager recognised this and had carried out a review of each referral. However, this was a “point in time” review and because of the high numbers of cases waiting to be seen, the service was struggling to monitor waiting lists effectively and to support patients who might need it while they were waiting for their treatment to begin. A parent told us they had felt “very alone” while they waited to be seen and described being “left to muddle through” website links. Staff and a parent told us that it was difficult for families to access support out of hours, especially if they were experiencing a crisis.

The service followed good practice for transfer of care, but we saw delays in patients being accepted into the community mental health service for adults. Managers were working to improve this process, so patients did not experience a delay. Senior managers in the integrated mental health service were supporting them to develop a new transfer of care protocol to improve the process.

**Facilities that promote comfort, dignity and privacy**

**The design, layout, and furnishings of treatment rooms did not always support patients’ treatment, privacy and dignity.**

The service did not have a full range of rooms and equipment to support treatment and care. Staff told us there were often problems finding a consultation room for them to see patients. There was no clinical room for patients to receive a full physical healthcare assessment.

Interview rooms in the service did not have sound proofing to protect privacy and confidentiality. Conversations taking place in a consultation room could be overheard.

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

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication and cultural and spiritual support.**

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff were skilled in communication and the building had some facilities which supported people with physical disabilities to access the premises. Staff routinely made home visits to support patients and their families and carers within their own home. The service was relocating to more suitable premises on the hospital site in the near future.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service provided details of how to access support from linked organisations.

The service provided information in a variety of accessible formats so the patients could understand more easily. Parents told us that the use of information technology was very supportive for their child.

The service had information leaflets available in English, the main language spoken by the local community.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

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

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives and carers knew how to complain or raise concerns. Information on how to complain was easily accessible.

Staff understood the policy on complaints and knew how to handle them. Managers had shared recent updates to the complaints policy with staff.

Managers investigated complaints and identified themes. The care, quality and safety team tracked all registered complaints for integrated mental health services and discussed these with managers in the relevant service. The service had received 6 complaints between February and July 2022, the themes were communication and clinical treatment. Staff told us that the length of time patients had to wait to access care and treatment was also a common theme.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. When a complaint was resolved, the response was sent from a senior leader.

Managers shared feedback from complaints with staff and learning was used to improve the service. Examples included the review of waiting lists and the implementation of new and alternative sources of support to address the lengthy wait patients were experiencing.

The service used compliments to learn, celebrate success and improve the quality of care.

## Is the service well-led?

We found this service was well-led in accordance with CQC's assessment framework.

**Leadership**

**Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.**

The service had been led by a succession of temporary managers until November 2021, when a permanent manager was appointed. Staff were positive about the new leadership and told us their leaders were knowledgeable and supported them in their day to day work. One member of staff told us “this is the first time we have had a compassionate manager”. We observed that managers were visible and accessible to staff. They understood the needs of the service and the young people in their care. Managers had a good understanding of the challenges the service faced and realistic plans to drive improvement.

**Vision and strategy**

**Staff knew and understood the provider's vision and values and how they applied to the work of their team.**

Manx Care's state their aim "is to create a high quality, integrated health and care service that organises care around patient and service user needs, delivering the right care, in the right place, at the right time. A service that, from prevention to cure, works together to keep people well; gives equal prioritisation to health and social care; and is one of the best 'person-centred' sustainable health and care services." Staff understood these aims and the team vision of how the service would change and improve to meet the needs of children and young people on the island.

### Culture

**Staff felt respected, supported and valued. They said Manx Care promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.**

Almost all the staff told us they felt respected, supported and valued for their work and for their contribution to the service. We observed that staff were able to share ideas and views about the challenges the service faced and about the service improvement work. All but one member of staff felt the organisation was supportive of the challenges the service was facing.

Staff told us they had opportunities to develop their knowledge, skills and careers. A number told us they had taken up these opportunities, such as funded master's degrees. However, some staff told us the options for accredited training in therapies was limited to core areas such as cognitive behavioural therapy and they felt there should be more opportunities for staff to train in play therapy and art therapy.

Staff told us there was no bullying in the service. They demonstrated that they were respectful of each other and worked well together as a multidisciplinary team to meet patients' needs. All but one member of staff felt the team worked well together.

All but one member of staff told us they were able to challenge and raise concerns without fear of retribution.

All the staff told us they were extremely busy with their workload but were committed and passionate about delivering the best care they could.

### Governance

**Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk management were improving.**

The service manager had sufficient authority to perform their role and was supported by the integrated mental health service senior leadership team.

Managers had reviewed the audit schedule and were in the process of implementing an improved schedule that included the care plans, patient records, prescribing of benzodiazepines and physical health. They planned to introduce a medicines management audit.

Managers were developing systems to monitor waiting lists. However, they knew that the increased number of referrals to the service was leading to the children and young people waiting excessively long to access care and treatment. They understood the impact and risk of the waiting

lists for the service, for children and young people and for staff.

The service manager had good oversight of mandatory training, staff supervision and appraisals.

### Management of risk, issues and performance

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect.**

The service had a risk register which the manager and senior staff reviewed regularly. Staff were able to escalate concerns to the manager who could then include them on the risk register. Staff were also able to escalate concerns directly to the senior leadership team. One member of staff told us they did not always get a suitable response when they had raised concerns with the senior leadership team. However, another told us that recent changes introduced to manage risk better, were working.

### Information management

**Staff collected analysed data about outcomes and performance.**

Managers in the service regularly reviewed data which was relevant to the safe and effective running of the service. This data was shared with staff and was monitored by senior leaders and presented to the Board of Manx Care. The service manager had access to an information "dashboard" which they used to share key information with staff, such as patient risk assessments that were overdue for review.

### Engagement

**Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.**

The service planned to launch the UK's national "iThrive Programme" and held a stakeholder event to showcase the programme in June 2022. The Thrive Programme was developed by Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust. The programme aims to provide early, needs led, holistic medical and psychological interventions to children and young people seeking support with their mental health. Staff met with the programme leaders to move forward with the introduction of the Thrive Programme to the Isle of Man.

Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. They were developing local protocols for joint working between agencies involved in the care of children and young people.

The service manager and senior leadership team was working closely with other relevant organisations to drive the implementation of "shared care" with GPs and the iThrive Programme. These are important initiatives, which would increase the availability of support for patients. Without effective shared care, the service may experience increased caseloads because patients who could be supported by their GP will remain locked into this specialist service.

**Learning, continuous improvement and innovation**

**All the staff showed a commitment to learning and improving the way they delivered the service. Senior leaders had approved funding to commission local third sector agencies to deliver accredited psychological therapies to children and young people.**

Managers had plans in place to introduce electronic prescribing to the service, which would improve their ability to carry out effective prescribing audits.

Staff had proposed introducing “Pat Therapy” for children and young people and were exploring how this could be done.

The service was moving to more suitable premises in the near future. Staff had proposed to place patient feedback boxes in the new waiting room.

There were no inpatient mental health wards for children and young people on the island, so if a patient was admitted to a general paediatric ward because of their mental health, the service was able to provide one to one support for them during the day, in addition to the care and treatment provided by the hospital. This provided supportive observation and engagement for patients while their needs were being assessed and addressed.

# Community Mental Health Service for Adults

## Overall summary

The Community Mental Health Service for Adults (CMHSA) provides multidisciplinary assessment, treatment and care for people aged 18-65 years old. The CMHSA provides a service to people who experience severe and enduring mental health conditions, which reach sufficient levels to significantly impact upon their quality of life and risk, as defined by “stepped care” principles and the National Institute for Health and Care Excellence guidelines. This includes a range of therapies including cognitive behaviour therapy, dialectical behaviour therapy and psychosocial interventions, such as relapse prevention. The service also provides a weekly depot clinic. A depot injection is a slow-release form of medication and can be used for various types of medicines.

Staff in the Community Mental Health Service for Adults included a pharmacist, mental health nurses, support workers, social workers, occupational therapists, psychiatrists, psychologists, and administrators.

**Our key findings**

- The service provided safe care. Clinical premises where patients were seen were generally safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic care plans informed by a comprehensive assessment but not always in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1998.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in care decisions, we found this was not always recorded.
- The service was reasonably easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude patients who would have benefitted from care.
- The service was well led, and the governance processes ensured that that procedures relating to the work of the service ran smoothly.

## The assessment

### About the service

The Community Mental Health Service for Adults is a multi-disciplinary service providing a specialist community based mental health support for adults with moderate to severe and enduring mental illness.

### During the assessment

We looked at the environment used by patients and staff. We observed interactions between staff and people who attended the premises and telephoned the service.

We spoke with 3 patients and a met with several carers who kindly invited us to their carers' group.

We reviewed written feedback from a member of staff and spoke with 19 members of staff including the service manager and deputy manager. We also spoke with senior leaders of the service.

We observed a multidisciplinary staff team meeting and a referral allocation meeting.

We reviewed a range of records. This included 6 patient care records, 3 medication records and 10 prescription records.

We reviewed a variety of records relating to the management of the service, including audits, policies, and procedures.

# Is the service safe?

We found that this service was safe in accordance with CQC's assessment framework.

### Safe and clean environment

**The clinical premises where patients received care were safe, visibly clean, well equipped, well-furnished and fit for purpose, but equipment was not always calibrated, and cleaning records were not available.**

Clinic rooms were fitted with alarms and staff were available to respond if necessary. Interview rooms were in the reception area and staff could respond easily if needed.

All areas were visibly clean, well maintained, well-furnished and fit for purpose. The general environment was visibly clean and well ordered. We found the cleaning was carried out by a third-party organisation, there were no cleaning records available for staff to be assured of the cleaning protocols and schedules. In collaboration with patients who used the service, staff were in the process of refurbishing, upgrading and redecorating the patient areas.

Staff followed infection control guidelines, including handwashing. Managers had ensured personal protective equipment (PPE) was made available for patients and staff.

The clinic room had equipment for patients to have physical examinations. There were limited assurances that staff made sure equipment was well maintained, clean and in working order. There was missing equipment and no records to show equipment had been suitably calibrated in

line with manufacturers' guidelines. There were no cleaning records to evidence the clinic room was cleaned and some confusion about who held responsibility for the cleaning of equipment.

### Safe staffing

**The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.**

#### Multidisciplinary team staff

The service had enough community mental health practitioners and support staff to keep patients safe. Managers monitored referrals, staff caseloads and activity in the team and adjusted staffing levels to take account of increasing referrals into the service.

The service had low vacancy rates, with new staff taking up advertised posts for additional roles.

The service had low rates of bank and agency staff and managers made arrangements to cover staff sickness and absence.

Managers limited their use of bank and agency staff, and staff were familiar with the service. Temporary staff had long term contracts.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Temporary staff were provided with essential learning and development opportunities as well as regular supervision. Staff told us that training to use the electronic patient record system could be better.

Sickness levels were low, and the service had low turnover rates. Managers supported staff who needed time off for ill health. Staff told us that managers were supportive of flexible working patterns and promoted a healthy work life balance.

#### Medical staff

The service had enough medical staff, we found many posts were filled by temporary staff. Recruitment to permanent roles was difficult and took a long time.

Managers used locums when they needed additional support or to cover staff sickness or absence, often on short term contracts.

Managers made sure all locum staff had a full induction and understood the service. They were provided with administrative support, supervision and access to learning and development opportunities. Those who needed it, were supported with accommodation.

The service could get support from a psychiatrist quickly when they needed to. Psychiatrists provided clinics on 5 mornings each week, with reserved slots for urgent consultations.

### Mandatory training

**Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff.**

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept spreadsheets of information identifying when staff were due to complete

or had completed their mandatory training. The organisation hoped to introduce an electronic training notification system for staff.

### Assessing and managing risk to patients and staff

**Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health.**

Crisis plans were not routinely developed with patients and their families and carers. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols**.**

### Assessment of patient risk

Staff completed risk assessments for each patient on admission to the service, using a recognised tool, and reviewed this regularly. Staff held a daily multi-disciplinary meeting, to review each referral that had been received the previous day. Staff carried out an initial risk assessment when each patient was accepted into the service and updated this when things changed.

Staff did not routinely develop crisis plans and advanced decisions with patients and their families or carers. Care plans identified which team or service a patient might use in a crisis but did not identify what a crisis might be for individual patients or how the patient and their family or carer might wish to manage that crisis according to their experience and preferences.

### Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. The patient care records we reviewed showed inconsistencies between identified risks and how they would be managed. We saw contradictory recording in the risk assessment, risk management plan and care plan. Staff knew their patients well but if another member of staff needed to support or treat a patient, reviewing the patient care record could mean they would not be able to gain a full understanding of what the patient risk was. This was because initial risk assessments were not routinely updated but the risk management plan was. The daily progress notes were a good source of information but searching these for the most up to date information could be time consuming and unnecessary work.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Patients could be seen urgently by a member of the Duty and Referral Team or a doctor if necessary.

Staff followed clear personal safety protocols, including for lone working. Staff were provided with personal alarms and told us they felt safe working in the service.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training on how to recognise and report abuse, appropriate for their role. Staff understood their responsibilities and the organisation had appointed a safeguarding lead.

Staff kept up to date with their safeguarding training. Safeguarding training was mandatory for

staff, with 98% having completed safeguarding adults and 79% safeguarding children training. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

The service had not been subject to any recent Isle of Man Safeguarding Adult Board Serious Case Management Review recommendations.

### Staff access to essential information

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

Patient care records were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records because the organisation used the same electronic patient care record system.

Electronic records were stored securely, and we observed staff using good information governance protocols, such as locking their computer screens when leaving their desks.

### Medicines management

**The service used systems and processes to safely prescribe, administer, record and store medicines. Staff did not always record if they regularly reviewed the effects of medicines on each patient's mental and physical health.**

Staff followed systems and processes to prescribe and administer medicines safely. The team included a pharmacist who conducted local audits and was available for staff to consult. However, prescriptions were individually stored in each patient care record, which meant it was difficult to carry out audits to ascertain prescribing themes across the service.

Staff did not always record if they had reviewed each patient's medicines regularly or had provided advice to patients and carers about their medicines. Families and carers told us they did not always feel informed about prescribing decisions and patient medicines. Patients were not able to speak with the pharmacist to discuss their medicines.

Staff completed medicines records accurately and kept them up to date. Manx Care recorded and audited drugs errors across all their services.

Staff stored and managed all medicines and prescribing documents safely. Depot medicines were stored appropriately, and checks were done to make sure they remained in date. We found some adrenaline that was over 5 months out of date, and out of date first aid kits, which we raised with staff immediately. The medicines fridge temperature had a weekly electronic check to make sure it remained within the relevant range to safely store medicines in line with manufactures' guidelines. This meant that any daily changes in temperature that might affect the efficacy of the medicine would not be identified straight away.

Staff learned from safety alerts and incidents to improve practice. Manx Care provided safety bulletin updates for staff and made sure local and national safety alerts were shared across the service.

The service had recently started running clinics to monitor the physical healthcare of patients

prescribed lithium and clozapine, which is good practice. However, we could not be assured that staff routinely reviewed the effects of each patient's medicines on their physical health in line with best practice guidelines such as the National Institute for Health and Care Excellence (NICE). This was because information about a patient's physical health was not always recorded in the patient care record. NICE guidance "Psychosis and Schizophrenia in Adults", Quality standard [QS80], Published 12 February 2015, recommends that practitioners ensure that they carry out comprehensive physical health assessments in adults with psychosis or schizophrenia, and share the results (under shared care arrangements) when the service user is in the care of primary and secondary services. Patients should have a regular health check (at least once a year) that includes taking weight, waist, pulse and blood pressure measurements and blood tests. This checks for problems such as weight gain, diabetes, and heart, lung and breathing problems that are common in adults with psychosis or schizophrenia and often related to treatment. The results should be shared between their GP surgery and mental health team. The records we reviewed showed limited or no recording that these checks had taken place nor that the GP would be managing this aspect of the care plan.

**Track record on safety**

The service had a good track record on safety.

**Reporting incidents and learning from when things go wrong**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff knew what incidents to report and how to report them. Managers were able to review incident information.

Staff raised concerns and reported incidents and near misses in line with Manx Care's policy.

The service had no never events and had not been subject to any recent Isle of Man Safeguarding Adult Board Serious Case Management Review recommendations. Never Events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

Manx Care had a duty of candour policy. Staff understood the duty of candour. They understood to be open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after incidents. Managers investigated incidents thoroughly. Staff received feedback from investigation of incidents, both internal and external to the service.

Managers shared learning with their staff about serious incidents that happened elsewhere in Manx Care and across the wider national healthcare landscape. Staff also had access to a regular "Safety and Learning Bulletin". Staff used team meetings to discuss the feedback and look at improvements to patient care.

## Is the service effective?

We found this service was effective in accordance with CQC's assessment framework.

**Assessment of needs and planning of care**

**Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and some were recovery oriented.**

Staff completed a comprehensive mental health assessment and care plan for each patient. These met their mental health needs but not always their physical health needs. Staff did not always make sure that patients had a full physical health assessment and knew about any physical health problems. We have discussed this in other sections of this report.

Staff regularly reviewed and updated care plans when patients' needs changed. Patient care records showed patients had several up-to-date care plans, which were specific to individual needs.

Care plans were personalised, holistic and some were recovery orientated. Patients and staff told us assessments were holistic and recovery focussed. We found, of the 5 patient care records we reviewed, 1 was fully and 4 were partially recovery oriented. Recovery and service exit plans were not always clear for patients who had been using the service for a long time. Managers told us the service was working towards increasing the focus on recovery for patients and had recently developed links with local education providers to establish a ‘Recovery College’. Recovery colleges support patients to move forward with their mental health in a planned and self-identified way, using lived experience, education and support for them as well as their families and carers.

**Best practice in treatment and care**

**Staff provided a range of treatment and care for patients based on guidance and best practice. They did not ensure that patients had good access to physical healthcare but did support them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They participated in clinical audit and quality improvement initiatives.**

Staff provided a range of care and treatment suitable for the patients in the service. However, staff, patients and relatives told us there were long waiting lists for some psychological and specialist therapies.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as the National Institute for Health and Care Excellence).

Staff did not routinely make sure patients had support for their physical health needs. Following a short gap due to staff changes, the service provided a weekly physical health clinic for patients to attend. GPs took the lead for physical healthcare on the island but communication between the service and patients’ GPs did not always show who would make sure that physical healthcare checks were done, so it could be possible that they were missed.

Of the 5 randomly selected patient care records we reviewed, none showed the patient had been given a physical health examination when they entered the service, and none showed any

evidence of ongoing physical healthcare checks. The Community Mental Health Service for Adults and GPs held separate patient record systems, so it was not possible to determine if patients' physical health was being assessed and monitored as effectively as it should be. This can be a concern when patients have complex physical and mental health needs.

Staff supported patients to live healthier lives by supporting them to take part in programmes such as exercise and activity or giving advice.

Staff used a recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Staff took part in clinical audits and quality improvement initiatives. The team routinely carried out Care Programme Approach (CPA) and pharmacy audits. CPA audits included checks to see if CPA reviews took place within the given timescale. Managers carried out patient care record audits, to see if care plans were recovery focussed and had been developed collaboratively between patients, carers and staff.

Managers used results from audits to make improvements. Examples included referral audits and developing links with partner organisations to reduce waiting lists and deliver additional treatment options for patients.

**Skilled staff to deliver care**

**The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.**

The service had a full range of specialists to meet the needs of each patient. This included occupational therapists, support workers, social workers, nurses, doctors and therapists.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Managers recognised the need to provide career development and progression opportunities for staff, so they had incorporated band 5 and band 6 roles into the team. Newly appointed staff were supported to develop their skills and knowledge in the service.

Managers gave each new member of staff a full induction to the service before they started work. Induction covered mandatory training, familiarisation to the building and to the service.

Managers supported staff through regular, constructive appraisals of their work. Staff had regular case management supervision with managers in the service. Medical staff had access to medical appraisals.

Managers supported non-medical staff through regular, constructive clinical supervision of their work, this included temporary staff.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Staff were encouraged to engage in the meetings and to provide feedback.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they were able to access training that was relevant to their role and had opportunities to attend specialist training courses.

The corporate capability policy pre-dated the establishment of Manx Care. We found, managers recognised poor performance, could identify the reasons and dealt with these. Staff were supported to improve.

### Multidisciplinary and interagency teamwork

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed one of these meetings and saw that it was well attended and provided a holistic approach to meeting patient need. Staff appeared confident and empowered to engage in the meeting.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. GP letters were clear and effective.

The service followed good practice for transfers of care. Staff had effective working relationships with other teams in the organisation including the drug and alcohol team and the inpatient unit. Staff reported some difficulties transferring people out of the service, for example when they reached the age of 65 and required ongoing care and treatment. Transfer of care into the service from the Child and Adolescent Mental Health Service were reported to have improved. Protocols to support patient transfer between services were being developed by managers across the integrated mental health service.

Staff had effective working relationships with external teams and organisations, including housing and social care.

### Adherence to the Mental Health Act and the Mental Health Act Code of Practice

**Staff understood their roles and responsibilities under the Mental Health Act 1998 and the Mental Health Act Code of Practice.**

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice.

Access to a free independent mental health advocacy service was not available on the Isle of Man. Manx Care's Mental Health Act Legislation Committee hoped to develop and introduce an independent advocacy service. Patients could instruct independent legal advice to support them with mental health matters such as Mental Health Review Tribunals and apply for legal aid to help with the costs.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 115 aftercare services they needed.

We were not able to review if staff completed regular audits to make sure they applied the Mental Health Act correctly or if managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

### Good practice in understanding mental capacity

**Staff supported patients to make decisions on their care for themselves but did not routinely assess and record capacity clearly for patients who might have impaired mental capacity.**

The Isle of Man did not have a legislative framework to assess and determine mental capacity. These decisions were made in line with common law. The Isle of Man government was in the process of developing this legislative framework and the Mental Capacity Bill was moving through parliament. Once enacted, the Bill would support practitioners to determine a patient's mental capacity and would include safeguards with respect to care and treatment when they might be deprived of their liberty. Manx Care introduced a capacity, best interest decisions and deprivation of liberty policy in June 2022. The policy included a formal assessment tool for staff to use. Managers were supporting staff to implement the new policy.

## Is the service caring?

We found this service was caring in accordance with CQC's assessment framework.

**Kindness, privacy, dignity, respect, compassion and support**

**Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

Staff were discreet, respectful, and responsive when caring for patients. We observed they gave patients time to express themselves. Patients told us staff were kind and respectful.

Staff gave patients help, emotional support and advice when they needed it. Patients told us they were able to get help and support from staff when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Staff directed patients to other services and supported them to access those services if they needed help. This included supporting patients to attend the newly developed Recovery College and to engage in therapeutic interventions such as cognitive behaviour therapy, which was also accessible online.

Patients said staff treated them well and behaved kindly. They told us staff listened to them and gave them time to express themselves.

Staff understood and respected the individual needs of each patient. Staff knew their patients well and spoke knowledgably about their needs and the support being provided.

Staff followed policy to keep electronic patient information confidential. However, we found many old paper patient care records which, while secured in the building, were not stored in a locked area. We raised this with staff who provided immediate assurances that the care records would be secured and that local information governance systems would be used to determine if the matter amounted to a breach under The Data Protection Act 2018, which incorporates the General Data Protection Regulation (GDPR).

**Involvement in care**

Staff involved patients in care planning and risk assessment and actively sought their feedback on

the quality of care provided. The provision of free advocacy services was not available on the Isle of Man, so community patients did not have access to free independent mental health advocates.

### Involvement of patients

Staff involved patients but did not always routinely give them access to their care plans. Records showed that staff had engaged patients in their care plans. However, 5 of the patients' care records we reviewed showed 3 were recorded as the care plan having been offered to the patient. One patient told us they had a copy of their current care plan but had not been given one in the past.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). The patients we spoke with understood their care plans and what their support looked like.

Staff involved patients in decisions about the service, when appropriate. The service had developed an expert by experience programme. The experts by experience were instrumental in developing and securing funding for the redesign and redecoration of the waiting area. One of them told us they also had plans to re-design patient information leaflets.

Patients could give feedback on the service and their treatment and staff supported them to do this. They were encouraged to complete a "Have we helped you today" feedback form which they could leave in a designated box in the reception area. Patients were also encouraged to complete a questionnaire when they were discharged from the service.

The patient care records we reviewed were somewhat focused on recovery but did not show that staff supported patients to make advanced decisions on their care. Supporting patients and their families to plan how they might wish to manage a future mental health crisis, using their lived experience and preferences, can be helpful.

### Involvement of families and carers

Staff generally supported, informed and involved families or carers. Families and carers told us they had good relationships with their relative's mental health practitioner, and when they contacted the service, the practitioner responded to them in a timely way. They told us the team communicated well with patients' GPs, but GPs did not appear to communicate well with the Community Mental Health Service for Adults. They told us they did not always understand their relative's care and support plan and were not routinely involved in developing it. They told us there was no access to family therapy for adults and it was difficult to get the right advice, care and support outside of office hours.

There was no legal entitlement to a carer's assessment on the Isle of Man. Families and carers told us they found it difficult getting support from health and social care services. The Community Mental Health Service for Adults facilitated a carers' group. The carers' group was actively involved in highlighting areas for improvement and development across the service. It drove initiatives such as improving information leaflets. However, people told us there was little information and support for them elsewhere and they did not feel heard. They did not receive an information pack about the service, explaining what to expect and who to contact, which they felt would have been useful. Those that attended the carers' group told us they found it very useful, and it helped them to direct feedback about the service to the service manager, who they found to

be responsive. They felt the group should be better publicised, especially amongst GPs, so more people could make use of the support which the group provided.

## Is the service responsive?

We found this service was responsive in accordance with CQC's assessment framework.

**Access and waiting times**

**The service was reasonably easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff did not always follow up patients who missed appointments.**

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. Families told us that GPs were not all responsive to their relative's mental health needs so this could impact on peoples' access to mental health care.

The service met Manx Care target times for seeing patients from referral to assessment and assessment to treatment. The average waiting time for people to receive a comprehensive assessment was 5 to 6 weeks from referral. Waiting times for initial assessments for specific psychological therapies such as dialectical behaviour therapy and schema therapy was longer. Waiting times for therapy were much longer, with one patient telling us they had been waiting for over 18 months. Staff told us the waiting time for Eye Movement Desensitisation and Reprocessing (EMDR) therapy was 2 years. The service hoped to reduce waiting times when newly recruited community mental health practitioners and non-medical prescribers took up post. The service had also commissioned an outside organisation to deliver some therapies, which would reduce waiting times for patients.

Staff saw urgent referrals quickly and non-urgent referrals within the target time. Staff risk assessed each referral to determine the urgency of support required. Consultant psychiatrists held regular clinics, with spaces allocated to see patients who had been referred as needing urgent support. The Duty and Referral team were able to target interventions based on patient need.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. We saw they worked with other professionals and services who knew the person well if that would help to promote their engagement.

Records showed when patients did not attend a planned appointment but did not always show that staff tried to contact people to find out why. Staff told us they would contact people if risk indicated that they needed to. Patients had some flexibility and choice in the appointment times available. We observed staff changing appointments in response to patient requests.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. They kept a record of cancelled appointments and the reason why they had been cancelled.

The service used systems to help them monitor waiting lists and support patients. Managers reviewed this regularly and adjusted waiting times accordingly if patient need changed. Waiting lists were not too high, with 40 people waiting at the time of our review. The service had

experienced an increase in demand and managers monitored this regularly.

Staff supported patients when they were referred or transferred between services but did not routinely support them with their physical health needs. The service was developing protocols for transfer of care between different teams. This was being supported by senior managers in the Manx Care Integrated Mental Health Services, to ensure safe and effective transfers of care for patients when they moved between services.

We saw some evidence of physical healthcare monitoring, for example for patients prescribed medicines for diagnosed Attention Deficit Hyperactive Disorder, but overall, this was not embedded across the service. For example, in one of the patient care records we reviewed, based on best practice guidelines, we would have expected to see the patient receiving regular physical health checks as part of their medicine's management, but this had not been recorded since 2019. Patient care records did not make it clear who was responsible for carrying out routine physical healthcare checks, which meant there was a risk they were not being done.

**The facilities promote comfort, dignity and privacy**

**The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.**

The service had a full range of rooms and equipment to support treatment and care. These included group spaces and individual interview rooms.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

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

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.**

The service could support and make adjustments for disabled people, people with communication needs or people with other specific needs. The building was accessible for people with restricted mobility. Corridors and doorways were wide enough to accommodate wheelchairs and there were accessible toilets for staff and patients to use. The building was easily accessible for people using public transport.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information was readily available in the patient areas and on the Manx Care website.

The service had information leaflets available in English. Staff were able to request leaflets in different languages.

Managers made sure staff and patients could get hold of interpreters or signers when needed. Patients could access an interpreter in British Sign Language and in other languages if they need to.

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

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

We found that patients, relatives and carers knew how to complain or raise concerns. Patients told

us they had a good response from staff when they raised issues. Manx Care had recently concluded a pilot service called MCALS – Manx Care Advice and Liaison Service. The service took calls and emails from patients, families, carers and members of the public who wanted a response to an enquiry. Manx Care concluded that MCALS would be a permanent service. For the first time this gave members of the public a direct helpline spanning both health and social care services. MCALS also supported people to raise a formal complaint about services if they wished to.

Staff understood the policy on complaints and knew how to handle them. There were 3 complaints for this service during the period February to July 2022, 2 of which had been approved. The number of complaints across all community mental health services was low, averaging 3 a month from January to June 2022. There were clear timeframes for responding to complaints, the target was 20 days. Across community mental health services, this target was achieved in just 2 months in this 6-month period. On average across the period, the target was reached in just 51% of complaints.

Managers investigated complaints and identified themes. The care, quality and safety team tracked all registered complaints for integrated mental health services and discussed these with managers in the relevant service. Enquiries to MCALS about mental health services across the whole of Manx Care, related mainly to referral waiting times, support available and access to the drug and alcohol or crisis team.

The service used compliments to learn, celebrate success and improve the quality of care. We saw several compliments that patients had submitted in relation to the support staff had provided for them.

## Is the service well-led?

We found this service was well-led in accordance with CQC's assessment framework.

### Leadership

**Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.**

Staff were aware of who the senior leaders were and told us they felt confident in speaking to them if they had concerns. Local service leaders were based in the service and had an ‘open door’ policy. Staff were aware of who their senior leaders were. Family carers knew the local service leaders and patients knew how to contact the service.

### Culture

**Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.**

Staff told us they were very busy in their roles but that morale in the service was good. Staff felt there were good relationships within the multidisciplinary team and that they supported each other. Staff told us they had a high level of job satisfaction, and they enjoyed their work.

Staff gave examples of opportunities that were available to them for career development. Manx Care was supportive of funding learning and development opportunities for staff. However, there were some disparities in the terms and conditions for staff depending upon whether they were employed by Manx Care or the local authority, and this caused frustration for some staff.

We were not informed of any issues of bullying and harassment within the service.

We observed an open culture and staff told us they would feel confident raising concerns without fear of victimisation or recriminations.

Staff were able to provide feedback and share ideas for service development. We saw evidence in team meeting minutes of staff giving feeding back and making suggestions about how they could do things differently in order to improve the service.

**Governance**

**Our findings from the other key questions demonstrated that governance processes operated effectively at service level and that performance and risk were managed well.**

Staff completed regular clinical and non-clinical audits. Audits included: Standards for the Depot Clinic, Care Programme Approach outcomes, depot clinic prescribing and patient care records. The service manager had oversight of the audits and action plans and used the findings of these to drive improvement.

The service manager had good oversight of mandatory training, staff supervision and appraisals. They had a service development plan and were engaging with staff to find ways to deliver changes and improvements in how the service was delivered.

The service manager had sufficient authority to perform their role and was supported by the leadership team.

**Management of risk, issues and performance**

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect.**

The service had an up to date risk register which senior staff reviewed regularly. Staff were able to escalate concerns to the manager who could then include them on the risk register if necessary.

**Information management**

**Staff collected analysed data about outcomes and performance.**

Managers in the service regularly reviewed data which was relevant to the safe and effective running of the service. This data was monitored by senior leaders and presented to the Board of Manx Care.

**Learning, continuous improvement and innovation**

**Staff were committed to learning and improving how they delivered the service.**

They had identified areas for improvement and initiatives were underway, such as developing co-production work with patients and a recovery college. To reduce waiting lists, more clinicians were being trained to deliver psychological therapies and the service had partnered with a third sector organisation to deliver psychological therapies to people.

# Community-based Mental Health Services for Older People and Memory Service

## Overall summary

The Older Persons' Mental Health Service (OPMHS) provides a range of community orientated, services to older people with mental health problems and their carers, and a memory service to all age adults.

**People's experience of using this service and what we found**

We spoke with 2 patients and 4 carers. People said that staff were kind and listened to their needs. They had access to support and activities. People also said that they were not routinely asked their opinion on service delivery or development and that they were not always aware of their own or dependents care plans.

**Our key findings**

- The service provided safe care. There were enough staff on duty to meet people's needs. Patient caseloads were not too high, enabling staff to give patients and carers the time they needed. Staff assessed and managed risk well and followed good safeguarding practice. Incidents and accidents were recorded and reviewed to reduce the risk of a reoccurrence.
- The service demonstrated how they were meeting the recommendations for treatment and care.
- Staff supported people to be involved in their own care and to make day to day choices. People received person-centred support, were supported to be part of their local community and to be as independent as possible. Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in care decisions.
- The service was well led, with managers who understood the needs of their staff and patients. There were governance processes that ensured the service ran effectively. Staff were very positive about working within the older persons mental health service.

## The assessment

**About the service**

The Older Persons Mental Health Service (OPMHS) provides a range of community orientated, services to older people with mental health problems and their carers. The multidisciplinary team provides assessment, diagnosis, treatment and support for people over the age of 65 with a variety of organic and functional mental illnesses. The majority of people referred presented with cognitive dysfunction, most often caused by dementia, such as Alzheimer's disease. The service also provides a memory service for any age adults.

**During the assessment**

We observed a multidisciplinary meeting and 2 patient consultations.

We spoke with 8 members of staff including the service manager, consultant psychiatrist,

registered nurses and a support worker.

We spoke with 2 family members by telephone and 2 carers and 2 patients during the visit.

We reviewed policy and procedure documents relating to the management of the service. We reviewed 10 patients' medicines records but were unable to carry out a full review of patient records whilst carrying out this assessment.

## Is the service safe?

We found that this service was safe in accordance with CQC's assessment framework.

**Safe and clean environment**

**The clinic premises where patients were assessed and reviewed appeared clean, suitably equipped, well furnished, well maintained and fit for purpose.**

We found the environment was cleaned by an external company and that there were no cleaning schedules available confirming when, and by whom cleaning was undertaken. Staff did not have oversight of the cleaning of equipment or environment. Staff commented that they had outgrown the location and were awaiting completion of a new purpose built building at the island's main hospital site.

All interview and clinic rooms had portable alarms hanging on the inside of the door and staff available to respond.

The clinic room had the necessary equipment for patients to have required physical examinations but equipment, for example scales and blood pressure monitors, did not display portable appliance testing (PAT) or calibration dates. Staff commented that the this was normally done by the hospital engineering department but there had been a change of contracts recently and they were awaiting confirmation of when equipment would be reviewed. This meant that staff were not assured equipment was maintained, and in working order.

**Staffing and recruitment**

**The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.**

**Nursing staff**

The service had enough nursing and support staff to keep patients safe. The service had very low turnover rates. There were no outstanding nursing vacancies at the time of the assessment. The service manager reported that they had a waiting list of staff who would like to join the service as and when vacancies arose.

The service did not use agency nurses and had a pool of bank staff who previously worked within the service available to support vacancies and cover sickness when needed.

Sickness levels were low at 2.5 %. Managers supported staff who needed time off for ill health.

Staff used a recognised tool to calculate safe staffing levels and reviewed it annually and the

number and grade of staff matched the provider's staffing plan.

**Medical staff**

There was prompt access to a psychiatrist either in the clinic or on the phone during the opening hours of Monday to Friday, 9am to 8pm.

The service had a vacancy for a full time consultant psychiatrist they were in the process of appointing to fill the vacancy. At the time of assessment there was only one consultant psychiatrist as the locum specialist was unavailable. Staff confirmed they were able to access medical staff support when they needed it, and we observed this occurring during the assessment visit.

There was a business plan in progress to support recruitment of a clinical psychologist.

Managers used locums when they needed additional support or to cover staff sickness or absence and made sure all locum staff had a full induction and understood the service.

**Mandatory training**

**Staff completed mandatory training and the compliance rate for the older peoples' mental health service (OPMHS) was 86% overall which exceeded the expected target of 85%. The mandatory training programme was comprehensive and met the needs of patients and staff.**

There were areas where the completion rates dropped below the expected completion target, for example in Infection Prevention and Control (IPC) at 75%, Equality and Diversity at 84% and Fire Prevention at 73% but there were plans to address these needs.

Managers monitored mandatory training but acknowledged that the service's electronic system was limited in value and kept their own records. We reviewed the electronic record held by the manager and noticed that there were several gaps identifying staff who had not completed training. We were not assured that the managers had oversight of staff mandatory training however we were told that Manx Care had plans to introduce an electronic training management system.

**Assessing and managing risk to patients and staff**

**Staff assessed and managed risks to patients well. They responded promptly to sudden deterioration in a patient's health. Staff monitored patients on waiting lists to detect and respond to increased levels of risk.**

There were no lone working devices available for staff when working away from the clinic location. Staff completed weekly electronic calendars detailing their visits and performed a risk assessment prior to attending a home visit and if they felt necessary attended in pairs. They also followed a local personal safety protocol which relied on them leaving a record in the reception area, of the location and expected return time when they attended a home visit. If they failed to return, then it was the reception staff who were responsible for raising an alarm. Senior staff checked where all staff were at the end of the day, and anyone not accounted for would be contacted with escalation if contact was not achieved. This meant that staff could potentially be at risk in a patient's home with no way to alert the service. Staff commented that there had not been any incidences where their personal safety was compromised but we found this to be a potentially unsafe practice.

**Assessment of patient risk**

**Staff completed risk assessments for each patient on admission to the service using a recognised tool, and reviewed this regularly, including after any incident.**

Staff used a range of recognised risk assessment tools.

Staff working in the clinic had access to basic life support equipment and we saw that this was checked and recorded regularly with no omissions.

**Management of patient risk**

Staff responded promptly to any sudden deterioration in a patient's health. We observed this in the multidisciplinary meeting when a member of staff brought an unscheduled complicated case to the meeting for discussion.

Staff monitored patients on waiting lists for changes in their level of risk and responded when risk increased.

Staff commented that they completed risk assessments prior to visits to patients' homes.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training. Compliance rates were 95%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2017.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We saw evidence of this during the multidisciplinary meeting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns or needed advice.

Managers took part in serious case reviews and made changes based on the outcomes.

**Staff access to essential information**

**We observed staff accessing patient care records and staff said that records were easily available to all staff providing care. We were unable to view any patient records or comment on the accuracy, or comprehensive nature of them and there were no patient records audits to review.**

Electronic records were stored securely with password protected access.

**Medicines management**

**The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.**

Staff followed systems and processes to prescribe and administer medicines safely. Most

medicines were prescribed and monitored by patients' general practitioners (GPs) following advice from the service. We reviewed 10 patient care records to understand information about prescribing. There was no clear place in the records to show what medicines a patient was prescribed but we found information by searching the clinic letters the service had sent to patients' GPs. We were not able to find an up-to-date list of medicines for 3 of the patient care records we reviewed. We found 2 records showed repeat prescribing for medicines such as hypnotics and benzodiazepines, which guidelines suggest should be time limited due to risk of dependence.

A very small number of medicines were kept on the service premises and were securely stored in the clinic room. We saw that prescription pads were stored securely. The medicine fridge was checked daily for temperature fluctuations with no omissions recorded for the previous 3 months.

Staff reviewed patient's medicines during visits and appointments and provided advice to patients and carers about their medicines.

**Track record on safety**

The service had a good track record on safety.

**Reporting incidents and learning from when things go wrong**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff knew what incidents to report and how to report them. We found managers commented that there was not a strong incident reporting culture and were encouraging staff to report incidents with a no blame focus.

Staff reported serious incidents clearly and in line with the service policy.

The service had no never events in the 12 months prior to the assessment.

The service had a duty of candour policy. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

The service had a monthly newsletter which highlighted and discussed incidents of concern and shared learning.

## Is the service effective?

We found this service was effective in accordance with CQC's assessment framework.

**Assessment of needs and planning of care**

**Staff assessed the mental health needs of all patients.**

A mental health care co-ordinator was allocated for every person who was accepted to the Older Persons' Mental Health Service (OPMHS). A care co-ordinator is a member of the multidisciplinary team responsible for co-ordinating a package of care aimed at addressing older persons mental health needs and the needs of their carers/families. During the period of intervention, the care-coordinator may change for a variety of reasons, but the views of the older person and their family were sought prior to any change of the key worker role.

The memory service constituted approximately 70% of the services delivered and provided assessment, diagnosis, treatment and support to patients with memory problems/dementia and their relatives and carers. The OPMHS also provided assessment, treatment and support to patients experiencing functional mental illness and their relatives and carers. Patients were predominantly over the age of 65 years; however, the service provision was needs-led.

The service had comprehensive inclusion and exclusion criteria and pathways to direct staff to the most appropriate form of assessment and treatment.

Staff completed comprehensive mental health assessments of each patient using a range of assessment tools and ensured that patients had a physical health assessment and knew about any physical health problems.

**Best practice in treatment and care**

**Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.**

Staff provided a range of care and treatment suitable for the patients in the service. The service had accreditation from the Royal College of Psychiatrists (RCP) Memory Services National Accreditation Programme (MSNAP)

Staff delivered care in line with best practice and national guidance (from relevant bodies e.g. the National Institute for Health and Care Excellence NICE).

Staff made sure patients had support for their physical health needs, either from their GP or community services.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. We saw that there were a number of programmes delivered by the service to promote healthy lives including activities delivered at local leisure centres

**Skilled staff to deliver care**

**Managers made sure that staff had access to training for the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.**

The community mental health team included a range of mental health disciplines required for the patient group including, consultant psychiatrists, community psychiatric nurses, mental health liaison nurses, occupational therapists, community support workers and associate practitioners. A

social worker was also available.

The service did not have access to the full range of specialists to meet the needs of the patients with the lack of a clinical psychologist, however they were in the process of trying to recruit to the post and were supporting staff with training to meet patient needs, for example, some staff were undertaking cognitive behavioural therapy training.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had access to training for the right skills, qualifications and experience to meet the needs of the patients in their care, including bank staff, however we were not assured that all staff had completed specific training for their role. Dementia training was not shown as completed for 15 out of 45 staff for whom it would be appropriate.

Managers gave each new member of staff a full induction to the service before they started work and gave newly qualified staff a period of preceptorship.

Managers supported non-medical staff through regular, constructive clinical supervision of their work on a 2 monthly basis although we saw that the recording of this was not always consistent on the managers database.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers recognised poor performance, could identify the reasons and dealt with these.

**Multidisciplinary and interagency teamwork**

**Staff from different disciplines worked very well together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

We observed excellent team working with multidisciplinary team members working well together and supporting each other for the benefit of patients.

Staff held twice weekly multidisciplinary (MDT) meetings to discuss patients and improve their care. We observed a meeting which was well attended and inclusive of all grades of staff. During the meeting we heard detailed discussion about patients care and treatment. Staff updated patients' care records during the meeting. The multidisciplinary team liaised with the crisis team, social services, GP practices and community nurses.

The team had developed effective working relationships with Admiral nurses, who are specialist dementia nurses who are supported and developed by an external national dementia organisation.

Memory assessment services had effective working relationships with local GP practices to support patients and their carers from initial assessment through to the diagnosis process. Dementia support workers offered support and advice on issues such as driving with dementia, employment and benefits.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

**Ensuring consent to care and treatment in line with law and guidance**

**Staff received training on the Mental Health Act 1998 and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.**

Staff had access to support and advice on implementing the island's 1998 Mental Health Act and its Code of Practice.

As far as possible, people should be enabled to make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The Isle of Man did not have a legislative framework to assess and determine mental capacity. These decisions were made in line with common law. The Isle of Man government was in the process of developing this legislative framework and the Mental Capacity Bill was moving through parliament. Once enacted, the Bill would support practitioners to determine a patient's mental capacity and would include safeguards with respect to care and treatment when they might be deprived of their liberty. Staff received and were consistently up to date with training on the Manx Care interim Mental Capacity policy and had a good understanding of the principles.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

## Is the service caring?

We found this service was caring in accordance with CQC's assessment framework.

**Kindness, privacy, dignity, respect, compassion and support**

**Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

Staff were discreet, respectful, and responsive when seeing patients.

Staff gave patients help, emotional support and advice when they needed it. There was a strong, visible person-centred culture. Patients were active partners in their care. Patients told us that they felt understood and well cared for.

Staff supported patients to understand and manage their own care treatment or condition. Staff gave explanations for the different treatments available. Patient individual preferences and needs were reflected in how care was delivered.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. The patients and carers we spoke with were positive about the way staff treated patients. Staff understood and respected the individual needs of each patient. Staff recognised and respected the totality of patient's needs. We observed 2 patient consultations with the psychiatric consultant and memory service support worker. The

psychiatric consultant put the patients at ease, used plain and simple language and were sensitive and respectful. They provided pauses in the conversations and gave the patients and carers time to reply and ask any questions. Patients emotional and social needs were highly valued by staff and embedded in their care and treatment.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff should they need to.

Staff followed policy to keep patient information confidential. Staff sought permission for us to contact patients during the assessment. There was a confidentiality policy and patient records were stored electronically.

**Involvement of patients**

Staff involved patients in care planning and risk assessment. Staff informed and involved families and carers appropriately. There was no access to an independent advocacy service and patient and carers views of the service were not routinely collected or used to develop the service.

The service provided a 6 week course of weekly sessions for patient carers to attend to gain insight into patient's conditions and ways to help them. Carers said that this was very useful.

Patients and carers said they did not have access to their care plans although it may be that they did not recognise documentation left at their homes as such. We were unable to visit patients' homes to confirm this.

Patients could give feedback on the service and their treatment through the Manx Care friends and Family feedback form and the post diagnosis and discharge feedback form, but this did not appear to happen on a regular basis. Feedback was audited on a monthly basis and fed back to the team via the governance meeting. Staff were unable to provide any audit of patient satisfaction surveys.

The service had no access to independent advocacy services, staff commented that they would signpost people to the Manx Care Advice and Liaison Service (MCALS) in lieu of advocacy. We saw in the MCALS leaflet displayed in the clinic reception that advocacy was not covered by MCALS.

We observed staff making sure patients understood their care and treatment during consultations.

**Involvement of families and carers**

Staff supported, informed and involved families or carers. Those carers and relatives said that the service was responsive when contacted.

The carers told us that staff were very patient and took time to explain and that they never felt rushed. One carer told us their partner was very much involved and that they looked forward to the team visiting and external activities provided such as coffee mornings and exercise classes. Families and carers told us staff explained about medicine usage and side effects.

Staff involved families and carers in discussions, options and decisions about the patient's holistic care. Families and carers were able to access local carers groups and organisations.

## Is the service responsive?

We found this service was responsive in accordance with CQC's assessment framework.

**Access and waiting times**

**The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.**

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. Staff saw patients who were referred urgently quickly and those with non-urgent referrals within the target time. The community mental health and memory assessment service waiting time as of July 2022 was 14 weeks.

The services operated 7 days per week, 9am to 8pm Monday to Friday and 9am to 5pm weekends and public holidays to meet patient's needs.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services and tried to contact people who did not attend appointments and offer support.

Patients had some flexibility and choice in the appointment times available.

Staff worked hard to avoid cancelling appointments and when they had, they gave patients clear explanations and offered new appointments as soon as possible. Appointments ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists/support patients.

Staff supported patients when they were referred, transferred between services, or needed physical health care.

**The facilities promote comfort, dignity and privacy**

**The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.**

The memory service and older persons community mental health teams worked from one room and staff commented that it could become crowded at times. There was a plan to move to new purpose built premises the following year.

The service had a range of rooms and equipment to support treatment and care. Interview/consulting rooms in the service had sound proofing to protect privacy and confidentiality.

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

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, cultural and spiritual support.**

The service could support and make adjustments for people with disabilities, communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. We saw leaflets in the clinic reception area relating to Manx Care Advice and Liaison Service (MCALS).

The service provided information and leaflets in English but said they could provide information in other languages if required. The staff were unaware of any formal translation service available, with staff commenting they would try and enlist a second language speaker within Manx Care to translate or use a family member if necessary.

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

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives and carers we spoke with knew how to complain or raise concerns.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Between 01 February and 31July 2022 the service received 2 complaints. Both were related to values and behaviour of staff and were upheld.

Staff understood the policy on complaints and knew how to handle them. Staff told us they knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Team leaders investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Team leaders shared feedback from complaints with staff and learning was used to improve the service.

## Is the service well-led?

We found this service was well-led in accordance with CQC's assessment framework.

**Leadership**

**Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.**

Staff consistently told us that morale was high, teams were supportive of each other, and their team leaders and they felt a high level of satisfaction within their roles.

Staff confirmed that there was an open door policy for accessing team and service leads and we observed this in action during the assessment.

Staff knew where to access the whistleblowing policy and told us that they would have no hesitation in using it if they needed to. Staff were able to make suggestions about the service with their team leaders.

The team managers understood the service well and had received leadership training to support

them in their roles. Team managers were aware of the problems within their service had had escalated concerns to the senior management team. Service managers had a clear understanding of the services and the issues they faced. Service managers described the governance systems in place to ensure they communicated across the geographical areas and shared learning and good practise.

### Vision and strategy

**Staff knew and understood the provider's vision and values and how they applied to the work of their team.**

The service had a mission statement "To provide an accessible, effective, efficient and high quality mental health service to older persons of the Isle of Man". Staff were highly motivated, passionate and inspired to offer care that was kind and promoted people's dignity. We saw effective team working linked to the mission statement.

Staff told us they strived for the best care and quality of life for the patients and carers and sought to place them at the heart of everything that they do.

### Culture

**Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could raise any concerns without fear.**

Staff said they felt respected, supported and valued by their team leaders and managers. There appeared to be a good culture within the team; and staff had a good understanding of the service they provided. staff said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Team leaders informed staff when changes were planned within the trust. Staff knew who the most senior managers were and told us they regularly visited services and were accessible.

We saw patients were respected and valued as individuals and were empowered as partners in care.

There was a well embedded culture of wellbeing across the service. All staff said that they felt like they were part of a big family, and gave examples of how their managers, and peers provided genuine support.

Managers and the teams demonstrated mutual respect and value for each other through their interactions and through the feedback they provided as part of the assessment process.

### Governance

**Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.**

The older people's mental health service (OPMHS) held governance meetings monthly to discuss a varied agenda including but not limited to; clinical concerns, risk management, client carer involvement, communication, resources, strategic issues and learning and development. The core members of the governance meeting were the manager, an OPMHS clinical nurse specialist, community mental health professionals, community registered nurses, community support workers

and occupational therapists. After each meeting, a copy of the minutes was saved in the OPMHS shared area and sent via email to all OPMHS team members.

Despite the submission of data to the Memory Service National Accreditation Programme, audit of other clinical areas did not appear to be well embedded, for example the service did not undertake routine compliance audit of patient care records, or environmental cleanliness.

There was regular discussion on safeguarding, mental capacity and the Mental Health Act at the multidisciplinary team meeting.

Caseload numbers were reviewed and reallocated, if necessary, by team leaders to ensure that staff workload was equitable.

There were electronic systems in place to collect data on supervision rates, staff appraisals and mandatory training but senior staff informed us that these were not reliable and kept their own data.

There were regular team meetings which were well attended by staff.

**Management of risk, issues and performance**

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect.**

Managers and team leaders used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Effective multidisciplinary meetings across the service helped to reduce patient risks and keep patients and staff safe. Managers ensured that staff were offered the opportunity to give feedback and input into service development. Staff did this through regular team meetings.

**Information management**

**Staff collected analysed data about outcomes and performance and engaged actively in national quality improvement activities.**

Staff used electronic patient care record systems. Information governance systems included policy on confidentiality of patient records.

Patient care records could only be accessed by staff with the appropriate authority by way of a personal log on and password. Any hard copy records were stored securely in rooms only accessible to staff.

**Engagement**

**The service did not regularly collect patient satisfaction data to review patient and carer views of the service which meant that patients and carers were not involved in service development.**

The OPMHS held regular team meetings and we reviewed the minutes of these. This meant there were opportunities for staff to meet formally to discuss issues relevant to the running and development of their service.

Staff were consulted about proposed changes and were able to input into the planning of the

service. We saw this in the staff input into the design and layout of the new clinic space currently under construction.

Managers engaged with other health and social care services within Manx Care to ensure that an integrated health and care system was provided to meet the needs of the local population.

**Learning, continuous improvement and innovation**

**All staff were committed to continually improving services and had a good understanding of quality improvement methods.**

All staff felt able to make suggestions. Staff were given time and support to consider opportunities for improvements and could feed these in to bring about positive change within the service.

Team meetings were used as forums for staff to share any ideas regarding improving the local service.

# Mental Health Acute and Older People's Wards

## Overall summary

Inpatient mental health services for the Isle of Man are based at Manannan Court at Noble's Hospital in Douglas. The unit is an admission facility for all people over the age of 16 who are experiencing acute mental illness or crisis of their mental health and wellbeing and who require an inpatient admission.

**Our key findings**

- All premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Further work was required to ensure that the Glen Suite was more homely and dementia friendly. However, we acknowledge that an audit had been commissioned and had made a number of recommendations to meet this need and that this was being addressed through improvement plans.
- The seclusion facility was found to be well designed and allowed for sufficient observation of patients when in use.
- We found significant gaps in staffing that had impacted on patient care. Patients and staff confirmed that staffing levels could lead to leave being cancelled and to a lack of activity at times. Not all staff had undertaken mandatory training including training in restrictive practice. Staff told us that while they enjoyed working at the service, they had contemplated leaving due to a lack of progression structure. Staff also told us that staffing levels impacted on their ability to fully engage in training, supervision and development opportunities.
- Further work was required to ensure that risk assessments and care plans are updated in a timely way to reflect patients risks and needs. However, we acknowledge that nursing notes did include details of issues of concern and some risk formulation.
- We were concerned about the gender and acuity mix of patients at the wards. There were no clear arrangements to manage the risk posed by gender mix within bedroom areas.
- We noted examples of seclusion which appeared to not have been terminated in a timely way due to a lack of available medical input. However, overall restrictive intervention was managed well and was reducing. We also observed an incident on Glen Suite in which a patient was managed in a side room: staff had not recognised this incident as seclusion and therefore the safeguards afforded by the Mental Health Act Code of Practice had not been followed. However, overall restrictive intervention was managed well and was reducing.
- The service used systems and processes to safely prescribe medicines. Staff recorded that they regularly reviewed the effects of medicines on each patient's mental and physical health.
- Staff knew how to report incidents and safeguarding concerns, managers investigated these concerns appropriate and shared learning with staff.
- Not all patients we spoke with were clear about their rights under the Mental Health Act. Patients do not have access to independent advocacy other that through a legal representative.

- Further work is required to ensure that the legal authority and consent are in place for the administration of medicines. Treatment certificates should be available to staff so that they can check that the legal authority was in place and what medication was authorised.
- Key leaders described that their workload was substantial despite working long and hard to deliver. We found that there was a lack of leadership capacity across the service.
- While we could see that the leadership team were working hard to improve the service, we did not see that there was a clear overarching mental health service strategy in place to drive this improvement and set out key priorities. In addition, there was not a clear operating model for the acute service.
- Governance and assurance processes need further work and the audit of key practices and outcome measures required further development. Data available to managers was not always helpful or indicative of areas of potential concern.
- Our findings from the other key questions demonstrated that governance processes required further development to ensure that the service operated effectively, and that performance and risk were managed safely.

## The assessment

**About the service**

Inpatient mental health services for the Isle of Man are based at Manannan Court at Noble's Hospital in Douglas. The unit is an admission facility for all people over the age of 16 who are experiencing acute mental illness or crisis of their mental health and wellbeing and who require an inpatient admission. The aim of the unit is to provide a safe environment delivering specialist care from a multi-disciplinary team which focuses on the individual needs of the patient while they receive treatment, support and care to help them recover as quickly as possible.

The unit has 2 wards: Harbour Suite and Glen Suite. Harbour suite is designed to meet the needs of adult patients while Glen Suite is designated to work with older adults who need inpatient care.

Glen Suite has 12 beds. Harbour Suite has 14 beds and access to 2 additional beds in Glen Suite which can be used flexibly to meet the needs of either population.
The island's seclusion facility is also collocated with Harbour suite within the Cushag Suite, staff from Harbour Suite manage the needs of patients when this practice is required.

**During the assessment**

We looked at the environment of the wards, seclusion facility and communal areas used by patients and staff.

We spoke with 7 patients who had used the service.

We observed the care provided to 4 patients.

We observed a ward round where patients met with the multi-disciplinary team.

We attended a morning handover meeting.

We spoke with 16 members of staff including the service manager, ward managers, doctors, nurses, health care assistants, a pharmacist and administration staff. We also spoke with all senior

leaders of the service.

We reviewed a range of records. This included 13 patients care records and 13 medication records.

We reviewed a variety of records relating to the management of the service, including audits, policies and procedures.

You can find information about how we carry out our assessments on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-assessment

## Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

**Safe and clean environment**

**All premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.**

All areas were visibly clean, well maintained and fit for purpose. The service manager confirmed that maintenance and additional cleaning requests were actioned in a timely way.

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Appropriate systems based on guidance had been put into place to manage the risks associated with COVID-19. This included the accessibility and use of personal protective equipment (PPE), COVID-19 testing and safe distancing measures for patients and staff.

Staff completed risk assessments of the wards, but wards were not always safe in all areas.

**Safety of the ward layout**

Staff completed and updated risk assessments of all wards areas and removed or reduced any risks they identified.

The wards had ligature risk assessments that were reviewed in December 2022. Overall staff knew where ligature risks where and where risks were found staff worked to mitigate these by increasing observations of patients and presence of staff in communal areas. There was ongoing work to reduce identified ligature risks. We saw staff took action to reduce risks.

The wards were mixed gender and there were no clear arrangements to manage the risk posed by gender mix within bedroom areas. While staff attempted to ensure separation of different genders in bedroom corridors this was not always possible due to demand. This did not meet CQCs guidance on mixed sex accommodation. During the assessment we noted patients of both genders, unobserved in bedrooms areas. On Glen Suite we also observed a male patient who was disinhibited around female patients. Female patients told of occasions when they had felt vulnerable to male patients.

Staff could observe patients in most communal areas of the wards although we noted that part of the bedroom corridor could not be observed from the night office on Glen Suite.

Staff had easy access to personal alarms however there was no nurse call system on the wards.

### Seclusion room

The hospital's seclusion facility was collocated with Harbour suite within the Cushag Suite. The seclusion room was well designed and allowed clear observation and two-way communication. There was a de-escalation area, and it had an ensuite shower room and a clock. Strong bedding and an anti-tear mattress were available. The suite had access to a small courtyard that patients could use under supervision.

### Safe staffing

**The service worked hard to improve staffing, but the service did not always have enough nursing and medical staff, who knew the patients and received basic training.**

We found gaps in staffing that had impacted on patient care. At the time of the assessment the wards were extremely busy with several patients who required intensive nursing. We noted this had impacted on the activity available to other patients, and some patients told us that they were bored.

Manx care told us that staffing was used flexibly across both wards therefore provided overall staffing levels for Manannan Court. The unit had a funded establishment of 81 staff. Recently the team had recruited a psychologist, an associate specialist doctor, a band 6 nurse and an activity coordinator however there remained 6 vacancies for: a band 6 nurse, an occupational therapist, an activity coordinator and 3 healthcare assistants. In addition, the ward manager role for Glen Suite was being delivered by an interim staff member. Recruitment was underway to fill these posts at the time of the assessment.

The staffing establishment on Harbour Suite was a minimum of 2 nurses for day and night shifts and 5 or more support workers during the day and 4 at night.

The staffing establishment on Glen Suite was a minimum of 2 nurses for day and one nurse for night shifts and 4 or more support workers during the day and 3 at night.

All shifts we reviewed had the correct number of qualified nurses on duty.

The service did not use agency staff at the time we visited but did use bank staff from other services and internal ward staff worked additional shifts to cover the wards. Most bank staff used had previously been permanent staff at the service, so knew the team and its procedures well.

Sickness hours were reported as low within the team. However, 13 staff were noted to be either on sick or maternity leave, involved in external training or deployed elsewhere at the provider at the time of the assessment.

Harbour Suite had a long term locum consultant psychiatrist and had recently recruited an associate specialist doctor. Glen Suite had a consultant psychiatrist who also worked within the community team. The consultant was due to leave the provider later this year. In the interim an additional consultant psychiatrist had been recruited and would join the service in the near future. The consultants described their role as very busy and welcomed the additional support and focus on the wards. However, we found that the patients could get support from a psychiatrist when they needed to.

### Mandatory training

**All new starters were provided with induction training and a copy of the induction booklet.**

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept spreadsheets of information identifying when staff were due to complete or had completed their mandatory training. The organisation hoped to introduce an electronic training notification system for staff.

A mandatory training programme was in place however staff told us they had limited time to keep up to date with their mandatory training. Thirteen courses were classed as mandatory dependent on role. At the time of the assessment overall compliance averaged 60%. Most courses were above 70% however not all staff had received training in:

- basic life support (25%),
- fire safety (42%),
- PMVA theory (Prevention Management of Violence and Aggression) (66%),
- PMVA breakaway (52%) and PMVA teamwork (31%).

Managers explained that this training had not been available during the pandemic and since it was reinstated the team had been struggling to book on to sufficient courses. At the time of the assessment the service manager provided details that confirmed that all relevant staff had enrolled on courses to take place in the near future.

**Assessing and managing risk to patients and staff**

**Staff undertook handover meetings at the start of shift which included a detailed update of patients risks. Staff continually monitored patients for changes in their level of risk and responded when risk increased.**

We found that known risks were recorded in patients' clinical notes and acknowledge that nursing notes did include some risk formulation. However, staff did not always complete a specific risk assessment tool or risk management plan for each patient on admission to the service, and where available these were not always reviewed regularly, including after any incident. In addition, we found that there was contradictory information within these documents where present.

**Use of restrictive interventions**

The wards followed the provider's observation policy and staff were required to complete general observations for all patients. During our assessment we reviewed general observation and seclusion records, it was clear that observations were completed and recorded by staff.

Manx Care had a programme in place to reduce restrictive interventions and met the Restraint Reduction Network Training Standards. Data reviewed indicated that the use of restraint, rapid tranquillisation and seclusion was decreasing. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. In the previous 6 months there had been 44 uses of restrictive practice. This included 17 occasions where rapid tranquilisation was administered and 9 occasions that resulted in seclusion. There were 9 occasions where prone restraint had been used. Following each incident of restrictive practice managers undertook a review of the practice and used this to inform further learning.

Staff followed NICE guidance when using rapid tranquilisation. Staff used medicines for rapid tranquilisation as a last resort. Patients usually received post dose physical health monitoring after

the administration.

We reviewed records for the 4 occasions when a patient had been secluded during January 2023. Staff kept clear and detailed records of seclusion practice and the circumstances that had led to the seclusion. We noted 2 examples where it appeared that the seclusion had not been terminated in a timely way due to a lack of available medical input.

We observed an incident on Glen Suite in which a patient was managed in a side room. This incident appeared to meet the definition of seclusion in that the patient had been prevented from leaving the area. It is unclear that staff had recognised this incident as seclusion and therefore the safeguards afforded by the Mental Health Act Code of Practice had not been followed.

Long-term segregation was not used on the wards.

**Staff access to essential information**

**The team had access to an electronic patient care record system which was shared across the provider.**

This system facilitated effective information sharing across mental health and acute care services. Any paper records were scanned on to the system to ensure access and safe storage. Electronic records were stored securely, and we observed staff using good information governance protocols, such as locking their computer screens when leaving their desks. We found that staff had recorded information in different areas of the electronic system meaning it was not always easy to locate important information.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had kept up to date with training on how to recognise and report abuse.**

Staff understood their responsibilities to protect patients from abuse and the organisation had appointed a safeguarding lead. The team also had a safeguarding lead who supported staff through training and advice. Training on how to recognise and report abuse was available to staff as appropriate and most staff had kept up to date with the training. Across acute services 81% of staff were up to date with adult safeguarding training and 87% of staff were up to date with children's safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The team demonstrated an understanding of safeguarding principles and practice and had made safeguarding referrals in the previous year. Safeguarding concerns were discussed at multidisciplinary team meetings.

**Medicines management**

**The service used systems and processes to safely prescribe medicines. Staff recorded that they regularly reviewed the effects of medicines on each patient's mental and physical health.**

Overall staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up to date. The provider was in the

process of procuring an electronic prescribing and medicines administration system to support staff to administer medicines safely and reduce medicines errors. Staff stored and managed all medicines and prescribing documents safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines in most cases. A pharmacist supported the wards with this.

Mental Health Act certificates were in place in patient records and were up to date with the correct medicines that patients were prescribed. However, further work was required to ensure that the legal authority and consent were available to staff in the clinic area as they administered medicines.

The service ensured that people's behaviour was not controlled by excessive and inappropriate use of medicines. "As and when required" medicines (PRNs) for the management of agitation and aggression or anxiety were usually used safely and appropriately.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Where patients were prescribed medicines with additional monitoring requirements such as clozapine, lithium or high dose anti-psychotic therapies (HDAT) their physical health was monitored in line with the provider policy and national best practice guidance.

**Clinic room and equipment**

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The wards shared a single clinic room. Medicines cabinets were locked when not in use and only accessible to authorised staff. Controlled drugs (medicines with additional storage and recording requirements) were stored securely and checks of these were conducted at each shift change on the wards. Medical oxygen was stored in clinic room; this was kept secured to an anchor point and there was appropriate signage on the door to the room to make people aware of the risk. However, staff were unable to locate records of the checks made on the oxygen equipment.

The provider checked, maintained, and cleaned equipment although not all records where available on the wards.

**Reporting incidents and learning from when things go wrong**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

There were no serious incidents under investigation at the time of the assessment. In the previous 3 months there had been 114 incidents that had resulted in moderate, low or no harm. The most common types of incidents were verbal or physical aggression, self-harm, medication and staffing issues.

The service had not been subject to any specific Isle of Man Safeguarding Adult Board Serious Case Management Review recommendations. Following a recent Safeguarding Adult Board Serious Case Management Review, recommendations had been made to all agencies about how to recognise and respond to self-neglect. Manx Care had shared this information with staff.

Staff knew what incidents to report and how to report them through DATIX system. Managers

debriefed and supported staff after incidents. Managers investigated incidents thoroughly. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff raised concerns and reported incidents and near misses in line with Manx Care's policy.

Manx Care had a duty of candour policy. Staff understood the duty of candour. They understood to be open and transparent and gave patients and families a full explanation when things went wrong.

Managers shared learning with their staff about serious incidents that happened elsewhere in Manx Care and across the wider national healthcare landscape. Staff also had access to a regular safety bulletin. Staff used team meetings to discuss the feedback and look at improvements to patient care.

## Is the service effective?

We found this service was effective in accordance with CQC's assessment framework.

**Assessment of needs and planning of care**

**Staff completed assessments with patients on accessing the service however they did not always work with patients to develop individual care plans or update them as needed. Care plans where present reflected most assessed needs but were not always personalised, holistic and recovery oriented.**

Staff completed an assessment of each patient's needs however they did not always work with patients to develop individual care plans or update them as needed. Care plans did not fully consider all patient needs particularly physical health and wider social needs. However, we did note further information about patient's care needs within nursing notes and heard about specific needs at the handover meeting we attended.

Care records did show that staff met regularly with patients and responded when patient's risks or needs changed.

**Best practice in treatment and care**

**Staff could not always provide a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Staff ensured that patients had good access to physical healthcare or support patients to live healthier lives.**

Staff provided a range of care and treatment for their patients as recommended by guidance. We found staffing levels could lead to leave being cancelled and to a lack of activity at times. At the time of the assessment the wards were extremely busy with several patients who required intensive nursing. We noted this had impacted on the activity available to other patients, and some patients told us that they were bored. In addition, we found limited evidence that staff had considered best practice guidance to assist their decision making about best available treatments.

GPs took the lead for physical healthcare on the island. The team described challenges patients had in accessing these services. We found that the team ensured that patients had a physical health assessment at admission and undertook ongoing physical health monitoring.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We reviewed food and fluid monitoring charts where relevant and saw these were fully

completed for patients who required this.

**Skilled staff to deliver care**

**The teams included or had access to the range of specialists required to meet the needs of patients under their care. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills however staff had limited capacity to fully participate in this.**

The service had a range of specialists to meet the needs of each patient. This included medical, nursing, psychology and pharmacy professionals.

Where a patient required care that was not available on the Island the team ensured that the person was referred appropriately to services in the UK. Staff told us that there could be delays in people being transferred which impacted on patient care.

Team meetings took place.

Staff told us they had management supervision with managers in the service. Managers supported non-medical staff through regular, constructive clinical supervision of their work.

The corporate capability policy pre-dated the establishment of Manx Care. Managers recognised poor performance, could identify the reasons and dealt with these. Staff were supported to improve.

**Multidisciplinary and interagency teamwork**

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held regular team and handover meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff had effective working relationships with other teams in the organisation including the emergency department, crisis services, community adult, older people's community, and drug and alcohol teams. Protocols to support patients transfer between services were being developed by managers across the integrated mental health service.

Staff described effective working relationships with external teams and organisations, including third sector agencies, the criminal justice teams, prison and police services, housing, social care and education.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**

**Staff understood their roles and responsibilities under the Isle of Man Mental Health Act 1998 and the Mental Health Act Code of Practice.**

Staff received and kept up to date with training on the Mental Health Act 1998 and the Mental Health Act Code of Practice.

Some patients were not fully aware of their rights under the Mental Health Act.

Access to a free independent mental health advocacy service was not available on the Isle of

Man. Manx Care's Mental Health Act Legislation Committee hoped to develop and introduce an independent advocacy service. Patients could instruct independent legal advice to support them with mental health matters such as Mental Health Review Tribunals and apply for legal aid to help with the costs.

### Good practice in understanding mental capacity

**Staff supported patients to make decisions on their care for themselves but did not routinely assess and record capacity clearly for patients who might have impaired mental capacity.**

The Isle of Man did not have a legislative framework to assess and determine mental capacity. These decisions were made in line with common law. The Isle of Man government was in the process of developing this legislative framework and the Mental Capacity Bill was moving through parliament. Once enacted, the Bill would support practitioners to determine a person's mental capacity and would include safeguards with respect to care and treatment when they might be deprived of their liberty. Manx Care introduced a capacity, best interest decisions and deprivation of liberty policy in June 2022. The policy included a formal assessment tool for staff to use.

## Is the service caring?

We found this service was caring in accordance with CQC's assessment framework.

### Kindness, privacy, dignity, respect, compassion and support

**Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care and treatment.**

Staff were discreet, respectful, and responsive when caring for patients. Patients told us that while staff were very busy, they did give them time to express themselves.

Staff gave patients help, emotional support and advice when they needed it. Patients told us they were able to get help and support from staff when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Staff directed patients to other services and supported them to access those services if they needed help. This included supporting patients to engage with community teams and third sector organisations and in a range of therapeutic interventions, which were also accessible online.

Staff understood and respected the individual needs of each patient. We observed staff knock on patient bedroom doors before entering. At the handover meeting we observed staff to be very knowledgeable about specific patients care needs.

Staff followed policy to keep patient information confidential.

### Involvement in care

Staff involved patients in decisions about their care, but staff did not always make sure that patients received copies of their care plans and risk assessments. They ensured that patients had easy access to additional support.

### Involvement of patients

Staff involved patients in decisions about their care and made sure that they understood their care needs and treatment plans. However, we were unable to identify if staff gave them access to their care plans. The patients we spoke with understood what their support looked like, but patient care records did not always show that staff had engaged patients in developing their care plans or that they had been given a copy.

Staff involved patients in decisions about the service, when appropriate. The team was working hard to engage patients and their carers in the development and delivery of the service. Patients could give feedback on the service and their treatment and staff supported them to do this. They were encouraged to complete feedback forms and to complete a questionnaire when they were discharged from the service.

## Is the service responsive?

We found this service was not always responsive in accordance with CQC's assessment framework.

**Access and waiting times**

**The service was accessible, and staff planned and managed discharge and transfers well. However, the wards catered for patients with a wide range of needs and experienced high acuity, this limited the level of care some patients received.**

The unit is an admission facility for all people over the age of 16 who are experiencing acute mental illness or crisis of their mental health and wellbeing and who require an inpatient admission. The aim of the unit is to provide a safe environment delivering specialist care from a multi-disciplinary team which focuses on the individual needs of the patient while they receive treatment, support, and care to help them recover as quickly as possible.

The unit has 2 wards: Glen Suite and Harbour Suite.

Harbour suite is designed to meet the needs of adult patients under 65 years of age while Glen Suite is designated to work with older adults who need inpatient care. Harbour Suite has 14 beds. Glen Suite is designated to work with older adults who need inpatient care while Glen suite provides care to older people with both functional and organic mental health needs. Glen Suite has 12 beds however 2 of the beds are accessible to Harbour Suite and can be used flexibly to meet the needs of either population.

Leaders told us that the service has seen an increase in demand and was extremely busy. Statistics supplied ahead of the inspection stated that the unit’s occupancy level was 93% during the previous 3 months. However, the team on Harbour ward had since undertaken some audit to look at numbers of patients under the care of their team. This stated that during December 2022 the number of patients allocated had ranged between 17 and 21. This equated to between 121 and 150% patients against bed availability. A number of these additional patients were ‘sleeping’ on Glen Suite but spending their day on Harbour Suite. Staff on Glen Suite told us that this meant that ward was very busy and that they needed to work with a range of patients with varying needs.

There is no psychiatric intensive care unit, or specialist wards for children or people with additional needs on the Isle of Man. Harbour Suite therefore worked with patients with a wide range of needs and acuity. We found the ward to be extremely busy with several patients who had very complex

needs and required intensive nursing. Some patients told us that at times there were patients on the ward who were very unwell and could be intimidating. Patients stated that this impacted on their own level of care.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff had effective working relationships with other teams in the organisation including the emergency department, crisis services, community adult, older people, and drug and alcohol teams. Protocols to support patients transfer between services were being developed by managers across the integrated mental health service.

Managers and staff worked to make sure they did not discharge patients before they were ready.

Staff carefully planned patients' discharge and worked with community teams to make sure this went well. Managers monitored the number of patients whose discharge was delayed and took action to reduce delays. However, some patients on Glen Suite had been there for a significant time. In 2 incidences we were unclear about why the individual needed to be in receipt of hospital care. Staff told us that this related to a lack of residential social care for these individuals.

**The facilities promote comfort, dignity and privacy**

**The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.**

The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Patient bedrooms were well designed, spacious and had access to an ensuite shower room. Patients were able to store their possessions safely. The wards had individual interview rooms, activity spaces and a full range of rooms to support treatment and care.

Further work was required to ensure that the Glen Suite was more homely and dementia friendly. However, we acknowledge that an audit had been commissioned and had made a number of recommendations to meet this need and that this was being addressed through improvement plans.

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

**The service met the needs of all patients, including those with a protected characteristic or with communication support needs.**

The service could make adjustments for disabled people, people with communication needs or people with other specific needs. The building was accessible for people with restricted mobility. Corridors and doorways were wide enough to accommodate wheelchairs and there were accessible toilets for staff and patients to use. The building was easily accessible for people using public transport.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information was readily available in the patient areas and on the Manx Care website.

The service had information leaflets available in English.

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

**The service treated concerns and complaints seriously, investigated them and learned**

**lessons from the results, and shared these with the whole team and wider service.**

We found that patients, relatives and carers knew how to complain or raise concerns. Patients told us they had a good response from staff when they raised issues.

Manx Care had recently concluded a pilot service called MCALS – Manx Care Advice and Liaison Service. The service took calls and emails from patients, families, carers and members of the public who wanted a response to an enquiry. Manx Care concluded that MCALS would be a permanent service. For the first time this gave members of the public a direct helpline spanning both health and social care services. MCALS also supported people to raise a formal complaint about services if they wished to.

Staff understood the policy on complaints and knew how to handle them. Staff had also received a bulletin including a reminder on how to recognise and manage complaints in July 2022. There had been one formal complaint for this service since October 2022. This had been fully investigated and resolved satisfactorily. Learning had been shared with the team.

Managers of Manx Care investigated complaints made across the services and identified themes. The care, quality and safety team tracked all registered complaints and discussed these with managers in the relevant service.

## Is the service well-led?

We found this service was not always well-led in accordance with CQC's assessment framework.

### Leadership

**Leaders had the skills, knowledge and experience to perform their roles and were visible in the service. However, there was limited managerial capacity.**

We found that managers worked hard to provide support and supervision to the service however there was limited managerial capacity.

Overall management was undertaken by an operational manager who also oversaw the crisis and community mental health team and was supported by a service manager who led at the unit. Harbour Suite had a manager however there was no deputy. Glen Suite had a temporary manager however there was no deputy. Staff told us that while the managers were very supportive, they were extremely busy and had limited time to support staff.

The Manx Care senior mental health leadership team recognised this issue and was considering how the service could be managed in the future. Staff were aware of who the leaders were and told us they felt confident in speaking to them if they had concerns however recognised the need for dedicated leadership of the service.

### Vision and strategy

**Staff knew and understood the service's vision and values and how they applied to the work of their team.**

While we could see that the leadership team were working hard to improve the service, we did not see that there was a clear overarching government mental health strategy in place to drive this improvement and set out key priorities for the service. In addition, while there was an operational policy for the unit the operating model for the acute or older person’s service was not clear.

Staff knew and understood the vision and values of the team and their role in achieving them. They felt that there needed to be a clearer strategy for the service and its role in wider mental health services. Staff were clear regarding their manager's and their own roles and responsibilities but considered that there needed to be a clearer operating model setting out what the service could and could not do, and their individual role in achieving this.

### Culture

**Staff felt respected and supported however the demands on the service impacted on their ability to access professional development. They felt able to raise concerns without fear of retribution but did not feel able to influence the development of the service.**

Morale was described as overall good at the service, staff said that they felt part of a cohesive team and that the team worked well together. Staff confirmed local leaders were approachable and supportive of their work but recognised that they had minimal capacity to lead on the development of the service. Staff told us that provider's senior leadership felt remote, and the needs of the mental health service were overshadowed by other directorates needs at the provider. Staff did not feel able to influence the development of the service beyond the local level.

All the staff told us they were extremely busy with their workload but were committed and passionate about delivering the best care they could.

Staff told us that there was no capacity to develop within their role due to the grading structure. A number of staff told us they were contemplating leaving the service in order to gain promotion opportunities.

Staff told us there was no bullying in the unit. They demonstrated that they were respectful of each other and worked well together as a multidisciplinary team to meet patients' needs. Staff told us they would feel confident raising concerns without fear of victimisation or recriminations. A whistleblowing process was in place that allowed staff to go outside of their line management should they need to raise any concerns. Staff knew about the whistleblowing processes and stated they would feel confident to use these should they need to. There had been no formal reported cases of whistleblowing or bullying about the team in the previous year. Where required, staff performance issues had been managed appropriately.

Staff had access to professional development, clinical supervision and management supervision appropriate to their role however, their ability to access this was hampered by demand on the service. Manx Care was supportive of funded learning and development opportunities for staff. Staff gave examples of opportunities that were available to them for career development, and some had undertaken nurse training or additional training in therapeutic interventions.

### Governance

**Our findings from the other key questions demonstrated that governance processes required further development to ensure that the service operated effectively, and that performance and risk were managed safely.**

The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning however this required further development. The acute service held governance meetings, but staff stated they had limited capacity to engage in this. Governance and assurance processes need further work and the audit of key practices and

outcome measures required further development. Data available to managers was not always helpful or indicative of areas of potential concern.

Systems and processes were in place to capture governance and performance information and local processes had been developed, including complaints procedures, training and supervision logs and local procedures for managing referrals, risk and safeguarding. The management team had access to information about performance against targets and outcomes. The service manager had good oversight of performance, staff supervision and appraisals. The provider had up to date policies and procedures to support staff to carry out their duties. However, our findings from the other key questions demonstrated that governance processes did not always operate effectively, and that performance and risk were not always managed well.

**Information management**

**Staff collected analysed data about outcomes and performance.**

Managers in the service reviewed data which was relevant to the safe and effective running of the service. This data was monitored by senior leaders and presented to the Board of Manx Care. In addition, local leaders had collected and used data to drive development.

**Learning**, **continuous improvement and innovation**

Due to limited capacity within the team, there was little opportunity for leaders and staff to engage in improvement and innovation activities.