Isle of Wight NHS Trust

Evidence appendix

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Newport
Isle of Wight
PO30 5TG

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Date of inspection visit: 23 to 25 January and 20 to 22 February 2018

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Acute hospital sites at the trust

A list of the acute hospitals at the trust is below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary’s Hospital</td>
<td>Pankhurst Road, Newport, Isle of Wight, PO30 5TG</td>
<td>Accident and Emergency onsite, Maternity Services, acute services</td>
<td>Isle of Wight</td>
</tr>
</tbody>
</table>

Community Health services

The trust provides community services for adults and community services for children, young people and families, which includes sexual health services. There are no community inpatient beds. End of life care services are provided by community services in partnership with the local hospice, this was inspected and reported under end of life care services at St Mary’s Hospital. Community health services are provided from the main hospital site and a variety of health centres, clinics, GP surgeries across three localities on the island, West and Central Wight, North and East Wight and South Wight.
Mental Health services at the trust

A list of mental health sites inspected at the trust is below:

<table>
<thead>
<tr>
<th>St Mary’s Hospital</th>
<th>Pankhurst Road, Newport, Isle of Wight, PO30 5TG</th>
<th>Dementia, Mental Health Inpatient wards, PICU</th>
<th>Isle of Wight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthur Webster Clinic</td>
<td>35 Languard, Manor Road, Shanklin, Isle of Wight PO37 7HZ</td>
<td>Learning Disability, Community Mental Health,</td>
<td>Isle of Wight</td>
</tr>
<tr>
<td>Chantry House</td>
<td>29-31 Pyle St, Newport PO30 1JW</td>
<td>Community Mental Health Services</td>
<td>Isle of Wight</td>
</tr>
<tr>
<td>The Gables</td>
<td>10 Halberry Lane, Newport PO30 2ER</td>
<td>Mental Health Services, Improving Access to Psychological Therapies</td>
<td>Isle of Wight</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites Acute tab)

Ambulance Service
The ambulance service is an integral part of Isle of Wight NHS Trust. The headquarters and all ambulance services, including patient transport service are located on the site of St. Mary’s Hospital in Newport.
Is this organisation well-led?

To write this well-led report, and rate the organisation, we interviewed both executive and non-executive directors and a range of senior staff across the hospital. This included a range of clinical and non-clinical service and business unit leads. We met and talked with staff at all levels to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, policies, audits and action plans, board meeting minutes and papers to the board, external reviews, incidents and investigations. We also obtained feedback from patients and stakeholders.

Leadership

The new trust Chair and chief executive (CEO) were at the start of building an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. The Chair had successfully appointed high calibre non executive directors but they were very new into role, and some had not begun. The CEO had been substantive for three months and the executive directors were new into post and/or interim. Leadership development and succession planning for the Board and all levels of the trust was needed. Not all leaders at all levels of the trust had the necessary experience, capacity and capability to lead effectively and make a demonstrable impact on the quality and sustainability of services. There was a lack of clinical leadership across services and leadership training was not embedded. Competency based recruitment to lead roles in the new organisational structure was planned but would not begin until executive director posts were filled.

Most of the Board had resigned during the year following the last inspection. A new Chair was appointed October 2017. The Chair had relevant skills from previous roles and had clear priorities for recruiting to and developing a properly functioning Board. He had been a NED for a year but was new to the role of NHS trust Chair; he was accessing mentor support from the chair of a mainland acute trust.

The CEO was appointed to the substantive post in December 2017, having been interim since May 2017. She had extensive experience of working with challenged trusts in special measures. We found she was universally highly regarded by directors, staff, patients, and partners who expressed confidence had in her ability to lead the significant changes needed. She had a good understanding of the challenges and showed conviction, commitment and focus on the work that needed to be done. She demonstrated the necessary skills, compassion and capability needed to lead sustained improvements across the trust. The Chair and CEO were working well together providing much needed cohesive leadership.

Soon after taking up interim post at the trust the CEO commissioned an independent review of Board leadership. The report, September 2017, identified shortcomings and recommendations for improvements in leadership at all levels of the trust. This included: a poorly functioning Board, poorly defined roles and responsibilities across the trust, leaders lacking credibility and experience, and very weak clinical leadership. The Board had recently adopted all the review recommendations, in December 2017, but was at the very early stages of implementation.

The Chair had recently recruited three non executive directors and two associate non executive directors, between January and April 2018. They had an appropriate range of skills and experience to perform the role and provide adequate challenge to the executive team, including finance, governance and clinical issues.

Observation of a Board meeting in February evidenced improvements in the functioning of the Board and we saw some appropriate challenge from the NEDs, when compared to previous board meetings. This was confirmed by stakeholders attending meetings. However, our reading of minutes and interviews during inspection evidenced there was still work to be done to fully refresh
the NED team and leadership of key Board committees. An induction programme for new NEDs and board development programme were planned, but had not yet commenced. NED specific roles were still being assigned, and supportive processes were needed to increase NED awareness of national policy and future strategy factors. For example a clinical associate NEDs, appointed September 2017, was chair of the Mental Health Act Committee, and their expertise in this area was not clear.

NHS Improvement (NHSI) appointed an NHSI improvement director early 2017, the current improvement director took over September 2017. NHSI also appointed an interim deputy CEO, July 2017, who was leading on implementing the ‘integrated improvement framework’ (IIF) programme and strategy development. An interim director of mental health was appointed June 2017. They were leading on strategic development of a modern mental health service on the island, but there was not strong and clear, day to day, operational leadership of the mental health services.

Since May 2017 the CEO had been leading a team of mostly interim executive directors, (chief nurse, director of finance, medical director and board secretary), bringing in additional support from external advisors on a short term basis. This brought in much needed experience and capability at senior level but the interim nature of the team created some uncertainty and anxiety.

A substantive director of human resources (HR) and organisational development (OD) was appointed September 2017. In previous years the HR portfolio was held by directors without professional background, most recently the director of finance. This had a detrimental impact on leadership of HR and OD functions and required urgent leadership and action. The director of HR and OD had identified the changes needed to improve the capacity and capability of the team across the CBUs and to make the HR service and processes to fit for purpose, this was still in progress.

The interim chief nurse was very experienced and was actively raising the voice of nursing and allied health professionals. She was challenging staff, in particular nurses, to deliver on their accountability, and empowering staff to make improvements in quality and safety. Deputies and key leads had been identified to support lead the work. As Director of Infection Prevention and Control (DIPC) she had identified areas of noncompliance with the Health and Social Care Act-Code of practice in infection prevention and control and was overseeing the action plan to meet requirements. She was the executive lead for safeguarding and leadership had been recently strengthened following the appointment of an experienced safeguarding lead, overseeing both adult and children’s safeguarding. There was a lead nurse for acute hospital patients with a learning disability.

The interim medical director did not have previous experience in the role, was previously a clinical director at the trust and was leading the trust’s input into the acute services review. He worked closely with interim chief nurse in leading improvements in patient safety and serious incident reviews. The board medical advisor supported him with managing and leading medical staff. The board medical advisor told us the terms of reference for medical managerial aspect of the medical director role at the trust had not been clear in the job description in terms of responsibilities, accountabilities and measures of performance, and this would need review.

The interim turnaround chief financial officer was appointed August 2017. He had financial leadership skills and experience and led the design and implementation of the financial recovery plan. This appointment was approved by Department of Health to run until end of March 2018, we were not aware of application for extension whilst awaiting substantive appointment.

A director of quality governance was appointed February 2018, following a period working on a consultant basis. They had clear understanding of the challenges and the necessary capabilities and experience to lead the improvements needed. New structures with clear roles and responsibilities for both the quality directorate and the chief nurse team were being developed.
Since the last inspection the trust had taken steps to comply with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This ensured staff with director responsibilities including NEDs, were fit and proper persons for the role. A comprehensive updated procedure, which reflects CQC guidance, was signed off 15 December 2017. We reviewed a random sample of two board level director’s personnel files and found evidence of all the necessary checks, including enhanced Disclosure and Barring checks. The new procedure required annual checks of fitness and appraisal.

The core executive team, both interim and substantive, displayed compassionate, inclusive and collective leadership. They were visible and accessible to staff across the organisation. The CEO and interim chief nurse regularly visited and worked alongside teams to gain an understanding of their work. The team were working cohesively with the NHSI improvement director.

There was not yet sufficient leadership across all levels and services of the trust. Our findings were similar to those highlighted in the external review report. We heard of a history of some managers being appointed on the basis of longevity at the trust rather than capability and experience. The current clinical business unit (CBUs) leaders did not all have the capacity and capability to lead the diversity of services across the trust acute, mental health, community and ambulance services. All CBUs with the exception of mental health who had an interim director in post from June 2017, reported to one trust wide chief operating officer and the issues of some services did not get heard at Board level.

Many doctors were reluctant to get involved in clinical leadership, particularly at clinical director level, in part due to experience and frustrations with previous senior management. Doctors were more reluctant than nurses to take ownership of quality issues. A lack of clinical leadership at all levels was compounded by the significant reliance on locum and agency staff. A former surgeon general was appointed as board level medical advisor and was planning to roll out a medical leadership development programme, at clinical service as well as clinical director level, but this had not yet begun and additional funding was needed. An associate medical director for mental health services was providing interim leadership for clinicians and leading on developing pathways. The CEO had recently recruited a previous medical director as director of clinical improvement for a year, to provide additional clinical leadership.

The systematic downgrading of nursing staff two years ago had depleted the capacity and capability of nursing leadership. There continued to be staff 'acting up' into interim roles without the necessary skills and support, particularly in mental health and on the acute hospital wards. The interim chief nurse had identified a clear need for the expansion of band 6 clinical leadership. Some clinical staff were not aligned to their roles in relation to their clinical qualifications and experience. The chief pharmacist provided experienced leadership of the trust medicine optimisation team; however, they had recently taken the additional role as clinical director for a CBU.

The leaders of corporate and support services did not have a fully understanding of how they contributed to the wider quality of patient care. For example external leadership support had been brought in to identify the operational actions needed in estates and hotel services to improve cleaning and infection prevention and control. There were concerns about the finance team’s capacity and capability, especially given the current divisional structure of the trust which has presented difficulties for the central team to achieve grip and control of the financial position. The interim finance director had taken some steps to improve the capacity and capability of the finance team. NHSI had supported the trust to appoint an external senior financial advisor and support to identify and deliver costs savings, to be in place between January and March 2018.

There was a leadership and organisational development strategy. There was not systematic oversight and roll out of leadership training and no system for talent management and succession planning. There was a four day "High performing Leaders and managers" training regarding the expected behaviours, skills and attributes required for positions of management and leadership,
with associated "building block" extra training modules. This course was run collaboratively with the Isle of Wight council, leadership department and HR. 75 staff had completed, or were engaged in, training. NHS leadership academy programmes were also accessed by staff, if supported by line managers, but this was not monitored by the trust. We were told that staff could also access leadership facilitators and coaching was available for any staff who required it. The leadership facilitator capacity had increased by 1 WTE. However our inspection of core services found that staff 'acting up' into interim leadership roles were not aware of or were not accessing this training and support.

Following the external review and since coming into substantive post, the Board agreed the CEO's proposal for a new organisational structure. This structure did not include a chief operating officer but four directors for acute, mental health and ambulance and community services. The chief nurse would have responsibility for community services. The intention was for experienced and capable leadership and representation of all trust services at Board. The CBUs would be restructured and aligned under the four directorates. The CEO recognised the importance of getting the leadership structure implemented and was working to fill the posts as soon as possible. These posts along with Medical Director and Director of Finance, Information and Estates were out to advert. The interim chief nurse was in post until December 2018, and would continue to support the community services in the new structure. The substantive post would be advertised later in the year. Competency based recruitment to CBU leads roles in the new organisational structure was planned but would not begin until executive director posts were filled.

Vision and strategy

The trust senior leadership team had recognised the urgent need to identify shared strategic priorities with stakeholders and partners. At the time of the inspection there was not a shared understanding of the vision of the trust as provider of integrated services, supporting high quality care, in the context of health and social care across the island and mainland. Some strategic plans had started for individual services but a credible trust strategy, aligned with plans in the wider health economy, was urgently needed along with robust enabling strategies to support sustainable delivery. In the absence of a clear vision and strategy staff were unclear as to the future of services and how it related to their daily roles. The immediate focus and priorities for staff were described in the “Integrated Improvement Framework” (IIF).

The trust’s current strategy was not fit for purpose; it was developed and approved by the previous Board in March 2016. The strategic direction to 2021 was described as ‘Working Beyond Boundaries to be the preferred choice for sustainable integrated care’. Limited progress had been made in the achievement of the strategy and the current senior team recognised that the strategy needed to be reviewed. The lack of coherent strategy was also highlighted in the external review of leadership on Isle of Wight, which went to Board 1 February 2018.

Since arriving at the trust CEO and senior team had actively promoted the trust vision ‘quality care for everyone, every time’ and many staff recognised the change in focus and expectations that were being demonstrated by their leaders. But the lack of a clear trust strategy left staff, and the Board, unclear on the detail of the vision and strategy for trust services and how that fitted with health and social care across both the island and the mainland.

The CEO had a clear ambition to demonstrate that an integrated trust system could work to benefit patients. She was clear that everyone needed to understand what an integrated organisation is and how it operates properly, so they can share in the vision. And the Board needed to develop a strategy to get there, so that the trust and partners could deliver good services for the people of the island. Her plan was to appoint to new director posts and align CBUs, mental health, acute, ambulance and community. Each of the four CBUs would develop their strategy for their component parts and bring into a trust wide strategy to take to the Board by September 2018.
The CEO told us she wanted to build on and bring together previous work. For example ‘My life a full life’ island wide vanguard project had started the integration of health and social care across the island’s three localities. This could be taken forward by the director of community services in developing a community services strategy in synergy with partners. A blueprint for mental health services on the island, and business cases for modernising services had been developed. The trust had been engaged in an acute services review and an option for future provision on the island had been agreed with partners on the island.

The CEO and Chair recognised a need to review what the trust was able to do across services; what they could do themselves, where they needed to involve others, what to do if they could not provide, and would somewhere else do this. Further work was needed develop the strategy with the wider Hampshire and Isle of Wight Strategic Transformation Partnership (STP) and the Solent alliances.

There was a complex strategic context and that some work was already underway:
- Follow through of the acute services redesign options paper, which required further detailed working up prior to consultation include discussions with Solent Acute Alliance (SAA) partners and resolution to currently challenging transfer arrangements.
- Creation of a community services redesign programme that combines work streams from the existing Local Care Board (LCB) priorities and the impact of the acute services redesign.
- Taking forward of wider LCB priorities including the development of a ‘blueprint’ for mental health and learning disabilities.
- Progressing some tactical actions within mental health including; relocation of early intervention services and community mental health.
- Work with the SAA to review how a range of services (e.g. pharmacy, specialist services such as spinal surgery, vascular and renal, back office) can be worked better between Isle of Wight, and mainland acute trusts.
- Creation of a pathology network including eight trusts within the SAA and Hampshire and Dorset.

The trust recognised that without a credible strategy it could not be sufficiently proactive within the complexity of the health economy. The Chair and CEO had recently asked the interim deputy CEO to provide additional support to develop a trust strategy and a number of enabling strategies, by the September 2018 deadline. They wanted to develop a strategy based on population need, building on existing work (joint area needs assessment, acute services review), with the focus on delivering safe, sustainable services delivering high quality and value for money, at its core. A sound methodology was planned to take into account the complexity, for example the use hypotheses to test critical aspects including: investment and disinvestment decisions, value of integration, opportunities to work differently (e.g. with primary care and social care). However there was a considerable amount of work to be done to realise the ambition. Monthly detailed reports to Board were planned. Additional external support was being sought to develop the strategy and an initial scoping brief was being produced. Support had also been secured from the NHSI regulation team.

It was expected that the appointment of directors for the four core service areas plus a wider leadership development programme would support CBU’s in describing and taking forward the trust strategy, IIF and enabling strategies. The CEO would take responsibility for overall trust strategy development when the interim deputy CEO’s term was completed.

Work was underway on some enabling strategies. The director HR and OD chaired the island system wide workforce group developing the workforce strategy for the future. The trust
recognised that successful implementation of the strategy was reliant on a workforce with the right 
skills to make it work, and this had not previously been a priority.

A ‘quality strategy’ was under consultation and due to go live in April, this was seen as key to 
understanding ‘what good looks like’ and supporting improvements in quality across services. A 
clinical strategy was being drafted

An island wide end of life care strategy was developed 2016, this required a refresh, but a newly 
recruited associated NED was hoping to get more trust services engaged in implementing this to 
 improve end of life services. The trust was now more engaged with a developing and 
implementing an island wide dementia strategy and was planning roll out of training for hospital 
staff in the summer. This was all at very early stages.

The chief pharmacist had led the development of the medicines optimisation strategy 2015-17 and 
the hospital pharmacy transformation plan (HPTP) from 2017, providing annual updates to the 
board on achievements and challenges.

In the absence of an overall trust strategy the immediate focus and priorities for staff were 
described in the “Integrated Improvement Framework” (IIF). The first priority was to come out of 
‘special measures’ by end 2018. There was an executive sponsor of each IIF programme chairing 
regular programme board meetings to monitor progress, with regular progress updates to trust 
Board. Ownership and implementation of the IIF programmes in CBUs was slow, although recent 
streamlining had made it more meaningful to services. The plan was not originally costed, so work 
on this had started, and work was ongoing to develop more extensive assurance metrics.

Recent work with the island Local Care Board (trust, local authority and CCG) has led to joint care 
delivery priorities and enabling programmes, which align with the IIF programme. Partners of the 
island were positive about the improvements on the integration agenda, at high level, since the 
CEO’s arrival. But there was not yet sufficient awareness, understanding and ownership across 
the trust.

**Culture**

The senior team understood the importance of a positive culture that supported and valued staff 
and created a common purpose of high quality patient care based on shared values. They were 
committed to making improvements but were at the very start of the huge amount of work needed 
to create the culture needed to support high quality sustainable care. There were some early signs 
of change and ‘hope’, but this was not yet evident across all levels and areas of the trust. Low 
levels of staff satisfaction, high levels and work overload persisted. There were areas of silo 
working and the culture tended to be defensive when under pressure. Not all staff felt respected, 
valued, supported or appreciated, particularly those from ethnic minorities. There was insufficient 
attention to staff development, appraisals took place inconsistently and were not high quality.

The trust recognised the significant amount of work to improve staff culture was essential to 
achieve sustained improvements in quality of services. The external independent Board leadership 
review, completed September 2017, identified culture of blame and lack of trust as contributing to 
a risk adverse approach and lack of effective leadership behaviour development at all levels.

The CEO described a ‘make do and mend’ culture where staff wanted to do a good job but with 
little expectation that things could change. She recognised a battered, fragile workforce that had 
suffered from lack of development. The CEO and team were aware, and our core service 
inspections confirmed that many staff did not know how, or could not sustain, delivery of safe, 
effective, responsive and well led care. Historically this had not been well managed or addressed 
over many years.

Staff we spoke with, at core service and well led inspections, recognised a change in the way the 
CEO and the interim executive team behaved, more approachable and focused on improving
patient care. There was the start of ‘holding people to account’ when they fell below standards expected. Some staff expressed signs of hope for sustained changes and improvements. We heard of matrons volunteering to work weekends for patient related issues and to support staffing. But this was not being seen at all levels and particularly in times of pressure there was a tendency for managers and staff to revert back to defensive, blame culture and silo working.

There were equality and diversity and discrimination issues across the organisation along with the vestiges of the historical bullying and unwillingness to speak out or raise concerns. HR policies and procedures were not always implemented appropriately or effectively. Senior managers spoke of a concern that things that should be ‘easy fixes’ in other trusts became a real problem to address because of some behaviours and resistance. Services on the island tended to be isolated from professional connections with others on the mainland and this was starting to be addressed in some areas, for example in mental health.

The CEO recognised that there were differences in staff cultures and ways of working across the different areas of the trust’s work, acute, ambulance, community and mental health and these differences needed to be acknowledged and valued, within an integrated trust. The CEO believed this would be better supported in the new organisational structure. Mental health leads told us that previously trust board didn’t have a focus on mental health, there was a lack of knowledge and staff did not feel they were listened to. They said staff gave up the ambition that patients should be at the heart of what they do.

**NHS Staff Survey 2017**

**Acute**

**Results better than average of acute trusts**

The trust has one Key Finding that exceeds the average for similar trusts in the 2017 NHS Staff Survey (in the top 20%):

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>13%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Results worse than average of acute trusts**

The trust has 19 Key Findings worse than the average for similar trusts in the 2017 NHS Staff Survey (in the worst 20%). Of these, the five worst performing Key Findings were:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>38%</td>
<td>25%</td>
</tr>
<tr>
<td>Percentage of staff felling unwell due to work related stress in the last 12 months</td>
<td>46%</td>
<td>36%</td>
</tr>
<tr>
<td>Support from immediate managers</td>
<td>3.55</td>
<td>3.74</td>
</tr>
<tr>
<td>Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>59%</td>
<td>52%</td>
</tr>
</tbody>
</table>
Percentage of staff agreeing that their role makes a difference to patients / service users

<table>
<thead>
<tr>
<th></th>
<th>86%</th>
<th>90%</th>
</tr>
</thead>
</table>

The remainder 14 scores in which the trust performed worse than the average for similar trusts in the 2017 NHS Staff Survey (in the worst 20%) are accessible via the source below.

Notably, there were also three Key Findings where staff experiences have deteriorated since the 2016 survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score 2017</th>
<th>Trust Score 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>Percentage of staff appraised in last 12 months</td>
<td>81%</td>
<td>90%</td>
</tr>
<tr>
<td>Organisation and management interest in and action on health and wellbeing</td>
<td>3.44</td>
<td>3.54</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

**Mental Health**

**Results better than average of mental health trusts**

The trust has three Key Findings better than average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>98%</td>
<td>93%</td>
</tr>
<tr>
<td>Percentage of staff experiencing physical violence from staff in last 12 month</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>3.97</td>
<td>3.91</td>
</tr>
<tr>
<td>Quality of non-mandatory training, learning or development</td>
<td>4.09</td>
<td>4.06</td>
</tr>
</tbody>
</table>

**Results worse than average of mental health trusts**

The trust has 25 Key Findings worse than the average for similar trusts in the 2017 NHS Staff Survey. Of these, the five worst performing Key Findings were:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>42%</td>
<td>60%</td>
</tr>
<tr>
<td>Percentage of staff appraised in last 12 months</td>
<td>73%</td>
<td>89%</td>
</tr>
<tr>
<td>Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.34</td>
<td>3.71</td>
</tr>
<tr>
<td>Recognition and value of staff by managers and the organisation</td>
<td>3.33</td>
<td>3.59</td>
</tr>
</tbody>
</table>
Percentage of staff able to contribute towards improvements at work | 66% | 73%

The remainder 20 scores in which the trust performed worse than the average for similar trusts in the 2017 NHS Staff Survey are accessible via the source below.

Notably, there were also two Key Findings where staff experiences have deteriorated since the 2016 survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score 2017</th>
<th>Trust Score 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff appraised in last 12 months</td>
<td>73%</td>
<td>92%</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>33%</td>
<td>22%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

Ambulance

Results better than average of ambulance trusts

The trust has 18 Key Findings better than the average for similar trusts in the 2017 NHS Staff Survey. Of these, the five best performing Key Findings were:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>52%</td>
<td>62%</td>
</tr>
<tr>
<td>Percentage of staff / colleagues reporting most recent experience of violence</td>
<td>84%</td>
<td>65%</td>
</tr>
<tr>
<td>Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>91%</td>
<td>82%</td>
</tr>
<tr>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>83%</td>
<td>69%</td>
</tr>
<tr>
<td>Recognition and value of staff by managers and the organisation</td>
<td>3.35</td>
<td>3.01</td>
</tr>
</tbody>
</table>

The remainder 13 scores in which the trust performed better than the average for similar trusts in the 2017 NHS Staff Survey are accessible via the source below.

Results worse than average of ambulance trusts

The trust has seven Key Findings worse than the average for similar trusts in the 2017 NHS Staff Survey. Of these, the five worst performing Key Findings were:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>29%</td>
<td>34%</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>56%</td>
<td>48%</td>
</tr>
<tr>
<td>Percentage of staff appraised in last 12 months</td>
<td>52%</td>
<td>81%</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Percentage of staff working extra hours</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.37</td>
<td>3.44</td>
</tr>
</tbody>
</table>

The remainder two scores in which the trust performed worse than the average for similar trusts in the 2017 NHS Staff Survey are accessible via the source below.

(Source: NHS Staff Survey 2017)

The trust identified the themes arising from negative feedback from staff included work volume, stress and pressure of work, and improvements needed to the management structure, training and development opportunities, patient communication, the trust's organisational communication. There were concerns regarding the culture and attitudes, with bullying and harassment seen as an issue.

Improving culture was recognised by the CEO and senior leadership team as an essential part of the improvement journey. The commitments and priorities were clearly described in the recent ‘Getting to Good’ guide produced for all staff. It set out the importance of values; patient experience; happy and healthy workforce; tackling bullying and harassment; helping staff to raise concerns; and being honest and open with patients. People and leadership was a programme within the trust integrated improvement plan (IIF).

The Director Human Resources (HR) and Organisational Development (OD) recognised the HR function at the trust was not fit for purpose and needed to be. This included improvement in recruitment processes to address the staff shortages that were adding to staff stress. The interim medical director was also concerned that not all issues relating to doctors behaviour were brought to his attention by HR processes. The Director HR& OD was working on improving the transactional work of the HR team and strengthening the impact of human resources policies and procedures. The Clinical Business Units (CBUs) were to have dedicated HR support for managing the workforce, as well as improving recruitment and retention. This work was in progress. Organisational development work was not yet fully developed or embedded across the trust. The trust was engaged with the external advisors who were supporting the roll out a two year programme based on the ‘collaborative and compassionate leadership’ model. This work was due to start at Board level.

Staff side told us of the long established bullying culture and poor implementation and application of human resources policies. There had not been a productive working relationship with the previous executive director, but this had changed and there was optimism about the positive changes happening. They like many staff we spoke with, expressed faith in the CEO, interim chief nurse and the director of HR and OD. They felt listened to by the senior team although there were constraints on their time to attend meetings. They recognised that sustained changes would take time.

The trust had adopted the Freedom to Speak Up: Raising Concerns (Whistleblowing Policy) for the NHS (April 2016). Five whistle blowing concerns had been raised formally in the last year. The Freedom to Speak up Guardian (FTSUG), who had been invited to take up a similar role in 2015, had been in the FTSUG role since 2016. They had received National Guardian’s Office training and attended regular meetings and conferences. They were given 7.5 hours a week protected time for the role, which they said was manageable. They were supported by a network of three FTSU advocates, who were recruited through expressions of interest.
The Bullying and Harassment policy had been recently reviewed, and an anti-bullying group formed. The trust wide anti bullying pledge, advisors, and FTSUG role was promoted, with the support of the CEO and executive team, during a launch event in anti-bullying week, November 2017. Eleven anti bullying advisors, aligned to the FTSUG, had been recently recruited and trained.

The FTSUG had received 37 referrals during nine months 2017-18, increasing from nine in both Q1 and Q2 to 19 in Q3. Most of the concerns were raised by nursing staff and related to staff behaviour, in particular medical staff/consultants to other staff. The FTSUG felt well supported and met regularly with the CEO and interim medical director.

Despite these initiatives to communicate, we found there was still limited awareness or trust in the FTSUG role amongst some front line staff. More were aware of the anti-bullying and harassment campaign but some were still fearful of raising concerns or felt it would not make any difference, based on previous experience. Our inspection of services at the trust found that some staff did not actively engage in incident reporting for similar reasons.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group. Percentages presented are a proportion of all staff working at the trust as a whole, therefore the percentages presented do not add up to 100%.

The remaining staff not included in the below table are healthcare scientists, estates and ancillary staff, additional prof scientific and technic staff, additional clinical services staff, administrative and clerical staff and allied health professionals. Percentages for these are provided in the RPIR, accessible via the link below.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and Midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>4.05%</td>
<td>23.34%</td>
</tr>
<tr>
<td>White – Irish</td>
<td>0.07%</td>
<td>0.30%</td>
</tr>
<tr>
<td>White – Any other White background</td>
<td>1.89%</td>
<td>0.64%</td>
</tr>
<tr>
<td>Mixed – White &amp; Black Caribbean</td>
<td>0.03%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Mixed – White &amp; Black African</td>
<td>0.13%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Mixed – Any other mixed background</td>
<td>0.20%</td>
<td>0.34%</td>
</tr>
<tr>
<td>Asian or Asian British - Indian</td>
<td>1.01%</td>
<td>0.07%</td>
</tr>
<tr>
<td>Asian or Asian British – Any other Asian background</td>
<td>0.30%</td>
<td>2.56%</td>
</tr>
<tr>
<td>Black or Black British - African</td>
<td>0.03%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Black or Black British – Any other Black background</td>
<td>0.34%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Any other Ethnic Group</td>
<td>0.37%</td>
<td>0.81%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>0.07%</td>
<td>1.28%</td>
</tr>
</tbody>
</table>

(Source: [Routine Provider Information Request (RPIR) – Diversity tab: link](https://example.com))

The trust had not undertaken an analysis of pay gender gap by the time of inspection.
Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Acute

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Description</th>
<th>White</th>
<th>BME</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White</td>
<td>27%</td>
<td>27%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>31%</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White</td>
<td>38%</td>
<td>25%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>37%</td>
<td>27%</td>
<td>33%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White</td>
<td>84%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>78%</td>
<td>75%</td>
<td>76%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>16%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Mental Health

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Description</th>
<th>White</th>
<th>BME</th>
<th>Average (median) for mental health</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White</td>
<td>39%</td>
<td>32%</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>-</td>
<td>36%</td>
<td>-</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White</td>
<td>34%</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>-</td>
<td>26%</td>
<td>-</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White</td>
<td>80%</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>-</td>
<td>77%</td>
<td>-</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White</td>
<td>14%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>-</td>
<td>14%</td>
<td>-</td>
</tr>
</tbody>
</table>
The Board membership did not include anyone from a BME background, the trust Chair confirmed it was not a priority in the appointment of new NEDs. The Chair recognised there had been no positive attempts to address this to date.

There had been very limited executive and non executive engagement in Equality and Diversity, it had not had senior leadership focus. Interviews with staff and leads identified that across the trust it was viewed as the role of HR and equalities lead and was not seen as everyone’s business.

The director of HR and OD was the trust lead for the Workforce Race Equality Standard (WRES). They recognised that the trust was far from a position of understanding and reporting to the national requirements for equality and diversity. An equalities lead was appointed August 2017, in recognition of the need for increased resource to address equality and diversity concerns at the trust. There had been some initiatives and communication of the role. The lead, who did not have experience of working in NHS, was starting to approach local and national networks for support. There was no established BME or other diversity networks. A draft Diversity and Inclusion Strategy was due to be presented to Board early March 2018.

A 2017 WRES report (April 16-March 2017) had been drafted but there was delay in presenting this to the Board due to some unreliable data, particularly on shortlisting. Initial analysis indicated that likelihood of white staff being appointed from shortlisting was 2.9 times greater than BME staff, and HR staff confirmed that no BME staff were shortlisted in 73 appointments last year. BME representation at band 5 clinical roles was over represented, and BME representation in all roles above band 7 was under represented. Application for funding for training was 1.17 times greater for white staff. There were not significant improvements in bullying and harassment, or discrimination for BME staff. The 2016/17 WRES action plan included some specific actions, responsibilities and timescales. Some of the work had been delayed due to long term absence of the lead. There had been review of the bullying and harassment policy and anti bullying advocates had been recruited, but these were not yet fully representative of the workforce.

In discussions with BME staff we heard that those recruited from overseas in previous years, were planning to move to other employers as did not feel adequately supported at the trust. They experienced racism from patients but were fearful of speaking out. They were also intimidated by the reaction of some other staff to plans for meeting up as a BME network. They cited indirect discrimination and lack of access to training and development. Some had been promoted, but to the lowest band and so were financially penalised. BME staff were not encouraged to attend and speak with us at focus groups, held specifically for BME staff. Those who came to speak with us

(Source: NHS Staff Survey 2017)
were required to ‘make up the time’ or had to arrange to speak with us in their tea break, without line manager knowledge.

**Friends and family test**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored about the same as the England average for recommending the trust as a place to receive care from December 2016 to November 2017.

(Source: NHS England – FFT Trust)

The feedback from patient surveys and the Friends and Families test was generally positive. The complaints team had identified themes relating to culture that needed to be addressed including communication, values and attitudes of staff.

The trust was starting to apply duty of candour appropriately, but there was not understanding by staff across all areas of the trust. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We reviewed a random sample of investigations following incidents of moderate or serious harm and found some had evidence of invoking duty of candour, but this had not always been the case. Data provided by the trust showed an increasing number of occasions when duty of candour had been applied, across all services, since the arrival of the new senior team. The CEO and interim chief nurse were proactive in promoting duty of candour and offering to meet with patients and families. The incident reporting and complaints processes had been reviewed, and were more closely monitored, but the trust recognised more needed to be done. This included providing mandatory training for all staff and embedding compliance with duty of candour.
Sickness absence rates

The trust’s sickness absence levels from September 2016 to July 2017 were consistently higher than the England average.

(Source: NHS Digital – Staff Sickness)

The sickness absence rates reflected in the findings from staff survey, and the issues raised with us, the impact work volume, stress and pressure, culture and attitudes. In the 12 months to February 2018 the cumulative sickness rate was 4.6%. Overall staff turnover was 10%. The ‘Getting to Good – our improvement journey’ guide for staff emphasised the importance of staff health and wellbeing and the support offered by the occupational health team. The director of HR and OD recognised the HR function to support CBU’s and managers needed to improve, both in sickness and absence management but also recruitment and retention of staff.

Flu vaccination figures for the winter 2017/18 had increased to 67.7% from 47% the previous year and the CEO saw this statistical improvement as a culture shift. Staff from across all areas of the trust had engaged in a campaign, and had produced an engaging short video, to promote uptake of the vaccine.

General Medical Council – National Training Scheme Survey

In the 2017 General Medical Council Survey, the trust performed worse than expected for five indicators; clinical supervision, clinical supervision out of hours, reporting systems, induction, and feedback. The trust performed the same as expected for the remaining nine indicators.

<table>
<thead>
<tr>
<th>Trust / Board</th>
<th>Isle of Wight NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Satisfaction</td>
<td>71.17</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>83.22</td>
</tr>
<tr>
<td>Clinical Supervision out of hours</td>
<td>80.23</td>
</tr>
<tr>
<td>Reporting systems</td>
<td>61.38</td>
</tr>
<tr>
<td>Work Load</td>
<td>49.44</td>
</tr>
<tr>
<td>Teamwork</td>
<td>70.90</td>
</tr>
<tr>
<td>Handover</td>
<td>58.55</td>
</tr>
</tbody>
</table>
Supportive environment | 68.64
---|---
Induction | 72.85
Adequate Experience | 73.43
Curriculum Coverage | 70.76
Educational Governance | 69.21
Educational Supervision | 85.42
Feedback | 66.85
Local Teaching | 54.17
Regional Teaching | 71.79
Study Leave | 49.43

(Source: GMC - Trainee Survey)

The trust reported that junior doctors had access to clinical supervision at all times and that all supervisors were accredited with GMC and HEE Wessex, however this was not reflected in the latest survey. Junior doctors we spoke with were concerned about the insufficient supervision from some locum doctors, particularly in medicine. The guardian of safe working supported the implementation of the junior doctor contract and better rota management. The guardian had regular contact with education supervisors and, when needed, the deanery. They told us junior doctors were reporting improved support during placements at IOW, GP trainees were particularly positive.

Staff survey results on access to appraisal had deteriorated since 2016. Staff in the medicines optimisation team had regular appraisals, including the chief pharmacist, but this was not happening across all services. Appraisal rates across the trust were below target, with compliance at 65% in February 2018. Some staff we spoke with felt that the appraisals were not of value as the paperwork was not geared to their roles or fit for purpose. Additional training on appraisals was planned through the future management and leadership development programme. There was an ambition to align appraisal with the trust values and behaviours.

**Governance**

There were serious shortfalls in the governance arrangements across all levels of the trust. There was not a systematic approach to governance and performance management, to support continual improving quality of services and standards of care, at all levels and areas of the trust. The trust had recently developed a governance structure to give clear responsibilities, roles and systems of accountability. This, along with strategic quality objectives, was still being developed and was not yet fully implemented or embedded. Improvements were needed in governance of the Mental Health Act and Code of Practice.

The shortfalls in governance were highlighted in previous reviews and reports including the external independent review into leadership at the trust, September 2017. Board governance structure and committees were not fit for purpose and roles were unclear. Our review of meeting minutes and interviews with staff, at core service and trust wide inspections, evidenced a lack of consistent and effective meetings and governance structures and processes in place.

The CEO, Chair and interim senior team recognised the issues and the significant work that needed to be done. The CEO described governance as ‘broken’ and in need of urgent and high level attention. She also identified that governance needed to apply differently to each of the different component parts of the service. This was an issue for ‘non acute hospital’ services and in particular community, ambulance and mental health services. The services were currently
arranged in five clinical business units (CBUs). This was to be changed under the new organisational structure. The CBUs would be restructured and aligned under the four directors acute, community, mental health and community. The new structure was signed off by the remuneration committee in January 2018 and agreed by the Board, February 1 2018, subject to consultation.

The CEO identified a need for a board post for governance to support improvements and the director of quality governance was an early substantive appointment in the new executive structure. Following the departure of the previous trust secretary a board advisor on corporate governance was appointed September 2017, he worked alongside the director of quality governance, to start making improvements at every level of the trust. The process to recruit a substantive board secretary had also begun.

There had not been a clear agenda of strategic priorities for the Board, and no clear methods of monitoring. A new format and agenda and focus on improving quality of papers, and level of scrutiny, at Board were introduced in November 2017. We heard from partners and Board members that there was improvement in the level of conversation debate and challenge was gradually becoming more sophisticated and robust. There was more coherent preparation by the executives and improved reports but this was still reliant on the limited information and governance structures throughout the trust. We observed the February public and private Board meeting and confirmed an improving picture. We noted discussion of ongoing refinement of the grouping of agenda items and what should be discussed in public and private. We saw there was an ambition to be open and transparent.

A revised governance structure was developed, discussed and agreed by Board end 2017. A Board Committee governance pack detailed the Board Committees from January 2018. The NED led were: Quality; Assurance, Risk and Compliance (ARC), Performance; Audit; Mental Health Act, Charitable Funds; Nominations and Remuneration. The responsibilities for the new NEDs were being finalised, newly appointed NEDs were to chair Audit committee and ARC committee. The executive led committees included Trust Leadership Committee, and Integrated Improvement Framework Committee. The new membership and terms of reference of all committees had been drafted. We were told the main Board committees were configured to cover all aspects of quality and organisational development was an important contributor so reported across committees. Quality functions had been separated from risk and assurance at Board committee level.

The draft Quality Governance Standards and Structures document clearly described the quality governance structure, supporting arrangements and key roles and accountabilities, from Board through the organisation. In the new structure executive chaired sub committees reported into Board committees and provided key messages/feedback to CBUs and working groups. The Patient Safety; Clinical Effectiveness; Patient Experience Committee; HR & Organisation Development sub committees reported into Quality Committee. Information Governance; Operational Risk; Health and safety, security and estates sub committees reported into the Assurance Risk and Compliance Committee. Health and safety, security and estates; Finance, contracts and information; ICT; HR & Organisation development sub committees reported into Performance Committee. Terms of reference of sub committees were being finalised. Headline Board committee work plans were drafted.

The new structure, mapped the CQC domains of quality safe, effective, caring, responsive and well led. A CBU quality committee and CBU performance committee reported into monthly CBU board, which reported to the Trust Leadership Committee. These were to feedback key messages to services and teams. The framework detailed weekly ward and monthly/bi monthly service meetings as well as supporting corporate meetings for executive review of serious incidents and triangulation meetings by the Quality team.

The new framework was comprehensive and was designed to support consistency across CBUs and services, from ward to Board. A series of meetings agendas and tools for CBUs and teams had been developed. The implementation of this framework, however, was just beginning and
included restructuring of the supporting quality governance directorate, and nursing AHP directorate with clearly defined roles and responsibilities. The interim chief nurse had appointed two deputies and held monthly meetings with CBU heads of nursing and quality. A regular meeting structure for matrons and ward managers had started. However meetings and governance processes were not in place across many services we visited.

The trust had a Mental Health Act administrator who supported services by providing training. However, there was a lack of accurate recording in the monitoring of patients detained under section 136 of the Mental Health Act. There was a lack of oversight of this by senior leaders. Meetings between the trust and partners such as the police to discuss issues were not recorded until we raised this with the trust. Trust policies and procedures were not compliant with the Mental Health Act Code of Practice. The trust had not reviewed them when the Code of Practice was updated three years ago in 2015. The trust took action to address this after we raised it with them.

There was an in house psychiatric liaison service; the trust was not a member of Psychiatric Liaison Accreditation Network (PLAN). Liaison team policies and practice did not align to PLAN quality standards. There was not a supportive management or governance structure for the recently expanded team and the team was not receiving peer support from liaison teams on the mainland.

Formal partnership and governance arrangements with external organisations were not always clear, for example a formal agreement for end of life care was still to be confirmed and agreed with the local Hospice.

The trust told us a realistic timescale for significant improvement of governance and assurance across the trust was end of 2018. A 2017/18 performance review of the Board was planned and would report April 2018.

Management of risk, issues and performance

The trust did not have effective systems for identifying, assessing and planning to eliminate or reduce risks. Some systems were starting to develop but there were still serious defects in the management of risks, issues and performance across all areas and levels of the trust. Financial challenges were starting to be managed but remained a risk.

Since arriving at the trust the CEO and her interim team uncovered a number of serious patient risks and concerns that had previously not been identified or properly responded to by the Board. There were very weak assurance systems and the risk management strategy and risk management policy was not fit for purpose.

In the pre inspection information request in October 2017 the trust stated:

The trust has not yet developed a risk register. The trust has agreed to send the board assurance framework and associated action plans, and risk registers to the CQC as soon as they have a Board approved document

(Source: P113)

A new Board Assurance Framework (BAF) was presented at Board for the second time in February 2018. This had been well received, as the previous BAF was not fit for purpose. The format was appropriate setting out structure, owners, risks, causes, controls, assurance, metrics, inherent risk, current risk, target risk. This would help people understand causes of risks, but the content needed to be refined. There were gaps, for example no risks were identified in relation to the Board undergoing transformation, no risks relating to lack of strategy and the challenges of the external environment. The NEDs needed further development to understand the BAF and
recognise its importance. The BAF was due to be reviewed in March and would be discussed at a Board seminar.

Everything around the BAF was either new, or requiring further development. The Board Committee structure was new and the risk committees were untested, the risk management policy was not fit for purpose and needed a complete rewrite. The operational and corporate risk registers had recently been reformatted but the content needed review.

The trust submitted services and corporate risk registers in February 2018. These contained a very large number of risks, and many risks dated from some time ago. The corporate risk register contained a number of strategic risks, for example failure to maintain effective partnerships, which did not appear on the BAF. Our inspections found that there was a lack of risk identification, escalation and management across many core services, some key risks identified by staff were missing from service and CBU risk registers. There was not regular and systematic discussion of risks at meetings.

Trust wide clinical audit and audits of national requirements were occurring but were fragmented with no overall management and oversight. The administrator overseeing the programme was unable to escalate delays and there was no overview of the conclusions and actions required. Some audits of NICE compliance, for example end of life care, focused on processes rather evidence of implementation and outcomes for patients, so provided false assurance when 100% compliance was achieved. Some services such as medicines optimisation team had a clear audit programme for controlled drug audit checks, clinical pharmacy visits, pharmacist intervention audit, and medicines being obtained within 24 hours. The trust had also taken part in national schemes, but action plans were not always followed through.

There was a trust internal audit (TIAA) programme which had identified some risks, for example audit of the management of medical devices had identified basic gaps in systems and resulted in actions to address. However, there was not a coordinated approach to using internal audit to manage risk and performance. New interim executives were critical of the way the internal audit had been planned and the inaction on key reports, as evidenced in Audit committee minutes dated 15 November 2017.

The senior team was starting work to address the significant deficiencies in quality assurance systems at the trust. The director of quality governance remit covered patient safety, risk and patient experience. Their immediate priority was management of serious incidents (SIs). Historically SIs were not being correctly identified and reported and managed. As immediate response the interim chief nurse and interim medical director started a bi weekly SI executive led panel to review all incidents to decide if they were SI. In the last two months a whole new SI system was introduced, and the documents to guide practice were on the trust intranet. These were helpful, appropriate and fit for purpose. The incident reporting form had been simplified and there was an improving level of reporting of incidents, although there was still work to do to embed this across all areas of the trust.

The director of quality governance told us that previously there was one person investigating incidents and this was not root cause analysis (RCA), despite trust investment in root cause analysis training. The trust had started to use of RCA and the national template. We reviewed a random sample of six closed SIs across services from early 2016 to November 2017. Overall we found evidence of improvements in structures, processes and outcomes. There was improvement in investigations and reports but more work was needed to identify learning and use in proactive risk management. The process needed embedding with pace with clinical leaders and with CBU ownership. Staff required more training in most aspects of SI management. A monthly serious incident activity report was presented to patient safety subcommittee. The February 2018 report detailed the development of key performance indicators to monitor performance. The SI team told us action plan monitoring was a challenge due to capacity and ownership issues. The report confirmed that the trust had not reported any new ‘never events’ since November 2016. A new SI policy was due for ratification.
There was not systematic trend analysis of themes arising from incidents, complaints and legal claims. But the greater scrutiny of incidents and serious complaints had highlighted some immediate areas of risk and need for focused work. For example, there was now a task and finish group leading on improving identification and escalation of deteriorating patients, and the consistent use of early warning scoring system. Recent inquests had uncovered significant risks and triggered external reviews, for example in maternity and neonatal services. Incidental risks were uncovered through day to day business, for example GP concerns about delays in discharge summaries. The interim medical director reported to Board on a subsequent deep dive investigation that uncovered a significant risk in terms of backlog and significant delays in sending of discharge summaries. Priority action to improve timeliness and issue within 24 hours was now being monitored by weekly escalation report. Action to improve quality of the summaries was also needed.

Since her appointment to director of infection prevention and control (DIPC), the interim chief nurse had identified noncompliance with Code of Practice for prevention and control of infection. There was a depleted infection control team, lack of assurance through audits of environmental cleaning and infection control practice, alongside poor understanding and engagement with estates and some clinical staff. The DIPC had reported to the Board and provided updates on actions to mitigate risks and achieve compliance.

The developing quality governance team was starting to work alongside services to support risk managing and improved performance. Quality managers were recently assigned to CBUs, but were early in development of that role. The mental health improvement group, set up to monitor improvement had not been as effective as expected. The deputy director of quality governance was working with the mental health service to pull together areas for improvements and clear outcome based actions. It was recognised that mental health services were at the very early stages of reducing day to day risk.

There was a system in place for managing medicines incidents. A senior member of the pharmacy team was the medicine safety officer (MSO). The MSO role was created following a NHS England Patient Safety Alert. The MSO automatically received and reviewed notifications of medicine incidents. A multi-disciplinary team at the medication safety committee reviewed these incidents.

The interim chief nurse provided monthly safer staffing reports to the board. These identified significant areas of shortages on some wards. A Safe care project, monitoring ward activity and patient acuity levels on each shift, was being piloted on some inpatient wards. The aim was to manage daily staffing needs more effectively, and was to be rolled out across wards by April 2018. The December six monthly staffing report was not presented due to incomplete information about workforce demands and related financial costs had not been agreed. The Board would receive the six monthly staffing report March 2018, along with five year plan for nursing workforce plan, with accurate information to inform decisions.

**Financial risks**

The trust had faced increasing financial risks over the past few years without sufficient grip or planning to control those risks. Increased spending on agency and locum staff, to fill staff vacancies, had been a significant contributing factor. There was also ongoing work to look at historical structural deficit, and work had commenced on detailed costings. There had been a lack of strategic approach, and the future strategy development will need financial input. Going forward the trust wanted a more constructive, risk sharing partnership with commissioners.
<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical Data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous financial year (2 years ago) 15-16</td>
<td>Last financial year 16-17</td>
</tr>
<tr>
<td>Income</td>
<td>£170,304k</td>
<td>£171,126k</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£(8,358)k</td>
<td>£(10,960)k</td>
</tr>
<tr>
<td>Full costs</td>
<td>£178,662k</td>
<td>£182,086k</td>
</tr>
<tr>
<td>Budget (budget deficit)</td>
<td>£(4,600)k</td>
<td>£(4,630)k</td>
</tr>
</tbody>
</table>

The trust provided this commentary to provide context:

‘The trust moved into a deficit position in 2015/16, having reported a surplus in previous years. The actual outturn deficit (£8.4m) compared to control total deficit (£4.6m) was due to contractual activity underperformance, fines and penalties, additional costs to deliver activity, opening additional contingency beds and CQUIN under delivery.

For 2016/17 a control total plan of £4.63m was approved, with a deficit of £10.96m delivered. The variance was due to significant under performance against PbR contract (£3.1m), non-delivery of CIP (cost improvement programme) requirements, Mental Health & Community contract income reduction by CCG, and CQUIN under delivery. These contributed to the trust control total not being met, resulting in Sustainability and Transformation Funding (STF) for Q3 and Q4 also being unavailable (£1.75m).

The Trust Board approved a deficit plan of £18.8m for 2017/18, against an NHSI control total of £0.366m deficit. This included a CIP requirement of £8.6m. The primary drivers of this increase in deficit are a reduction in CCG income for QIPP (£6.4m) and non-recurrent benefits and transition funding received during 2016/17. As a result of not complying with the control total, no STF funding has been assumed for 2017/18.

The deficit figure has been validated by a recent KPMG independent review commissioned by the Trust.

A financial recovery plan is currently being developed. This approach was approved by Trust Board in October 2017.

2018/19 position is still being worked on and will follow.’

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The trust did not provide a medium term income risk summary for each service when requested pre inspection. The top priority task of the IOW Local Care Plan were listed stating ‘the detail of each initiative and overall impact of changes to quality, access and financial stability of island services will be reviewed by the Local Care Board’

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

NHSI confirmed that in March 2017 the trust submitted a final plan to deliver an £18.8m deficit. An independent reviewer subsequently found that the underlying deficit at the trust was £17.3m for 2016/17, and £27.0m for 2017/18. The trust’s plan represented deterioration on the actual 2016/17 deficit but an improvement on the 2017/18 underlying position. At month 9, December 2017, the trust reported a year to date deficit of £19.1m.
An interim turnaround chief financial officer was appointed August 2017. He was overseeing a financial recovery plan (FRP) that showed how it will still achieve the £18.8m full year deficit. There had been some month on month improvement in deficit, from a month 5 worst case £2.5m in month deficit to a month 9 in month deficit of £2.0m. The trust’s end of year position was expected to be an improvement on the underlying deficit as projected by the independent reviewer at the start of 2017/18, but there were risks to delivery. NHSI was working with the trust to ensure this improvement was sustained and at pace.

The interim chief financial officer had taken steps to establish financial grip and control, work was ongoing and an efficiency and productivity stage had begun. A new structure focusing on financial recovery was implemented in January 2018. A fortnightly financial recovery board with executives and a fortnightly meeting with CBUs had been instigated.

The trust had a core cost improvement programme (CIP) of £8.6m, of which £3.3m was delivered at Month 8. These core CIPs were being supplemented by additional CIPs in the Trust’s FRP. Agency spend to end January was £6.9m (7.9% of total pay) which was £3.5m above the agency ceiling set by NHSI. The interim chief nurse and the interim medical director took overall responsibility for sign off CBU cost impact assessment of CIPs.

The trust provided in house psychiatric liaison services, and this service had been enhanced following successful bid for winter funds, staff had been moved from crisis and community teams, which were being back filled. It was not clear how the liaison service would be sustained going forward.

The IOW Council also required service and income reduction in the trust’s 0-19 and sexual health services 2018/19. It was not clear how the risks to these services were being managed. The community occupational therapy contract, currently provided by the trust, was to be tendered in 2018/19. This was confirmed by the IOW director of adult services who had significant concerns about the service’s value for money.

Last summer, the recently appointed medical advisor to the board reviewed the business continuity plan to address potential risks associated with the influx of visitors to the Isle of Wight Festival and galvanised support across the island and the wider NHS. He also re wrote the trust emergency plan. The trust agreed a clear winter plan with partners across the island to support staff in winter pressures and avoid unplanned and unsafe escalation areas across the hospital. This had worked well to February and any escalation areas had been very short term. Individual services had business continuity plans.

The ambulance service has recently failed a compliance inspection with regard their ability to deal with a CBRN incident. The service was working closely with NARU to fulfil their requirements to be compliant. In the interim, the trust was receiving support from another ambulance trust to provide cover should a CBRN incident occur on the island.

**Information management**

There were significant issues and risks in information management across the trust a lack of trust strategy and historical under investment. Performance and quality monitoring information was often inaccurate, unreliable or out of date. There was inadequate access to and challenge of performance by leaders and staff, particularly at service level. Finance and quality management were not integrated to support decision making across all areas, and the trust could not demonstrate that financial resources were being used optimally to manage quality and safety risks.

The information technology and wide range of patient records systems were not all fit for purpose. The inadequate access to information by relevant staff created a risk to patient care. There were
significant gaps in information governance, and the systems and processes for the management and sharing of data.

The Performance Information Data System (PIDS) team were a competent resource but reactive and there was a lack in strategic oversight of their work. The PIDs team produced arrange performance information for use by CBUs and the Board, but did not have understanding of how this contributed in terms of assurance or identification of risk. The team had produced multiple of dashboards for different teams, to monitor a wide variety of different things. A theatre's dashboard had been developed but the team told us more engagement was required to fully utilise this dashboard as envisaged. There was not a trust wide integrated dashboard providing information on risk and quality for, and accessible to, all levels of the trust.

The trust told us in pre inspection information request that quality of internal data and information varied. There had been a focus on improving the data quality of some metrics particularly acute KPIs, for example referral to treatment times (RTT) and out patients. There was much less assurance around the quality of data coming from some other systems such as theatres and, community, ambulance and mental health services. We heard of some clinicians refusing to use information systems which had impacted on information quality. The quality of information from emergency department had increased with the appointment of the urgent care improvement manager. The trust told us that the PIDS team regularly ran data quality checks on completeness and validity of data. That any staff persistently making input errors were targeted for additional training or ultimately login rights may be withdrawn.

Staff across services and CBU leads consistently told us they had concerns about information reliability, timeliness and quality. The CBUs told us they needed to check the accuracy of information before it was presented to Board, and it was not analysed when received. Ward dashboard information was three months out of date. Safety information was not displayed for patients and public as unreliable. A deputy director of nursing was developing new quality dashboards to support matrons and ward leaders. The ambulance service had begun to work with PIDs team to highlight where the data quality issues lie and provide indication of how to address them.

The trust information technology network was unreliable, we heard from staff unable, complete clinical records or incident forms, to access emails or complete mandatory training. There were at least five different electronic patient record systems across the trust, these were not interconnected and many services used paper records. The assessment prompts in some EPR systems were decided by non-clinicians and this created a risk. For example the mental health liaison team were not completing a comprehensive care assessment and risk assessment for every patient seen. At inspection we found information was not always shared effectively between the liaison team, emergency department (ED) and GPs as not all staff were trained on the ED EPR system and scanning equipment was broken.

The EPRS for child health services was not fit for purpose; it was unreliable and not accessible by all relevant staff across the services. Faults in the system were a significant risk, as records went missing or appointments were lost. Boxes of child patient paper records, from the last five years, were in offices waiting to be scanned on to the EPRS. The hospital patient administration system had a fault since July 2017 and was auto discharging patients if they had not been in contact for 90 days; this had led to a serious incident.

There had been some recent investment to make improvements since our last inspection but this was piecemeal and not part of an overall strategy. There had been clinically led revisions of key data collection forms mental health electronic patient record system (EPRS). The trust planned replacement of the ambulance Computer Aided Dispatch (CAD) system and the introduction of eReferrals.
An EPRS, the same as used by GP surgeries, had been recently introduced for community nurses, but there had been issues with implementation as many staff were not computer literate and they felt the support was insufficient. Other healthcare professional and teams working in community adult services did not have access to the EPRS and were continuing to use paper records.

There had been a rollout of pharmacy staff access to patients’ summary care records to allow accurate and timely medicine reconciliation on admission to hospital. Medicines optimisation staff annotated discharge medicine records and forwarded a copy to the patients’ GP. The trust was introducing the use of an electronic system for complaints handling, to enable easier capture of lessons learnt and improved process for monitoring actions from the investigation of complaints.

There had been some improvement in the quality of external reporting, for example the local authority reported a previous 81% error rate in the delayed transfer of discharges (DTOC) submission, February 2017. This had masked the trust’s poor performance internally. A greater focus on reliable evidence and use of information had improved flow through the hospital and understanding of where the wider community needed to invest to support the trust. The director of quality told us that previously just 14% of serious incidents were reported externally within the 48 hour timeframe. Commissioners confirmed improvements in reliability and transparency of reporting SIs since the arrival of the new executive team.

The trust has provided information to the Care Quality Commission in an open and transparent way. However information requests relating the inspection were not always timely or complete, which is indicative of the challenge the trust faced in accessing and processing of information to support performance and quality monitoring and the improvement of services.

The deputy CEO was recently appointed as the trust senior information risk owner (SIRO). He had no previous experience in the role but had identified significant concerns through chairing the information governance meeting. Significant risks had been identified in records management with respect to the number and variety of ‘libraries’ and the mix of electronic and paper patient records. There was a records management policy but this did include clear accountabilities and there was not one controlling person responsible. It was recognised more work was needed to clarify arrangements for future use of electronic patient records and links into wider STP systems, for example to ensure data was received and was going to the correct person.

The SIRO told us there were limited asset owners (IAOs) in the trust and the information asset register was not comprehensive or complete. He recognised the trust urgently needed to build on IAOs network, to create job descriptions and provide training. He cited an increased number of data mishandling incidents across the trust as a concern.

In order to gain more clarity on information management risks, internal audit were undertaking reviews of General Data Protection (GDP) regulations readiness requirements and the Information Governance Toolkit (IGT). A draft status update report on IGT, January 2018, indicated there was considerable work needed to be done to meet level 2 by end March 2018 deadline. There had been eight information governance incidents to January 2018, five had been closed and none required Information Commissioner’s Office (ICO) action. The SIRO had also asked the Information Commissioner’s Office to review security records management, and data sharing to provide a base line assessment.

The trust had a joint info security officer with local authority and had £250K cyber security capital funding. Recognising the previous underfunding the interim CEO was seeking an investment strategy to address the information management risks, and will use ICO assessment to inform that.
Engagement

There was a limited approach to engaging patients and the public in planning and managing services. The trust collaborated with partner organisations on the island much more effectively since the arrival of the new CEO and senior team. They contributed to an increasing island wide approach to developing services for the population. This effectiveness of working needed to extend to other partner organisations on the mainland, to address the significant challenge of ensuring sustainable services to meet the needs of island patients. The trust also had considerable work to do to improve engagement with staff, particularly clinicians, in achieving improvements in services and shaping future services for the island.

The trust sought patient feedback through NHS Friends and Family Test and ‘iWantGreatCare’ survey as well as service specific surveys for example Endoscopy and 111 services. The majority of patient feedback collated was quantitative and based on patients and their loved ones direct experiences of care, but participation was low.

The trust held regular meetings and engaged on day to day business with long standing patient groups. A patient council circa 20 - 25 members, drawn from the trust's 5,600 membership, a 'Mental health service user and carer group' and a 'Patient with a disability working group'. The latter was discussing problems implementing accessible information standards. Mental health services were recruiting peer volunteers who were using the service (staff and patients) to facilitate groups and conduct interviews. Five 'Medicine for members meetings were held each year with circa 80 members attending each. The trust told us there had also been engagement with the public via social media platforms.

The patient experience lead at the trust had started to engage externally, for example with Age UK but wanted to do more. The patient experience strategy was out of date and going forward would be incorporated into the new quality strategy. There was concern that patient experience was still low on the agenda with little action arising from engagement. The trust did not have systems to ensure that patients and families and carers were encouraged to be involved in reviews and investigations of serious incidents. The trust did not use co-production or patient experience design methodology. Commissioners and other external stakeholders told us the CEO valued any feedback on patient care and was positively focused on patient issues, but the trust needed to do more to engage patient and the public proactively.

The trust was a partner in the development of the new care model for the island (My Life a Full Life) which held public and staff participation in consultation events. An ‘Empowering Engagement’ development programme was designed to support staff who were working to implement the new care model for the island, trust, council, commissioners and voluntary sector. The training helped staff to develop knowledge, skills and confidence to ensure patients and the public were both informed and involved in helping to shape local services. We heard that some mental health staff and the trust transformation team lead were involved, and would help embed public and patient engagement going forward at the trust.

There was a positive developing relationship with Healthwatch who found the interim chief nurse responsive to feedback on poor care, and safeguarding issues. They had meetings planned with the CEO and interim chief nurse. The interim mental health director had attended a recent Healthwatch listening event and was contacting attendees regarding a mental health user group developing the new model of mental health services.

An independent provider with expertise in dementia services told us the CEO had adopted a more collaborative approach to working with partners to improve dementia care. This included the development of a dementia training programme in 'positive care giving in dementia'. They were hoping for more integrated working in future, for example volunteers supporting and modelling good dementia care at the trust. This had not previously been successful but they now had more confidence as there was more focus on positive action and not just talking at meetings.
The partnership working to improve end of life care needed to improve, a newly appointed associate NED was also chair of a local hospice, hoped to support more collaborative and island wide work. Meetings between the trust and local hospice had started and a re-launch the island wide strategy, with a range of relevant partners and providers, was being planned.

External stakeholders such as commissioners and system partners told us their relationship with the trust had improved significantly since the arrival of the CEO and senior team. There was improved partnership and system wide working at trust leadership level, although there were still some barriers within the trust services. Commissioners were now receiving open and transparent feedback on performance from the trust, for example on serious incidents. They had more assurance since being invited to attend the Board quality committee and patient safety sub-committee.

The trust was actively engaged with the recently established Local Care Board. This was attended by senior representatives from local authority, commissioners and the trust Chair, CEO and interim medical director. Partners described a better awareness, collective agreement and focus on the issues for people across the health and social care system on the island. They described strategy being developed in partnership, were positive about development of a community CBU and the interim chief nurse’s expertise in community services. To date there had been particular focus on the acute services with joint working, for example, to reduce delayed transfers of care (DTOC). Weekly tripartite meetings (commissioners /trust/LA) identified blocks and lessons learnt in discharge planning as well as ‘signing off’ DTOC. The better relationship and more evidence based understanding had led to huge changes in adult social care processes and services in the community to support the hospital. All partners were optimistic despite the huge challenges faced by the trust.

The CEO recognised that engagement with organisations on the mainland needed to increase and improve. Engagement was needed to develop operational systems, for example off island transfers, and for the planning of future sustainable services to meet the needs of island patients. The CEO told us that one of the key system leaders from the island would need to represent health and social care at the area sustainable transformation partnership (STP) and Solent alliances as there were some key people leaving.

In the NHS Staff Survey 2017, the staff engagement score for this trust acute services was 3.63, in the lowest (worst) 20%, when compared with England overall (3.79).

The overall staff engagement score for mental health services was 3.66 below (worse than) average when compared with the England average.

The overall staff engagement score for ambulances services was 3.49, improved from 3.32 in 2016, and above the England average (3.45).

(Source: NHS Staff Survey 2017)

The NHS friends and family test is also completed by staff The percentage of staff that would recommend this trust as a place to work in Q2 17/18 was 40%, decreased when compared to the same time last year. The percentage of staff that would recommend this trust as a place to receive care was 55% in Q2 17/18, about the same when compared to the same time last year. The response rate was 10%.

The trust carried out a ‘medical engagement score’ survey in September 2017, this found engagement with doctors was generally very poor. We heard consultants were getting in contact to raise concerns but felt that they were heard, but not listened to as there has been no follow through. They told us there were three drop in sessions to discuss the acute services review but poor attendance was poor, eight attendees at one of the meetings. The CEO had started attending the clinical senate, set up as a forum for clinicians and staff to raise any concerns/issues in relation to patient safety. Junior doctors were able to raise patient safety concerns directly with the
CEOs or interim medical directors at a junior doctor's forum, started by the guardian of safe working hours.
Volunteers told us they were concerned they did not receive sufficient communication about what was happening at the trust, and were not clear how to raise concerns.

The trust recognised the importance of improving engagement in delivering improvements and shaping future services. An employee engagement plan was being to be produced as part of Leadership and organisational development improvement framework.

The Chair had undertaken visits across services, with more visits planned by the new non-executive directors. Mental health staff told us they now believed the trust was taking mental health seriously, and the new non-executives wanted to shadow their services.

The interim executive team made an effort to be visible and engage with staff. Since her arrival the CEO held regular drop in sessions for staff. The trust HQ had been deliberately moved from a peripheral building to accommodation within the main hospital. The CEO sent the message to all staff that the executive team wanted to be accessible to all teams. Community staff were not always able to attend trust wide sessions but found the CEO approachable and willing to give feedback. Staff told us of many examples of the CEO’s efforts to work alongside staff across services and to understand the issues they faced, this was highly valued. CBU leads told us they told us they appreciated that the CEO had communicated new directorate structure and plans for CBUs in January as soon as they were agreed by the Board. The interim chief nurse was similarly highly praised by a range of staff at all levels for leadership and visibility across services, empowering nursing and allied health professionals.

Learning, continuous improvement and innovation

There was minimal evidence of learning and reflective practice across the trust. Systems to improve the review of serious incidents, complaints and deaths were at the early stages of development. There had been a lack of investment in improvement skills and systems at all levels of the trust. Staff did not always recognise that improvements were needed or improvement actions were not followed through. There had been insufficient pace in the implementation of quality improvement plans at CBU and service level, although recent review had clarified key priority areas of focus. Improvements in mental health inpatient environments led to the decision to lift some conditions on the trust registration. There had been insufficient improvements in other areas, such as community mental health services, so those conditions remain on the trust’s registration.

Historically there had not been learning and improvement as a result of external reviews but this was changing, both in the focus of reviews commissioned and the understanding of the steps needs and the commitment to sustained change. The board had committed to implementing the recommendations of the external review of leadership report September 2017.

The interim deputy CEO was leading on the implementation of the "Integrated Improvement Framework" (IIF). The IIF was first developed in response to the trust being placed in Special Measures. Over the last few months this had been restructured and simplified to set out immediate priorities for change and to make more accessible to staff. The immediate focus and priorities for staff were described in the actions agreed within the IIF. There was executive sponsor of each programme and regular programme board meetings to monitor progress. The CEO and Chair and partners were disappointed there had not been greater the pace in the improvements at service level, particularly in community mental health services. During interviews staff told us of the challenges of getting pace alongside sustainability of improvement.

Following the last inspection of mental health services in November 2016, enforcement action was taken and urgent conditions were placed on the trust’s registration, these remained in place following inspection in May 2017. At this inspection, January 2018, we found improvements in the
mental health inpatient environments, with respect to the removal and mitigation of ligature points and other environmental risks to patients. This improvement was sufficient for the relevant conditions on trust registration to be removed. However, the significant concerns about the day to day quality and safety of community mental health services remained, with insufficient progress on improvements. The conditions on the trust registration remain in relation to those continued areas of concern.

The trust had initiated a ‘Getting to Good’ by 2020 programme and was encouraging staff to get involved. A pocket sized guide, ‘Getting to Good- our improvement journey programme’ had recently been given to all staff. The guide clearly described commitments and key areas for staff to contribute to improvement along with a summary of IIF programmes. There was a dedicated website detailing improvements so far and opportunity for sharing improvement ideas.

Improvements to the serious incidents process had begun, with clear plans for improvements in the future, but learning from incidents was not yet embedded across the trust. The Serious Incident Activity report presented to the patient safety subcommittee February 2018 summarised learning from four never events 2016/17 and ‘learning bites’ from serious incidents closed in January 2018 but it was not clear how this learning would be disseminated in a structured way. There was some evidence of learning arising from recent inquests, with medical and nursing staff working together to make improvements. The trust had commissioned an independent review to support this work.

The trust had recently updated the Mortality Review Policy and had adopted the national ‘Learning from deaths framework’. The interim MD acknowledged the trust was ‘behind the curve’ with implementation of learning from deaths. The interim medical director’s mortality quarterly report was in accordance with the framework, the Board were presented with data, trends, assessment and analysis. There was a mortality review team and a process for reviewing deaths. There was appropriate governance around the process with the interim MD as accountable officer. There was a weak structure and the team had limited capacity which impacted on timely completion of reviews. A senior lead nurse was recently appointed to the team, they would help with backlog of reviews and ensure timely assessment of all deaths. Their role would help address the challenges of: enabling robust and effective learning, embedding the framework, determining a method of assessment of avoid ability and embedding duty of candour. There were some links between complaints, SIs and deaths but it was too early in the process to evidence outcomes.

The medicines safety group managed medicines incidents, which reported to the drugs advisory committee. Learning from incidents and near misses were discussed at the medicines safety group. These were summarised and then circulated to all wards and departments via a safety matters briefing.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 working days</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint*</td>
<td>20 working days. Although they do negotiate response timeframes with complainants</td>
<td>53% of all complaints responded to on time</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what</td>
<td>45 to 65 working days if SI leading</td>
<td>Not recoded</td>
</tr>
</tbody>
</table>
that is here

| Number of complaints resolved without formal process in the last 12 months? | 888 between October 2016 and September 2017 | N/A |

*Completing* defined as closing the complaint, having been resolved or decided no further action can be taken
(Source: Routine Provider Information Request (RPIR) – Complaints Overview tab)

**Number of complaints made to the trust**

The trust received 246 complaints from October 2016 to September 2017. Surgery core service received the most complaints with 52.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Surgery</td>
<td>52</td>
<td>21.1%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>40</td>
<td>16.3%</td>
</tr>
<tr>
<td>AC - Medical care (including older people's care)</td>
<td>30</td>
<td>12.2%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>20</td>
<td>8.1%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>9</td>
<td>3.7%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>6</td>
<td>2.4%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>5</td>
<td>2.0%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>4</td>
<td>1.6%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>AC - End of Life Care</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>16</td>
<td>6.5%</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>12</td>
<td>4.9%</td>
</tr>
<tr>
<td>Community Services</td>
<td>7</td>
<td>2.8%</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

There was a complaints, concerns and compliments policy, which was due for review July 2019. This did not reflect the current processes or the organisational and reporting structures at the trust and had no direct reference to Duty of Candour. The complaints function was running separately to the patient advice and liaison service (PALS). We heard that since arriving at the trust the CEO took personal responsibility for signing complaint responses and returned a large number that were not suitable. Gradually over the past few months the quality of responses had improved. We reviewed a random sample of six closed complaints across services, 2016-2017, under the previous and current leadership. There was evidence that final responses to complaints had improved considerably from a very poor level. The recent responses we saw were high quality, sincere, apologetic and compassionate. Considerable improvement was still needed in meeting timescales and key performance indicators, training investigators and implementing systems for first contact resolution.
Complaints were not used systematically for local and trust wide learning, action planning and embedding improvements, and a lot of work was needed to achieve this. In the new structure the reporting of complaints would be monitored through the patient experience sub-committee. The CEO had recently started signing off litigation claims as the previous process meant there was insufficient oversight of claims and any risks arising.

There was not trust wide use of standardised improvement tools and methods. There was evidence of improvements and innovations in some areas. Increasing the length of the pharmacy day and weekend opening hours had improved hospital effectiveness. The trust was regarded as a Beacon site for the automation of medicines optimisation which included a pharmacy robot, ward based electronic medicines cupboards and the significant roll out of electronic prescribing and medicines administration. There had been some progress in reducing community pressure ulcers and a quality improvement approach to reducing inpatient falls. Staff cited the frailty pathway project as making a difference to patients, the processes and outcomes were being monitored.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy Unit - Medicine (including older people’s care)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Blood Sciences – CPA accredited Medical Microbiology – CPA accredited Cellular Pathology - UKAS accredited</td>
</tr>
<tr>
<td>Accreditation for Inpatient Mental Health Services (AIMS) AIMS - WA (Working Age Units)</td>
<td>Osborne Ward</td>
</tr>
<tr>
<td>Accreditation for Inpatient Mental Health Services (AIMS) AIMS - PICU (Psychiatric Intensive Care Units)</td>
<td>Seagrove PICU</td>
</tr>
<tr>
<td>ECT Accreditation Scheme (ECTAS)</td>
<td>ECT clinic</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)
Details of emergency departments and other urgent and emergency care services

The trust has one emergency department (ED), located at St Mary’s Hospital in Newport. It provides a 24-hour, seven day a week service. It is a designated trauma unit but patients with multiple trauma are usually flown directly to the major trauma centre in Southampton.

The ED consists of a major treatment area with 10 cubicles, a minor treatment area with six cubicles, and resuscitation room with three trolley bays. Children have a separate waiting room and are treated in three rooms adjacent to the major treatment area. There are separate rooms for mental health assessment, eye examinations and application of plaster casts.

We last inspected the department in November 2016 and rated it as Requires Improvement.

We carried out an announced inspection from 23-25 January 2018 and an unannounced inspection during the evening of 8 February 2018. During our inspection, we spoke with 11 patients and two family members, reviewed records of 25 patients and spoke with 18 staff. We also reviewed the trust’s ED performance data. We inspected the whole core service, looked at all five key questions and followed up concerns from our previous inspection.

Activity and patient throughput

Total number of urgent and emergency care attendances at Isle of Wight NHS Trust compared to all acute trusts in England.

There were 59,965 attendances from April 2016 to March 2017 at Isle of Wight NHS Trust as indicated in the chart above.
The percentage of A&E attendances at this trust that resulted in an admission increased from 2015 to 2016. In 2016, rates were lower than the England average.

(Source: NHS England)

Urgent and emergency care attendances by disposal method

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff but did not ensure everyone completed it.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training in urgent and emergency care, medical, dental and nursing staff failed to meet the target with medical/dental staff achieving 62% and nursing staff achieving 83% compliance overall.

Mandatory Training Completion by module – Medical and Dental Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>13</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>13</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>13</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>11</td>
<td>81.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>13</td>
<td>76.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>11</td>
<td>63.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 – Extinguishers</td>
<td>13</td>
<td>53.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>13</td>
<td>46.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>9</td>
<td>44.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>7</td>
<td>42.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>13</td>
<td>30.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>13</td>
<td>23.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>13</td>
<td>23.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>13</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>13</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical/dental staff working within urgent and emergency care met the target for two of the 21 training courses listed above. Courses with the lowest compliance levels included prevent training levels 1 & 2 (three out of 13 members of staff completed this), and hand hygiene (three out of 13 members of staff completed this).

We asked the trust to confirm how many senior doctors in the department held current qualifications in advanced life support and paediatric advanced life support. Although, they confirmed that three consultants held these qualifications (and were also instructors on these training courses) they could not confirm that there was always a senior doctor on duty with these essential skills.
Mandatory Training Completion by module – Nursing Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>26</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>26</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>26</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>26</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>26</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>26</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>26</td>
<td>96.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>26</td>
<td>96.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>26</td>
<td>96.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling</td>
<td>26</td>
<td>96.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>26</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>26</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>26</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>26</td>
<td>88.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>26</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Maths &amp; Medicines Calculations</td>
<td>26</td>
<td>76.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>26</td>
<td>73.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>26</td>
<td>61.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>26</td>
<td>7.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>49</td>
<td>2.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>26</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>26</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

At our previous inspection the trust was unable to provide information about the number of staff who had completed training. Although they have provided us with the training figures shown above, information given to us during and after our inspection indicated that it was not accurate. We were therefore not assured which training was provided and who had attended. For example, figures above show that 84.6% nurses had completed paediatric resuscitation training. Figures later supplied to us showed that 77% of nurses had completed intermediate paediatric life support training which is required by nurses in an emergency department. Although this is a lower number than the trust target it had improved since our last inspection. It ensured there was always one nurse on duty with sufficient skills to assist in the resuscitation of a child. Some staff were also undertaking a neonatal resuscitation course.

Safeguarding

Staff did not always understand how to protect patients from abuse. Training in the recognition and reporting of abuse had improved since our last inspection but staff did not always apply it in practice.

Although some training had improved since our last inspection nurses had only been provided with
basic (Level one) adult safeguarding training. None had undertaken the more advanced adult level two training despite a large number of vulnerable adult patients attending the department. This meant that staff may not have been able to identify a vulnerable adult at risk of abuse.

During our inspection we found that best practice did not always take place. Safeguarding assessments were not routinely carried out at triage (initial clinical assessment) and triggers which might indicate abuse were not easily available. There was confusion about how to report potential abuse of children and adults. Some staff told us that they would telephone social services, some would contact the hospital’s safeguarding lead and other said that they would complete an alert on-line.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

**Safeguarding Training Completion by module – Medical and Dental Staff**

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for medical/dental in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>13</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>11</td>
<td>81.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>13</td>
<td>76.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>13</td>
<td>61.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At our last inspection the trust were not able to supply us with training figures. During this inspection staff told us training improved.

However, medical/dental staff working in urgent and emergency care did not meet the trust’s target for any of the safeguarding modules. None of them had completed level 2 adult safeguarding training.

**Safeguarding Training Completion by module – Nursing Staff**

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>26</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>26</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>26</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>26</td>
<td>65.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff working within urgent and emergency care met the trust’s target for two out of the four safeguarding modules; safeguarding children level 1 and safeguarding children level 3.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Cleanliness, infection control and hygiene

There had been improvements in hand hygiene since our last inspection and infection risks were well controlled. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. Results from monthly infection control audit (29 September 2017) showed 95% compliance with hospital policies.

The department was visibly clean and we saw support staff cleaning the department on a regular basis. The majority of staff used antibacterial hand gel regularly and washing their hands before and after patient contact.

‘Bare below the elbow’ policies were adhered to and staff wore minimal jewellery in line with the trust’s infection prevention and control policy. Personal protective equipment such as gloves and disposable aprons were used in accordance with the trust’s infection control policy.

There was no cleaning schedule for the toys in the children’s waiting room. Many of them were, of necessity, on the floor but none of the staff that we spoke with could tell us how often they were cleaned.

Environment and equipment

On the whole the service had suitable premises and equipment and looked after them well. Improvements had been made to the children’s waiting area and to the mental health assessment room since our last inspection.

The children’s treatment area had three cubicles large enough for a patient trolley and equipment for immediate assessment and treatment. One was equipped for the resuscitation of small babies and a second for the resuscitation of all other children. The rooms were child-friendly and safe. Although the treatment area was to one side of the department it was not separated from adult treatment areas and was not secured. A nurse explained that the department would have to be extensively rebuilt before this could be achieved. There was a separate waiting area for children in order to maintain audio and visual separation of adults from children. There was a selection of toys for a wide age range of children.

The resuscitation room was cramped. When several members of staff were needed to resuscitate patients it was difficult for them to move around. We checked a range of specialist equipment, including adult and children’s resuscitation equipment. It was clean, tamper-evident, clearly organised and well maintained. It had been checked on a daily basis to ensure that it was ready for use.

There was a designated room for seeing patients who required a mental health assessment. This had been re-furbished since our last inspection so that it met the Psychiatric Liaison Accreditation Network quality standard requirements.

The department had a dedicated ambulance entrance, which was located near to the major treatment and resuscitation areas. A helipad was situated close to the ED to enable air ambulances to land.

Clinical waste and specimens were appropriately labelled and segregated. They were stored safely and disposed of according to hospital policy.

An adjacent imaging department provided X-rays and scans for walking patients and those on trolleys.
Assessing and responding to patient risk

Systems within the department did not always minimise the risk to patients when they first arrived. Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation room. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient. Staff in the department also had access to the ambulance radio system so that they could speak directly to a crew. However, on the first and third morning of our inspection all three bays in the resuscitation room were full, as were all other treatment areas, with patients waiting on trolleys in the corridor. Although staff had identified one of the patients as well enough to leave the resuscitation room, it was not clear where they would have been treated if a further emergency patient had arrived. Staff told us this was a frequent dilemma.

Hospital managers had been informed that the resuscitation room was full, in accordance with the full capacity standard operation procedure. However, they were unable to provide any immediate solution.

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for all 12 months over the 12 month period from October 2016 to September 2017, and consistently performed better than the England average.

The trust met the standard (set at 60 minutes) for the time patients should wait from time of arrival to receiving treatment for all 12 months from October 2016 to September 2017. Performance in this metric showed a trend of decline from February 2017 (24 minutes average) to September 2017 (44 minutes average). However, this average time in September remained lower than the England average of 58 minutes for that month and below the standard set at 60 minutes.

Ambulance – Time to treatment from October 2016 to September 2017 at Isle of Wight NHS Trust

Although the average (median) time to receive treatment was less than the England average there were still long delays for some patients, particularly at night. On the first night of our inspection there were two patients who had waited between three and a half and five hours to see an ED doctor. Both were sufficiently ill to merit admission to a ward.

The crowded department contributed to delays in treatment. Some patient had to wait on trolleys in the corridor that ran through the major treatment area. We reviewed the notes of a patient with a serious heart condition. The ED doctor had written that the patient was "In the corridor as no cubicle spaces, so I am unable to do an examination currently". Patients who had been referred to specialty teams sometimes experienced similar delays. We observed one team speaking to a patient in a busy corridor. They were waiting for a cubicle to become free so that
they could examine the patient and commence specialist treatment.

**Median time from arrival to initial assessment (emergency ambulance cases only)**

Any delays in the initial assessment of patients were not accurately recorded. Trust managers confirmed that the ambulance information system was not able to accurately record arrival times and handover times. A new computer aided dispatch system was planned but it was not known when it would be implemented. The trust reported the median time from arrival to initial assessment was consistently better than the England Average from October 2016 to September 2017. The trust score appeared to be stable through this time period ranging from one to two minutes. In September 2017, the trust’s reported median time from arrival to initial assessment was two minutes, lower than the England average of seven minutes for the same month.

However, when we observed ambulance handovers we found that crews waited longer than the one or two minutes that had been reported. We regularly observed ambulance handover throughout our inspection and observed that crews waited between two and 14 minutes. This was better than the practice that was taking place at our last inspection. It was also better than the 15 minute standard set by the Royal College of Emergency Medicine. However, it did not reflect the reported times of one or two minutes.

**Ambulance – Time to initial assessment from October 2016 and September 2017 at Isle of Wight NHS Trust**

![Graph showing ambulance time to initial assessment](image)

(Source: NHS Digital - A&E quality indicators)

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

**St Mary’s Hospital**

From November 2016 to October 2017, the monthly percentage of ambulance journeys with turnaround times over 30 minutes at St Mary’s Hospital fluctuated between 38% and 53%. May 2017 was the worst performing month for the trust with 53% of ambulance journeys having turnaround times over 30 minutes. From May 2017, there was a period of improvement through to October 2017 (38%). October 2017 was the best performing month of the trust.

**Ambulance: Number of journeys with turnaround times over 30 minutes - St Mary’s Hospital**

![Graph showing ambulance journeys with turnaround times](image)
**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From January 2017 to September 2017, the trust reported 205 “black breaches”, with a downward trend over the period. The majority of these breaches occurred from January 2017 to May 2017. Since June 2017, there was an improvement in the number of breaches recorded, with only three recorded in August 2017 and seven recorded in September 2017.

The trust attributed the poor performance at the beginning of this time period to ‘Longstanding issues with ambulance handover delays and cultures of ambulance and ED.’ The trust told us this had been ‘largely addressed using ECIP methodology and change management’.

Please note that the trust only provided data for this nine month period, and so it was not possible to populate a graph including a 12 month period of data.

**Number of Black Breaches from January 2017 to September 2017**

*Information sent to us by the trust before our inspection (RPIR) stated “Current CAD (Ambulance Computer Aided Dispatch) system does not provide accurate data for handover times but crews report significant decrease in delays.” We did not observe any significant delays in the handover of ambulance patients and this was an improvement since our last inspection. However, because of the data collection issues we could not fully rely on the figures sent to us.*
patients during our inspection we observed that the assessment was not always carried out correctly. The Royal College of Emergency Medicine states that “Triage is a face-to-face contact with the patient” and that it should be carried out by a qualified healthcare professional who has had specific training. Although triage was carried out by ED nurses who had been trained, there was often a lack of face-to-face contact with patients. Instead, for much of our inspection, the triage nurse sat down with a member of the ambulance crew and entered information on to a computer. Based on this information a triage priority was decided and entered into the computer record. There was no attempt to confirm information with the patient or to assess their current condition by, for example, checking a pulse rate. One patient told us that he had been in the department for 30 minutes and none of the nurses had spoken to him.

We raised this with senior hospital staff and found that practice improved towards the end of our inspection.

Following the triage assessment we observed that incorrect triage priorities were assigned to some patients. The department used the Manchester triage system which results in categories one to five to indicate how quickly a patient should receive treatment. Records of patients with significant and immediate health problems showed a triage category of four which indicates that a patient can wait for two hours before receiving treatment. A category two (see in 10 minutes) or three (see within one hour) would have been safer.

The triage nurse would allocate ambulance patients to a cubicle where further recordings such as blood pressure and temperature readings would take place. During the first day of our inspection these tests were carried out by a healthcare assistant. The results were recorded on the patient’s chart which stayed in the cubicle. The nurse did not return to the patient to check the results of the tests and so any new risks were not assessed by qualified healthcare profession in a timely fashion.

Triage of patients who arrived independently was methodical and pain relief was offered if necessary. The Royal College of Emergency medicine states that it is appropriate to triage patients within 15 minutes. During the day we observed that patients were triaged between five and twenty minutes. At night and in the evenings there were sometimes longer delays. We observed a patient register at reception and then sitting in the waiting room for over 40 minutes. The patient was in pain and becoming increasingly uncomfortable. After 45 minutes we alerted the receptionist who arrange for a nurse to triage the patient. During a records audit we noted that two patients, both children, had waited 33 minutes and 48 minutes respectively before they were seen by the triage nurse. There was a risk of their condition deteriorating while they waited.

The National Early Warning Score (NEWS) was used for adults. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. The charts used in the department were not the same as the chart recommended by the Royal College of Physicians and some staff found it confusing. We found that some scores had not been calculated correctly. Audits of NEWS were not undertaken and it is unclear whether senior staff checked the charts for accuracy.

The frequency of the observations was sometimes less than was required. For example, two patients with unstable heart conditions who required at least hourly observations were sometimes left for three hours with no NEWS being calculated. This meant that their condition could have deteriorated without staff being aware.
A patient safety checklist had recently been introduced. This was aimed at reminding nursing staff to undertake hourly safety checks of all patients in the major treatment area. However, some patients had not had the safety checks applied. One patient, with multiple medical conditions, who stayed in the department for six hours only had one safety check. Another, who had been in the department for 14 hours, had four.

Patients being cared for on trolleys did not always have their skin integrity examined in order to assess their risk of developing pressure ulcers. Although all trolleys had pressure relieving mattresses, a formal risk assessment would have identified other measures needed to prevent pressure ulcers developing. The records of one patient had two entries from nurses indicating that a pressure sore was at risk of developing. However, no preventative action, such as a change of position, had taken place. Documentation aimed at reducing the risk of complications associated with intra-venous cannulas was not always completed.

Systems within the department did not always minimise the risk to patients who needed to be transferred to other hospitals for urgent specialist treatment. Senior staff told us that there was no clear pathway for referring patients in an emergency to hospitals on the mainland. Instead, there was often a prolonged series of telephone messages and exchange of faxes to on-call doctors. We saw reports of patients whose clinical condition had deteriorated significantly while ED doctors spent hours trying to find a specialist who would agree to carry out urgent treatment. This problem had been recognised at a senior level within the trust. Minutes from a board meeting on 1 February 2018 showed that discussions were taking place with mainland hospitals with a view to establishing an efficient retrieval service for patients with urgent specialist needs.

**Emergency Department Survey 2016**

The trust’s scored “about the same” as other trusts for the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Nurse staffing**

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From October 2016 to September 2017, the trust reported an overall vacancy rate of 14% for registered nursing staff working within urgent and emergency care.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

All vacancies were advertised on the NHS Jobs website. The department was taking part in a Return to Practice scheme and two nurses had applied.

Turnover rates

From October 2016 to September 2017, the trust reported an overall turnover rate of 12% for registered nursing staff working within urgent and emergency care.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From October 2016 to September 2017, the trust reported an overall sickness rate of 5% for registered nursing staff working within urgent and emergency care.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From October 2016 to September 2017, the trust reported an overall bank usage of 366 shifts, and an overall agency usage of 810 shifts. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

During the inspection we looked at the staff rota for the month ending 22 January 2018. This showed that agency staff were used regularly throughout the month (29 out of 30 day shifts and 23 out of 30 night shifts). 16 of 30 day shifts had two or more agency staff. Although agency nurses are fully qualified they do not always have the specialist experience needed in ED and have often not worked in the department before. This means that some patients were not looked after by nurses with the experience required. Senior staff told us that agency nurses often did not have the clinical assessment skills required in an emergency setting and did not have up-to-date resuscitation skills.

Although some of the agency nurses worked regularly in the department others had never worked there before and some had not worked in an emergency department before. The department did not provide an information pack for new agency nurses and senior nurses told us there was often no-one available to provide even a brief orientation to the department.
The trust attributed this high bank/agency usage to vacancies. The trust plans to address this by ‘having focused recruitment’ and by ‘holding regular meetings with the CBU to discuss strategy and activity’.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

A review of nurse staffing levels had recently been undertaken using evidence-based recommendations by the National Institute for Health and Care Excellence (NICE). These use the following minimum nurse: patient ratios to establish the number of registered nurses needed at any one time.

1 registered nurse to 1 cubicle in triage
1 registered nurse to 4 cubicles in minor and major treatment areas
1 registered nurse to 2 cubicles in the resuscitation area

At St. Mary’s hospital ED this would result in nine registered nurses during the day and seven at night supported by a “Twilight” nurse who left at 2am. (Senior staff told us the number of children and triage patients after 2pm was very small). During the day there were often between two and six patients being cared for in the corridor, meaning a tenth nurse was needed.

We looked at the nurses’ rota for the month before our inspection and found that there was only one occasion when there enough nurses to meet the NICE recommendations. During most days there were seven nurses in the department. On 12 days there were eight nurses.

There were usually between five and six nurses at night, with or without a twilight nurse. There were six nights when only four registered nurses were on duty. This meant that one nurse was looking after 10 patients in the major treatment area, one nurse looking after 6 patients in the minor treatment area (often occupied by major treatment patients waiting to be admitted to a ward) and one nurse looking after three patients in the resuscitation room. This left the nurse in charge to run the department, triage ambulance and walking patients and look after sick children. We saw that sometimes this was not always possible and that a healthcare assistant was looking after the patients in the minor treatment area. One nurse told us that the department sometimes felt unsafe at night and that it was difficult to find time to take meal breaks.

The NICE guidance used in the staffing review also recommends that an experienced band 7 nurse should lead the nursing team on all shifts. The department only employed one band 7 nurse and so this was not possible. A business case had been sent to the trust board describing the need for six additional band 7 nurses. It was not clear when a decision would be made.

Nursing handovers were structured but not always comprehensive. We found a patient lying across some chairs in the waiting room at the beginning of the day shift. We asked the nurse in charge if anything was wrong with the patient but she was not aware of their presence or condition. After investigation the patient told staff that she had been treated during the night and was waiting to be taken home. However, the night staff had not handed this information over to the day staff. Nurses in individual areas were not told about activity in the rest of the department.

The number of qualified sick children’s nurses had improved since our last inspection. There was now a lead children’s nurse and one other full-time children’s nurse employed by the department.
There was also a third nurse provided by a rotational role with the children’s ward. It was recognised that this was still not enough to ensure that a children’s nurse was on duty at all times. In order to fill any gaps in the rota a training plan had been designed to enhance the skills of other nurses in the emergency department. However, no-one had yet completed this training and it was not clear how long it would take for this to happen.

**Medical staffing**

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section. *(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of -1% for medical/dental staff working within urgent and emergency care, apparently demonstrating a surplus in staffing numbers. *(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

However, the current doctors’ rota showed a reliance on locum (temporary) doctors and shift patterns that left insufficient time for adequate rest. For example, doctors completing one shift at midnight were expected to be at work at 8am the next morning. Some junior doctors reported feeling tired and “burnt out”.

**Turnover rates**

From October 2016 to September 2017, the trust reported an overall turnover rate of 5% for medical/dental staff working within urgent and emergency care. *(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

From October 2016 to September 2017, the trust reported an overall sickness rate of 0.7% for medical/dental staff working within urgent and emergency care. *(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

However, there was at least one doctor on sick leave on most shifts during our inspection.

**Bank and locum staff usage**

From October 2016 to September 2017, the trust reported a bank usage of 14 shifts and an agency usage of 247 shifts. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked. *(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)*

**Staffing skill mix**

As of July 2017, the proportion of consultant staff reported to be working at the trust were lower
than the England average and the proportion of junior (foundation year 1-2) staff was also lower.

**Staffing skill mix for the 17 whole time equivalent staff working in Urgent and emergency care at Isle of Wight NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>37%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>16%</td>
<td>31%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>25%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

There were not enough consultants to ensure a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine. Instead, the rota allowed one consultant to be in the department from 8am to 8pm on week days and 8am to 4pm at the weekends. Due to the appointment of an additional locum consultant these hours had improved since our last inspection. The shortage of consultants was recorded on the hospital risk register. A business case had been sent to the trust board describing the need for four additional consultants. It was not clear when a decision would be made.

We looked at the rota for the month before our inspection and saw that, when there were no consultants in the department, there was always a senior middle grade (ST4 or above) on duty. There was a consultant on-call from home at night.

The middle grade doctor was supported by a junior doctor at night. Due to large numbers of patients staying in the department overnight two doctors was not enough. On each night of our inspection there had been two to three patients in the resuscitation room during the night and between fourteen and seventeen in the rest of the department. Most were sufficiently ill to require a specialist opinion and admission to a ward.

Most junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and accessible. In-house teaching took place each week although pressure of work meant that it was not always possible to attend.

There were no formal handover sessions between doctors. As each individual doctor left the department, they would hand over their patients to one other doctor. It was not clear if the senior doctor in the department had an overview of all the patients being treated or those who were awaiting treatment. There were no multi-disciplinary handovers that enabled nurses to report concerns or for senior doctors to check that treatment pathways were being followed.

**Records**

Staff did not always keep detailed records of patients’ care and treatment. When a patient was
registered their details were entered onto a computer system that showed how long patients had been waiting and the investigations they had received. ED medical staff entered information onto the patient's computer record. Nurses entered some information into the computer and some onto paper records. Nurses could not always access a computer when they needed to and so records of some nursing care was missing or were entered more than an hour after they took place. The mixture of computer and paper records produced a fragmented patient record that was difficult to follow.

The computer system did not print out a paper record or labels to attach to separately produced paper records. This meant that the patient’s names and other unique identifiers were hand written and were not always legible or complete.

When patients were admitted to a ward, or referred to outpatients, their paper records were scanned into the computer system. If a patient returned to the department their previous records could be viewed on screen. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure.

Medicines
The department followed best practice when prescribing, giving, recording and storing medicines. This had improved since our last inspection. Patients received the right medication at the right dose at the right time.

There was an electronic system in place for the checking and dispensing of medicines. We saw that staff handled and recorded controlled drugs correctly. Spot checks on recorded controlled drug balances showed that the contents of the controlled drug cabinet matched the register.

Medicines were stored securely within locked rooms and cupboards with access restricted to authorised staff. Overall improvements in monitoring and checking medicine room and refrigerator temperatures were seen.

Resuscitation trolleys containing medicines and equipment required in an emergency were accessible. The trolleys were all safely secured with tamper proof seals. Checks were in place to ensure emergency medicines were available and safe to be used.

Members of the pharmacy team undertook medicine reconciliation to ensure patients medicines were available as well as checking for safe prescribing. Any known allergies or sensitivities to medicines were recorded on medicine charts. This information is important to prevent the potential of a medicine being given in error and causing harm.

Incidents
The service did not always manage patient safety incidents effectively. Although medical and nursing staff recognised some incidents and reported them appropriately, this rarely included “near miss incidents” that were due to staff shortages. For example, staff told us about a night shift the previous week when there was an acute shortage of nurses. They were concerned about the level of care that they were able to provide. However, no incident report had been submitted. Some staff told us that there was no time during a shift to write an incident report and so they had to do it in their own time at the end of the working day. Those staff who had reported incidents told us that managers had investigated them and provided feedback.

A new quality and safety bulletin had been produced the week before our inspection by the interim head of nursing of the clinical business unit. This described themes from clinical incidents and learning from them. However, it was a new initiative and we were not assured that it would continue.

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From December 2016 to November 2017, the trust reported no incidents classified as never events for urgent and emergency care.
(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2016 to September 2017.

A breakdown by incident type was:

- Major incident/ emergency preparedness, resilience and response/ suspension of services with 17 (57% of total incidents).
- Treatment delay meeting SI criteria with six (20% of total incidents).
- Diagnostics incident including delay meeting SI criteria (including failure to act on test results) with two (6% of total incidents).
- Sub-optimal care of deteriorating patient meeting SI criteria with one (3% of total incidents).
- Environmental incident meeting SI criteria with one (3% of total incidents)
- HCAI/Infection control incident meeting SI criteria with one (3% of total incidents).
- Medical equipment/ devices/disposables incident meeting SI criteria with one (3% of total incidents).
- Slips/trips/falls meeting SI criteria with one (3% of total incidents).

(Source: NHS Improvement - STEIS (01/10/2016 - 30/09/2017)

When we showed this information to the ED leadership team they did not recognise it. They believed that there had been six reported serious incidents in the last year. The trust had not shared this information with them and they thought that a mistake may have been made. We asked the trust for copies of the root cause analysis of the three most recent serious incidents. Two of them were unrelated to the emergency department and one was only partially related. It
is possible therefore that the trust is allocating serious incidents to incorrect services. This means that analysis and monitoring of incidents will not be effective and the ability to prevent a re-occurrence reduced.

Learning from incidents was not always implemented. A recommendation from one serious incident was that there should be a checklist for ED clinicians to complete before transferring a patient to the intensive care unit. We asked to see a copy of this but the trust told us that there was no checklist. Instead, the previous practice of critical care outreach staff completing different documents had continued.

**Safety thermometer**

The department did not carry out regular safety monitoring. The safety thermometer is a ward-based measurement tool which was not designed to monitor safety in emergency departments. There was no other patient safety monitoring such as triage times, recognition of deteriorating patients or completion of safety checklists.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, zero falls with harm and three new catheter urinary tract infections from October 2016 to October 2017 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Isle of Wight NHS Trust**

![Graph showing prevalence rate of pressure ulcers]

**Prevalence rate (number of patients per 100 surveyed) of total CUTIs at Isle of Wight NHS Trust**

![Graph showing prevalence rate of total CUTIs]

(Source: Safety thermometer - Safety Thermometer)
Is the service effective?

**Evidence-based care and treatment**

It was not possible to establish whether the emergency department (ED) provided care and treatment based on national guidance and evidence of its effectiveness.

We asked nursing and medical staff of different levels of seniority to show us the clinical guidelines they followed. Only one person was able to do this. The guidelines were contained in a large file and were not dated. It was not possible to tell whether they were based on the most recent national guidance. There was no internal audit programme aimed at monitoring compliance with best practice.

**Nutrition and hydration**

It was not clear whether staff gave patients enough food and drink to meet their needs and improve their health.

Although we occasionally saw staff offering refreshments during the course of our inspection, this was not done on a regular basis and was not always recorded in the patient record. A system of hourly care rounds had been recently introduced aimed at ensuring that patients felt comfortable and had been offered food and drink. However, there were often long gaps between these rounds. One patient, who spent 15 hours in the department, had only two rounds recorded. There was only one record of the patient being given tea and a sandwich.

Another patient, who had arrived in the early hours of the morning told us they had not been offered refreshment for many hours. He had to ask a nurse if any lunch was available. Records showed that the patient had spent 14 hours in the department but had only been offered refreshment on three occasions. They had been given a cup of tea during the morning and lunch at 1.55pm.

Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.2 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was ‘about the same’ as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain.

Patient records showed that patients’ pain levels were assessed and recorded. Appropriate pain relief was given and the effects monitored. We observed that nursing staff administered rapid pain relief when they assessed patients who had walked into the department and those who had arrived by ambulance.

During our inspection special monitoring tools were used to assess children’s pain. We observed timely pain relief administered to children. The results of the pain relief were
monitored in accordance with the RCEM Management of Pain in Children guidance.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.8 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was ‘about the same’ as other trusts.

The trust scored 7.7 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was ‘about the same’ as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (30/09/2016)

**Patient outcomes**

Managers monitored the effectiveness of some care and treatment. They compared local results with those of other services to learn from them. This had improved since our last inspection.

**1.1.1 RCEM Audit: Moderate and Acute Severe Asthma 2016/17**

In the 2016/17 Moderate and Acute severe Asthma report, the trust failed to meet of the standards (all set at 100%).

The hospital was in the upper UK quartile for one standard:

- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within ten minutes of arrival at the ED. The trust score 60% which was higher than the England average of 25%.

The hospital was in the lower UK quartile for three standards:

- Standard 2a: Vital signs should be measured and recorded on arrival at the ED. The trust scored 0.0%, which was worse than the England average of 26%.
- Standard 5a: if not already given before arrival to the ED, steroids should be given as soon as possible within one hour of arrival (acute severe). The trust scored 0.0% which was much lower than the England average of 19%.
- Standard 5b: if not already given before arrival to the ED, steroids should be given as soon as possible within four hours (moderate). The trust scored 0.0% which was much lower than the England average of 28%.

The hospital’s results for the remaining three metrics were all between the upper and lower UK quartiles.
**1.1.2 RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 Consultant sign-off audit, the trust failed to meet any of the four standards (all of which were set at 100%).

The hospital was in the lower UK quartile for all four standards:

- Atraumatic chest pain in patients aged 30 years and over (seen by a consultant). The trust scored 1.2%, lower than the National average of 10.6%.
- Fever in children under one year of age (seen by a Consultant). The trust scored 0% which was lower than the National average of 8.3%.
- Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge (seen by a Consultant). The trust scored 1.1%, lower than the National average of 12.2%.
- Abdominal pain in patients aged 70 years and over (seen by a Consultant). The trust scored 2.7%, lower than the National average of 9.7%.

(Source: Royal College of Emergency Medicine)

We looked at two sets of recent records for patients with each of these conditions. We found that, although they had not been seen by an ED consultant, they had been referred to a specialist doctor and had received effective treatment.

**1.1.3 RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 Severe Sepsis and Septic Shock audit, the trust failed to meet any of the standards (all of which were again set at 100%).

In the 2016/17 Severe sepsis and septic shock audit, the trust was in the upper UK quartile for one standard:

- Standard 2: in 82.0% of cases, patients received a review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. This was higher than the England average of 64.6%.

The trust was in the lower UK quartile for no standards.

The trust's results for the remaining seven metrics were all between the upper and lower UK quartiles.

Notably, the trust performed much worse in the 2016/17 audit compared to their results in the previous 2013/14 audit for four of the standards:

- In 25.7% of cases, Oxygen was initiated to maintain SaO2>94% oxygen levels in the blood (unless there is a documented reason not to): Within one hour of arrival, much lower than the 2013/14 result of 96.0%.
- In 45.7% of cases, Blood cultures were obtained: within one hour of arrival. This was lower than their previous score of 82.0% in the 2013/14 audit.
In 35.0% of cases Fluids-first intravenous crystalloid fluid bolus (up to 30 ml/Kg) was given: within one hour of arrival. This was lower than their previous score of 56.0% in the 2013/14 audit.

In 27.8% of cases, antibiotics were administered within one hour of arrival. This was lower than their previous score of 52.0% in the 2013/14 audit.

(Source: Royal College of Emergency Medicine)

Although the results of this audit were not as good as in 2013/14, we observed good screening for, and treatment of, sepsis. A later internal audit showed that, by September 2017, 100% of patients with sepsis received intravenous antibiotics within one hour. Screening of patients for sepsis had improved from 70% in October 2017 to 100% in December 2017.

1.1.4 RCEM Audit: Vital signs in children 2015/16

In the 2015/16 Vital signs in children audit, the trust met the standard for one of the six standards. The trust was in the upper England quartile for one developmental standard and no fundamental standards.

- Standard 5. Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). The trust scored 100.0% meeting the standard, which was higher than the England average of 60.0%. However, the trust only submitted one case for this standard, and therefore this is not a meaningful result.

The hospital was in the lower England quartile for no fundamental standards and two developmental standards:

- Standard 1b. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of: Capillary refill time. With the sample size of 50, the trust scored 2.0%, which was lower than the England average of 22.5%.

- Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. With a sample size of 26, the trust scored 0.0%, lower than the England average 4.4%.

The trust’s results for the remaining three metrics were all between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

Since this audit, two additional children’s nurses have been employed, and further education has been provided to adult emergency nurses. Senior staff told us that practice had improved. However, they had not carried out any further audits to confirm this.
1.1.5 RCEM Audit: Procedural sedation in adults 2015/16

In the 2015/16 Procedural sedation in adults’ audit, the trust failed to meet any of the audit standards (which were all set at 100%).

The trust was in the upper England quartile for no fundamental standards and no developmental standards.

The hospital was in the lower England quartile for four fundamental standards and one developmental standard:

- **Standard 1 (fundamental):** Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including: ASA grading, b. Prediction of difficulty in airway management and c. Pre-procedural fasting status. Out of sample of 51 cases, the trust scored 0.0%, which was lower than the England average of 7.6%.

- **Standard 2 (developmental):** There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Out of a sample of 50, the trust scored 0.0%, which was much lower than the England average of 51.8%.

- **Standard 4 (fundamental):** Procedural sedation requires the presence of all of the below, a. A doctor as seditionist, b. A second doctor, ENP or ANP as procedurist, and c. A nurse. Out of a sample of 51, the trust scored 9.8%, which was lower than the England average of 40.8%.

- **Standard 5 (fundamental):** Monitoring during procedural sedation must be documented to have included all of the below: a. Non-invasive blood pressure, b. Pulse oximetry, c. Capnography and d. ECG. Out of a sample of 51, the trust scored 0.0%, which was lower than the England average of 23.9%.

- **Standard 7 (fundamental):** Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below: a. (fundamental): Return to baseline level of consciousness. b. (fundamental): Vital signs within normal limits for the patient. c. (fundamental): Absence of respiratory compromise. d. (fundamental): Absence of significant pain and discomfort. e. (developmental): Written advice on discharge for all patients. Out of a sample of 23 cases, the trust scored 0.0%, which was lower than the England average of 2.6%.

The hospital’s results for the remaining two metrics were all between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

1.1.6 RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit, the trust failed to meet either of the audit Standards (which were set at 100%).
The hospital was in the lower England quartile for one standard:

- Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. Out of a sample of 50 cases, the trust scored 0.0%, which was lower than the England average of 2.0%.

The trust failed to provide data for Standard 1: If a need for thrombo-prophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment.

(Source: Royal College of Emergency Medicine)

We asked the trust to supply us with information about any repeat audits they had undertaken in order to assess whether practice had improved. The information that they supplied indicated that only sepsis practice had been re-audited.

**Unplanned re-attendance rate within 7 days**

The trust’s unplanned re-attendance rate to A&E within seven days consistently breached the 5% standard from October 2016 to September 2017, as did the England average. The trust’s rate was higher than the overall England rate in all 12 months of the 12 month period. There was a trend of decline from October 2016 (8.5%) to February 2017 (12.5%), which was much higher than the England average of 7.6% for the same month. Notably, there was a big deterioration in the trust’s performance from July 2017 (7.9%) to August 2017 (15%). August 2017 was the worst performing month for the trust. In September 2017, the trust had an unplanned re-attendance rate to A&E within seven days of 8%, which was just higher than the England average of 7.7% for this month.

Senior ED staff explained that this was due to large numbers of holidaymakers staying on the island during August. They often attended the department with minor injuries and ailments. They did not have access to a GP and so would return to the department for on-going care.

**Unplanned re-attendance rate within 7 days - Isle of Wight NHS Trust**

(Source: NHS Digital - A&E quality)

**Competent staff**

The service did not ensure staff were competent for their roles. Managers did not appraise all
staff’s work performance. There were no supervision meetings with them to provide support and monitor the effectiveness of the service.

**Appraisal rates**

From October 2016 to September 2017, 76% of staff within urgent and emergency care at the trust had received an appraisal, not meeting the trust’s target of 100%.

A split by staff group can be seen in the graph below:

**Appraisal Completion rates by staff group, October 2016 to September 2017**

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

One of the consultants had responsibility for medical education and ensured that junior doctors received appropriate training and supervision.

We were shown an induction booklet for new nurses but it was produced in 2014 and contained out-of-date information. There was no nursing competency framework aimed at ensuring nurses had the right skills and knowledge to provide effective nursing care. The department did not have a practice development nurse to develop nurses skills and to ensure their knowledge was up-to-date.

**Multidisciplinary working**

Staff from different professions worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We observed staff working together well with positive interaction between different professional groups. ED staff reported a particularly good relationship with the imaging and pharmacy departments. A senior doctor told us that there was also a supportive relationship between the ED and the acute physicians. The physicians were always happy to give advice over the phone. At night, they were often based in the department because it was not always possible to admit medical patients to a ward. ED staff worked collaboratively with the psychiatric liaison team in order to meet the needs of patients with mental health problems.

There was improved multi-disciplinary working between the paediatric team and ED staff since our last inspection. The lead ED children’s nurse was invited to monthly children’s ward meetings and the clinical leads met on a weekly basis.
We saw records of a discussion at night between a microbiologist and an ED doctor regarding an unusual infection that was difficult to treat.

**Seven-day services**

ED consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call.

Patients could access diagnostic imaging services at all times, in line with the NHS Services Seven Days a Week Priority Clinical Standards. The department had access to radiology support 24 hours each day, with rapid access to computerised tomography (CT) scanning when indicated. There was always a senior radiology doctor available within the hospital.

A seven day clinical pharmacy service operated in the ED. There was an on-call pharmacy service outside of normal working hours. An enhanced psychiatric liaison team now provided a seven day a week service although; at the time of writing it had only been funded for three months.

**Health promotion**

Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. We observed a doctor advising a patient about techniques for stopping smoking in order to improve a lung condition. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Support for patients with mental health problems had improved since our last inspection. The psychiatric liaison team had increased from two nurses to seven with the addition of three support workers. They provided a service from 8am to midnight. During the night the psychiatric crisis team were able to respond to patients with severe mental health problems.

The staff we spoke with had sound knowledge about consent and mental capacity. All patients in the major treatment area and resuscitation room had a brief assessment of their mental capacity. However, some nursing staff did not appear to be able to accurately assess this. During a review of patients’ records we found two patients with severe dementia (one with delirium) who had been assessed as having capacity to make decisions.

When patients lacked total capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent. Consent forms were available for people with parental responsibility to consent on behalf of children. The staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (Gillick competency). Otherwise, consent would be sought from the child’s parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.
Staff reported that restraint was not used in the department and that physical violence was uncommon. If physical violence occurred, security and/or the police would be contacted. Staff reported that response from both services was rapid and effective.

**Mental Capacity Act and Deprivation of Liberty training completion**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Trust Provider Information Return P14/P49)
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. During our inspection patients had the opportunity to complete anonymous feedback forms. Out of the five forms that were returned 14 were complimentary about the staff in the department. There were comments such as “The staff here are always friendly and willing to help” and “Excellent service all round”.

During our inspection we saw many examples of patients treated with compassion, dignity and respect. Emergency department (ED) staff introduced themselves by name and explained treatment plans in terms that were easily understood. Many staff expressed compassion for patients spending excessive amounts of time in the department. One member of staff said “I must apologise a thousand times a day”.

We spoke with 11 patients and two family members. Most of them had been in the department for many hours but they frequently mentioned the kindness of the staff. One patient said “The staff have put me at my ease during a very stressful time”.

Confidentiality was provided to patients at reception by means of signs asking people to stand at a distance from the reception desk. Receptionists were cheerful and welcoming and took trouble to inform and reassure patients and their families.

Staff maintained patient’s privacy and dignity by ensuring cubicle curtains were closed during transfer from trolleys to beds and during active treatment. However, there was no privacy for patients waiting in the corridor. Although the clinical condition of these patients had been stabilised and little active treatment was required, they were still exposed to the noise and activity of a busy corridor.

We observed an emergency department porter interacting with an elderly patient whilst taking them to a ward. They put the patient at ease by laughing and chatting with them throughout the journey.

Staff displayed patience and understanding with patients who had mental health problems or were living with dementia.

Friends and Family test performance

From October 2016 to September 2017, the trust’s urgent and emergency care Friends and Family Test performance (% recommended) fluctuated above and below the England average. From January 2017 to April 2017, the trust’s performance was higher than the England average scoring 91.9% in January 2017 compared to the England average of 86.7%.

The trust’s performance improved from May 2017 (83.9%), where it performed lower than the England average of 86.8%, to July 2017 (94.4%), which was the best performing month for the trust. Since July 2017, there has been a deterioration in the trust’s performance to September 2017 (86%), which was similar to the England average of 86.9%.
Emotional support
Staff provided emotional support to patients to minimise their distress.

We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.

Support was particularly strong for relatives of patients who needed to be in the resuscitation room. We observed nursing staff preparing relatives before they entered the resuscitation room and then carefully explaining what had happened and the details of the immediate treatment plan.

There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people and was appropriately equipped. We observed staff making frequent visits to the room to make sure that relatives were comfortable.

Multi-faith chaplaincy services were available day and night for people who would benefit from spiritual support.

Understanding and involvement of patients and those close to them
Staff involved patients and those close to them in decisions about their care and treatment.

Patients and their families told us they were kept informed of all care and treatment due to be carried out. Staff were praised for the quality of their communication with families so that they understood the sequence of events and the likely timings around these. One patient told us “Staff listened to my concerns and were very well informed”.

We heard staff updating relatives about patients’ progress whilst maintaining confidentiality. Communication with children was well thought out, age appropriate and effective. We observed a nurse holding the hand of a distressed patient while they explained what was happening and how they were going to try to make things better.

We spoke with two patients as they left the unit. They had all been given advice about what to do when they were at home. One had been given information leaflets to reinforce the verbal advice.
The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all 24 of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If you're family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 30/09/2016)
Is the service responsive?

Service delivery to meet the needs of local people

The trust did not always plan and provide services in a way that met the needs of local people.

Although ED staff could describe changes that had occurred since our last inspection, there was no agreed, co-ordinated plan to improve safety and quality in the department.

A full capacity standard operating procedure had been developed in 2017. However, it did not relate to the whole system escalation surge plan and appeared to be of limited use in improving patient flow through the department. The trust did have a winter plan which described actions that needed to be taken to address the needs of additional medical patients who arrive during winter months. Additional medical beds had been opened. However, there were long periods of time during our inspection when there were no medical beds for ED patients to go to.

A new seven day a week psychiatric liaison service had been implemented in January 2018. However, it had only been funded for three months and there was no certainty that it would continue in the medium or long-term future.

Meeting people’s individual needs

The service took account of patients’ individual needs.

There was wheelchair access to all parts of the department and the reception desk had a hearing loop for those who had hearing impairments.

Staff had received training in responding to the needs of people living with dementia. They described the care needed in a knowledgeable and sympathetic fashion. They knew, for example, that patients with dementia should be cared for in a quiet part of the department in a low stimulus environment. However, because the department was frequently crowded, patients with dementia were often placed in the only available treatment cubicle. This was often in the busiest and noisiest part of the department.

A specialist dementia nurse was available in the hospital from 4pm to 11pm each day to support staff in the caring for patients with dementia. However, at other times of the day no additional support was available. We observed two patients with dementia who were disorientated and agitated. Nurses were busy with other patients and there was no one available to sit with the patients in order to calm them.

We were told that patients with complex needs would be treated by a senior doctor who had the experience necessary to meet their requirements.

Staff did not always meet the individual needs of patients waiting on trolleys in the corridor. Although these patients had received initial treatment and were stable, it was still a confusing and sometimes disturbing environment for them. We observed two specialist doctors who were unable to examine patients in a timely manner because they were in the corridor and a cubicle could not immediately be found.

The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice. Nursing staff told us that they encouraged the involvement of families and carers so that they could understand patient’s specific needs.

The department largely complied with NHS England’s Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of patients with a disability or sensory loss.
Translators could be accessed via the telephone translation system provided by the hospital. Details of translation services were displayed in reception using 20 different languages.

**Emergency Department Survey 2016**

As per the below table, the trust scored “about the same” as other trusts for all of the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 30/09/2016)

**Access and flow**

People could not always access the service when they needed it.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

The trust met the standard once from November 2016 to October 2017. This was in August 2017, where the trust scored 95%, meeting the standard, and performing higher than the England average of 90% for the same month. From November 2016 to July 2017, the trust consistently performed lower than the England average, fluctuating between 81 and 88%. From May 2017 (80%), there has been a general trend of improvement for the trust, peaking at 95% in August 2017. Senior staff explained that that an increase in holidaymakers with minor injuries and illnesses occurred in the summer. This meant that more people could be treated quickly which helped to increase the percentage of patients who could be treated and discharged within four hours.
Managers in the ED and throughout the hospital had been working to improve performance against the four hour standard. Information sent to us by the trust showed that in November and December 2017 their performance was the same as the England average. (86%)

Patients who had been referred to the hospital by their GP were not taken directly to an acute assessment unit as recommended by the NHSI document “Focus on improving patient flow (July 2017)”. Nor did the specialist team, who had accepted them, assess them directly. Instead they were assessed and diagnosed by ED doctors and were cared for by ED nurses. Only when a patient required admission to a ward were they seen by the specialist doctor who had accepted the referral from the GP.

There were sometimes long delays before specialist doctors came to see patients in the department. ED staff told us that specialists from surgical teams were often in the operating theatre when they were on-call for emergencies. There was no monitoring of response times so staff could not accurately describe the scale of the problem.

The responsiveness of the mental health team had improved since our last inspection. In January, when a new psychiatric liaison team was implemented, 95% of patients had been seen within one hour.

### Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From November 2016 to October 2017, the trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted has been in general higher than the England average. However, there has been an overall trend of improvement across this time period from 47% in November 2016 to 3% in August 2017. This pattern of improvement brings the trust’s score in line with the England and also reflects the same trend seen in the four hour target. Similar to the four hour target, since August 2017 there has also been a deterioration in the trust’s performance for this metric to October 2017.
There were long delays to be admitted to ward for most adult patients during most of our inspection. We observed patients with serious illnesses such as heart conditions and internal haemorrhage waiting up to 11 hours to be admitted. They sometimes had to be treated and monitored in the resuscitation room. As a result it was often full and it was unclear where any further patients requiring resuscitation would be treated.

We found that some patients spent up to twenty hours in the department, usually because they needed to be admitted to a ward but there was no bed available. This resulted in a severely crowded department with sick and immobile patients often waiting on trolleys in a corridor. The number of patients in the corridor varied from two to six for most of the day.

The trust’s escalation surge plan stated that two hourly bed management meetings should take place when there were too many patients in the ED. We were aware of these taking place during the inspection. However, one senior member of staff told us that there were often no decision makers present at these meetings. This meant that decisions required to provide more empty beds could not be taken.

However, during our unannounced visit the department was not crowded. There were free cubicles when patients needed them and there were no patients waiting in the corridor. Senior staff told us that this was an increasing trend. We asked the trust to supply data to substantiate this but, at the time of writing, this had not been received.

We observed that children who need to be admitted were taken promptly to the children’s ward. This practice had improved since our last inspection.

**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from November 2016 and October 2017, 52 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in December 2016 (23) and January 2017 (14). Since March 2017, no patients have waited over 12 hours from decision to admit until being admitted.
There was much focus was on admitting patients within 12 hours of the decision to admit (DTA) being made. The nurse in charge of the department was required to keep a list of patients waiting for admission, together with the time when they would breach the 12 hour target. Every effort was made to ensure this did not happen.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

From October 2016 to September 2017, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was in general similar to the England average.

There was a decline in the trust’s performance from July 2017 (3.2%), which was in line with the England average of 3.4%, to August 2017 (15%), which was much higher than the England average of 3%. August 2017 was the worst performing month for the trust.

In September 2017, the monthly median percentage of patients leaving the trust’s urgent and emergency care services was 2%. This demonstrated an improvement for the service from August 2017, and bringing the median percentage back down to lower than the England average of 3.1% in the same month.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-16</td>
<td>366</td>
<td>5</td>
</tr>
<tr>
<td>Dec-16</td>
<td>286</td>
<td>23</td>
</tr>
<tr>
<td>Jan-17</td>
<td>396</td>
<td>14</td>
</tr>
<tr>
<td>Feb-17</td>
<td>218</td>
<td>6</td>
</tr>
<tr>
<td>Mar-17</td>
<td>192</td>
<td>4</td>
</tr>
<tr>
<td>Apr-17</td>
<td>166</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>287</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>259</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>98</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>83</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>269</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)
Percentage of patient that left the trust without being seen - Isle of Wight NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

The median total time spent in A&E per patient was consistently similar to the England median from October 2016 to September 2017. However, there has been a general trend of decline from February 2017 (124 minutes), where the trust performed better than the England average of 149 minutes, to June 2017 (180 minutes), where the trust performed much worse than the England average of 144 minutes for this month.

Since June 2017, the trust’s performance has improved, bringing the average minutes back down in line with the England average. In September 2017 the median total time spent in A&E per patient was 158 minutes, slightly higher than the England average of 148 minutes.

Median total time in A&E per patient - Isle of Wight NHS Trust
There was not an ambulatory emergency centre aimed at treating patients without them being admitted to a ward. Although one cubicle in the acute medical unit had been designated for ambulatory patients and often had a bed placed in it in order to accommodate a medical patient.

Learning from complaints and concerns

From October 2016 to September 2017, there were 39 complaints about urgent and emergency care. 31 complaints were closed, and eight from April 2017 to September 2017 still remain open. The trust took an average of 57.9 working days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints. 22 complaints took over 45 working days to close. Of these, one in November 2016 took 154 working days to close.

A breakdown by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment - Accident and Emergency</td>
<td>15</td>
</tr>
<tr>
<td>Communication</td>
<td>8</td>
</tr>
<tr>
<td>Admissions and discharges excluding delayed discharge due to absence of a care package</td>
<td>5</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>4</td>
</tr>
<tr>
<td>Patient Care</td>
<td>2</td>
</tr>
<tr>
<td>Trust admin/Policies/Procedures including patient record management</td>
<td>1</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Integrated Care (Including Delayed Discharge due to absence of a care package)</td>
<td>1</td>
</tr>
<tr>
<td>Privacy, Dignity and Wellbeing</td>
<td>1</td>
</tr>
<tr>
<td>Transport (Ambulances)</td>
<td>1</td>
</tr>
</tbody>
</table>

Many complaints received by the department would normally be investigated by the ED matron. The absence of a matron had resulted in delayed responses to complaints. We although senior staff told us that they learned from complaints, there was no service-wide dissemination of this learning.
Is the service well-led?

Leadership

The leadership team did not have sufficient time or experience to lead effectively. The emergency department (ED) was part of the ambulance, community and urgent care clinical business unit (CBU). There were three leadership roles in the ED - a clinical lead (senior consultant), a matron and an operations manager.

There had not been a matron in post for several months and a recently appointed sister was acting up into the role as well as continuing their existing clinical duties. The sister told us that there was some support from the clinical business unit’s head of nursing. However this was an interim role for six months and the post holder did not have a background in emergency nursing. There were plans to appoint an interim matron for three months but it was not known when this would happen.

The clinical lead was liked and respected by ED staff, but due to a shortage of consultants, they prioritised clinical duties which left little time for governance or performance management responsibilities. The operations manager was knowledgeable about ED issues and provided strong operational support. The role also encompassed operations management of the acute medical unit. This was thought to be an advantage as it gave greater insight into patient flow from the ED into the medical unit.

The current ED leadership team worked well together. They were highly visible in the clinical environment supporting junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose.

An emergency care improvement lead had been appointed in 2017. The role was aimed at improving the emergency patient pathway from the moment an ambulance was called to the day of discharge from hospital. Staff welcomed the focus on the needs of emergency patients which they felt had been lacking previously. There had been a reduction in delayed ambulance handovers since the role had been established.

One member of staff described the new chief executive as “a force for good”. All staff were impressed when, shortly after arriving, the chief executive spent a day in the department in the role of a healthcare assistant. ED staff felt that this was a good way to quickly understand the complexity of activity in an emergency department. The chief executive continued to make regular visits to the department as did the interim chief nurse and the chief operating officer.

Vision and strategy

There was no current strategy for the department. Although senior staff had similar values they had not been translated into substantive objectives for the sustainable delivery of high quality care and treatment.

Culture

The leadership team tried to promote a positive culture that supported and valued staff. Many staff told us that they did feel supported and valued by their colleagues but, until recently, not by the rest of the hospital. Many staff expressed a sense of despondency and resignation about the long delays for assessment and treatment and about having to care for patients in a corridor. They felt that many people in the hospital had blamed them for this, rather than recognising that it was a whole-hospital problem. There was a sense of weariness associated with constant change which
had resulted from a series of interim directors and managers in previous years. Senior staff were frustrated that they had been unable to improve the situation. However, other staff were more positive. There was hope that some of the small improvements in recent months would gather in momentum and would lead to greater improvements.

Despite widespread frustration there was a positive culture in the department which was centred on the needs and experience of patients. One member of staff said “It’s the patients who should come first.” Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED. One doctor said “There is a real family atmosphere here”. Staff told us that the support they received from their colleagues in the department helped them to cope with the pressures which resulted when the department was severely crowded.

The leadership team were concerned about the well-being of staff. “Decreased staff morale” was one of the consequences of the ED risks described on the risk register. Leaders were aware that staff were often stressed and took opportunities to improve this where possible. For example, team building events were promoted in the staff newsletter.

**Governance**

The department did not have a systematic approach to continually improving the quality of its services or safeguarding high standards of care.

The governance arrangements were unclear. Senior staff could not describe the governance structure or processes to review key items such as the strategy, values or objectives. Although one of the consultants had been appointed as the governance lead they were able to devote little time to it because of clinical responsibilities. We asked for the minutes of the last two governance meetings but instead were sent the annual mortality report.

When poor practice was identified, for example during national clinical audits, there were no action plans to improve practice. Only one repeat audits had taken place to identify whether practice had improved.

A quality newsletter had been introduced by the interim head of nursing and quality in January 2018. This shared learning from incidents. For example, staff were reminded about the escalation procedure for patients with high early warning scores.

**Management of risk, issues and performance**

Systems for identifying risks and planning to eliminate or reduce them were poorly developed.

Senior staff were able to describe the main risks in the department but the ED did not have its own risk register. Risks identified in the department were entered onto the hospital register and reflected the concerns of staff that we spoke with. For example, poor patient flow with patients being cared for in a corridor and a shortage of nurses.

The measures to reduce the risk were clearly described on the risk register. The dates for the implementation of risk reduction measures were recorded but not the date that the risk was identified. Staff were unsure about the process for departmental risks being entered on to the hospital risk register. There seemed to be no objective criteria that would achieve this. Instead, ED staff would hold a discussion with a senior manager who would decide which risks would be considered at board level.

There were no established processes for the ED to manage current and future performance. We asked for the minutes of the last two performance meetings. Instead we were sent notes from a performance review meeting between the CDU managers and the chief operating officer held in November 2017. Three items regarding the ED had been discussed - patient flow, recruitment and the poor results from a documentation audit. Although actions were planned around staffing and recruitment there were no actions documented for poor patient flow documentation. It was
not clear if the ED leadership would take part in any actions.

**Information management**

The department collected and analysed information using secure electronic systems with security safeguards.

The information used in reporting, performance management and delivering quality care was not always accurate. Information systems were not always able to give staff the information that they required. For example, ambulance systems could not accurately record time of arrival at the hospital and so the time from ambulance arrival to initial assessment could not be recorded accurately. Training data also proved to be inaccurate.

Nurses sometimes found it difficult to access computers in order to record activity. We found that the admission times of two children was recorded as taking place over an hour later than the actual admission time. Decision to admit times and staff training data was also found to be inaccurate on some occasions.

The operation manager described a “heat map” that showed the number of patients in the department at any one time. This was to be used to help with a staffing review and would indicate when most staff needed to be in the department.

Two large display screens had been installed near the staff base. They were designed to display real time information such as the number of patients in the department, how many were waiting for beds and how many were still in the department from the day before. During our inspection at least one of the screens had stopped working and was displaying information from the previous day. During our unannounced inspection both screens were displaying out-of-date information.

**Engagement**

There was some engagement with patients, staff, and the public and local organisations to plan and manage appropriate services.

The department engaged with public by taking part in local Healthwatch surveys. One survey took place at the end of 2017 at looked at the reasons why people attended the department. The current survey was aimed at assessing the impact of recent changes in GP surgery opening hours.

Results of the latest Friends and families test were displayed on the wall in the waiting room.

There were no regular staff meetings. We asked for the minutes of the last two meetings and were sent minutes from July 2017. Although the ED clinical lead was present the roles of the other seven people were not clear. Topics, such as training, performance and learning from incidents and complaints were discussed. Letters of thanks and praise for staff were also displayed on the staff noticeboard.

The trust had held a competition which offered a prize for the ward or department that had given the most flu vaccinations to staff. One of the ED doctors had volunteered to be the departmental “champion” for the completion. At the end of the completion the ED was found to have given the most flu vaccines and the doctor received a prize of a large hamper.

The ED operations manager sent departmental updates to staff via e-mail. They included information such as current performance, proposed changes and development and details of teambuilding activities. A newsletter, to which all staff were invited to contribute, was circulated in November 2017. This included information about flu vaccinations, staff changes, training dates and compliments form patients and their families.
Learning, continuous improvement and innovation

The department had started to improve services by learning from when things went well and when they went wrong. There had been a number of improvements since our last inspection.

Services for children had improved and more staff had undertaken advanced child resuscitation and safeguarding training. There was better practice in medicine storage and infection control precautions. The department took part in more national clinical audits. There were safer and more responsive facilities for patients with mental health problems. Patients no longer waited in excess of twelve hours to be admitted to a ward and delays for ambulance patients arriving at the department had reduced significantly.

However, many of the improvements were dependant on recommendations from external agencies rather than internal improvement programmes.
Within the trust’s medicine clinical business unit (CBU) unit there are four medical inpatient wards, these are:

- Colwell Ward (28 beds) for General Medical and Gastroenterology.
- Appley Ward (28 beds) for General Medical/Respiratory.
- Stroke and Rehabilitation Unit (54 beds with plans to reconfigure this to a 24 bedded stroke/rehab ward and a 30 bedded general medicine ward).

(Source: Routine Provider Information Return - Acute-Sites)

The trust also provided medical care and treatment in the Coronary Care Unit, the Medical Assessment Unit (MAU), the endoscopy unit and the chemotherapy unit which were not part of the trusts medicine CBU.

The trust had bought forward their plans to reconfigure the stroke and rehabilitation ward. This was in response to the increased number of medical patients who required admission. These plans had been implemented ten days prior to our inspection. This change meant there was now a 24-bedded stroke and general rehabilitation unit and a 30 bedded medical ward named Compton ward.

The trust had 8,624 medical admissions from July 2016 to June 2017. Emergency admissions accounted for 6,761 (78%), 188 (2%) were elective, and the remaining 1,675 (20%) were day case.

Admissions for the top three medical specialties were:

- General Medicine: 6,411
- Gastroenterology: 915
- Pain Management: 663

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

There was an overall low rate of compliance with mandatory training, with very low rates of completion for some courses.

The trust set a target of 85% for completion of mandatory training. This was lower than the target set by the trust in November 2016. At the inspection in November 2016, mandatory targets were not met across the medical services, including community inpatient services, which are now part of the medicine clinical business unit (CBU).

Information provided by the trust before the inspection showed in the medicine CBU, both medical/dental staff and nursing staff failed to meet the target with medical/dental staff having 64% and nursing staff having 82% compliance overall.
Mandatory Training Completion by module – Medical and Dental Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>17</td>
<td>76.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>25</td>
<td>76.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>25</td>
<td>76.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>25</td>
<td>72.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>25</td>
<td>72.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>17</td>
<td>70.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>17</td>
<td>70.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>17</td>
<td>70.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>25</td>
<td>68.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>26</td>
<td>65.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>25</td>
<td>64.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>25</td>
<td>64.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>25</td>
<td>60.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>24</td>
<td>58.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>25</td>
<td>56.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>25</td>
<td>28.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>1</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff working within medicine CBU failed to meet the target for any of the 17 training courses listed above. Courses with the lowest compliance levels included adult resuscitation (14 out of 24 members of staff completed this), and hand hygiene (14 out of 25 members of staff completed this).

Mandatory Training Completion by module – Nursing Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load Handling</td>
<td>7</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>166</td>
<td>99.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>165</td>
<td>98.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Module</td>
<td>Days</td>
<td>Percentage</td>
<td>Days</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------</td>
<td>------------</td>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>163</td>
<td>98.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>166</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>166</td>
<td>97.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>166</td>
<td>96.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>166</td>
<td>96.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>166</td>
<td>95.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>166</td>
<td>94.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>166</td>
<td>94.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>166</td>
<td>91.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>166</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>166</td>
<td>82.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>155</td>
<td>78.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>166</td>
<td>77.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>164</td>
<td>77.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling</td>
<td>146</td>
<td>74.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Maths &amp; Medicines Calculations</td>
<td>156</td>
<td>71.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>166</td>
<td>70.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>142</td>
<td>49.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>86</td>
<td>29.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>138</td>
<td>8.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff working within the medicine CBU met the target for 13 out of the 23 modules listed above. Notably, immediate life support training had the lowest compliance rate, only 12 out of 138 members of staff completed this.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Most nursing staff and allied health professionals (AHP) we spoke with across the medical wards and units said they were up to date with their mandatory training. However, this conflicted with the mandatory training compliance data provided by the trust. The trust informed us this was because AHPs training was not monitored and reported by the medical business unit. Staff said there were processes to remind them when they needed to update mandatory training.

Following the inspection the trust provided updated training figures for all the medical services we inspected. They provided information about twelve subjects (adult resuscitation, adult resuscitation – non clinical, breakaway, conflict resolution refresher, fire safety theory and extinguishers, Mental
Capacity Act, safeguarding adults level 1 and 2, safeguarding children level 1, 2 and 3). Although the percentage of nursing staff who had completed people handing was below the trust target, there was an improvement from 40% in 2016 to 74% of staff who had completed this training. Over all for the medicine business unit, staff had only met the trust target of 85% compliance for fire safety theory and safeguarding children level 1. Compliance against the other subjects ranged from 16% to 83%.

The trust also provided data about the number of staff on each ward or unit that were up to date intermediate life support (ILS) training. This showed that only 45% of those members of staff who worked in the medical business unit and were identified as requiring this training, were currently up to date with their ILS training. The highest rate was on the medical admissions unit (MAU) where 82% of staff were up to date with ILS training. The lowest rate was Colwell ward where only 11% of staff were up to date with their ILS training. On the surgical wards which were being utilised for medical patients during the winter pressures period, the overall rate of up to date ILS training was 17%, both Luccombe and Whippingham ward had no members of staff up to date with their ILS training.

Medical staff had mixed experiences of completing mandatory training. Two junior doctors said there was no mandatory training planned for them, they felt the trust should have provided this during their induction period. Some junior doctors said they believed their mandatory training was up to date, but could not give any detail about what mandatory training they had completed or when they had completed it. A further two junior doctors said that most of their mandatory training had been completed on time.

Safeguarding

Lack of training meant not all staff had the required knowledge to protect patients from harm or abuse. Some medical staff lacked understanding about safeguarding.

The trust set a target of 85% for completion of safeguarding training. This was lower than the target set by the trust in November 2016. At the inspection in November 2016, the safeguarding training target of 90% had not been met by most staff who worked in the medical services. At this inspection, we identified that although the 85% target set by the trust had not been met, overall nursing staff completion of safeguarding training had improved. However, the number of medical staff who had completed safeguarding training had reduced.

Safeguarding Training Completion by module – Medical and Dental Staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for medical/dental and nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>25</td>
<td>68.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>25</td>
<td>64.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>25</td>
<td>44.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical/dental staff working in medicine did not meet the standard for any safeguarding modules. Notably, there was an extremely low compliance for safeguarding children level 2 with 11 out of 25 members of staff having completed this training.
### Safeguarding Training Completion by module – Nursing Staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>166</td>
<td>97.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>166</td>
<td>87.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>161</td>
<td>72.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff working within medicine met the standard for two of the safeguarding modules, including safeguarding adults level 1 and safeguarding children level 2. Level 2 safeguarding for children had the lowest compliance with 117 out of 165 members of staff completing this training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust only provided data for safeguarding adults level 1 training prior to the inspection. Following the inspection, the trust provided data for both level 1 and level 2 adults safeguarding training. The trust’s ‘Training Framework 2018’ gave guidance about which members of staff were required to complete level 1 and level 2 safeguarding adults training. For the medicine CBU, overall compliance with safeguarding adults level 1 was 82% and safeguarding adults level 2 was 16%. The information provided by the trust showed nursing staff met the trust target, but junior medical staff and bank staff did not.

The medicine CBU reported, that in December 2017, 91% of eligible staff had completed safeguarding children level 1 training, 69% eligible staff had completed safeguarding children level 2 training and 55% eligible staff had completed safeguarding children level 3 training.

Most nursing and AHPs demonstrated a good understanding about safeguarding vulnerable adults and children in conversation. Not all staff knew who the safeguarding lead for the trust was, but knew they needed to report concerns to their line manager. They knew they could access guidance about making safeguarding alerts on the trust’s intranet.

Several nursing staff and AHP’s described examples, such as concerns about the behaviours of a family member towards the patient or concern about the welfare of a child whose single parent was admitted to hospital, about when they raised safeguarding alerts. This showed staff took action to protect patients from abuse. However, some expressed concern they received no feedback about alerts they made. This meant, although they followed trust and local authority processes, they were not assured their actions had effectively safeguarded vulnerable people. We found some medical staff did not fully understand safeguarding. One middle grade doctor, who believed they had completed safeguarding training, was not able to describe what safeguarding meant.

Review of the reported incidents showed staff alerted the adult safeguarding team if the incident suggested a safeguarding concern. This included allegations from patients about members of staff.

However, despite most staff demonstrating a good understanding about safeguarding, the poor uptake of safeguarding training across the trust especially for medical staff, meant the trust could not be assured that staff had the relevant knowledge in order to take appropriate steps to protect patients from abuse and harm.
Cleanliness, infection control and hygiene

The service did not control infection risks. We observed frequent episodes of poor infection control practices carried out by staff. Nursing staff routinely only wore disposable gloves, and not the national recommended disposable gloves and aprons, for removing used bedpans and urinals from patients. We observed this on Appley ward, Compton ward and the MAU. This was the same as our findings at the inspection in November 2016.

Bathrooms and toilet rooms on wards did not always have toilet roll holders. Toilet rolls were kept on top of toilets, shelves and on the floors of bathrooms and toilet rooms. This meant toilet rolls were handled several times during usage, and increased the risk of cross contamination of faeces or urine between patients. This was the same as our findings at the inspection in November 2016.

Medical staff did not always adhere to the trusts bare below elbows policy. We saw medical staff on the MAU and Appley ward with sleeves below their elbows. We did not see any trust staff challenge medical staff about this, unless prompted by the inspection team.

During the afternoon of 23 January 2018, we saw nursing staff on MAU did not adhere to the World Health organisation “5 Moments for Hand Hygiene”. They did not always wash their hands before touching a patient, before carrying out clean or aseptic procedures, after body fluid exposure, after touching a patient and after touching patient surroundings. Not all staff used aprons and gloves when attending to patients, or changed aprons and gloves between delivering care to different patients. During the same period, we observed staff moving equipment and using it on different patients without cleaning it.

On Compton ward, we observed cleanliness assistants did not change their gloves and aprons when moving to different parts of ward to carry out their cleaning duties.

Staff on all wards used “I am clean” stickers to identify the date and time equipment, such as commodes and monitoring equipment, was cleaned. However, the appearance of some pieces of equipment suggested they had not been recently cleaned. In the MAU one of the drawers in the resuscitation trolley, which was checked daily, contained a lot of dust. The blood gas machine on the MAU was also dusty. On the stroke unit, the drug trolley was dusty.

All wards had side rooms, which staff could use to isolate patients who had infectious diseases to reduce the risks of cross infection. Where side rooms were used for isolation purposes, there were signs outside rooms which informed visitors of the precautions they had to take. There was sufficient supply of personal protective equipment (PPE) such as disposable gloves of different sizes, aprons and where needed, face masks. We saw nursing staff, medical staff, AHPs, and visitors using PPE and disposing of it in accordance with trust procedures.

There were insufficient numbers of side rooms to meet the demand for isolation purposes. This meant some patients, who would ideally be nursed in side rooms, had to be nursed on open wards. Where possible, patients with infections were nursed together in the same bay. Staff said the infection and prevention control team and the microbiology team made the decision about who was nursed in side rooms and who was nursed in ward bays. At night decisions about the use of side rooms was made by the night bed manager with the support of the on call consultant microbiologist. Staff said when they could not isolate patients in side rooms, they reported this as an incident.

However, on Compton ward, we observed staff moved a patient who had had an antibiotic-resistant strain (Extended-spectrum beta-lactamase (ESBL) of E. coli from a side room to the general ward. Public Health England guidance about management of ESBL details, “robust infection control measures are always important to prevent the spread of infection. These include..."
interventions, such as, hand washing and patient isolation." The patient, who staff moved into the side room, was distressed and confused but did not have a condition that necessitated isolation to reduce risk of cross infection. It was unclear how assessment of risks had informed this decision or if staff had sought advice from the infection prevention and control team.

Management of clinical waste did not protect people from risk of cross contamination. Staff removed clinical waste from the wards and placed it in locked containers in cupboards outside the ward areas. However, not all cupboards and containers were locked. This meant unauthorised people had access to clinical waste. We observed a member of staff not wearing PPE when transferring clinical waste bags to the clinical waste cupboard.

Hand sanitizers and hand gels in all the medical services were full and signs advised all visitors to use the hand gel on entering and leaving clinical areas.

Infection prevention and control was managed well in the endoscopy unit and the chemotherapy unit. The endoscopy unit had dedicated staff to decontaminate used equipment. Staff followed nationally recognised processes to decontaminate the equipment. This included tracking of scopes, which included the time taken to clean and the patient they had been used on. Staff wore full PPE (eye visor, gloves and apron) and washed their hands before and after decontaminating equipment. Air pressure in the decontamination room was set to keep the room charged with clean air, which promoted effective decontamination of equipment. Tracking and effective auditing ensured staff used endoscopy equipment within the required timescale (three days) after decontamination. Throughout the endoscopy unit, there was an effective dirty to clean flow process that all staff followed. The endoscopy unit was visually clean, routine cleaning of surfaces was built into the staff competencies.

Staff working in the chemotherapy unit used PPE appropriately when they delivered care and treatment to patients and the unit was visibly clean.

In line with the trusts policy, only patients who were identified as previously having MRSA were screened for the possibility of having MRSA. Review of patient records showed evidence that staff considered this during the patient’s admission process. Information provided by trust detailed they had been MRSA bacteraemia free for 411 days at 21 January 2018.

In the period 1 April 2016 to 31 March 2017 medical services had nine cases of clostridium difficile. From 1 April 2017 to 1 January, the trust had a total of 16 cases of clostridium difficile. This was above the trust’s target of no more than seven cases of hospital acquired cases between 1 April 2017 to 31 March 2018.

The trust monitored infection control practices, including hand hygiene, urinary catheter insertion, urinary catheter management, management of central venous catheters, commode cleanliness, equipment cleanliness and bed space cleanliness. The trust provided information for these audits for September, October, November and December 2017. The data showed Appley ward, The Stroke unit and the endoscopy unit failed to meet the trust 90% target for compliance with hand hygiene environment. None of the medical wards, with the exception of Compton ward, met the trusts target for hand hygiene observation.

All medical wards, with the exception of Colwell ward and CCU had consistently met the trust’s target for urinary catheter insertion. However, Colwell ward and CCU had addressed their practices and had met the trust target by December 2017. Across the medical services there was mixed compliance with ongoing management of urinary catheters to prevent infection. With the exception of November 2017, Colwell ward consistently failed to meet the trust target. The stroke unit failed to meet the target in December 2017, CCU failed to meet the target in September 2017 and Compton ward failed to meet the target in September and December 2017. Appley ward was
the only clinical area that consistently met the trust target for compliance with urinary catheter management procedures.

CCU, the chemotherapy unit, the endoscopy unit, MAU, and Compton wards all consistently met the trust target for compliance with management of intravenous catheters, Appley ward, Colewell ward and the stroke unit did not.

Audits of the cleanliness of commodes showed Appley ward did not meet the trust target on two of the four months of data provided, with Compton ward and the stroke unit not meeting the target for one of the four months. All the other medical wards and units met the target for all the four months.

Following environmental audits, wards developed action plans to address any issues identified. We reviewed three action plans. Although these had detailed descriptions of the actions staff needed to take to address shortfalls, and named the member of staff responsible for ensuring the action was taken, not all action had dates for completion or review. Plans to address shortfalls in hand hygiene and other infection prevention practices including management of urinary catheters, were not available.

**Environment and equipment**

There was a lack of assurance that equipment was available and safe to use. All wards and units had emergency trolleys equipped with a defibrillator and equipment required in the event of a cardiac or respiratory arrest. The emergency trolleys were not tamper evident. There is no national guidance to dictate that emergency trolleys must be tamper evident however, the Resuscitation Council (UK) states, “The potential vulnerability of resuscitation trolleys must be recognised by healthcare provider organisations; this should be included in their risk register, and appropriate policies and procedures to manage the risk should be in place.”

Review of the trust risk register showed the use of non-tamper evident emergency trolleys had been identified as a risk. There was a requirement that staff must check the trolleys twice every 24 hours to ensure all equipment was on the trolleys and was in date and the defibrillator was in working order.

Records, we reviewed, did not evidence staff carried out checks of emergency trolleys according to the trust policy. On Appley ward, records showed there were seven occasions in December 2017 that staff had not checked the trolley and equipment in the trolley. For January 2018 up to the 21 January, records showed staff had not checked the trolley and equipment on seven occasions. On the MAU records showed staff had not checked one of their two trolleys on the nights of 4, 5 and 17 January 2018 and the day of 19 January 2018. On Compton ward records showed staff had not completed daytime checks of the emergency trolley twelve times since 1 December 2017, all night-time checks were completed. Emergency trollies in all areas of the coronary care unit, (acute, step down and pacing room) all had gaps in the recording of emergency trolley checks. This was the same as our findings at the inspection in November 2016.

The checking process for emergency trolleys, did not include a process to identify staff had checked every piece of equipment that was in the trolley. When we asked one ward sister how they were assured all equipment was available in the emergency trolley, they explained they trusted their staff to make sure all equipment was available. There was no process which provided assurance that all equipment was available and in working order.

We observed the positioning of sharps bins meant risks to them being knocked over were minimised. This was an improvement from the inspection in November 2016.
Staff who used the blood gas analyser in MAU did not have assurance that the equipment was in working order. There were no records on the MAU that showed the machine had been checked and was in working order. The ward sister said she relied on the pathology department, who maintained the machine, to notify the unit if there were any problems with the machine.

Across all wards and units, equipment had servicing stickers that gave assurance they were serviced and maintained in line with trust policy and manufactures guidance. This included moving and handling equipment that at the inspection in November 2016 was not serviced regularly.

Staff on Compton ward described initial challenges with accessing sufficient equipment such as sphygmomanometers and oxygen monitoring probes in the period of transition from rehabilitation to a medical ward. They said the trust had addressed this, but occasionally they experienced delays in accessing equipment not used routinely such as enteral feeding pumps.

We reviewed maintenance request logs. This detailed the date and time staff made maintenance requests and whether maintenance staff had completed the associated job, or if had been cancelled or was pending. Staff did not record the date the request was completed, so there was no opportunity to monitor the timeliness of response to maintenance requests. There were requests that were left as “pending” spanning June 2017 to February 2018. Most of these pending requests had the reason for staff not yet completing the job, as “due to low staffing levels, and a high number of CQC requests, we will be undertaking this request when we have staff availability.” Apart from action the trust needed to take to meet requirement notices following the CQC inspection in November 2016, CQC had not made any maintenance requests to the trust. Many of the pending requests related to protecting patients dignity and wellbeing, such as blinds not working in side rooms, leaking windows and locks broken on toilet doors. Some of the pending requests included action required to ensure compliance with regulations, including redecorating areas of wards in order to meet infection and prevention standards and putting a lock on patient notes cupboards.

**Assessing and responding to patient risk**

Staff did not always assess, monitor or manage risks to people who used the service.

It is nationally recognised that the number of bed moves a patient experiences whilst in hospital has a negative effect on the health and wellbeing.

Information about patient bed moves per admissions is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data.

At the inspection in November 2016, staff did not always complete sepsis screening for patients. At this inspection, we found staff did not always fully complete patient assessments. Patient records we reviewed showed that in some wards and units, both nursing and medical staff did not always fully complete patient risk assessments. Medical notes were prepared booklets that included a number of assessment bundles medical staff were required to complete. These included sepsis, alcohol and acute kidney injury (AKI) assessments. We reviewed three sets of medical notes on Colwell ward. One had no assessment bundles completed, no alcohol assessment completed and no base line screening for the patient completed. The second set of medical notes had no sepsis bundle or screen completed, the third set of notes had all assessments fully completed. We reviewed three sets of notes on the MAU. There were assessments not completed in all three sets of notes, including one set that had no AKI, sepsis or alcohol assessment completed.
There was a lack of consistency with the tool used to identify and manage the risk of sepsis for patients. The sepsis care bundle used by medical staff on MAU was different to that used by medical staff in the accident and emergency unit.

The trust carried out audits about the management of patients with suspected sepsis. Results from audits for July 2017 to December 2017 showed of 50 patient records reviewed 100% of patients who required sepsis screening received it in July, August September and December, with 95.5% receiving the screening in October and 89% in November 2017. Out of those patients identified as requiring antibiotic therapy for suspected sepsis 100% of patients received antibiotics within the required timescale of less than 90 minutes.

There was no assurance that the early warning detection system for identifying and managing deteriorating patients was protecting patients. Prior to the inspection, we had received concerns about the detection and management of deteriorating patients. The trust said they were taking action to address this concern.

Staff used a nationally recognised tool, the National Early Warning score (NEWS) to identify patients who were at risk of deteriorating. The trust’s NEWS guidance required staff to complete a “NEWS” sticker and add it to the patient’s medical records if their NEWS score indicated a possible deterioration in their condition. We saw staff added NEWS stickers to patients’ medical records. However, for the majority of the entries, staff had not dated the sticker or recorded actions taken in response to the patient’s condition.

Staff recording of NEWS observations was mostly completed correctly and frequency of observations followed the guidance. However, on Luccombe ward, (a surgical ward that had medical patients on it as part of the winter pressures programme), we found for one patient had an altered NEWS recording, staff had not escalated the patient’s condition as per the guidance on the NEWS document.

The trust’s NEWS audit for December 2017 showed that only the stroke unit and Compton ward had achieved the trust target of 90% compliance with NEWS recording. Appley and Colwell ward failed to engage with the audit process and did not submit any data. CCU provided an action plan in response to their score of 78.4% compliance with NEWS recording. This detailed they had made improvements and had met the trust target of 90% compliance on 31 January 2018. However, the action plan also detailed the recording charts for patients who received non-invasive ventilation used a different scoring system, which posed the risk of confusion and staff not identifying deteriorating patients. The action plan detailed new recording charts had been ordered, but had not yet been received.

There was a significant risk that time critical treatment in response to deteriorating health or medical emergencies was not timely. The management of deteriorating patients sometimes necessitated transfer of some patients to acute NHS services on the mainland for specialised treatment. There was no standardised process to manage these transfers of care. Staff said they experienced challenges with accessing relevant mainland clinicians in order to refer deteriorating patients and challenges with accessing appropriate transport in a timely manner. However, staff did not report any incidents where patients had suffered harm because of delayed transfers to mainland health care facilities.

The management of patient’s naso gastric tubes (NG) on the Stroke unit did not fully protect patients from risks associated with the use of NG tubes. In line with national guidance, the trust policy detailed that the position of the NG tube must be checked by aspiration at least daily. Review of the records for two patients with NG tubes showed that staff did not consistently carry out daily checks. For the first patient there was no record of checks on the 17, 22 and 23 January
2018. For the second patient there was no records of checks on the 30 and 31 December 2017, 3, 5, 6, 8, 10, 11, 15, 18 and 19 January 2018. We escalated this concern to the unit sister. Failure to carry out daily position checks for NG tubes was identified at the November 2016 inspection. The service had not addressed this patient safety failing.

Records showed relevant consultants assessed most, though not all, patients admitted as an emergency within 14 hours of arrival at the hospital.

Staff assessed patients for their risk of malnutrition using the nationally recognised Malnutrition Universal Screening Tool (MUST). However, where risk of malnutrition was identified, staff did not detail any action they needed to take to lessen the risk. For example, one patient on Luccombe ward their records showed staff had identified the patient was not eating or drinking. Staff had not detailed that any action, escalation or follow up had taken place.

Staff in the endoscopy unit followed processes to reduce risk to patients. They used a nationally recognised scoring tool to determine patient’s likelihood of bleeding post procedure. If a patient was identified as high risk of bleeding the procedure was carried out by a consultant endoscopist rather than a nurse endoscopist. Throughout the procedure, a member of staff monitored the wellbeing of the patient, monitoring the patient’s vital signs in order to identify and act on any signs of deterioration. Staff in the endoscopy unit followed the World Health Organisation (WHO) safety checklist “Five Steps to Safer Surgery”, to reduce harm to patients.

Staff on Colwell ward had introduced a ‘Baywatch’ process to reduce the risk of patients falling. From review of incident reports, staff had identified that despite using one to one supervision for patients at risk of wandering and falling, this had not reduced the number of reported falls. To address this risk and reduce the number of patients falling, patients identified at risk of falling were nursed in the same bay and the bay was put on ‘Baywatch’. A member of staff was allocated to remain in the bay at all times. The member of staff wore a Baywatch badge. If the member of staff had to leave the bay to collect equipment, or for meal breaks, the badge was handed over to another member of staff, in order to ensure there was always a member of staff in the bay. The ward sister said the use of ‘Baywatch’ had reduced the number of reported patient falls. The Baywatch programme was not directly audited to demonstrate its effectiveness. However, the CBU reviewed all falls through the Ward Performance Review process.

**Nurse staffing**

Substantial nursing and allied health care professionals shortages and a high use of agency staff increased the risk of patients receiving unsafe or inadequate care and treatment. Information about planned and actual staffing numbers is routinely requested from the trust within the universal provider information request. Trusts provide this information on a standard template. The trust was unable to provide this data.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 15% for registered nursing staff working within medicine.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Turnover rates

From October 2016 to September 2017, the trust reported an overall turnover rate of 5% for registered nursing staff working within medicine.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From October 2016 to September 2017, the trust reported an overall sickness rate of 3.6% for registered nursing staff working within medicine.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From October 2016 to September 2017, the trust reported an overall bank usage of 3,610 shifts, and an overall agency usage of 3,791 shifts. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

When we asked staff about their main concerns and worries, all staff reported that staffing was a significant concern. All staff reported there were times when there were insufficient numbers of staff to deliver safe patient care.

We reviewed the safer staffing information for December 2017 and January 2018 in records of the trust board meetings. The records showed medical wards were not filling all their required shifts. The trust set a target of filling 90% of all nursing shifts. In December 2017, overall the trust achieved over 90% average fill rate for registered nurses and health care assistants for both day and night shifts. However, the service did not meet the 90% fill rate in all ward areas and the medical wards had the highest number of unfilled shifts. The trust measured the fill rates for registered nurses and health care assistants on day and night shifts. In December 2017, the service only met the fill rate target for registered nurses on day shifts on Compton ward and for health care assistants (HCAs) on the stroke unit and the coronary care unit (CCU). For night shifts, the service met the target for registered nurses working on the stroke unit and Compton ward and for HCAs on the stroke unit and Colwell ward. Where wards did not meet the target, the fill rates ranged from 75% to 89%, with Appley ward achieving only 76.4% for registered nurses and 75.3% for health care assistants at night.

In January 2018, there was some improvement. The service met the daytime fill rate target for registered nurses on the MAU and Compton ward, but did not meet the target for HCAs working in any of the areas. The service met the night time fill rate target for registered nurses on the MAU and Compton ward. For HCAs the night target was met on the stoke unit, CCU, Compton and Colwell wards. Where wards did not meet the target, the fill rates ranged from 75% to 89.5%, with Appley ward achieving only 70.3% and 65.6% for health care assistants at night.

We asked the trust to provide nursing staff rotas for all the medical wards. Our review of the CCU staffing rota showed for December 2017 there were 19 unfilled registered nurse (RN) shifts and five unfilled health care assistant (HCA) shifts. In January 2018, there were 23 unfilled registered nurse shifts and 12 unfilled health care assistant shifts. The service provided two months nurse staffing numbers for Appley, Colwell, Compton wards and the stroke unit. They did not detail what the planned staffing numbers were. They stated they did not allow the wards to go under four RNs and four HCAs working a morning shift, and three RNs and three HCAs working a late shift. At night they stated they did not allow Appley, Colwell and Compton wards go below two RNs and two
HCAs working the night shift and for the stroke unit three RNs and two HCAs working the night shift. The information provided detailed, “We have not previously moved the staff on the roster but we now have access to ‘safecare’ which makes it much easier to redeploy staff on the system. The attached is therefore not an accurate reflection of the staffing levels that were provided on the day.” This meant, for each shift, there was no accurate record of how many nursing staff worked on the individual wards.

Staff explained how lack of permanent staff affected the delivery of care to patients. On Appley ward, the therapists described that they were finding it difficult to manage their workload which meant patients did not always receive the support they needed. Staff told us a lack of speech and language therapists affected the support patients with communication difficulties received. To reduce the impact this had on stroke patients with swallowing difficulties, the critical care outreach team carried out swallowing assessments. Acute physiotherapy cover at weekends also ensured stroke patients were seen by a physiotherapist within the required period of 72 hours from admission.

Nursing staff on the coronary care unit (CCU) said that nurse vacancies were now being recruited into, and that staffing was better since there had been increase in staffing numbers due to winter pressures. However, they reported when they were not at full establishment, for example if agency nurses were not available or did not arrive for duty, pressure area care and observations of patients was delayed.

Registered nurses spoke about the pressures of being the only permanent trained member of staff on duty with agency registered nurses. They described the challenges such as agency nurses who refused to support the care of patients other than their allocated patients. On one ward we observed an agency refuse, when asked to do so, answer a call bell, as the patient calling for assistance was not her allocated patient. Staff said the high use of agency staff, who required supervision resulted in delayed care for patients.

Staff on Compton ward told us they relied heavily on agency staff to fulfil the required numbers of staff. Staff told us the planned staffing numbers in the morning were four registered nurses and four health care assistants. However, they said there were often only three registered nurses and two HCAs to look after 30 medical patients. Some staff told us some staff members were often in tears because they found the lack of staff and the workload very difficult to manage. On the morning of 24 January 2018, there were only three registered nurses and two HCAs on duty. Staff told us this would be raised at the morning bed meeting. We attended the morning bed meeting and noted there was no discussion about staffing concerns throughout the trust. The ward clerk for Compton ward said she always came into work an hour and a half early in order to complete all the work she had to do.

Across all areas, staff expressed concerns about patient’s safety, though they gave no examples where patients had come to harm.

We reviewed incident reports for the period 1 November 2017 to 31 January 2018. There were 40 reports of insufficient nurse staffing numbers. There was no detail in the reports that indicated insufficient staffing numbers resulted in patient harm. The most common outcome was delays in provision of care, including administration of medicines and answering of patient call bells. Despite Compton ward staff describing challenges with filling their required staffing levels, there were no incident reports made about insufficient staffing.

The trust was aware of the challenges associated with nurse staffing. They identified that planned staffing numbers did not always match the acuity and dependency of patients. They were in the process of introducing Safe Care rostering. The Safe Care rostering is a nationally recognised tool
that enables service to calculate required staffing from patient numbers, acuity and dependency. Staff who worked in pilot areas, including Colwell ward and CCU, monitored the acuity and dependency of patients on each shift. The trust’s review of the pilot areas indicated the tool would help them manage acute inpatient staffing on a daily basis more effectively. It would enable them to utilise nursing staff to areas most in need. The trust planned to have all acute areas working with shift by shift acuity and dependency measures by April 2018. Staff who were piloting this tool explained it would enable dynamic management of the staffing and skill mix across the whole hospital.

To support consistency of care, the trust had approved ‘long lines’ of agency in some areas. This meant the same agency nurse worked on the same ward.

**Medical staffing**

Substantial medical staff shortages, high use of locum staff and variable numbers and skill mix of medical staff on duty increased the risk of patients receiving unsafe or inadequate care and treatment.

At the inspection in November 2016, it was identified there was a significant number of medical staff vacancies. We found a similar scenario at this inspection.

Information about planned and actual staffing numbers is routinely requested from the trust within the universal provider information request. Trusts provide this information on a standard template. The trust was unable to provide this data.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 25% for medical/dental staff working within medicine.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From October 2016 to September 2017, the trust reported an overall turnover rate of 10% for medical/dental staff working within medicine.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From October 2016 to September 2017, the trust reported an overall sickness rate of 1% for medical/dental staff working within medicine.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

From October 2016 to September 2017, the trust reported a bank usage of 89 shifts and an agency usage of 2,994 shifts. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

Medicine was the worst acute core service with agency use. The trust attributes this to vacancies. They plan to address this by: ‘Focused recruitment developed by the recruitment strategy as part
of the IIF. We have monthly meetings with the Associate Medical Director and Lead clinicians to develop innovative recruitment strategies’

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Staffing skill mix**

As of July 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 63 whole time equivalent staff working in medicine at Isle of Wight NHS Trust**

<table>
<thead>
<tr>
<th>Staffing Level</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>32%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>14%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior</td>
<td>52%</td>
<td>25%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Workforce statistics (01/07/2017 - 31/07/2017)

When we asked staff about their main concerns and worries, all staff reported that staffing was a significant concern. All staff reported there were times when there were insufficient numbers of medical staff to deliver safe patient care. They described a high use of locum medical staff at all grades that sometimes affected the treatment plans for patients and the support medical staff received.

Medical staff who worked on the MAU said medical staffing levels were rarely full. When junior doctors were on leave the trust did not source a replacement, locum cover for planned leave was rare. Junior medical staff said two to three times a month there was only one junior doctor working on the unit. The trust provided the medical staff rotas for December 2017 and January 2018. These showed there were six occasions across December and January where there was only one junior doctor on duty. There were 22 occasions when there were two junior doctors on duty and 17 occasions when there were three on duty. We asked the trust to provide detail about planned medical staffing numbers. They provided this for consultant medical staff only. This meant we could not make a judgment whether actual junior medical staffing met the planned numbers. There was no indication on the rota that the trust sought locum junior doctors to fill gaps in the rota.

Junior doctors on the MAU described that a significant number of the consultants were locum staff. They said this resulted in a lack of consistency in practices, with treatment plans frequently changed by differing locum consultants. Junior doctors believed this put patients at risk, but could not provide any examples where this had adversely affected any patients, the staffing rota did not detail how many of the consultants were locum staff.

The trust confirmed there was a lack of permanent consultants working in the MAU. There was one permanent consultant and one NHS locum consultant on a one year contract. The trust said the unit worked on a minimum of three consultants though they preferred to have four consultants
on duty. The third and fourth consultants were agency locum consultants. Our review of the MAU rotas showed there were rarely four consultants working in the MAU. For the week days in December 2017 and January 2018 there were eight occasions when there were four consultants working in MAU. There were 30 occasions when there were three consultants working, three occasions when there were two and two occasions when there were no consultants working. The two days there were no consultants working, were Christmas day and Boxing day.

There was variable skill mix of medical staff on duty each day on the MAU, with no clear rationale as to why. Over December and January there were 11 days when there were two middle grade doctors on duty, one middle grade doctor on duty for 25 days and no middle grade doctors on duty for five days.

There was a ‘cover’ rota, which consisted of one junior doctor who worked 5pm to 8pm Monday to Friday and 8am to 8pm Saturday and Sunday. It was not clear what the role of the ‘cover’ doctor was or whether they were included in the daily work plans for the MAU.

Consultants were present on the MAU between 8am to 8pm Monday to Friday, however they were not rostered to work weekends. One of the two on call medical consultants carried out ward rounds on the MAU at weekends and provided consultant cover, for all medical wards, at night.

Review of the medical award rotas showed there was no consistency in the number and grade of medical staff who worked on the individual wards each day. Appley, Colwell and Compton wards had the most variability. For example on Appley ward, there was one middle grade and two junior doctors working on 2 January 2018, one middle grade and three junior doctors working on 3 January 2018 and just four junior doctors working on 5 and 6 January 2018.

There were 10 occasions across the medical wards (excluding the MAU) when there were no junior doctors on duty on a ward. There were 66 occasions when there were no middle grade doctors on duty on a ward. Some of the middle grade doctors took part in the on call and night duty rota. However, this was unlikely to account for all of the 66 occasions when there was no middle grade doctor allocated to work on a ward.

There were 15 occasions across the medical ward (excluding the MAU) when there was no consultant on duty on a ward. The majority of these (14) occurred on bank holidays (Christmas day, Boxing day and New Year’s day). The trust said that two consultants covered all medical wards on Christmas and Boxing day. However, details in the rotas across the medical wards and the MAU showed only one consultant worked Christmas day and Boxing day. Three MAU consultants worked New Year’s day.

On Compton ward, both nursing and medical staff said there had been no increase in medical cover since the ward transitioned from providing a rehabilitation service to providing a medical service. They described there was only 1.5 consultant cover and variable junior doctor cover, with sometimes only one junior doctor to look after 30 patients. We raised concerns about medical staffing on Compton ward with the trust during and immediately following the inspection. They informed us that the medical staffing for Compton ward was set at two consultants (both long-term locum staff, one who worked three days a week and the other who worked five days a week), two permanent trust speciality registrars and two locum senior house offices. However, the specialty registrars took part in the on call rota and were not available to the ward if they worked the on call or night rota. Review of the daily medical staff records for Compton ward for 15 January 2018 to 31 January 2018 showed there was only one day, 25 January 2018 when the actual medical staffing met the planned staffing numbers.

Junior medical staff expressed frustration with the “major discrepancy” between weekend workloads for medical and surgical team junior staff. They described huge challenges with the
capacity to complete their work, when the surgical team had less patients to care for and were able to complete their work.

The stroke unit had two stroke consultants, which meant a stroke consultant was available Monday to Friday, 9am to 5pm. Consultant cover for stroke patients outside this time was provided by the on call medical team. Staff on the stroke unit, said this caused delays with decision-making and thrombolysis treatment for stroke patients. One of the stroke consultants was leaving employment with the trust in February 2018. Staff were not aware of any succession planning. However, a locum stroke consultant had been recruited as a replacement.

During the week day hours, the stroke unit had dedicated junior doctor cover, but out of hours the junior doctor cover was provided by the medical junior doctor who covered all medical inpatients. Staff said, these doctors were based in the MAU and were reluctant to come out of the MAU to attend to patients on the stroke unit. This included attending to acutely ill stroke patients on the Hyper Acute Stroke Unit (HASU).

Medical staff who worked on the coronary care unit (CCU) explained that they had respiratory patients who required non-invasive ventilation on CCU. These patients remained under the care of the respiratory consultants. Medical staff on CCU explained that there were occasions when, due to staff shortages, it was challenge to get the respiratory medical consultants to review their patients on the unit.

Staff expressed concerns with the lack of overarching support from a clinician with the care and treatment of elderly patients. The trust only employed a 0.8 whole time equivalent (WTE) consultant geriatrician. This had contributed to the delay in implementing a frailty pathway for elderly patients and no oversight of the care and treatment of elderly patients in the hospital.

All staff expressed concerns with medical cover for the hospital at night and at weekends. The night medical cover team supported all inpatient medical patients in the hospital. Staff said patient safety and timely treatment was compromised due to the number of medical staff on duty. One junior medical staff said they felt “one junior doctor looking after the hospital (medical inpatients) at night is a horror.” Planned medical staff cover for night was one middle grade doctor, one junior doctor and an additional doctor who worked a twilight shift (6pm to midnight). We reviewed the medical staff rota for December 2017 and January 2018. This showed there was always one junior and one middle grade medical doctor on duty at night. However, for 13 out of the 62 shifts the junior doctor shift was covered by a bank junior doctor. For 3 out of 62 shifts, a bank middle grade doctor covered the middle grade doctor shift. There were no occasions when the night shift was covered by only bank staff.

The trust had introduced the twilight shift in response to concerns raised by junior doctors. However, staff said this was very dependent on the availability and willingness of locum junior medical staff to cover the twilight shift. Junior doctors told us there had been no twilight shift doctor the week before our inspection. However, the December and January medical staff rotas showed only three occasions when the twilight shift was not filled.

The critical care outreach team supported the night medical staff. There was always one member of the critical care outreach team on duty, who had the skills to carry out some of the junior doctor roles. The critical care outreach team commented that it was “hit and miss as to whether there were sufficient medical staff on duty at night.”

An on call medical team provided an on call service 8am to 8.30pm seven days a week. The team consisted of one middle grade doctor and two junior doctors. At the weekends, the on call team and the night team were the only medical staff rostered to provide care and treatment to all medical inpatients. There were no consultants detailed on the rota to cover weekends. The trust
told us two medical consultants worked weekends and bank holidays. The two consultants provided the medical care for patients on all the medical wards and the MAU.

As part of the trust’s winter pressures plan, the trust converted the use of beds on surgical wards from surgical to medical services. The trust had employed locum junior and consultant doctors to provide treatment for patients admitted to these wards. One of the locum junior doctors commented that at times when there were large numbers of medical patients on the ward, they felt the workload was overwhelming. However, they did say the surgical junior doctors on the ward, provided support and assistance at times of increased medical patients.

The trust employed haematologists and consultant cover from NHS trusts on the mainland through service level agreements that provided medical cover for patients receiving treatment on the chemotherapy unit.

Records

Staff did not always have the complete information they needed before providing care, treatment and support. Staff did not always fully complete patient records. During the course of the inspection, we reviewed 37 patient records; of these 15 were medical records, 15 nursing records and seven allied health professional records. There were gaps in most records, assessments were not completed and information in some records was conflicting.

We reviewed nursing records for two patients on the MAU. There were gaps in the records of both patients. For one patient the admission pathway was not signed. Risk assessments for infection prevention were not completed. The mental capacity assessment was not completed. The patient was an amputee, but there was no associated plan of care to inform staff how to support the patient with their additional needs. The nursing record detailed a diagnosis of chest infection, pneumonia and dehydration, there were no relevant risk assessments or care plans to inform staff about the support the patient needed with regard to their diagnosis. For the second patient staff had not completed a sepsis screen, despite trust policy and the admission documents stating all patients must have a sepsis screen completed and the ambulance transfer details stating the patient possibly had sepsis. The mental health assessment for the patient detailed they had no problems with mental capacity, but also detailed that the patient had dementia and a learning disability. There was no detail recorded of the effect the patient’s dementia and learning disability had on their capacity to make informed decisions.

Our review of eight patients’ medical records on Appley ward, showed there were gaps in most records. In all eight records, care bundles were not fully completed. Only one of the eight records had dementia screening completed, despite the fact all patients were over the age of 70 and four patient records detailed the patient had confusion. Only five of the eight records had detail that showed the patient was reviewed by their consultant within 14 hours of admission. Only five of the eight records had written handover details for the weekend covering medical staff.

Our review of nursing records for two patients on Appley ward showed that patients who required their fluid intake and output monitored and their food intake monitored, did not have records of this fully completed. For the first patient, detail on their fluid record chart stated “Strict Fluid Balance Chart.” The chart provided space to include detail about the rationale for fluid balance chart, daily fluid balance aim, and detail of when staff needed to escalate concerns and information to medical staff. This was not completed. Staff had not added up the total input and output each day, so there was no record of the patient’s fluid balance. Despite instructions for a strict fluid balance chart, this was not achievable because staff did not weigh the patient’s continence aids to determine how
much urine the patient had passed. The fluid charts recorded the patient had taken between 100mls and 730ml per day, with no intake recorded for 22 and 23 January 2018.

For the second patient who was having their food intake monitored, there was space on the food chart for staff to detail the reason that food intake needed to be monitored. Staff had not completed this. Staff had completed the food chart for 23 January 2018. However, on 22 January 2018 they had completed entries only for breakfast and lunch. There was no indication on the record as to whether staff had offered the patient food. The record for 21 January had no detail for food intake other than “she said she ate weetabix” at 8.30am. Failure to complete the food record chart meant staff could not accurately monitor the patient’s nutritional wellbeing.

Our review of nursing records for two patients on Colwell ward showed gaps where they had not recorded fluid intake and food input. For one patient staff had fully completed the food intake record on 20 and 21 January, but had not completed the food record chart for 22 January 2018. For the second patient, staff had not totalled the fluid intake and output and had not calculated the fluid balance each day.

Our review of medical notes for three patients on CCU showed medical staff did not fully complete them. For one patient the medical clerking booklet had six of 20 pages completed, medical staff had not completed the no care bundles or dementia screening. However, the record did show the patient was seen regularly by their consultant. For the second patient, medical staff had only completed seven of the 20 paged medical clerking booklet was completed, there were no care bundles completed and no dementia screening. There were regular entries by the consultant and records of decision making. However, for that patient the record did not demonstrate that staff had followed through on all the decisions. For the third patient, medical staff had only completed six of the 20 paged clerking booklet.

Our review of two sets of therapy records on the stroke unit showed that therapy staff had not fully completed the records, which included assessments and goal setting.

Our review of two sets of nursing records for medical patients being cared for on the surgical ward Luccombe, showed staff had not fully completed both records. In one patient’s record, there was conflicting information about their social situation. The record detailed the lived alone and that they also lived with their spouse. For the second patient staff had not completed the sepsis assessment, acute kidney injury assessment, alcohol assessment. The patient was having intravenous therapy treatment, however there was no care plan to inform nursing staff about the care the patient needed with regard to this treatment.

For staff who work in health and social care there are a number of record keeping codes that people associated with certain professional bodies must adhere to as part of their profession. The trust used the Royal College of Physicians (RCP) guidelines and audit tool to monitor the completeness of medical records and compliance with professional standards for record keeping.

The results from the 2017 audit showed some improvements from the audit results of 2016. However, the results still showed they did not meet the professional standards for record keeping. Only 30% of records reviewed showed staff achieved good compliance with meeting the RCP guidelines, 16% of records reviewed showed staff achieved medium compliance and 53% achieved poor compliance. The nursing records audit, dated November 2016 reviewed 50 patients’ records. However, none of these were for patients cared for on any of the medical wards.

The trust did not share information about patients’ care and treatment appropriately with other organisations and health care providers. Prior to the inspection, we received information from patient relatives and care providers that the trust often failed to provide discharge summaries and relevant information when they discharged patients. The trust was not meeting its discharge
policy. This detailed the hospital based doctor responsible for the patients care must make the discharge summary available to the patient’s GP within 24 hours of discharge.

Record of the trust board meeting held in February 2017 detailed the number and percentage of uncompleted discharge summaries for the period 1 January to 31 December 2017. The medical services had a total of 510 uncompleted discharge summaries. The greatest percentage was for gastroenterology service where medical staff had not completed 29% of discharge summaries. The percentage of uncompleted discharge summaries ranged from 2% to 7% in the other medical specialities.

However, staff fully completed records for patients receiving treatment in the chemotherapy unit and undergoing procedures in the endoscopy unit.

At the previous inspection in November 2016, patient records were not always stored securely and staff did not ensure computerised records were not accessible to unauthorised personal. At this inspection in January 2018, we found staff stored patient records in lockable cabinets. Only essential information for the immediate care of patients, such as nursing care plans and observation charts, were stored at the patients’ bed space. The exception to this was Luccombe ward where the notes trolley was not lockable. To mitigate risk of unauthorised access to patient records, the notes trolley was stored in the medical staff room that was locked when no one was in there. The ward sister said a lockable notes trolley had been ordered. We observed all staff logged out of computers, when they were not accessing information on the computer.

However, patient screens in the public area of all wards detailed the names of all patients on the ward. There was no documentation to indicate staff gained patients” permission to have their names displayed in a public area. There was no indication that the trust had considered guidance provided by the National Information Governance Board in 2012 about this practice. Part of this guidance included carrying out of a privacy impact assessment. The trust had not completed a privacy impact assessment about the affect this might have on patients.

**Medicines**

The service did not have sufficiently robust processes, to manage medicines safely. Staff did not always follow best practice guidelines for storing and recording medicines. Medicines were not always stored appropriately. On the Stroke unit staff reported there were issues with storage space for patients own controlled drugs. This meant that two people’s medicines were sometimes stored in the same locker within the computer controlled medicines cupboard. This created a risk that staff might pick incorrect controlled drugs from the compartment leading to medicines administration errors. Records showed staff did not always complete controlled drugs balance checks. Balance checks are a legal requirement to ensure controlled drugs are managed appropriately and safely.

There was mixed assurance that medicines stored in clinical or treatment rooms were kept at recommended temperatures. Treatment rooms in the new parts of the hospital buildings were remotely monitored in a similar manner to the medicine fridges. However, treatment and clinical rooms in older parts of the hospital building were not monitored remotely. Staff reported the treatment room on CCU became very warm in summer. Both the treatment rooms on CCU and Compton ward felt warm at the time of the inspection. Staff did not measure and record the room temperatures. This meant patients were potentially at risk of receiving medicines that had reduced effectiveness because they had not been stored at appropriate temperatures.
The trust used computerised access to medicines ‘vending machines’. In the MAU staff did not know about any contingency plans to access the medicines in this machine in the event of power failure. We did not identify whether this was the same across all wards and units, or specific to the MAU.

Our review of incident reports showed a number of them related to problems ensuring patients received the correct medicines to take home on discharge. This occurred when medical staff altered patient’s prescriptions after the patient’s medicines to take home had been ordered and then they failed to amend the order. The trust’s medicine policy dated 13 December 2016 did not give guidance about processes for staff to follow to ensure these incidents did not occur.

Medicine fridge temperatures were monitored centrally, staff explained the were notified if a medicine fridge went outside it’s recommended operative temperatures and guidance was provided about the actions they needed to take.

Staff stored most medicines in a secure manner. Most medicines were accessed using swipe card access to treatment rooms or by finger print access to computer-controlled cupboards. We found treatment rooms on all wards were locked and staff stored medicines securely in the discharge lounge. These were improvements from the findings at the November 2016 inspection.

Chemotherapy was supplied pre-prepared to the hospital, and staff reported a timely service. The hospital pharmacists verified prescriptions and checked blood results before they allowed chemotherapy administration. The oncology pharmacists at the hospital had completed specialised oncology training.

All chemotherapy was prescribed through an electronic prescribing system and local cancer network protocols were used. Oncology nurses used the trusts electronic prescribing system to perform checks and record administration.

Pharmacy staff visited or were based on wards to an agreed schedule. On the MAU a pharmacy technician and pharmacist were based on the unit seven days a week for eight hours per day to ensure they reconciled all patients medicines within 24 hours of admission. Information provided by the trust showed that for all areas medicine reconciliation within 24 hours was constantly above 80% .

The stroke unit, was the only clinical area where patients were actively encouraged to manage and administer their own medicines whilst in hospital. Nursing staff completed a capacity assessment. Patients assessed as having capacity and capability to manage their own medicines were given a personalised key to their medicines cupboard.

We observed administration of medicines on the wards. Nurses administered medicines in a safe manner in accordance with national guidance.

**Incidents**

Staff did not always recognise concerns, incidents or near misses. There was little evidence of learning from events or action taken to improve safety.

The service had recognised that it had not previously managed patient safety incidents well and had taken action to review incidents more promptly and to encourage reporting of incidents. The trust had audited the serious incident process and encouraged reporting. A new serious incident process was launched in November 2017 and was still being embedded and linked to an investigation process. Learning from incidents was not yet embedded in the management of incidents.
Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From December 2016 to November 2017, the trust reported no never events for medicine. 

*Source: NHS Improvement - STEIS (01/10/2016 - 30/09/2017)*

In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in the medicine CBU which met the reporting criteria set by NHS England from December 2016 to November 2017.

A breakdown by Incident type was:

- Slips/trips/falls meeting SI criteria with seven (44% of total incidents).
- Confidential information leak/information governance breach meeting SI criteria with three (19% of total incidents).
- Treatment delay meeting SI criteria with one (6% of total incidents).
- Operation/treatment given without valid consent criteria with one (6% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (6% of total incidents)
- HCA/Infection control incident meeting SI criteria with one (6% of total incidents)
- Adverse media coverage or public concern about the organisation or the wider NHS with one (6% of total incidents).
- Medication incident meeting SI criteria with one (6% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Staff did not consistently identify and report patient safety incidents. Most staff said they would recognise a safety incident, and described situations when they had reported an incident.
However, some said they did not always report staffing and infection control issues such as lack of side room availability.

We reviewed the incident reports for the medical wards for the three-month period prior to the inspection. This showed that although staff on all wards said they experienced staff shortages, not all wards reported staff shortages as an incident. The records showed infection control issues, including lack of side rooms were reported, but from conversations with staff, we were not assured that all such incidents were reported. Staff did not always report near misses. Staff told us about incidents that had occurred, but had not been reported because the patient had not suffered permanent harm. Staff spoke about delays in transferring patients to mainland acute NHS services for time critical specialist treatment. We only identified one such incident reported in the three months before the inspection. This indicated staff did not report delayed transfers as an incident. Staff reported pressure ulcers as an incident. The reporting detailed whether the pressure ulcer was acquired in hospital or acquired prior to admission to hospital.

We identified incidents that had caused harm to patients such as fractures following a fall. On MAU there was a reported fall in which the patient suffered a fractured neck of femur. On Colwell ward there was a reported fall which the patient suffered a fracture to their leg. There was no detail to indicate the service had considered whether the incident was reportable to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

The service carried out root cause analysis (RCA) on serious incidents. We reviewed a sample of these. These showed that although areas for improvement and learning were identified, for some there was no detail about how the service would measure the success of any actions taken. There was little information about how the service was assured the changes were implemented and embedded into the delivery of care.

The RCA reports showed the service followed duty of candour processes where required. The Duty of Candour legislation is a regulatory duty that relates to openness and transparency and requires health and social care services to notify patients (or relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person.

Discussion with the medicine CBU leads, indicated that the trust had identified incident reporting had not been robust and work had been done to improve this. They said incident reporting had improved, with staff more aware of the types of incident they needed to report and there was a reduced tolerance about the level of incident that was acceptable. This, they said, resulted in staff reporting a greater number of incidents. However, they said, learning from incidents had not yet been embedded into the incident reporting process. Staff said they received minimal or no feedback from incidents they reported.

The trust held monthly mortality review committee meetings. Review of records of the meetings for May, July, December 2016 and February 2017 showed there was opportunity for learning from mortality and morbidity reviews. However, these records did not reference any mortality and morbidity reviews carried out by the medical services.

**Safety thermometer**

The service did not use safety monitoring results to support improvements.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering
harm free care. Measurement at the frontline, it is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 20 new pressure ulcers, four falls with harm and seven new catheter urinary tract infections from October 2016 to October 2017 for medicine CBU services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Isle of Wight NHS Trust**

<table>
<thead>
<tr>
<th>Total Pressure ulcers</th>
<th>(20)</th>
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<tbody>
<tr>
<td>Total Falls</td>
<td>(4)</td>
</tr>
<tr>
<td>Total CUTIs</td>
<td>(7)</td>
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</table>

*Source: Safety thermometer - Safety Thermometer*

Despite staff collecting information for the safety thermometer, they did not use the information to monitor and improve their service. There was no information displayed in the wards about their safety thermometer results. Staff on Luccomb ward said they received no feedback from the data they collected for the safety thermometer, this meant they were denied the opportunity of using this information to make changes to improve the safety of patients.

**Is the service effective?**

**Evidence-based care and treatment**

Care and treatment did not always reflect current evidence based guidance or best practice standards.
Medical services had pathways and protocols for a range of conditions, which took account of national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. For example, for heart failure, stroke, diabetes, respiratory conditions, falls prevention, pressure ulcer prevention and sepsis. However, poor completion of patient records, meant the service did not have assurance the pathways were always followed. For example, records showed staff did not check the position of patients NG tubes, staff did not always follow the NEWS process and staff did not always complete assessments.

The service used a nationally recognised sepsis bundle to support identification and treatment of patients with suspected or actual sepsis. There was an action plan to support ongoing and effective use of the sepsis bundle. The service monitored compliance with the sepsis bundle.

The endoscopy unit achieved accreditation from the Joint Advisory Group (JAG) in February 2014. JAG is a quality improvement and service accreditation programme for gastrointestinal endoscopy. They assess endoscopy units to monitor whether they meet and maintain the JAG quality standards. This meant the endoscopy unit met the national guidance for delivering an endoscopy service, which included routine auditing of the service provided.

The hospital used the national cancer intelligence network chemotherapy protocols, based on NICE guidance.

In line with national guidelines, patient records on the medical assessment unit (MAU) showed they were seen and reviewed by a consultant twice daily. Once transferred to general ward, records showed, in line with national guidelines, most patients were reviewed during a consultant led ward round once every 24 hours. However, the service did not consistently meet the national guidelines that patients should be assessed by a consultant within 14 hours of emergency admission to hospital.

**Nutrition and hydration**

Care assessments did not fully consider patients nutritional and hydration needs.

Patients had assessments of their nutritional and dietetic needs on admission using a nationally recognised tool. However, for patients who staff identified as needing fluid and nutritional monitoring, the assessments provided little information about their usual or required nutritional and fluid intake or the support they needed.

Staff referred patients to dieticians for dietetic support if their assessments indicated the need. Staff referred patients identified at risk due to swallowing difficulties to speech and language therapists. However, lack of numbers of speech and language therapists meant there was a risk of delay of support for such patients. Critical care outreach staff carried out swallow assessments for stroke patients when there was no access to speech and language therapists. However, this was not available for patients who had swallowing problems not related to a stroke.

We saw staff on the stroke unit assisted patients at meal times if additional help was required.

**Pain relief**

Care assessments did not fully consider pain patients might be experiencing.

Staff used a numerical score measure pain experienced by patients. If a patient was unable to communicate verbally, for example a stroke patient or someone with advanced dementia, medical, therapy and nursing staff took into account the patient’s body language to determine the level of
pain they were experiencing. However, there was no evidence that staff used nationally recognised tools such as the Disability Distress Assessment tool (DisDAT) to help identify pain in people with severe communication difficulties or the Abbey Pain Score for people with dementia.

Patients we had conversations with told us their pain was well controlled, they received pain-relieving medicine when they requested it.

Pain relief in the endoscopy unit was well managed. Staff prescribed and administered appropriate pain relief and spasm relieving medicines.

**Patient outcomes**

The service did not consistently carry out audits or use national audit findings to improve services.

**Relative risk of readmission**

**Trust level**

From July 2016 to June 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions.

- **Elective admission** Patients in Gastroenterology and Respiratory Medicine had a higher than expected risk of readmission for elective admissions.
- **Patients in Pain Management** had a lower than expected risk of readmission for elective admissions.

**Non-Elective admissions**

- **Patients in General Medicine, Stroke Medicine and Respiratory medicine** had a lower than expected risk of readmission for non-elective admissions

**Elective Admissions – Trust Level**

**Non-Elective Admissions – Trust Level**

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

*(Source: HES - Readmissions (01/07/2016 - 30/06/2017))*

The Medicine CBU monitored emergency readmissions within 30 days of discharge to the medical wards. Between 1 April 2017 and 31 November 2017 there was an overall rate of 8.9% of
discharged patients being readmitted as an emergency to the medical wards within 30 days of discharge. This showed there was a trend of improvement with fewer patients (an improvement) readmitted within 30 days of discharge for Colwell ward, Compton ward and the stroke unit compared to April 2016 to December 2016. Appley ward had a small increase in the number of patients readmitted within 30 days of discharge.

Medical service services took part in a number of national audits, which are described below. It was not evident that, the service always acted on the results of audits to continually improve the service.

**Sentinel Stroke National Audit Programme (SSNAP)**

St Mary’s Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in latest audit, April 2017 – July 2017. This score is an improvement from the previous audit results where it was rated a D from December 2016 to March 2017.

The service was rated as A for scanning (both patient- and team-centred) for all time periods recorded. It was also rated as A for Discharge processes (both patient- and team-centred) for the last three time periods. This site has showed improvements in areas of Occupational therapy and Speech and language therapy scoring a B in April 2017 to July 2017, an improvement from B in the previous audit. This site has also improved in standards by discharge, now scoring an A compared to a B in the previous audit. Most notably, this site was rated as E for Stroke unit and Thrombolysis (both patient- and team-centred), the same score as the previous three time periods. This overall team-centred rating score as E for key stroke unit indicator performed much worse than other NHS acute trusts in the national comparison as indicated by CQC insight.

### St Mary’s Hospital

<table>
<thead>
<tr>
<th>Overall scores</th>
<th>Jan-Mar</th>
<th>Apr-Jul</th>
<th>Apr-Aug-Nov</th>
<th>Dec-Mar</th>
<th>Apr-Jul</th>
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<tbody>
<tr>
<td>Overall Scores</td>
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<tr>
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<tr>
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<td>B↑</td>
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<tr>
<td>Combined Total Key Indicator level</td>
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### Patient centred Performance

<table>
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<tr>
<th>Domain 1: Scanning</th>
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<th>Jan-Mar</th>
<th>Apr-Jul</th>
<th>Aug-Nov</th>
<th>Dec-Mar</th>
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Staff on the hyper acute stroke unit (HASU) said stroke patients received thrombolysis treatment in the accident and emergency department and were transferred to HASU for intensive monitoring after completion of this treatment. If a stroke patient needed thrombectomy (removal of a blood...
clot using an interventional radiological procedure) patients were transferred to a specialist centre on the mainland. However, staff said, this generally resulted in delayed treatment whilst they made transfer arrangements.

The stroke nurse consultant had reviewed the findings of the SSNAP audit and presented the findings to the stroke team. They identified that the target for admitting a person with a suspected stroke to a specialised stroke unit within the national guidance of four hours after presentation was massively impacted upon by decisions to admit to the MAU rather than directly to the stroke unit by general medical physicians who worked in the accident and emergency department. This practice was not in line with national guidance.

They identified thrombolysis was administered to four patients in this data collection period, which was an increase from the previous data collection period. However, these patients were not thrombolysed within the recommended guidance of less than one hour from presentation of the stroke.

Records from the Medicine CBU leadership and quality meeting in January 2018 detailed that in November 201780% of stroke patients spent 90% of their hospital admission on the Stroke unit; this was above the trust target of 80%.

During the well led part of the inspection of the trust, the stroke nurse consultant provided us with the most recent SSNAP audit results, which were published on 5 March 2018. This showed the stroke service continued to improve with the overall score improving from C to B. The score for admission to a stroke unit within four hours increased from level E to D and administration of thrombolysis therapy from level E to D.

**Heart Failure Audit**

In 2015/16, a lower proportion of heart failure patients, 42.5% were cardiology inpatients at St Mary’s hospital than was the case nationally, 45.7%.

**In-hospital Care Scores**

Results for Isle of Wight NHS Trust in the 2015/16 Heart Failure Audit were similar to the England and Wales average for two of the standards relating to in-hospital care; Input from consultant cardiologist and Received echo. The Isle of Wight trust performed worse than the England and Wales average for the other two metrics in the audit; Cardiology Inpatient and Input from specialist

- 61.8% of patients at the trust received an input from specialist, compared to 79% in England and Wales.
Discharge Scores

Results for the Isle of Wight NHS Trust results were better than the England and Wales average for two of the standards relating to discharge; ACEI on discharge and ACEI/ARB on discharge. However, the trust performed worse than the England and Wales average on the remaining metrics; Beta blocker on discharge, MRA on discharge, Received discharge planning, Referral to HF nurse follow up, Referral to HF nurse follow up (LVSD only), Referral to cardiology follow up and Referral to cardiac rehabilitation.

Some of the worst performing metrics for the trust are listed below:

- 22% received discharge planning compared to 87.3% nationally.
- 26.1% were referred to a heart failure nurse follow up on discharge, compared to 54.8% nationally.
- 29.4% of patients with left ventricular systolic dysfunction (LVSD) were referred to heart failure nurse follow-up, compared to 70.8% nationally.

**SOURCE:** NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)

Following the inspection the trust provided a plan about the action they were taking to address the areas of this audit where they had underperformed. This included meeting the NICE guideline on Acute Heart Failure (CG187).

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.
The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 41 inpatients with diabetes at St Mary’s hospital. This was equal to 16.3% of the beds audited, which placed St Mary’s hospital in Quartile 2. 74.8% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in Quartile 1.

Areas where St Mary’s hospital outperformed compared to national average:

- **Foot risk assessment**: 81.1% of patients with diabetes received a diabetic foot risk assessment within 24 hours of admission, compared to 30.1% in England, which places this site in Quartile 4. 91.9% of patients received a diabetic foot risk assessment at some point during their hospitals stay, compared with 37.5% in England, which also places this site in Quartile 4.

- **Medication Errors**:
  - Somewhat lower proportions of the trust’s patients experienced Medication errors; 25.0% of patients had one or more medication error, compared to 37.8% for England, which places this site in Quartile 1.
  - 21.9% of patients with diabetes experienced at least one medication management errors compared to 24.1% for England, which places this site in Quartile 1
  - Of patients on insulin, 9.4% experienced one or more insulin (prescription or medication management) error, which places this site in quartile 1.

Areas where St Mary’s Hospital underperformed compared to national average:

- **Diabetes Control**: In St Mary’s hospital, a smaller proportion of patients reported that they could take control of their diabetes care while in hospital (39.0% compared to 60.0% in England), which places this site in Quartile 1. This is also 21.8% lower compared to 2015, where 60.8% of patients with diabetes reported they could take control, Quartile 3.

- **Overall satisfaction**: In St Mary’s hospital, the overall satisfaction percentage was 74.8%. this was lower than the England average of 83.7% and places the trust in Quartile 2 for this metric.

(Source: NHS Digital)

We asked the trust to provide information about any action they were taking to address the two areas of this audit where they had underperformed. They provided information about actions the trust was taking in the community to prevent admission to hospital for diabetic patients. We did not receive any information about what the trust was doing to increase the number of patients who managed their diabetes whilst in hospital or to improve overall patient satisfaction.

**Myocardial Ischaemia National Audit Project (MINAP)**

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 71.2% of nSTEMI patients were admitted to a cardiac unit or ward at St Mary’s hospital, (compared to 55.8%, the England’s average) and 98.3% were seen by a cardiologist or member of the team, which was higher than the compared England average of 96.2%.
The proportion of nSTEMI patients who were referred for or had angiography at St Mary’s hospital (Isle of White) was 66.1%, which was narrowly lower than the England’s average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

**Lung Cancer Audit**

In the 2016 audit, the trust’s results do not show any areas of ‘significantly poorer’ performance compared to other trusts.

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 87.0%, which was worse than the National Aspirational standard of 90%. The 2015 figure was 95.0%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 24.7%. This was similar to the National Average, 24.0%, and higher than the 215 report, 9.0%. The national aspirational standard is not available.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 45.5%. This was lower than the 2015 score of 50.0%, and not significantly lower than the National Average score of 64.0% for 2016. This did not meet the National Aspirational Standard, 60%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 60.0%. This was lower than the 2015 score, 88.0%, and not significantly worse than the National Average, 69.0%. This did not meet the National Aspirational Standard of 70%.

The one year relative survival rate for the trust in 2016 is 36.4%. This is not significantly lower than the National Average of 38.0%. The National Aspirational Standard is not available for this measure.

(Source: National Lung Cancer Audit)

**National Audit of Inpatient Falls**

Results from the 2015 national audit of inpatient falls showed St Marys hospital performed poorly for this audit.

St Mary’s failed to meet the four aspirational standards in the audits (which are set as 100% for each metric), and performed poorly in three, fair in the other. In all four cases, a crude performance of 49% or lower is rated as poor performance (the below are all crude proportions):

- 16% of patients had a vision assessment, compared to 48.3% nationally. For this metric, the trust submitted 25 cases.
- 0.0% of patients had a lying or standing blood pressure assessment, compared to 16.1% nationally. For this metric, the trust only submitted 12 cases.
- 41.2% of patients were assessed for the presence or absence of delirium (as a percentage of applicable cases), compared to 36.7% nationally. For this metric, the trust submitted 17 cases.
- 63.6% of patients had an appropriate mobility aid in reach (as a percentage of applicable cases), compared to 67.6% nationally. This performance is rated as Fair in comparison with the England and Wales average, however, for this metric, the trust only submitted 11 cases.

Results from the 2017 National Audit of Inpatient Falls showed the trust had made significant improvements and were one of the two best performing trusts in the country.

- The crude proportion of patients who had a vision assessment (if applicable) was 93%. This did not meet the national aspirational standard of 100%.
• The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 50%. This did not meet the national aspirational standard of 100%.

• The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 100%. This met the national aspirational standard of 100%.

• The crude proportion of patients with a call bell in reach (if applicable) was 100%. This met the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The endoscopy unit carried out monthly decontamination efficiency and tracking audits. Review of the November 2017 and January 2018 audits showed staff met the decontamination standards consistently.

In the MAU we reviewed paper copies of audits and audits held electronically. There some action plans that related to the findings of the audits, but they were difficult to locate on the electronic system. The unit sister said they discussed audit results at morning meetings and handover sessions.

Following the inspection we asked the trust to submit information about audits carried out in the medical services and any associated action plans in order to evidence they took action in response to audit findings. We received ward audits about their use of dementia tools. This showed variable use of the tools across the wards. There were no action plans to improve the use of the tools.

Competent staff

The service did not make sure all staff were competent to carry out their role. There were gaps in the management and support arrangements for staff, such as induction, supervision and appraisal.

Appraisal rates

From October 2016 to September 2017, 59% of staff within the medicine CBU had received an appraisal, not meeting the trust target of 100%.

A split by staff group can be seen in the graph below:

Appraisal Completion rates by staff group, October 2016 to September 2017
Following the inspection the trust provided the following update of appraisal rates at 12 February 2018 for medical wards.

<table>
<thead>
<tr>
<th>Medical Ward</th>
<th>Appraised</th>
<th>Total Staff #</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>470 4Appley Ward J61250</td>
<td>15</td>
<td>32</td>
<td>47%</td>
</tr>
<tr>
<td>470 4Colwell Ward J61254</td>
<td>4</td>
<td>36</td>
<td>11%</td>
</tr>
<tr>
<td>470 4COrmonary Care J61190</td>
<td>36</td>
<td>43</td>
<td>84%</td>
</tr>
<tr>
<td>470 4General Rehabilitation Unit J61226</td>
<td>13</td>
<td>38</td>
<td>34%</td>
</tr>
<tr>
<td>470 4MAAU J61231</td>
<td>31</td>
<td>44</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>99</strong></td>
<td><strong>193</strong></td>
<td><strong>51%</strong></td>
</tr>
</tbody>
</table>

The figures included nursing, medical and allied health professionals (AHP). This showed that the service was far from meeting the trust’s target of 100% of staff receiving an annual appraisal. Compared to the findings at the November 2016 inspection, the percentage of staff who received an annual appraisal had gone down on Colwell ward, the general rehabilitation ward (now Compton ward) but had increased on Appley ward.

The trust required all new members of staff to complete induction training when they started working for the trust. Nursing and AHPs confirmed they had completed induction training. This included trust induction and local induction to the area they worked in. Bank and agency nursing staff completed a short induction to the trust and the area they were working in. At the previous inspection in November 2016, copies of each bank and agency workers completed induction was not held on the wards and units. At this inspection we found this had been addressed and copies of bank and agency staff induction were held in files in each ward and unit.
However, conversations with medical staff showed a mixed picture as to whether they had completed induction to the trust and their role. We spoke with six medical staff about their induction. Two said they had received induction, but that the induction process was poor and there was not enough time for induction. Two confirmed they had received full trust induction. A middle grade doctor thought they had had induction 15 months ago, but was not sure about this. A sixth doctor, a locum doctor, who had worked at the trust for seven months said they had had induction about how to use the trust’s computer systems, but no other induction.

At the inspection in November 2016, nursing staff who worked on CCU had not received training about the non-invasive ventilation they carried out on the unit. At this inspection in January 2018, we found CCU staff had completed training about non-invasive ventilation. Nursing staff across all medical wards confirmed they completed competency assessments that ensured they had the appropriate skill set to meet the needs of the patients they were caring for.

At the time of inspection, we did not see evidence that nursing staff who cared for medical patients on surgical wards during the winter pressures period had had completed assessments to determine they had the required skill set. Staff told us because they looked after elderly orthopaedic patients who had comorbidities they had the skills and knowledge to provide care to medical patients. The trust said high level medical need patients were not admitted to the surgical wards, they were appropriately admitted to the dedicated medical wards.

Staff on Compton ward told us they had completed competency assessments to identify they had the skills to care for medical patients. However, the sister on Compton ward explained that many staff were anxious and lacked confidence in caring for medical patients. The trust had recruited a team of nurse practice developers. We spoke with two of the nurse practice developers, who supported staff on Compton ward. The nurse practice developers said that as a group they were developing packages to support ongoing nurse education and development that would be in place by April 2018.

Allied health care professionals and medical staff confirmed they received clinical supervision. However, for nursing staff this was less evident. The ward sister on the stroke unit said one to one supervision was offered, but was declined by all staff. However, they did have informal group supervision sessions.

Medical staff confirmed they received formal supervision. Records provided by the trust showed that all junior medical staff received formal clinical supervision. However, it was acknowledged by the medicine CBU leadership team, that the quality of that supervision was dependant on the consultant’s commitment to providing supervision.

The trust checked all newly employed nurses and monitored all employed nurses to ensure they maintained registration with the nursing and midwifery council. The trust had recognised some nursing staff did not have a full understanding about their responsibilities associated with their registration with the NMC. To support staff they arranged support sessions for staff to increase their awareness of their professional accountability.

Results of the 2017 trainee survey, by the General Medical Council, did not indicate any particular trends from responses, except that rotas were poorly designed.

**Multidisciplinary working**

Staff and teams did not always work together as a team to benefit patients.

We asked staff about any joint working with the trust’s mental health teams or the community teams. They had mixed experiences of shared working with the trust’s mental health teams. Staff on some wards said they had easy access to mental health team support for support and advice
when patients required it. However, staff on another ward told us about a mental health patient with medical needs, who had been ‘ping ponging’ between the mental health and medical services. Staff had identified that neither the medical or mental health teams had been working together to provide the best possible care and treatment to this patient. At the time of the inspection, staff from the mental health team and the medical team had reached an agreement about how they would both support this patient whether they were on a medical ward or a mental health ward.

We observed multidisciplinary meetings on Compton ward, the stroke unit and the MAU. On Compton ward and the stroke unit, the meeting was fully multidisciplinary with attendance from medical staff, nursing staff, physiotherapists, occupational therapist and the speech and language therapist. There was clear communication between staff from the different teams. Participants demonstrated a good knowledge of patients’ needs, which resulted in and agreed ongoing processes to facilitate patients’ discharge. However, the multidisciplinary board round on the MAU involved only medical and nursing staff, there was no input from therapy staff.

The inpatients stroke unit worked closely with the community stroke team to facilitate effective discharge and ongoing rehabilitation for stroke patients in their own homes. However, occupational therapists who provided treatment for acute medical patients said they were only involved once a patient was medically fit and they had no involvement if a patient was discharged to a care home.

The trust held twice weekly meetings for ‘super stranded’ patients. These patients had been in hospital for over 21 days following the decision they were medically fit for discharge. They usually had complex social care needs. We attended one of these meetings at the well led inspection and observed different organisations worked together to enable patient discharges. There was involvement from hospital nursing and therapy staff, community nursing and therapy staff, reablement team and adult social services.

The trust was aware of limitations to the chemotherapy service they could offer and worked collaboratively with neighbouring mainland trusts. They had developed shared care pathways with specialist consultants from mainland trusts.

Due to the limitations of some of the services provided by the trust, and lack of provision of some services at weekend, some care pathways meant patients were transferred to trusts on the mainland for treatment. We heard from staff this sometimes posed challenges with getting transport to the mainland.

**Seven-day services**

Seven day services were not fully established.

The NHS seven day services programme is a set of 10 clinical standards, four identified as priorities, to ensure patients admitted to hospital as an emergency receive high quality and consistent care whatever time of day they enter hospital. NHS England requires trusts to carry out surveys to measure their performance against the four priority standards. NHS England publishes the results. The trust carried out surveys in September 2016, March 2017 and September 2017. Only the March 2017 results were available, the September 2017 results had not yet been published.

Priority clinical standard 2 requires trusts to ensure all patients admitted as an emergency to be assessed by a consultant with 14 hours of arrival at the hospital. The March 2017 survey results showed 70% of patients had a consultant review within 14 hours during Monday to Friday, but this dropped to 60% at weekends. Our review of patient records during the inspection showed not all
patients, admitted as an emergency, had a consultant review within 14 hours of arrival at the hospital.

Priority clinical standard 5 requires trusts to ensure all inpatients to have scheduled seven-day access to diagnostic services, such as ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. This standard also dictates timescale for reporting on diagnostic tests. The March 2017 survey results showed 100% performance against this standard Monday to Friday and 82% performance at weekends. The trust reported, due to staff shortages, access to emergency echocardiography was not possible seven days a week and although patients accessed MRI scans in a timely manner, reporting did not meet the seven-day clinical standard. However, when we spoke with staff, they did not report any concerns about accessing diagnostic services at weekends.

Priority clinical standard 6 requires trusts to ensure inpatients to have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. The March 2017 survey results showed 78% performance against this standard Monday to Friday and 67% at weekends. However, a self-audit carried out by the trust identified 93% performance with the standard during the week but performance dropped to 36% on Saturdays. There was no endoscopy service provided at weekends. Staff said recruitment was in progress in order to establish a weekend service.

The trust did not carry out interventional radiology. Patients had to be transferred to acute trusts on the mainland for interventional radiology. Challenges with accessing transport meant achieving timely access to interventional radiology was difficult. There was no consultant led endoscopy service at weekend; patients who needed emergency endoscopic procedures had to be transferred to acute hospitals on the mainland. Patients who required emergency cardiac intervention procedures such as pacing and percutaneous coronary interventions had to be transferred to acute hospitals on the mainland. The trust also experienced challenges with accessing thrombectomy treatment for certain stroke patients in a timely manner. Patients had to go to acute trusts on the mainland for this treatment where seven days services had not yet been established.

Priority clinical standard 8 requires trusts to ensure all patients with high dependency needs are seen and reviewed by a consultant twice daily and other inpatients are seen and reviewed by a consultant at least once every 24 hours. The March 2017 survey results showed 74% performance against this standard Monday to Friday and 91% at weekends. Our review of patient records consultants reviewed most but not all patients once every 24 hours.

Since the March 2017 survey, the trust had taken some action to improve seven-day services. This included improved access to ultrasound and MRI at weekends. In February 2018, the trust board agreed a work programme to improve seven day working.

Since the last inspection in November 2016, physiotherapy availability at weekends had improved. Stroke physiotherapists worked at the weekend to ensure the SNAPP targets for physiotherapy were met. For the rest of the medical patients, there was an on call physiotherapy service to provide urgent respiratory support.

In the MAU, there was a consultant on site 12 hours a day, which met the Royal College of Physicians guidelines. Outside these hours, there was a medical consultant on call who could reach the hospital within 30 minutes. However, prior to the inspection and during the inspection staff told us there was reluctance from some consultants to return to the hospital out of hours to provide support.
Staff said one of the two on call consultants at the weekend, saw new and patients at risk of deterioration, this included patients on the coronary care unit and the stroke unit. The trust said a consultant cardiologist carried out a ward round on bank holidays.

There was no stroke consultant on duty at night or at weekends, which sometimes led to delays in treatment and inappropriate admissions to MAU for stroke patients, rather than the specialist stroke unit.

There was no phlebotomy service at weekends. Despite most junior doctors we spoke with saying the lack of phlebotomy service at weekends posed a potential risk to patients receiving delayed treatment, they did not describe any examples. Review of incident reports for the period 1 November 2017 to 31 January 2018 showed only one reported incident about lack of phlebotomy staff. The incident report did not indicate this resulted in any harm to patients.

Health promotion

It was not evident that the service actively supported all patients to live healthier lives.

Some patients we spoke with told us they were involved in their care. They felt information was explained by staff in ways they could understand. They felt they were involved and supported in the decision making process of their treatment. For example, patients’ having an endoscopy or chemotherapy treatments were given information leaflets with advice and guidance about managing their condition to keep well. In the stroke unit, leaflets from the Stroke Association, included advice on how to reduce the risk of having a further stroke.

However, it could not be assured that health promotion leaflets in some areas provided up to date and relevant guidance. Some leaflets were old with dates going back to 2002.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Not all staff understood their roles and responsibilities towards the Mental Capacity Act 2005. There was no overall improvement since the inspection in 2016 when it was identified staff did not fully understand their roles and responsibilities regarding the Mental Capacity Act 2005.

The trust reported that from the last financial year, Mental Capacity Act (MCA), which included the associated Deprivation of Liberty Safeguards, training had been completed by 29.1% of staff within the medicine CBU. This was lower than the trust target of 85%.

(Source: Trust Routine Provider Information Return (RPIR) P40)

Nursing staff, in conversations, demonstrated an understanding about their responsibilities towards the Mental Capacity Act and associated Deprivation of Liberty Safeguards. However, patient nursing records did not show nursing staff applied their understanding in practice. Patient nursing assessments did not always have mental capacity assessments fully completed. For some patients, their completed mental capacity assessments did not match the information included in their general assessments. For example, the nursing records for a medical patient on Luccombe ward, detailed they were admitted with confusion, but their records showed they had signed the consent for their admission and treatment in hospital.

One patient’s records on Colwell ward showed staff had not completed a mental capacity assessment about the person’s capacity to consent to hospital admission and care.

Review of patients’ nursing records on Appley ward, showed inconsistencies in the completion of mental capacity assessments and information about patients capacity to make their own decisions. For one patient staff, had not completed a mental capacity assessment. For a second patient, staff detailed in the mental capacity assessment that they had concerns about the
The patient’s capacity to consent to admission and care at hospital. In the deprivation of liberty assessment staff detailed they would try to stop the patient leaving the ward. The assessment required staff to complete further questions in response to this decision. Staff had not completed these questions. There was no detail that staff had acted within the Mental Capacity Act and had submitted an application to deprive the liberty of this patient in order to safeguard their wellbeing. The property disclaimer was signed by this patient, despite assessment indicating they did not have capacity to do so.

Staff routinely used bed rails without fully considering whether patients needed them to protect them from harm. Staff completed bedrail assessments for all patients, but there was no detail about their decision making process that bed rails were required. The process did not include an assessment of the patient’s capacity to make their own decision about the use of bed rails or the views of their family members in making a best interest decision about the use of bedrails. In practice, this meant staff routinely restrained patients within their beds.

For a patient on Colwell ward their bed rail assessment detailed, “Patient is orientated, alert and also immobile.” Staff detailed the patient required bed rails, but there was no detail about why the patient needed them, no record of discussion with the patient or that the patient consented to the use of bed rails.

Two of the nursing care records we reviewed on Appley ward, showed nursing staff completed bed rail assessments and concluded bed rails were required. However, there was no evidence that the patient had given consent, or that relatives had been involved in a best interest decision process about the use of bed rails.

However, on the chemotherapy unit and the endoscopy unit discussion with staff and review of records showed staff applied the Mental Capacity Act to their practices appropriately. Records and discussion with patients showed all patients gave informed consent for their treatment.

Discussion with medical staff showed they did not all have a good understanding about their responsibilities towards the Mental Capacity Act and associated Deprivation of Liberty Safeguards. On Colwell ward, a junior doctor gave a good description about how to assess mental capacity and demonstrated in conversation a good understanding about the associated Deprivation of Liberty Safeguards. However, a middle grade doctor on the same ward could not describe their responsibilities towards the Mental Capacity Act and could not describe what Deprivation of Liberty Safeguards meant.

A locum middle grade doctor who worked on the Coronary care Unit (CCU) was aware of the Mental Capacity Act, but not what they needed to do to comply with the act. They had no awareness of the associated Deprivation of Liberty Safeguards. A junior doctor working on the stroke unit was aware of the Mental Capacity Act and knew the questions they needed to ask to assess a patient’s mental capacity. However, they had no awareness of Deprivation of Liberty Safeguards.

In contrast, on the medical admissions unit (MAU) a junior doctor demonstrated in conversation they had full understanding of their responsibilities towards the Mental Capacity Act and associated Deprivation of Liberty Safeguards.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The Friends and Family Test response rate for medicine at the trust was 41% which was better than the England average of 25% from September 2016 to August 2017.

Friends and family Test – Response rate between September 2016 to August 2017 by site.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Avg Resp Rate</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Ann. Perf.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Emergency Care</td>
<td>20</td>
<td>23%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Appley Ward</td>
<td>157</td>
<td>20%</td>
<td>92%</td>
<td>86%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>91%</td>
<td>86%</td>
<td>100%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Colwell Ward</td>
<td>146</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>97%</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>594</td>
<td>76%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Inpatient Physiotherapy Rehab &amp; Stroke</td>
<td>38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90% 94% 90% 92%</td>
</tr>
</tbody>
</table>

Please note that the red, amber and green colour coding above is not a judgement of performance but merely highlights the highest and lowest scores. This showed that, overall, between 88% and 100% of patients would recommend family and friends to have treatment at St Marys hospital.

The lowest score was 71% for Ambulatory Emergency Care in March 2017. At the time of the inspection, the trust did not provide an ambulatory emergency care service. Otherwise, all wards scored over 90% in all months.

(Source: NHS England Friends and Family Test)

We observed staff treated patients with compassion, kindness and respect. Staff introduced themselves to the patients before they started any care interventions. Most of the time, staff
ensured curtains were drawn around patients, on individual room doors were closed to ensure patients dignity maintained.

We observed staff interactions with patients throughout the medical care service showed compassion and care. This included non-clinical staff, such as ancillary and porters as well as clinical staff across all locations. We saw staff spoke with patients in a caring and sensitive manner, for example if a patient required assistance with their meal.

There were numerous positive comments from patients we spoke with, these included, ‘The staff are lovely’, ‘staff have been nice and caring’, ‘I give it 11 out of 10’, ‘the staff in here are brilliant, cannot fault them’, ' staff are wonderful cannot do enough for you’ and ‘the attitude of staff is very good’.

We received 17 comments cards from patients or their relatives regarding care received within the medical service. These also included many positive comments about the kind and caring attitude of staff.

The key findings for the endoscopy specific patient satisfaction survey were that patients felt that the staff made them feel comfortable and at ease during the procedure. They felt that staff were considerate and kind. Patients in the endoscopy unit corroborated the results from the satisfaction survey. They told us staff were lovely and reassuring.

Patients receiving treatment in the chemotherapy unit were consistently positive about how staff treated them. Comments included, “Staff very friendly” and that staff made them “feel a sense of wellbeing and things will be OK.”

However, we observed one incident where staff did not fully protect the dignity of a patient on Appley ward. The patient had to ask another patient’s relative to get a urine bottle for him, as staff had not left one accessible for him. The patient pulled the bedside curtains around himself to protect their dignity. However, did not close the curtains fully and they could be seen by anyone walking by whilst they passed urine. There were no nursing staff in that area of the ward to assist the patient close their curtains. Later, when a member of the nursing staff was in that area of the ward, he tried to tell the nurse he had a full urine bottle to give her. The nurse did not fully pay attention to what that patient was telling her and thought he was saying he wanted a urine bottle to use, which caused the patient to become irritated with the nurse.

Healthwatch published a report on the discharge of patients from the Isle of Wight NHS trust to residential care, nursing homes and peoples own homes in 2017. This showed there had been improvements with staff protecting peoples dignity on discharge since a previous report in 2012. However, Healthwatch did receive some comments about the lack of dignity paid to patients on discharge. This included patients discharged in their night clothes, without incontinence pads and wearing no underwear.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Throughout our inspection, we witnessed staff supporting patients, responding to their needs and communicating in an appropriate way. On the medical assessment unit patients we spoke with commented about prompt response to a request for help, which helped them to feel supported. Patients’ comments included, ‘when I called for help the response was straight away’ and ‘always checking on me’. A patient we spoke with following an endoscopy procedure we observed being undertaken, told us how reassured they had felt during the procedure.
A broad range of specialist nurses supported patients, these included, a heart failure, stroke, cancer, oncology, palliative care, diabetic care and a clinical nutrition nurse. Nurse specialists are able to give support, advice and information about investigations, treatment and follow up care.

We saw evidence of self-care being promoted for patients’ in the medical and nursing notes, and saw this in action with patients where needed being assisted by staff to walk to the toilet and practice stairs. Patients told us how this assistance promoted their sense of well-being.

Patients on the stroke unit told us how they enjoyed and liked the interaction with other patients’ during activities with the activities co-ordinator in the day room. Patients’ told us activities included painting, colouring and puzzles.

Patients felt well supported on the chemotherapy unit. Support included staff giving patients’ a contact number to telephone in and out of hours if they had any concerns, that was also supported with an information booklet. Patients we spoke with found this information provided them with reassurance.

However, we observed, due to staffing numbers generally staff had very little time to interact with patients, other than when delivering direct care and treatment. This meant we could not be fully assured staff always took account of and addressed the emotional needs of both patients and their family members.

One of the 17 comments cards from the relative of a patient in the coronary care unit, expressed concern about whether the emotional needs of a patient had been considered in relation to a particular condition.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

Patients and relatives we spoke with felt informed about what was happening. Patients and their visitors in the medical assessment unit told us, ‘they are keeping me informed of his progress’, ‘They are talking to him as well’ and ‘They have kept me informed and I am waiting for my transport home’. In the stroke unit, a patient told us that ‘when I ask questions they give me straightforward answers’.

On Appley ward, a relative told us that staff were able to give information over the telephone about their loved one when they were unable to visit.

Patients in the endoscopy and chemotherapy unit told us staff gave them the time needed and written information to support them in making decisions about their care and treatment.

However, a key finding from the endoscopy patient satisfaction survey was that on occasions some patients felt the waiting times to be confusing, and that the length of wait at times was too long. On rare occasions, they felt communication was lacking.

Three relatives out of four we spoke with on Appley ward had some concerns that no one staff member seemed able to give a clear update about patients’ health and their discharge plans. The eleven relatives or visitors we spoke with on the medical assessment unit and the three relatives or visitors we spoke with on the stroke unit did not express similar concerns to us. They felt staff kept them fully informed about their family member’s health and discharge plans.
Is the service responsive?

Service delivery to meet the needs of local people

The service did not plan and provide services to fully meet the needs of the local population.

Average length of stay

Trust Level

From July 2016 to June 2017, the average length of stay for medical elective patients at St Mary's Hospital was 2.1 days, which is lower than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 9.2 days, which is higher than the England average of 6.6 days.

Average length of stay was shorter than or similar to the England average length of stay for the top three elective specialties by activity (Cardiology, Clinical Haematology, and Gastroenterology). Of the top three elective specialties by count of activity, Gastroenterology, although lower, was the most similar to the England Average length of stay.

Average length of stay was higher or similar to the England average length of stay for the top three non-elective specialties by activity (General Medicine, Stroke Medicine and Cardiology). Of the top three non-elective specialties, Cardiology was the only average length of stay similar to the England average. Notably, the average length of stay for patients in Stroke Medicine was much longer than the England average (17.2 and 11.0 days respectively).

Elective Average Length of Stay – Trust Level

(Source: Hospital Episode Statistics)

The medicine CBU leadership and quality meeting records included detail about length of stay on the medical wards. The report for January 2018 showed a trend of reduced length of stay for patients on Appley, Colwell, Compton wards and the stroke unit.
There was a rising population of older people living on the Isle of Wight. However, dedicated inpatient geriatric medicine was not commissioned or provided by the trust. Activity for inpatient geriatric care and treatment was included in the general medicine service. This position was unchanged since the previous two inspections in June 2014 and November 2016. There was no frail elderly care pathway. The trust now had a frailty programme delivery plan. The plan indicated the elderly frailty pathway would be fully implemented by 1 August 2018. There was no hospital to home service.

Staff did not use a system to enable them to quickly identify patients who had dementia or who may have a memory problem. The trust told us they had reintroduced the national Butterfly scheme to help them identify and support patients with dementia or impaired memory. Part of this scheme is that patients who have dementia or impaired memory have a butterfly displayed by their bedside. However, we did not see this in use in any of the wards we inspected.

Therapy staff on Appley said there was no specific means of identifying patients with dementia in the trust. They said the trust was not using the butterfly system. However, they were aware there was a dementia liaison nurse working in the trust. Staff who worked on the MAU gave multiple reasons why the butterfly system was not used. These included staff were new to the unit and did not know where the butterfly stickers were kept and the butterfly stickers did not stick to the boards above the patients bed. Other staff said they needed permission of the person with dementia to put a butterfly sticker by their bedside. The unit sister said butterfly stickers were put in the notes for patients who had dementia. Patient records we reviewed showed medical staff did not do this.

Staff on Luccombe ward (a surgical ward where medical patients were cared for) said the butterfly scheme had been relaunched, but they were not sure why it was used. We identified a patient with dementia on the CCU. There was no butterfly to identify this person had dementia or communication difficulties. When asked, staff said they did not use the butterfly system on CCU, but they could not give a reason why they did not use it.

The trust had a learning disability nursing team. They provided support for patients with a learning disability who were admitted to the hospital and provided guidance to nursing staff about how to meet the individual patient's needs.

At the time of the inspection, the trust did not provide an ambulatory emergency care service. This had previously been provided in one of the bays on the medical assessment unit. This space was now the trust operations centre. We asked the trust to submit any evidence that they had assessed the impact the lack of an ambulatory care unit would have on the population of the Isle of Wight. The trust provided a review of the emergency department and the medical admissions unit carried out in July 2017. The review was undertaken by external advisors, one of the recommendations was to stop the ambulatory care service, as the department did not have appropriate level of staffing to all it to run safely and effectively. However, discussion with staff indicated they were not aware of this reason. They believed ambulatory care had stopped to allow the trust’s operation centre to be located there instead.

As part of the winter pressure planning the trust had taken steps to ensure patients were treated and cared for safely. The trust recognised there was no staffing capacity to open additional beds in response to winter pressures. The winter pressures plan, involved accommodating medical patients on surgical wards in a planned manner, which included recruitment of locum medical staff to provided treatment for medical patients on the surgical wards. This had significantly reduced the number of medical outliers. There were no medical outliers at the time of our inspection. However, it was apparent the demand for medical beds exceeded the availability of beds on the surgical
wards. This resulted in the planned change of the general rehabilitation ward to a medical ward being brought forward.

**Meeting people’s individual needs**

There were shortfalls in how the needs and preferences of different patients were taken into account.

The trust and staff did not fully consider the needs of patients with dementia. The National Audit of Dementia care in General Hospitals 2016 – 2017 carried out by the Royal College of Psychiatrists and published in July 2017 identified the trust as one of the poorest performing trusts for care of patients with dementia. The trust had the worst performance for carer rating of information and communication and carer rating of patient care. The trust was slow to respond and develop an action plan to improve their dementia care.

Some staff spoke about activities they could facilitate for patients with dementia, this included the use of twiddle muffs. However, we did not see any activities taking place during the inspection of the service.

The trust told us they used the Isle of Wight’s version of the “This is me” document. This is a simple form for anyone who receives professional care who has dementia or experiences delirium or other communication difficulties. It provides an easy and practical way of recording who the person is and supports the delivery of person centred care. However, we only saw one of these forms in use on the wards. When we spoke to patients’ relatives, they said they had not seen these documents and had not been asked to contribute to the document.

Review of patients’ nursing care plans showed there was scant information about how to support patients with dementia to meet their individual needs. For one patient on Appley, their records detailed they had dementia. We confirmed this in conversation with their wife and daughter. They said he was not able to understand what was going on and was confused. The patient’s care plan detailed, “confused” for normal presentation, presentation on admission and plan of care. There was no other detail other than “confused”. There was no guidance about how to promote and support communication with him. His wife and daughter confirmed staff had not asked them how to best communicate with the patient.

However, the service was taking some action to improve the experience of people living with dementia and their carers had whilst in hospital. There was a plan to introduce dementia friendly lounges on Colwell and Appley wards, which any patient in the hospital with dementia and their carers could use. The service had a plan to train a group of health care assistants to provided support and stimulation to dementia patients using the lounges. The service did not give a timescale for implementation of this resource. In partnership with Carers Isle of Wight, the service had introduced a carers lounge. This was staffed by volunteers from Carers Isle of Wight and provided advice and support to relatives.

The trust said they were working with a local care home provider who specialised in the provision of care to people with dementia. The goal of this work was to improve the experience patients with dementia and their relatives had in hospital. The work was in the initial stages of development and had not yet effected any changes in the provision of care to patients with dementia in the hospital setting. They were in the process of developing a dementia training programme training in 'positive care giving in dementia.' The trust planned to roll this training out to staff in June and July 2018.

The environment and décor of some ward and unit areas was in line with best practice dementia care. For example on Appley and Colwell wards, door openings were decorated in bold colours to
enable easy identification of door openings. Toilet seats were bold colours to aid easy identification of toilets. Signs for bathroom and toilets were pictorial to aid identification. The endoscopy unit had large signs and was boldly coloured to aid orientation. The stroke unit used colour coding to aid patients find their way around the unit. Day and month boards and clocks in bays supported patients with their orientation. However, this was not the same for all ward areas. The environment and décor on Compton ward was not dementia friendly. Only one bay on Luccombe ward had an environment that was dementia friendly.

Staff told us they had opportunity to attend training about dementia. Data provided by the trust evidenced both nursing and administrative staff attended training about supporting patients living with dementia. The trust’s mandatory training did not include supporting and caring for patients with dementia.

Staff had mixed experiences across the wards and units about supporting patients with mental health needs. On Colwell ward, staff told us they had easy access to advice and support from the trust’s mental health services, in order to support patients who were experiencing mental health issues due to alcohol withdrawal. However, we saw records for a patient on the stroke unit that showed they had a mental health issues but there was no evidence that staff had considered seeking mental health support for the patient. On Appley ward, a patient who had a mental health condition and a learning disability did not have their mental health or communication needs fully met. The patient communicated using Makaton. Staff on the ward did not know how to use Makaton and no Makaton interpreters were used to support communication. Staff reported they had a lack of guidance from the trust’s mental health team to enable them to support the patient to meet their individual needs.

Staff had access to telephone translation services, for patients whose first language was not English. The trust had identified the need to source face-to-face interpreting facilities in response to the growing number of people living on the island whose first language was not English. However, the trust had not yet sourced a face-to-face interpretation service. The service had access to British Sign Language (BSL) interpreters. Invoices for the services of BSL interpreters evidenced the trust used them across all the medical services.

Our review of care plans across all wards and units, showed there was minimal information to promote individualised care for patients. For one patient on Appley ward, their assessment detailed they needed assistance with eating and drinking. There was no description of the assistance the patient needed, whether they just need their food cutting up, whether they needed to be promoted or whether they needed to be fed. For elimination, the care plans stated they needed assistance. There was no description of what assistance the patient needed, whether they needed support to walk to the toilet, whether they needed prompting or whether they used incontinence aids and if so what sort and size. Patients were at risk of not receiving individualised support to meet agreed goals, because therapy records did not include patient goals.

The trust employed a team of ‘navigators’ to support discharge processes for patients with complex health and social care needs. This was a team of nurses who coordinated discharge arrangements, including health and social care assessments and allied health care professional assessments. They liaised with social care providers, care homes and reablement teams to affect timely and effective discharges. Nursing staff on ward spoke positively about the navigators. They believed discharge of patients ran smoothly when the navigators supported the discharge process.

Staff understood that to protect patient’s privacy and dignity and meet their individual needs, patients, with the exception of those needing critical care treatment, must be nursed in single sex accommodation. This meant patients had to be accommodated in single sex bays and have
access to toilet and bathing facilities without passing through opposite sex accommodation. Review of incidents reported for the period November 2017 to February 2018 showed staff on CCU reported six mixed sex breaches. These related to incidents when patients no longer needed critical care treatment on the CCU, but there was no available bed elsewhere in the unit or the hospital to prevent a mixed sex breach. There was no indication of what action staff took to protect the privacy and dignity of patients in this situation. Colwell ward reported one mixed sex breach when male and female patients were nursed together in bay in order to cohort patients and lessen the risk of cross infection of influenza. Detail in the incident report indicated staff had discussed and sought patients’ agreement for the mixed sex accommodation to occur. All trusts are required to declare mixed sex breaches to NHS England. Review of the NHS England mixed sex accommodation data showed the trust reported mixed six breaches.

Access and flow

Patient flow through medical services was affected by difficulties in discharging patients who were medically fit for discharge. Some patients experienced delays in accessing some time critical treatments.

Referral to treatment (percentage within 18 weeks) - admitted performance

The previous inspection in November 2016 identified there was improving performance with referral to treatment times (RTT). The findings at this inspection have shown that overall the medicine CBU has sustained this trend.

From September 2016 to August 2017, the referral to treatment (percentage within 18 weeks) for admitted pathways was similar to the England average.

Within this time period, the trust’s referral to treatment time fluctuated from 100% in September 2016 to 89% in August 2017. July 2017 was the worst performing month for the trust with 71% of patients treated within 18 weeks for this pathway compared to the England average of 90%. This decline in performance was not indicative of a trend, as rates have improved subsequently.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Three out of the four specialities that submitted data for this metric performed better than the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>92.7%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>100%</td>
<td>94.1%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

One speciality performed lower than the England average:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>90.9%</td>
<td>95.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Records of the medicine CBU leadership and quality meeting held on 30 January 2018 detailed that the overall RRT for medical services was 97.5% in November 2017, with only respiratory medicine failing to meet the national target of 92%.

When we asked staff about the risks and challenges to their services, all described there were challenges to patient flow throughout the service. At the previous inspection in November 2016, the trust did not manage the access and flow through the hospital in an effective and efficient manner. There were a large number of patient bed moves between 10pm and 8am (958 between April and November 2016), some patient were moved multiple times (379 were moved three times and one patient was moved 11 times). At that time, the trust did not monitor daytime bed moves.

Information provided by the trust as part of this inspection showed there had been a significant reduction in the number of non-clinical bed moves. The trust had started monitoring patient bed moves using an electronic patient transfer form in July 2017. This showed that between 1 July 2017 and 31 September 2017 most patients (99%) were not subject to a non-clinical bed move. Of those patients who experienced non-clinical bed moves, three patients were moved twice and one patient was moved three times. The remaining 10 patients experienced only one bed move.

Bed moves between 10pm and 8am had also improved. Between 1 July 2017 and 31 September 2017, 49 patients experienced a bed move between 10pm and 8am. The majority of these (39) were from AMU to accommodate admissions from the emergency department. The trust monitored the location patients moved between 10pm and 8am went to. For the same period the majority of patients were transferred to Appley (16) and Colwell(15) wards.

At the previous inspection in November 2016 there were significant numbers of medical patients cared for on non medical wards and other areas of the hospital (medical outliers). Some patients were cared for in inappropriate settings such as the discharge lounge and the surgical day case unit. At that time the trust was not able to demonstrate how they managed the flow of medical outliers, nor provide data about the bed usage for medical outliers. Since the November 2016 inspection, the trust's new executive board had implemented a new winter pressures programme. This meant during the winter pressures period surgical wards admitted medical patients in a planned and measured way. The trust only admitted elective surgical patients when bed space was available and cancelled or postponed surgery in a planned manner. The trust employed...
additional medical staff to provide care and treatment to medical patients on the surgical wards. The effectiveness of the winter plan, meant that, at the time of inspection, there had been only two occasions over the winter pressure period that patients were cared for in unsuitable environments such as the discharge lounge. The trust said that effective bed management meant that on both occasions, they closed the escalation areas within 12 hours.

At the inspection in November 2016, we identified there were significant delays in discharging patients in a timely manner. At this inspection, we found the trust was taking action that was resulting in some improvements in reducing the number of patients waiting significant lengths of time for discharge.

Staff started planning for patient discharges at an early stage in the patient admission to hospital. Patient records showed staff considered discharge planning. Observations and review of patient records showed that staff carried out daily board rounds. We observed a sample of board rounds across the medical services. Patients medically fit for discharge were identified and the multidisciplinary team made decisions about what action was needed to promote discharges for both patients medically fit and those who were not yet medically fit.

The trust held bed meetings three times a day, increasing to five times a day at times of intense pressures. They were led by the emergency department improvement lead and were attended by matrons and ward managers. We observed one of the bed meetings. The process identified how many empty beds were available in the hospital, how many planned discharges and how many further discharges were required to enable patients waiting in the emergency department to be admitted to ward beds. The emphasis on the meeting was on avoidance of 12 hour breaches for patients in the emergency department waiting to be admitted to inpatient wards, rather than promoting effective and safe discharges.

Staff across all of the medical services spoke about the challenges they faced with discharge processes. Therapy staff spoke about challenges with accessing equipment from community stores, such as moving and handling equipment and specialist beds, which resulted in delayed discharges. Nursing and social work staff spoke about the challenges with accessing care homes on the Isle of Wight, which had contributed to delayed transfers of care.

We received information prior to the inspection that the hospital had large numbers of patients who had delayed transfers of care (DTOC). This included patients who were still in hospital 21 days and over after medical staff had declared them medically fit for discharge. The trust referred to this group of patients as ‘super stranded’ patients. We were informed by the local Quality Surveillance Group that on 9 January 2018 there were 52 ‘super stranded’ patients still in hospital. That equated to 25% of the hospital’s acute inpatient beds. When we visited the operations centre on 22 January, the ‘super stranded’ board detailed there were 43 patients who had been in hospital 21 days and over following the decision they were medically fit for discharge. When we returned during the well-led inspection, this number had reduced further.

Multidisciplinary ‘super stranded’ meetings occurred twice a week. These were attended by a member of the executive team, the patient flow lead, the navigator team, representatives from the trust’s community stroke and general rehabilitation therapy team, adult social services, reablement teams, district nursing teams, and the nursing care home team. The team reviewed each patient’s discharge plans, and identified actions that named staff needed to take to accelerate the discharge plans for the patient. The team reviewed progress against the action at the previous ‘super stranded’ meeting. The meetings demonstrated the trust was committed to working with different trust teams and the wider health and social care teams across the island to promote effective discharge and reduce the number of delayed transfers of care.
At the inspection in November 2016, we identified poor discharge processes with staff discharging patients without adequate support and dressed in inappropriate clothing. This remained a concern at this inspection.

Prior to the inspection, CQC received information from relatives and the local authority about a number of poor discharges from the hospital to patients’ homes. This included patients who were unfit for discharge and had to be readmitted to hospital. A Healthwatch report on the discharge of patients from the Isle of Wight NHS trust to residential care, nursing homes and peoples own homes dated 2017 showed that out of 36 responses to the question whether the care home thought that their resident had been discharged too soon 15(41%) said yes. This was deterioration from a similar survey carried out in 2012 when 32% respondents thought their resident had been discharged form hospital too soon. Comments from this survey included “they are putting people’s lives at risk” and “discharge can be rushed and they sometimes want to discharge them before they are medically fit”.

To support effective discharges to care homes the trust was implementing the ‘Red Bag’ scheme in partnership by Isle of Wight Clinical Commissioning Group, Isle of Wight NHS Trust and representatives of the Isle of Wight care homes. The ‘red bag ‘scheme is a national initiative designed to support care homes and acute hospitals to meet the needs of patients between inpatient hospital setting and care homes. The Isle of Wight initiative was focusing on elderly residents in care homes who were transferred to St Mary’s Hospital, with the objective of reducing length of stay by promoting early discharge back to care home. The trust told us a pilot of the scheme was staring on 11 February 2018. However, when we asked staff about discharge processes, no one mentioned this scheme. The trust used the NHS Safer Care bundle to improve patient flow through the hospital. This recommends that of patients ready for discharge, trusts should discharge 33% of them by midday. The trust monitored the percentage of patients ready for discharge who were discharged home in time for lunch. The trust did not meet the 33% target in the 12 months before the inspection. The number of patients discharged home in time for lunch had decreased (got worse). For the period April 1 2016 to 31 March 2017, the trust discharged 17.8% in time for lunch. In the period 1 April 2017 to 31 January, this had reduced to 12.8%.

The trust used the ‘Red2green days’ approach, which was part of the NHS Safer Care bundle. This is a visual management system to assist identification of wasted time in a patient’s journey. It is used to reduce internal and external delays as part of the SAFER Care bundle. A red day is when a patient receives little or no value adding acute care. A Green day is when a patient receives value adding acute care that progresses their progress towards discharge. Each ward had a visual display of how many red and green days each patient had experienced. The displays showed a large number of red days.

The wards monitored the number of red and green days, but there was no formalised action plans to increase the number of green days and reduce the number of red days patients experienced. Data provide by the trust showed wards identified the reason for red days. Some of these were internal issues such as waiting for therapy assessments, speciality review and treatment. Others were external issues such as waiting for diagnostic procedures and treatment by other providers.

Practices at the time of inspection meant all suspected stroke patients did not access the specialist stroke unit in a timely manner. Trust policy and national best practice dictated that all suspected stroke patients should be admitted directly to the hyper acute stroke unit (HASU), rather than follow the general medical pathway of admission to the MAU. Staff who worked on the stroke unit spoke about the challenges in ensuring the stroke pathway was adhered to. There was no specialist stroke consultant availability out of hours. This meant stroke patients were often admitted to MAU and cared for by general medical staff based on MAU, rather than be admitted to
the specialist stroke unit where there were appropriately skilled nursing staff. The stroke consultant nurse had provided education sessions to medical staff and had developed a standard operating procedure (SOP) for the management of stroke patients which was due to be implemented on 29 February 2018. They said the SOP and education of medical staff, meant the incidents of stroke patients admitted to the MAU was decreasing.

Staff spoke about challenges relating to the transfer of patients to the mainland. For some specialities and urgent conditions, the trust did not have the facilities to provide the treatment. For example, access to urgent cardiac radiological interventions was carried out at a NHS trust on the mainland. Staff described challenges with accessing transport and additional challenges were created when poor weather impacted on the availability of transport to the mainland. These issues had an effect on the flow of patients through the hospital and patients ability to access the services they required in a timely manner.

Our review of incident reports indicated staff did not always report delays in the transfer of patients to mainland acute trusts as an incident. However, one incident report showed it took four hours to affect a transfer of a patient to a mainland acute trust for time critical treatment. Reasons for the delay included delay in support from the on call consultant and failings in the coordination of the different transport providers needed to carry out the transfer.

The senior nurse on the MAU spoke about challenges with patient flow throughout the unit. They were pressurised by the emergency department to admit patients, to ensure the four hour decision to admit target was not breached. This conflicted with a lack of beds in the medical wards to admit patients into. They demonstrated the challenge this posed. At 6 am on 23 January 2018 there were 16 patients waiting to be admitted from the emergency department. By 1pm that had reduced to eight patients waiting to be admitted to the MAU. At 6am on 24 January 2018, there were 12 patients in the emergency department waiting to be admitted to the MAU. They could not be admitted to the MAU, because there were no beds on the medical wards at that time to take patients from the MAU and free up beds for the ED admissions.

Learning from complaints and concerns

The service was starting to take complaints and concerns seriously, but learning from complaints was not yet part of routine practices.

From October 2016 to September 2017, there were 29 complaints about medicine. 17 complaints were closed, and 12 from January 2017 to September 2017 still remained open. The trust took an average of 53.6 working days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints. Two complaints took over 91 working days to close; one from November 2016 (152 working days) and one from January 2017 (128 working days).

A breakdown by subject type is shown below:
Records of the Medicine CBU leadership meeting held on 30 January 2018 showed that in November 2017 they had received 28 formal complaints and 82 concerns about medical services since April 1 2017. There was no analysis to identify trends and themes of complaints and concerns.

Detail about how to raise a concern or complaint was available on the trust’s website and in information leaflets available on the wards. The information on the trust website was available in different languages, different size and colour fonts and background and in the spoken word, making it accessible to all who accessed the website.

Patients we spoke with said they had no complaints about their care.

The trust’s complaints process was being reviewed to improve the timeliness and quality of response, and the trust complaints policy had not been updated. As a result of the complaints project, the trust reported improved quality of complaint responses. Quality managers had been appointed to CBUs to help coordinate complaint investigations and responses. The trust recognised that further work was required to update policies, procedures, patient information and the implementation of learning from complaints.

We reviewed the complaints record for the period 1 October 2016 to 30 September 2017. This showed the trust took up to seven months to respond and eventually close the complaints. Of the 37 formal complaints listed for medical services, 17 of them remained open, the longest being open since January 2017. There was little information in the complaints log to show learning from complaints occurred.

From talking with staff, it was not clear that learning from complaints was communicated and acted upon effectively. Staff spoke about changes, such as the reintroduction of discharge checklists. They believed this must have been introduced because of an incident or complaint, but this had not been communicated to them. Staff told us complaints were discussed at team meetings. Records of team meetings for the four medical wards in the medicine CBU showed that only one ward, Compton ward, referred to learning from patient complaints.

On the MAU staff used a “You said, We did” tree to display how they responded to patients concerns, complaints and feedback. Some examples included “Staff do not have time to talk and consequently feel isolated” with the response “work closely with the volunteer team to provide additional people to talk to” and “hard to tell what role people have” with the response “clarified different roles with uniform identifiers in each bay.”

<table>
<thead>
<tr>
<th>Subject</th>
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<tbody>
<tr>
<td>Clinical Treatment - General Medicine group</td>
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</tr>
<tr>
<td>Communication</td>
<td>5</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>4</td>
</tr>
<tr>
<td>delayed discharge due to absence of a care package - see integrated care</td>
<td>4</td>
</tr>
<tr>
<td>Appointments</td>
<td>3</td>
</tr>
<tr>
<td>Patient Care</td>
<td>3</td>
</tr>
<tr>
<td>Privacy, Dignity and Wellbeing</td>
<td>2</td>
</tr>
<tr>
<td>Trust admin/Policies/Procedures including patient record management</td>
<td>1</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
Is the service well-led?

**Leadership**

Leadership arrangements had not yet been fully embedded and staff were not assured all leaders had the appropriate skills and capabilities to carry out their roles.

Most of the medical wards (Stroke unit, HASU, Compton ward, Appley and Colwell wards) were part of the Medicine Clinical Business Unit (CBU) The Medicine CBU was led by a clinical director, head of operations, head of nursing and quality, operating manager and two assistant operating managers. The MAU was part of the ambulance, urgent care and community services CBU. This was led by a clinical director, head of operations, head of nursing and quality, four operating managers and an assistant operating manager. The coronary care unit was part of the Clinical Support, Cancer and Diagnostic services CBU, which had a similar leadership makeup.

The medicine CBU had two matrons who supported and led the nursing teams. Staff spoke positively about the support and leadership provided by the CBU matrons.

Most staff commented positively about the new appointments to the executive board. They reported both the CEO and the chief nurse were visible, they visited the wards and units, were approachable and listened to their concerns. Staff believed the CEO and the chief nurse understood the concerns of staff, the previous failings of the trust and they had confidence in their ability to make the required improvements to the service.

However, some staff expressed a lack of confidence with some of the leaders at CBU level. Some staff said they felt undervalued by the CBU leaders. Other staff expressed the belief that some of the CBU leaders had been allocated posts they did not have the experience or skills to carry out.

The trust had recognised this as a concern and had implemented a leadership development programme, to support development of competent and effective leaders.

Ward sisters, a significant number of which were interim posts and recently been appointed, led leadership at ward level. This meant for most medical wards, the direct leadership of the ward was not fully established. However, all staff we spoke with expressed satisfaction with the support and guidance they received from the ward sisters.

**Vision and strategy**

The service did not have an established vision and strategy for the development of their service.

At the time of the inspection, the medical service was primarily focused on improving operational management and the immediate winter pressures. The CBU leads quoted the trust ambition of ‘getting to good by 2020’ as one of the visions of the trust, they shared. However, they said that the moment their strategy was simply survival, care of patients and coming out of special measures. They commented that the trust needed a strategy, that the trust had not had a strategy for the past few years.

The CBU had drafted a business operating plan for 2019/20 which was based on the trusts vision of ‘quality care for everyone, every time,’ and values of ‘we care, we are a team, we innovate.’

This included a five year vision and plans for the medical services. At unit or ward level, there was little evidence staff were engaged in the service vision and values. Individual wards, with the exception of the stroke unit, did not have their own visions or strategy for their ward.
Culture

There was an improving culture in the service. However, some staff still felt undervalued and reported in some areas of the service there was still a culture of bullying.

At the previous inspection in November 2016, staff reported there was a culture of bullying within the trust and that grievances raised were not acted upon. This meant the trust did not resolve issues raised by staff and staff felt disrespected and undervalued.

Since the November 2016 inspection, the trust had taken action to improve the culture of the organisation. Senior leaders, acknowledged that it would take time to change the culture of all the people who worked in the organisation. The trust had relaunched the Freedom to Speak up Guardian role in November 2017. The Freedom to Speak up Guardian was supported in their role by 11 Anti-Bullying Advisors and three Freedom to Speak up Advocates. However, discussion with staff showed there was a mixed picture of staff who understood and had knowledge of the role of the Freedom to Speak up Guardian and their advisors and advocates.

One member of staff spoke about how they now felt able to raise a grievance about a senior member of staff who demonstrated bullying behaviours. The member of staff had confidence that the situation would be addressed through human resources (HR) processes. They felt this was an improvement. They had not previously raised a grievance because they had no confidence the trust and the ability of HR to handle it in an appropriate manner.

At the time of the inspection, staff on Compton felt undervalued and disrespected. All staff had been aware that the ward was transferring from a general rehabilitation ward to an acute medical ward, with a target date of April 2018 for this to happen. However, the change happened earlier than planned, and many staff, including medical staff, were not informed of the change until they arrived at work. We found many of the staff on this ward were very upset about the change of function of the ward and how it was managed.

Staff on Compton ward also felt disrespected by the nurse practice educators who were supposed to be supporting them. Staff felt there was no acknowledgement from the practice educators about the impact the change of service (from general rehabilitation to medicine) had had on them. Staff reported the nurse practice educators were continually telling them they had to ‘pick up the pace’ and ‘work quicker’, rather than providing constructive support.

Both nursing and junior medical staff spoke about the behaviours of some medical staff. This included challenges with medical staff not fully engaging with the acute stroke pathway and lack of consistency of guidance on MAU for junior medical staff due to the number of locum consultants who did not work as a team.

Some staff reported there were still pockets of bullying behaviour by some staff, they said this was generally ‘hidden’ bullying, such as staff views being ignored and belittled.

However, most staff generally reported enjoying working at the trust, valuing the good teamwork of colleagues and felt proud of the care they provided for patients. Some staff spoke of the development opportunities they had received. The appraisal system had slipped but most teams expected to complete annual appraisals by the year end. There was some frustration that access to training was constrained due to winter pressures; however staff felt there was generally renewed emphasis on safety and staff skills within the service.
Governance

The service’s governance processes were not developed sufficiently to provide an effective systematic approach to improvement of the service. The lack of a trust governance framework meant there was insufficient management oversight of the safety and quality performance of medical services.

There was a requirement following the last inspection in 2014 that the provider must improve governance, risk management and quality measurement, to include reviewing audits and risks effectively. The medical CBU was developing a systematic approach to continually monitor and improve the quality of its services and safeguard high standards of care. However, the CBU leadership team acknowledged this governance service was not yet fully established.

The CBU had set a structure of committees and meetings that supported the governance of the service. This included a leadership committee that met monthly and reviewed performance, finance, quality and risk. The CBU also had a Safety committee, Quality Committee a Physicians committee. We reviewed records for three medicine CBU Leadership and Quality meetings. The meetings used a standard agenda to ensure consistency of coverage of items in meetings. Performance, including clinical incidents, complaints and compliments, appraisals and mandatory training rates, referral to treatment times, patient length of stay, occupied bed days, sickness rates and financial situation were reviewed. The leadership team identified actions to improve performance and the person responsible for the action. The records showed the team reviewed actions at each meeting.

Records of the Physicians committee held monthly, showed they identified and reviewed actions. Medical staff always reviewed performance and the financial position of the service at these meetings.

Records of ward and sisters meetings showed an inconsistent approach to how they discussed governance matters. Staff did not use a standard agenda to prompt such discussions. It was unclear how effective the governance processes were at involving staff in decision-making processes. For example, one of the interim ward sisters said they had been instructed to reintroduce the discharge checklist, but had not been given any reason or rationale to enable them to understand the decision.

Review of records of sisters meeting records, showed there was very little information detailed on them. There was no set agenda, no reference to review performance and no review of action taken following the previous meeting. One ward sister described these meetings as a forum for the ward sisters to moan rather than a forum for them to engage with the governance and improvement of the service.

Records of ward meetings showed they were predominantly forums for giving information to staff. There was little review of performance; there were no actions to take forward and no review of actions at the following meeting. There was no evidence of ward staff participation in decision-making processes.

Management of risk, issues and performance

The service did not have consistently effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. This was similar to the findings at the November 2016 inspection.
The trust had set up a new system for recording risks (November 2017) and the CBU s managed their own risk registers. These identified and described the risks, controls, updates and actions, as well as the accountable person and action due dates. We asked the trust for the individual risk registers for the medical wards and the medical CBU. The trust provided a written description of how the medicine CBU managed the risk register. They only provided risk registers for Colwell ward and CCU. Review of the risk register for the acute hospital, showed the single risks detailed on the risk register for Colewell ward and CCU were also included in the hospital wide risk register. However, the register did not show when the risk had been added, so it was difficult to monitor the time taken to manage and close risks.

The description of the management of the medicine CBU risk register detailed they had recognised their CBU risk management had not been robust over the previous years. They had recently completed a complete revalidation of the risk register where a large amount of risks and issues were updated, closed and removed.

Staff unanimously said patient flow and staffing (both nursing and medical) were the main risks to the safety of the service. However, this was not included in the two ward based risk registers we viewed. The hospital wide risk register included a risk about lack of consultant medical staff, but there was no reference to nurse staffing or patient flow. There was no detail on the Medicine CBU risk register about risks we had identified as part of the inspection process. Staff were asked to “remember when doing the bed rail assessment that if a patient is confused and disorientated then we need to clearly document in the care plan that we are using bed rails at times in best interest of the patient” and were told that care plans at the moment were “in no way patient centred.”

The medicine CBU leaders said performance and monitoring of KPIs occurred at the monthly leadership meetings. Records of the Medicine CBU Leadership and Quality meetings confirmed this occurred. The Stroke unit monitored their performance with the use of the national SSNAP audit and took action to improve the service. The endoscopy unit carried out regular audits to measure their performance and identify areas for improvement.

**Information management**

The service did not produce sufficient relevant and accurate information to support robust challenge and service improvement.

This had been recognised by the new management team. Some staff spoke about the lack of assurance that data collected was accurate which meant performance could not be measured accurately. The CBU leads, when asked how they ensured data was accurate, described manual ways of validating the data, which included manually checking the data provided such as referral to treatment times. They described that the rostering data was not accurate, but expected this to improve with the role out of the safe staffing rostering system.

The service provided monthly data on staffing, quality and safety for committee and board reviews. In addition, the service monitored top line key performance indicators in the ‘getting to good’ dashboard, and tracked these against ‘what good looks like’. Additional measures, such as those relating to the assessment of the deteriorating patient, compliance with mandatory training an appraisals and agency spend had been added to help assess performance and analyse areas of weakness.

The trust used the automated bed management system to improve the auditing of patient moves to help inform operational practices. Staff reported that decisions were sometimes made about the
placement of patients, without clinical input or consideration of their clinical need. For example, stroke patients were admitted to MAU rather than HASU. We were told matrons were required to intervene to promote patient safety. This indicated that the system was not used effectively by staff.

Delays and inability to provide data requested by us as part of the inspection process indicated the service did not manage information well.

**Engagement**

There was a limited approach to sharing information with and obtaining the views of staff and people who used the service. Feedback was not always reported or acted on in a timely way.

Patients were invited to complete feedback forms about their care, and we saw boxes for these on the wards. However, there was no evidence that the service reviewed and used patient feedback to support improvements to the service.

The trust had carried out a Medical Engagement Score survey in September 2017, which had identified low levels of engagement by some of the medical staff. This, presented a potential barrier to improvement of service delivery. The trust had since adopted a leadership programme to address the issues raised and to work collaboratively to improve performance.

There were some examples where staff felt essential information was not shared with them. This included staff on Compton ward who were not notified about the change of function of the ward. Most staff knew the ward was now a permanent medical ward. However some of the long term locum medical staff said they did not know whether the ward would go back to being a rehabilitation ward after the winter pressures period had resolved or whether it would remain as a medical ward. They felt that although the trust engaged with permanent staff, there was a lack of engagement with locum staff. Staff on the MAU did not know the background and reasons why the trust had stopped providing an ambulatory emergency care service.

However, Healthwatch Isle of Wight reported an improved level of engagement under the new executive team and a stronger commitment to listen and act on findings. This was confirmed by staff, who reported they felt more prepared to contribute and were more likely to be listened to. Staff recognised that engagement was ‘a work in progress’. Staff were hopeful that the new trust leadership team would support front line services more effectively, and already reported that the winter plan demonstrated a proactive management approach.

The trust had a ward recognition scheme in place, and this was being relaunched to give it more impact.

Nursing and clinical staff generally felt engaged with their leaders and described a positive relationship with the Interim Director of Nursing. Staff meetings were still held, despite the staffing difficulties and staff were encouraged to attend; however, this was not always fully possible.

On the MAU staff and patient views and opinions were actively sought with the use of a “You said, We did” tree. The unit sister encouraged staff and patients to put their views and opinions on paper leaves. Response to the staff comments was added onto the paper leaves and displayed on a tree poster on the unit. Some staff examples included “Staff needed somewhere to secure their belongings” with the response “purchased staff lockers for the changing rooms” and “drug rounds took too long to complete” with the response “ implemented a ‘Do not Disturb’ policy for nurses on a drug round and have sourced additional computers for use in the rounds
Learning, continuous improvement and innovation

The trust had not established an embedded learning and improvement culture. However, it had started to create a framework for learning from incidents, complaints and staff and patient feedback.

Where professional external bodies identified required improvements, the service was slow to respond and make the necessary improvements. The service had not made all the changes needed to comply with the requirement notices made following the previous CQC inspection in November 2016. Following the receipt of the National Dementia Report, the service was slow to start making improvements to the service provided for patients with dementia.

However, the trust had responded to the 2015 national audit of inpatient falls in which they had performed poorly. Results from the 2017 National Audit of Inpatient Falls showed the trust had made significant improvements and they were now one of the two best performing trusts in the country. Improvements in the service were mainly trust led, with little innovation and improvements implemented at service or ward led. The trust demonstrated commitment to improving patient experience in hospital, by taking action to improve patient flow and reduce the number of non-clinical moves patients experienced. The introduction of ‘navigators’ and the multi-agency super stranded meetings supported effective discharge and reduced the length of stay in hospital for patients who had complex discharge arrangements.

There were some localised innovations to improve services for patients. This included the introduction of the ‘Bay watch’ scheme in order to reduce the number of patient falls on Colwell ward. The stroke unit demonstrated continued commitment to the improvement of services for patients who had a stroke. Since the previous inspection, a Hyper Acute Stroke Unit (HASU) was opened, this provided dedicated specialist nursing care to patients in the acute stage of their illness. Their commitment to improving the stroke service provided to the local population was demonstrated by the trend of improving results with the sentinel SSNAP.
Surgery

Facts and data about this service

The trust covers 18 specialties across one site in surgery; St Mary’s Hospital:

- Allergy
- Breast Care
- Chronic & Acute Pain
- Endoscopy
- Ear, Nose & Throat
- General Surgery
- Maternity
- Maxillofacial
- Neo-Natal
- Gynaecology
- Ophthalmology
- Orthopaedics
- Outpatient Booking
- Outpatient Department and Fracture Clinic
- Pre-Assessment Unit
- Paediatrics
- Theatres
- Urology

Across 11 wards, the trust has 15 day case and 82 inpatient beds.

(Source: Routine Provider Information Request (RPIR) – “Sites-Acute” tab)

The trust had 13,621 surgical admissions from July 2016 to June 2017. Emergency admissions accounted for 2,765 (20%), 8,914 (65%) were day case, and the remaining 1,942 (14%) were elective.

(Source: Hospital Episode Statistics)

Surgery at St Mary’s Hospital is carried out in four main theatres and two day-case theatres in the day surgery unit (DSU), for both elective and emergency procedures. Additional facilities in day surgery include one minor operations room and one treatment room. The day surgery ward provides capacity for 15 day case trolleys (plus one seated cubicle) and a seating area for seven patients.
Specialties utilising theatres at St Mary’s include: general surgery, breast, gynaecology, orthopaedics and urology, with a mix of access to main theatres and the DSU. Other specialties include ear, nose and throat, ophthalmology, maxillo-facial and chronic pain.

For this core service, we reviewed care in five wards, the four main operating theatres and theatre suite, the day surgery unit and the sterile services department. Because the trust had implemented the ‘winter plan’, and had postponed elective surgery to support an anticipated increase in demand for medical and emergency patients, the five wards normally assigned for surgical patients had admitted medical as well as surgical patients. The pattern of surgical activity was different from that normally planned at the trust.

We visited the following wards and departments during the inspection:
- Pre-operative assessment unit
- Day surgery unit
- Theatre suite
- Recovery area
- Alverstone ward (16 beds)
- Lucombe ward (23 beds)
- Whippingham ward (27 beds)
- St Helens ward (15 beds)
- Mottistone ward (10 beds)
- Hospital sterilisation and decontamination unit
- Discharge lounge

During our visit we spoke with 14 patients and/or their relatives, reviewed 12 patient records and observed and spoke with 59 members of staff. These included non-clinical staff, healthcare assistants, therapists, nurses, operating department practitioners, doctors and managers. We also received 22 comment cards from patients or their relatives, collected on wards.

**Is the service safe?**

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

Staff had difficulty accessing the mandatory training in key skills and although the service monitored completion rates, there was an overall low rate of compliance, with some courses showing very low rates of completion.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training.

In surgery, both medical/dental staff and nursing staff failed to meet the target with
Medical/dental staff working within surgery met the target for seven of the 18 training modules listed above. Modules with the lowest compliance levels included paediatric resuscitation (18 out of 33 members of staff completed this), prevent training levels 1 & 2 (9 out of 36 members of staff completed this) and hand hygiene (19 out of 35 members of staff completed this).

When we inspected in January 2018, up to date data showed that as a group, medical staff within the surgical division had completed 75% of their mandatory training against the 85% target. The courses with the lowest level of completion were medical devices theory (16%), safeguarding children level 2 (27%), safeguarding adults level 2 (15%) and the Mental Capacity Act (30%). Of the 37 mandated training courses for surgical medical staff, 25 showed a completion rate of less than 85%.

Training in how to support patients with dementia or other cognitive impairments was not mandated.

Mandatory Training Completion by module – Nursing Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load Handling</td>
<td>2</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>36</td>
<td>94.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>36</td>
<td>91.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>35</td>
<td>91.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>35</td>
<td>91.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>36</td>
<td>88.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>35</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>36</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>36</td>
<td>72.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>36</td>
<td>69.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>35</td>
<td>68.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>34</td>
<td>67.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>36</td>
<td>63.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>36</td>
<td>63.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>36</td>
<td>61.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>33</td>
<td>54.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>35</td>
<td>54.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>36</td>
<td>25.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical/dental staff having 73.9% and nursing staff having 75.9% compliance overall.
Equality & Diversity

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Completers</th>
<th>Compliance</th>
<th>Target</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>127</td>
<td>99.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>83</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>83</td>
<td>96.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>127</td>
<td>96.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>125</td>
<td>96.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>77</td>
<td>94.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>127</td>
<td>93.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>127</td>
<td>91.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>127</td>
<td>91.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>127</td>
<td>90.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>127</td>
<td>90.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>127</td>
<td>81.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>127</td>
<td>72.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>126</td>
<td>72.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling</td>
<td>110</td>
<td>69.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>118</td>
<td>67.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>127</td>
<td>64.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Maths &amp; Medicines Calculations</td>
<td>125</td>
<td>64.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>61</td>
<td>57.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Newborn Life Support</td>
<td>12</td>
<td>33.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>110</td>
<td>30.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>36</td>
<td>22.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>120</td>
<td>7.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff working within surgery met the target for 13 out of the 25 modules listed above. Modules with the lowest compliance rates included immediate life support (nine out of 120 members of staff completed this), medicines management – competency assessment (34 out of 110 members of staff completed this) and paediatric resuscitation (35 out of 61 members of staff completed this).

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

When we visited in January 2018 we found that nursing staff within theatres had completed 83% of their mandatory training, and nursing staff on surgical wards 80%. Healthcare assistants in theatres and on wards had completed 73% and 76% of their mandatory training respectively. Only ward staff on the DSU and on Mottistone ward had met the 85% training target, achieving 90% and 86% respectively. In theatres, non-nursing staff had completed 68% of mandatory training. Administrative and clerical staff had achieved over 85% compliance with mandatory training.

Subjects with the lowest level of compliance, with most departments showing less than 30% completion, were: Mental Capacity Act, medical devices theory, safeguarding adults level 2 and medicines management. All staff said it was difficult to access the safeguarding training as the courses filled quickly.

According to the Association of Anaesthetists of Great Britain and Ireland (AAGBI), every member of the recovery team should be competent in basic life support and last one member of
staff per shift should hold an advanced life support certificate. At least one member of the paediatric team should hold an advance paediatric life support qualification. The service was not able to demonstrate compliance with this guidance.

There was a requirement from the last inspection in 2014 that mandatory training rates for life support training and moving and handling training must improve to achieve the trust target. The data from January 2018 showed compliance in these topics had not been met, with the results as follows:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of eligible staff</th>
<th>Adult resuscitation</th>
<th>Paediatric resuscitation</th>
<th>People handling</th>
<th>People handling e learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alvestone ward</td>
<td>18</td>
<td>89%</td>
<td>Not listed as mandatory</td>
<td>83%</td>
<td>100%</td>
</tr>
<tr>
<td>Day surgery unit</td>
<td>16</td>
<td>75%</td>
<td>56%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>Day surgery ward</td>
<td>13</td>
<td>92%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td>General theatre</td>
<td>54</td>
<td>70%</td>
<td>65%</td>
<td>61%</td>
<td>98%</td>
</tr>
<tr>
<td>Luccombe ward</td>
<td>27</td>
<td>56%</td>
<td>Not listed as mandatory</td>
<td>59%</td>
<td>93%</td>
</tr>
<tr>
<td>Mottistone ward</td>
<td>13</td>
<td>92%</td>
<td>Not listed as mandatory</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td>St Helens ward</td>
<td>23</td>
<td>83%</td>
<td>Not listed as mandatory</td>
<td>78%</td>
<td>100%</td>
</tr>
<tr>
<td>Whippingham ward</td>
<td>31</td>
<td>84%</td>
<td>Not listed as mandatory</td>
<td>52%</td>
<td>77%</td>
</tr>
<tr>
<td>Surgical medical staff</td>
<td>9</td>
<td>44%</td>
<td>38%</td>
<td>56%</td>
<td>56%</td>
</tr>
</tbody>
</table>

We found no staff in the recovery unit had completed the ALS training. There was no clear guidance on who was required to complete this, yet the AAGBI guidance was for at least one practitioner to be ALS trained. Within theatres there was only one staff member trained for paediatric life support.

Mandatory training results indicated that compliance had deteriorated since the last inspection and areas identified with poor levels of compliance in 2014 had not been addressed. Anecdotally, staff reported the training figures were inaccurate, and were lower than the data shown. They said that face to face sessions were ‘sometimes or often’ cancelled, yet for staff booked onto these courses, their attendance appeared in their training records, because they had been electronically booked to attend.
Staff also said work pressures sometimes meant they did not complete e-learning courses as it was difficult to access the courses within work time.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so, however training completion rates were low in some areas.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

**Safeguarding Training Completion by module – Medical and Dental Staff**

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for medical/dental in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>36</td>
<td>91.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>36</td>
<td>80.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>36</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical/dental staff working in surgery met the standard for one of the safeguarding courses; safeguarding children level 1. Notably, there was a low compliance rate for safeguarding children level 2, with 18 out of 36 members of staff having completed this module.

Nursing staff we spoke with were clear what constituted different types of abuse, how to report it, and where they could seek local and expert help. They provided examples of situations they had faced, actions they had taken and described the referral monitoring system.

The training completion rates were low, particularly for safeguarding adults level 2 and safeguarding children level 2, and staff reported difficulty accessing the courses.

In January 2018, the clinical leads were aware that staff needed to complete this training and commented that access to courses was difficult. Compliance with this training had worsened since September 2017. The levels of completion for safeguarding children level 2 and safeguarding adults level 2 were 27% and 15% respectively, which meant there was a risk staff would not identify people at risk of abuse and take appropriate actions. Completion of training in the Mental Capacity Act was also only 30% in this staff group.

**Safeguarding Training Completion by module – Nursing Staff**

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>127</td>
<td>84.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>127</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>114</td>
<td>63.2%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff working within surgery met the standard for one of the three safeguarding modules; safeguarding children level 1. They were close to meeting the standard for
safeguarding adults level 1 (107 out of 127 members of staff completed this). They did not reach the standard for safeguarding children level 2, with 72 out of 114 members of staff having completed this module.

(Source: Trust Provider Information Request P18)

Data provided by the trust in January 2018 showed that only 6% of surgical nursing staff had completed the safeguarding adults level 2 mandatory training. However, staff we spoke with could explain what was meant by the term safeguarding and described how they would recognise and report abuse of adults or children.

Most staff were not aware of the UK’s counter terrorism training, known as Prevent to safeguard vulnerable people from being radicalised. However, a ward sister told us there was a new on-line training course available on this topic. Staff understood the broad principles of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), but had not completed training. Senior staff said this shortfall had been identified and training was being arranged for 2018.

All staff said it was difficult to access the safeguarding training as the courses filled quickly. One said there was no availability before June 2018. Staff were not aware of training on how to identify and take action in response to female genital mutilation (FGM) nor child sexual exploitation. The trust advised that the FGM training was within the safeguarding children level 2 training.

The surgical wards had made 24 DoLS applications in the 12 months to October 2017, with most applications made by Whippingham general surgical ward.

Cleanliness, infection control and hygiene

Staff controlled infection risks well. Staff kept equipment and premises visibly clean, complied with appropriate personal hygiene advice such as “bare below the elbows” and used control measures to prevent the spread of infection.

Data provided by the trust showed that all ward staff groups had achieved over 85% compliance with infection prevention and control (IPC) training. However, compliance with hand hygiene training was lower, with staff on Mottistone and Whippingham wards, and surgical medical staff, not consistently achieving this target.

Hand hygiene audits were carried out each month on the wards or departmental area. The wards carried out their own self audits and the IPC team validated the results by re-auditing areas that had failed the target 90%. Results for April 2017 to December 2017 showed that self-audits of Alverstone, the Day Surgery ward and St Helens ward all achieved the 90% target. Main theatres failed the audit most months and Whippingham and Luccombe failed the audit on two months or more. The IPC team observational hand hygiene audits found St Helens and Whippingham wards failed to achieve the target. The IPC audit results for hand hygiene and environment found the surgical wards (Whippingham, Alverstone, Luccombe, Mottistone and St Helens failed to reach the target 90%, however the Day Surgery Unit scored 100%. The IPC follow up audits had recently been postponed due to staff shortages in the IPC team. It was not clear whether wards had been tasked to pick up this shortfall in the audit programme.

We observed that staff were bare below the elbows and wore clean uniforms. There was good access to hand sanitisers and wards had hand washing sinks, but not always in the most accessible locations for people entering the wards. We observed that staff washed their hands and used hand sanitiser appropriately.

Staff had good access to personal protective equipment (PPE), such as gloves and aprons. These were colour coded for different purposes. Staff aimed to protect people from the spread of
infections by isolating patients with an infection risk in side rooms. We observed that in these cases, staff placed appropriate signage on the doors and decontaminated their hands before and after each contact. We observed relatives wearing aprons and discarding them when they left an isolation room.

We observed that staff did not use aprons when cleaning the bed areas, however, which meant there was a risk of cross infection.

In theatres, we observed theatre staff used aseptic techniques and followed appropriate skin antisepsis when undertaking procedural scrub. They wore PPE and decontaminated equipment in line with guidance.

The ward environments were visibly clean, and evidence of ‘I am Clean’ stickers applied to newly cleaned equipment such as commodes. Sluice areas were clean.

The trusts surgical sterilisation unit was compliant with the standards set out in the decontamination of surgical instruments Health Technical Memoranda (HTM 01-01).

The trust required wards to carry out monthly audits of commodes. Results from September 2017 and December 2017 showed the day surgery ward and Mottistone achieved over 90% compliance with this audit. Lucombe scores dropped month by month to 70% in December 2017. St Helens, Whippingham and day surgery theatres achieved compliance, but did not carry out the audit each month. Not all wards carried out audits of equipment cleanliness routinely, for example Alverston, Whippingham and St Helens had not audited equipment cleanliness during this four month period.

The trust had updated the urinary catheter pathway to reduce the risk of infection, in line with NICE QS61 (Statement 4). We reviewed two catheter care plans and saw that all actions had been completed. Wards also audited their procedures for urethral catheter insertion, which included checking staff aseptic techniques. The results for 2017/18 showed improved results for Whippingham and St Helens in November 2017, after failing to achieve 90% in October 2017.

The trust monitored MRSA and Clostridium difficile. The trust had been MRSA bacteraemia free for 411 days as of 21 January 2018. Elective surgery patients were screened and needed to be MRSA free before being admitted to the Alverstone elective orthopaedic ward. Alverstone was redesignated as orthopaedic trauma. It did not take medical outliers. Elective orthopaedic patients were moved to single rooms on Mottistone. In December 2017, 97% of patients on Alverstone ward were MRSA screened. The trust had experienced a rise in Clostridium difficile infections, and the rate exceeded the local target. Root cause analysis had led to the revision in the catheter care pathway.

The intraoperative phase of patient care and preparation was in line with the National Institute for Clinical Excellence (NICE) clinical guidance 74. Staff scrubbed aseptically for theatre, wore the correct sterile gowns and gloves and administered the correct antiseptic skin preparation.

**Environment and equipment**

The service did not have consistently suitable premises and equipment.

The trust provided the theatre equipment maintenance log which listed ‘last tested’ dates and ‘last serviced’ dates. A few listed items had not been tested for a year, for example, the mains distribution board in theatre 1 was listed as last tested in November 2016. However, there were many omissions under ‘last serviced’ date, with only 23% of items showing a service date. Of these, the last service dates for three diathermy machines were 2011 and 2014 and the resuscitaire in the labour theatre was listed as last serviced in 2015. The trust said the log was maintained by the medical equipment management service however individual wards or
departments raised and renewed their own equipment contracts and they did not always ensure the service dates were logged centrally. This meant there was a lack of assurance that equipment was regularly serviced.

The DSU did not have suitable premises because the layout of the unit compromised patient privacy and dignity and caused mixed sex breaches. These risks associated with the DSU were listed on the clinical business unit (CBU) risk register, and the control measures included providing screens and planning surgical lists to minimise the impact on patient privacy. Staff said they did not routinely report these breaches. The trust had not finalised plans to remodel the unit but was liaising with the commissioners on the issue. At the last inspection in 2014 we made a requirement that the provider must maintain single sex accommodation and report any breaches in a timely way. The trust had not met this requirement.

The route from the main theatre suite to the St Helens surgical ward was via a long, public corridor and lifts. To Mottistone ward, the route was along this corridor and then a further narrow corridor. Staff told us of occasions when the lifts had broken down. We were told these routes had not been risk assessed with management plans to minimise risks to patients and staff.

The ophthalmology facilities were also on the CBU’s risk register, due to inadequate facilities for patients. A new satellite area had been approved for implementation in 2018/19.

Within main theatres, there was damaged flooring and the protective covering on patient supports was compromised (anaesthetic room 4). These presented an infection control risk. This was highlighted to the management team at the inspection. There was rust visible on the wheels of stools.

The fluid store within theatres was generally well organised, with labelled storage cupboards displaying warning signs when appropriate. At the last inspection we required the provider to store intravenous fluids securely. This requirement had been met.

We found portable oxygen was not consistently secured to the wall, for example on Mottistone ward and anaesthetic room 4 within the theatre unit. This meant there was a risk of hazardous items being removed. Clinical waste bags from theatres were not labelled with patient trackable information.

The hospital sterilisation and decontamination unit (HSDU) was designed to maintain a dirty/clean flow to minimise the risk of cross infection. The unit provided evidence of regular equipment servicing, and safe traceability and management of equipment.

Wards were old but mainly fit for purpose, with most wards having a cubicle and bay layout. Flooring was in good repair with no trip hazards seen. Each surgical inpatient ward had individual rooms that could be used as isolation rooms for patients with infections or who were being cared for at the end of their life. There were disposable curtains to separate individual beds on wards and patients could use televisions and had their own lockers for storage.

Equipment had service date tags and was functional. Patient beds had pressure-relieving devices and mattresses and staff reported good access to equipment. However, with the winter plan in place, staff said there was an increased need for walking aids and there were sometimes delays in acquiring these. On Alverstone, there were insufficient numbers of blood pressure recording machines. As several of these were utilised for cubicle patients, staff said this sometimes made it difficult to make timely observations.

Resuscitation equipment was immediately accessible via well placed and highly visible resuscitation trolleys. Staff checked the resuscitation equipment against a standard contents diagram. They ticked the checklist booklets and noted any items about to go out of date or any
actions taken. The checklist did not include a check for individual items. The resuscitation trolleys were closed using hook and loop fastened curtains and the drugs were not secured in tamper evident containers. This meant they could be accessed by non-authorised persons. The defibrillators we viewed were in date. Daily documented checks had been completely, for the most part, which had been a requirement from the last inspection. The policy however required trolleys to be checked twice daily, which was not being carried out.

Fire equipment was regularly serviced and we spoke with one fire warden who explained the fire drills they carried out.

**Assessing and responding to patient risk**

Staff did not consistently monitor and manage risks to patient safety.

NHS England published national safety standards for invasive procedures (NatSSIPs) in 2015, to reduce the number of patient safety incidents related to invasive procedures, in which surgical ‘never events’ could occur. These are additional to the World Health Organisations surgical safety checklist (WHO checklist) and the ‘5 steps to safer surgery’, which include safety-briefing, sign in, time out, sign out and debriefing. We found inconsistent levels of engagement amongst the medical staff with this approach to patient safety. Although we observed good practices, we also observed a theatre list where the anaesthetist was not fully engaged in this process. For example we observed on two occasions where the theatre sign-in had not been completed, the anaesthetist did not check patient identity or their consent, and did not lead the patient transfer from the trolley to the table. One checklist was ticked to show the sign in had been completed, when we observed it has not been carried out in full. We observed a surgeon did not stay present for the checklist. The full team were not in attendance for the brief or for the start of the procedure, and the anaesthetist was not present for the sign out. We observed not all elements of the timeout section of the checklist were verbalised, but all elements of the timeout checklist were ticked as completed. The sign out stage was not used for reflection. From our observations and discussions with the theatre team, we found they had raised concerns with service managers and the medical director about the inconsistent behaviours of the medical staff, with some staff routinely disregarding safety procedures, but this had not been addressed. The trust sent us a root cause analysis report from December 2016, concerning an appendectomy, which identified the lack of a robust WHO check list. They also sent the six most recent monthly WHO checklist audit reports. These showed that in main theatres, sign in was completed in full on only 42% of the 255 forms audited and the sign out only 29%. Non-compliance was primarily caused by no anaesthetist signatures on the sign in and no surgeon signatures on the sign out. In day theatres, there were some omissions, but overall compliance was higher.

We also observed good practices in the theatre team, where they followed the recommendations for safe perioperative practice (AfPP 2016). Different staff told us how they had used the ‘stop before you block’ initiative before an anaesthetist inserted a nerve block to prevent a never event occurring. Staff said they used ‘stop the line’ and felt supported to do this.

In theatres we observed two changes to the operating list, one at the start of the list and one part way through. This is not safe practice as it risks causing confusion for staff and may impact on patients who have fasted for an operation. For example, we observed the delay caused by list changes meant one patient with diabetes needed a variable rate intravenous insulin infusion because of increased fasting time. We also observed that a correct operating list was not displayed within theatres for reference, to minimise errors and promote safe practice.

The trust had recently adopted the National Early Warning System (NEWS) to detect and escalate a deteriorating patient. This is based on a scoring system. We reviewed three records and found
the total scores had not always been calculated correctly and staff were not consistently familiar with how to use the form. Nursing staff also gave different views of what score would trigger them to call for medical staff (suggesting scores between 3 and 8). This lack of understanding meant the NEWS had not been implemented effectively and there was a risk staff might not escalate a deteriorating patient.

The trust’s new end of life policy, based on the National Institute of Health and Care Excellence (NICE) End of Life Care for Adults guidance, had not been fully implemented. Some staff were aware that patients on the end of life pathway would have a Blue Ribbon sticker placed on their notes, to flag their specific needs, but said this had not been rolled out to all wards. Do Not Attempt Coronary Pulmonary Resuscitation (DNACPR) forms showed omissions relating to capacity assessments. This meant there was a risk that unsafe decisions might be made about treatment.

Staff used standardised risk assessments for each patient, but these were not always completed and updated with management plans. Our observations and discussions with staff indicated that staff did not always update risk assessments because they were extremely busy. Records showed that staff were not reassessing patients regularly, for example malnutrition risk assessments were not repeated for one patient when records showed their needs had changed.

Nurse staffing

The service did not have enough nursing staff in all areas with the right qualifications, skills and training to keep people safe from avoidable harm and to provide the right care and treatment.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From October 2016 to September 2017, the trust reported an overall vacancy rate of 33% for qualified nursing staff working within surgery.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The ward vacancy rates for December 2017, as reported to the Board, were as follows:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Vacancies</th>
<th>% vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alverstone</td>
<td>2.6</td>
<td>13</td>
</tr>
<tr>
<td>Luccombe</td>
<td>7.3</td>
<td>22</td>
</tr>
<tr>
<td>Whippingham</td>
<td>7.0</td>
<td>20</td>
</tr>
<tr>
<td>St Helens</td>
<td>7.2</td>
<td>28</td>
</tr>
<tr>
<td>Mottistone</td>
<td>4.4</td>
<td>29</td>
</tr>
</tbody>
</table>
The trust had recruited additional healthcare assistants in December 2017 and was continuing to interview for new staff.

The trust monitored safe staffing levels and reported when staff levels dropped below 95% (amber rating) and 90% (red) and used regular bank and agency staff. The trust used an acuity tool and introduced a safe staffing approach in October 2017. There was a high vacancy rate in theatres and staffing levels in theatres was added to the service risk register in January 2018. Vacancies were filled by agency staff and the service’s ability to maintain establishment staffing levels was on the surgery service risk register.

Some recruitment had been successful, with three new staff on the day surgery ward, following the safer staffing review. Staff described the recruitment processes as “very slow” and “not fit for purpose”, and told us of known vacancies not being recruited to for many months.

Theatre staffing was reviewed in line with the Association for Perioperative Practice (AfPP) recommendations for safe staffing. The department had carried out a recent staffing review which identified a need for 15 additional whole time equivalent registered staff. Whilst on the winter plan, with protected time for emergency admissions, there was less pressure on theatres and the staffing was sufficient. Recruitment and retention plans were in development, but the high level of vacancies were likely to impact on the capacity of the service.

Data showed that in December 2017, St Helens ward had a 40% vacancy rate (13.2 staff), Mottistone 29% (4.6 staff), Luccombe 22% (7.3) and Whippingham 20% (7). Although bank and agency staff were used, there were between 20 and 25 unfilled shifts on the surgical wards during the month.

During the inspection we observed ward staff were very busy. For example, on Alverstone ward, the four nursing and healthcare staff on duty were unable to respond promptly to call bells when one nurse was administering medicines, two staff were assisting a patient with mobility and the fourth was carrying out personal care in a side room.

**Turnover rates**

From October 2016 to September 2017, the trust reported an overall turnover rate of 5% for qualified nursing staff working within surgery.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From October 2016 to September 2017, the trust reported an overall sickness rate of 4% for qualified nursing staff working within surgery.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Nursing staff told us that sickness was comparatively low despite the high vacancy rate. This was described as being ‘cultural’, where nursing staff came to work even if they were not entirely well ‘so they would not let down their team or their patients’. We saw evidence of this on both Alverstone and Whittingham wards, where staff attempted to come back to work but were sent home as they were not deemed sufficiently well to work.

Within theatres, there had been increased levels of sickness in January 2018, and this was attributed to theatre staff working additional day and night shifts in different areas of the hospital, to support the winter pressures.
Ward staff reported there had been increased sickness levels over the winter but this was not higher than expected. On Whippingham ward in January 2018, sickness among nursing staff had resulted in the ward being short of a trained nurse on at least one or two daytime shifts a week. In these cases the senior sister, who was supernumerary in the staffing establishment, provided cover on the ward. When we visited, the staff sickness and non-availability of a booked agency nurse meant the ward was short of a trained nurse, with four staff looking after 27 patients, 23 of whom were medical patients with multiple complex needs.

**Bank and agency staff usage**

From October 2016 to September 2017, the trust reported an overall bank usage of 1,619 shifts, and an overall agency usage of 1,400 shifts. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

Notably, the wards with the highest bank and agency usage were General Theatre (bank usage of 151 shifts, and an agency usage of 600 shifts), and Whippingham Ward (bank usage of 369 shifts and an agency usage of 746 shifts). The trust attributes this high bank/agency usage to vacancies. The trust plans to address this by ‘having focused recruitment’ and by ‘holding regular meetings with the CBU to discuss strategy and activity’.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

We inspected when the hospital had introduced the ‘winter plan’, to support increased non-elective demand. This meant there were medical patients on surgical wards and this impacted on the staffing needs of the wards. We observed that ward staffing was reviewed throughout the day by the matron and the site management team. There was a high reliance on bank and agency staff, and permanent staff were moved to work on different wards or departments on a daily basis to manage the risk.

The theatre departments relied on bank and agency staff, and overtime. DSU staff were often asked to work on wards, as theatre lists were reduced or cancelled due to the winter plan. They said the criteria for where they could work were not always adhered to.

Bank and agency staff were not always available to fill gaps in staffing. In December 2017, St Helens ward achieved less than 90% fill rate for nurses and healthcare staff on day shifts and less than 90% fill rate for healthcare staff on night shifts. The fill rate was lower than 90% for healthcare staff on both day and night shifts on Whippingham ward. On Whippingham ward we were told they aimed to avoid using of agency staff at night, and organised the mix of staff to a maximum of two agency nurses to three permanent staff during the day. Data showed this was not easy to achieve in practice. Luccombe ward had higher that the establishment level of healthcare staff at night, but was at less than 90% fill rate for nurses on days. Alverstone was amber rated (90-95% fill rate) for nurses on both day and night shifts. In terms of impact, both Whippingham and Alverstone were ‘red-rated’ for newly reported pressure ulcers and there had been three patient falls on Whippingham ward in December 2017. Luccombe and St Helens wards also had two newly reported pressure ulcers in the month.

To minimise the risks associated with a high dependency on agency staff, some wards used agency staff on a long term basis.
Mottistone, in contrast, was open to eight patients of lower dependency rating, and had a similar standard of staffing to Alverstone (16 beds for high dependency patients).

**Medical staffing**

The service did not have enough staff with the right qualifications, skills and experience in all areas, to keep people safe from avoidable harm and to provide the right care and treatment.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 15% for medical/dental staff working within surgery.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

From October 2016 to September 2017, the trust reported an overall turnover rate of 19% for medical/dental staff working within surgery.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

The high turnover rates and vacancy rates within surgery were not fully reflected in the December 2017 board minutes. The minutes showed ward vacancy rates were high, and staff turnover for the trust was stable at 10.5%. They did not highlight the vacancy and turnover within medical staff.

**Sickness rates**

From October 2016 to September 2017, the trust reported an overall sickness rate of 1% for medical/dental staff working within surgery.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and locum staff usage**

From October 2016 to September 2017, the trust reported a bank usage of 13 shifts and an agency usage of 1,116 shifts within surgery. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

*(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)*
The theatre team were dependent on locum anaesthetists and reported difficulty recruiting to posts, and a national shortage. We found the behaviours of some anaesthetists was an identified issue within the trust that had not been addressed. It was not clear if this was linked to the high proportion of locum staff.

**Staffing skill mix**

As of July 2017, the proportion of consultant staff reported to be working at the trust was lower than England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the whole time equivalent staff working at Isle of Wight NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>47%</td>
</tr>
<tr>
<td>Middle career</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>7%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>27%</td>
<td>13%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

The service recognised they had fewer consultant grade doctors but their specialty trainees reflected a higher proportion of the junior doctor cohort than foundation year junior doctors, particularly in orthopaedics. The trust did not train anaesthetists or ENT doctors. The service had recently recruited additional specialty doctors in ophthalmology.

Patients on surgical wards told us they were seen by a doctor every day. The service broadly operated a pattern of 1 in 6 on call rota, with consultants on site during normal working hours and relieved of elective commitments during their on call week. Due to the numbers of consultants involved, the rotas differed within different specialties, with consultants in urology for example having a 1:4 on call rota. The service was subject to an acute services review across this and neighbouring trusts, and medical vacancy rates and hospital facilities would be considered in this review.

Consultants had identified concerns with the on-call rotas. The trust had developed a draft procedural document detailing medical responsibilities throughout the week, based on the NHS Improvement SAFER bundle, to improve patient flow and decision making. This was planned for introduction in January 2018.

**Records**

Staff recorded patient care and treatment inconsistently.

Records showed evidence of good multidisciplinary patient care and in some areas, records were written clearly, signed and dated. However, in the theatre suites, the WHO checklist was not consistently signed as completed by appropriate staff. Our reviews of the WHO checklist showed omissions, and this was also reported in the monthly audits provided by the trust. We observed an
The anaesthetist ticked that all elements of the sign-in checklist had been completed, when in practice, they had not checked the patient identity, or consent had been given. This is against record keeping practice code of practice for health and social care and the Royal College of Surgeons Good Surgical Practice 2014 standards.

We noted the anaesthetist had not signed the 'sign in' and this was completed by a registered nurse in their place. We found differences in the assessment of a patient’s cognitive ability and their mental capacity to consent to procedures. When queried, the reasons were explained to us however they had not been described in the notes.

Nursing records of care did not always provide detail of the care provided. For example, the statement 'safety maintained' was used in place of detail. The therapy staff provided clear records of their reviews and care, which were signed and dated. We observed that all elements of the surgical care plans were completed. However we found gaps in nursing care records; date/time when patients were admitted onto wards, the fluid and food charts and NEWS charts. We saw two examples where the NEWS scores were not added up correctly. In one case, this meant the next set of observations were later than recommended by the risk score. The care record for a patient with an indwelling urinary catheter showed omissions, with no record of the date of the next catheter change or the frequency of changes recommended. Patient addressographs were not on each page of the patient notes. These gaps in records meant there was a risk patients did not receive the right care at the right time, and showed staff were not following the Records Management Code of Practice for Health and Social Care 2016, as well as guidance from professional bodies.

People’s individual care records were not always held securely, to protect people’s confidentiality. In most cases, records were held in trolleys and not easily accessible by unauthorised persons. Wards had lockable notes trolleys, but on St Helens ward records were left open and on top of the trolley, outside patient rooms and unattended. On Alverstone ward, care notes were left unattended on the nurse’s station. It had been a requirement from the last inspection in 2014 that all patient identifiable or confidential information must be kept secure at all times. This had not yet been fully achieved.

Electronic patient information boards were visible to anyone who entered the ward areas and these displayed patient names, and their likely discharge date. Although they did not include the patient’s date of birth, patients might be known by visitors and it was not clear if they had consented to having their names displayed.

Patient records demonstrated a multidisciplinary collaborative approach to patient care and were well maintained. We reviewed six sets of medical records and all were well completed, legible, timed dated and had the name and grade of the doctor looking after the patient recorded. Each set of records had a diagnosis and management plan documented and regularly updated.

Discharge summaries were not consistently issued promptly to patients and their GP, which meant that GPs might not have all the information they needed to support safe care and treatment. We observed this in the DSU, and the CBU managers recognised that medical staff needed to improve the timeliness and accountability of this process. There had been two safeguarding referrals within the past year, made as a result of concerns relating to the quality of discharge summaries.

We observed that patient records often did not include individual addressographs. The service’s audit of nursing notes for Whippingham, Luccombe and St Helens wards in December 2016 also identified omissions in addressographs, patient names and NHS/IoW numbers on notes. The audit found higher compliance with completed care plans and risk assessments (over 95%), but low...
rates of infection control risk assessments, and patient involvement. Compliance with best practice was rated as very low, at 50%. The action plans had not been completed.

A trust wide medical records audit in November 2017 also showed low compliance with attaching the addressograph on patient notes, with a year on year reduction from just above 15% to just over 5% compliance. The audit found that only about 25% of notes had the patient name on each page and only 10% displayed the NHS or Isle of Wight patient number. This creates a risk of records not being linked to the correct patient notes. There had been improvements year on year on documenting assessments, diagnoses, reviews and medical history. The report concluded that compliance with the Royal College of Physicians’ guidance was low, at 54%.

**Medicines**

The trust did not have sufficiently robust processes in the surgical service, to manage medicines safely.

Medicines were not always stored appropriately. On Luccombe ward, the door to the treatment room where medicines were stored was not secure. This meant that access to medicines was not appropriately restricted. The trust had audited medicine storage and had proposed new locks for treatment rooms. In theatre 1, we observed intravenous fluids stored in an open access room. On Whippingham ward, we found an oxygen cylinder that had not been secured. Cylinders should be stored upright with measures to prevent them falling over and causing harm.

The trust had audited treatment lockers for patients’ own medicines, and had identified areas of non-compliance with security.

The emergency drugs on the resuscitation trolleys were not stored in tamper-evident containers, as recommended by the Resuscitation Council (UK). This meant they might be accessible to unauthorised access.

The treatment room on Whippingham ward felt warm, staff told us that it often became warm in the summer. There were no records of the room temperatures being monitored on the ward, as the estates department monitored the temperatures of the treatment rooms in the main building. There was no evidence that the treatment room was maintained below 25 degrees Celsius, as required for medicine storage. Medicine fridges on all wards were locked and the trust had completed monthly audits of fridge temperatures and showed 100% compliance.

Medicines and medical devices were not checked consistently. Controlled drug (CD) balance checks were not always undertaken. Balance checks are important in ensuring CDs are managed appropriately. The CDs in theatres were checked twice daily, however there were gaps in the sign sheets and it was not clear if the checks had not been done because theatres had not been in use that day. CD waste was managed appropriately.

On Alverstone ward, the resuscitation trolley was not checked twice a day as the trust guidelines advised. Records showed ward staff were checking the trolley once a day. On Whippingham ward, the trolley had not been checked six times in the last month before the inspection. This meant there was a risk that items from the trolley could have been used and not replenished ready for use in an emergency. Oxygen cylinders were all in date.

Pharmacy audited patient medicines on wards each month. They reviewed the allergy status documentation, medicines reconciliations, and warfarin patients with raised International Normalised Ratios (INRs). In 2017, staff consistently documented patient allergies. Timely completion of medicine reconciliation (within 24 hours) was variable, with wards generally failing to achieve 95% compliance, and often achieving less than 70%. This meant there was a risk patients
were not receiving their medicines at the right time. The audit template included opportunities to audit VTE prophylaxis, but these had not been completed.

Emergency blood supplies were available and major haemorrhage protocols were in place in theatres. The theatre fluid store was well organised however there was one bag of potassium 10mmol that had expired.

A daily pharmacy service provided discharge medicines for patients discharge from the ward, helping to reduce delays in discharge. The pharmacy team spoke with patients to give them advice about their medicines when they were discharged.

**Incidents**

The service had recognised that it had not previously managed patient safety incidents well and had taken action to review incidents more promptly and to encourage reporting of incidents. The trust had audited the serious incident process and encouraged reporting. A new serious incident process was launched in November 2017 and was still being embedded and linked to an investigation process. Within surgery, recent incidents raised related to staff shortages on busy shifts.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for surgery.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2016 to November 2017.

A breakdown by incident type is shown below:

- Surgical/invasive procedure incident meeting SI criteria with three (43% of total incidents).
- Pressure ulcer meeting SI criteria with one (14% of total incidents)
- Treatment delay meeting SI criteria with one (14% of total incidents).
- Slips/trips/falls meeting SI criteria with one (14% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (14% of total incidents).
The staff did not consistently identify and report patient safety incidents. Most staff said they recognised a safety incident, and described situations when they had reported an incident. However, there was evidence of reporting fatigue in theatres, where staff said they did not always report failing to complete the safety WHO checklist, as they felt nothing changed as a result. Staff said they did not always receive direct feedback on incidents they reported, but they said incidents were discussed at meetings.

Theatre staff said they received feedback from incidents and staff were encouraged to ask questions, which they found useful. They provided examples of incidents discussed and how individuals were supported to raise concerns.

There had been five unexpected deaths reported as serious incidents between September 2017 and December 2017 in surgery, women’s and children’s health CBU. Two related to patients on end of life care where their care had not been wholly in line with their wishes or trust policy.

There had been six requirements from the last inspection relating to end of life care. These included: patients must be allowed to die in their preferred place of care; all patients nearing end of life must be assessed and have an individualised end of life care plan. The analysis of these incidents indicated improvements in end of life care had not yet been fully embedded.

The service carried out root cause analysis (RCA) on serious incidents. We reviewed a sample of these and from one, the ‘key service delivery problems’ listed the following: planning, communication, failure to carry out a robust WHO checklist, the absence of clear protocols and the lack of skills and experience of the surgeon. Some of these delivery problems were observed during our visit, which indicated that learning from the incident had not been shared effectively.

Learning from another RCA showed a patient’s deterioration had not been recognised and responded to in line with best practice. Our inspection findings indicated the new system for recognising the deteriorating patient had not been effectively implemented to ensure all nursing staff understood the triggers and purpose.

Morbidity and mortality (M&M) meetings were not held regularly and a backlog had built up during 2017. Minutes of these meetings did not show any record of the discussion, but listed the case numbers.

(Source: Strategic Executive Information System (STEIS))

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>No. of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>3</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
</tr>
</tbody>
</table>
In December, the M&M meeting was for 18 cases, and the duration of the meeting was one hour 10 minutes, indicating an average discussion time per case of less than four minutes. Meeting minutes did not make it clear if the relevant staff were present to discuss the cases listed. There were no actions recorded or escalated to prevent the recurrence or errors and adverse incidents. This approach to M&M meetings was not in line with the Royal College of Surgeons guidelines and did not protect patient safety.

The trust had recently taken steps to improve the review of and learning from incidents. The head of nursing and quality attended the twice weekly clinical review meetings, set up in June 2017, to review incidents of moderate harm and above. The trust patient safety committee reported on the timeliness of reporting serious incidents and the actions taken forward for learning. Staff carried out an RCA of each serious incident to identify lessons learnt and recommendations. Although we were told this had led to identification of themes, and opportunities for learning across business units, this was not evidenced during our inspection. For example, the learning from one RCA was the DNACPR form was not filed consistently in patient notes, which meant staff did not see them immediately in an emergency. The trust planned to share learning on this, however from our observations, this learning had not been shared effectively, or sufficiently quickly.

Between April and December 2017, the largest category of incidents reported was patient slips, trips and falls. Staffing levels was the third most prevalent incident.

The trust said that patient safety incidents which had organisation-wide impact were circulated to all wards and clinical areas through the central alert broadcast alert system.

The trust reported that staff had applied the duty of candour four times in general surgery, twice in ophthalmology, once in ENT, five times in orthopaedics and once in theatres. Of note, this number is higher than the reported number of serious incidents.

**Safety thermometer**

The service monitored patient harms but did not communicate the results to patients, staff and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported four new pressure ulcers, three falls with harm and one new catheter urinary tract infections from October 2016 to October 2017 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Isle of Wight NHS Trust**

![Graph showing prevalence rate of pressure ulcers, falls and catheter urinary tract infections at Isle of Wight NHS Trust]
The safety thermometer, or an equivalent patient safety report, was not on public display on any of the wards. Staff were not familiar with recent trends indicated by the safety thermometer and patients and visitors would not know the safety record of the ward or department they were visiting.

An internal audit report from September 2017 concluded there was 'reasonable' assurance in relation to the management of safety alerts. It found that all alerts published on the Central Alerting System (CAS) website during the previous two years had been added to the internal databases. There were some instances where updates were not recorded to show the current status or date completed. These were updated at the time of the review. It was found that alerts were sent to the relevant person and were actioned but the evidence for implementation was difficult to audit.

Staff were able to tell us about safety alerts and how they responded to them.

The Clinical Nutrition Nurse Specialist (CNNS) had reviewed the NPSA alert relating to nasogastric tube insertion and competency. The CNNS audited compliance with education and had set up training as a result to improve compliance.

(Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

The service did not always ensure that care and treatment was consistently based on national guidance and that staff followed this guidance. Patients physical, mental health and social needs were assessed, but further actions did not always take account of current legislation and standards of effective practice.

In theatres, there was evidence that the theatre team was not consistently following Health Organisation (WHO) Surgical Safety Checklist and “five steps to safety” surgical approach. The clinical lead said the trust had adapted the checklist having experienced reluctance from surgeons and anaesthetists to sign for tasks they had not done, such as the swab count. This indicated that the medical team had not accepted their accountability in the WHO checklist process, and instead had chosen to use local “work-arounds” which did not fulfil the required surgical rigour.

There were no trust theatre protocols to guide practices. The unit had recently produced their own local versions of the 2015 national safety standards for invasive procedures (NatSSIPs). However policies and procedures were not available for reference. There was no fasting policy available at the time of our inspection, and we observed practices that meant one patient fasted longer than necessary before their operation.

A ‘task and finish’ group had been set up in 2017, in response to a serious incident, to improve recognition of the deteriorating patient, in line with National Institute for Health and Care Excellence (NICE) clinical guideline 50. In December 2017, the trust had implemented the National Early Warning Score (NEWS) tool for monitoring the deteriorating patient, replacing a modified version. At the time of the inspection, the use of the tool was not fully embedded, as shown by the first monthly audit carried out in December 2017.

There was a lack of evidence that staff consistently carried out venous thromboembolism (VTE) assessments and prescribed appropriate prophylaxis, in line with NICE quality standard QS3. Some medical staff we spoke with were not aware of a VTE policy and how assessments led to the use of compression stockings.

The trust normally had a daily planned trauma list. As part of the winter plan, NCEPOD lists were assigned where elective activity had been stood down. With only four theatres, there was no dedicated emergency operating theatre, as this would limit the service’s potential to offer a responsive service for elective patients. Instead, the service carried out emergency surgery at the end of the theatre lists or, if delay would be life limiting/threatening, the patient would be fitted into the elective list. For some emergencies, patients were transferred to the mainland.

The service offered enhanced recovery programmes for patients requiring joint replacements or revisions. This included asking patients to attend the ‘hip and knee school’ in advance of the procedure, to prepare patients for their surgery and what to expect after the operation. Enhanced recovery programmes have been shown by the NHS Institute for Innovation and Improvement, to help patients recover more quickly after surgery.

Physiotherapists told us they felt their role had diminished, and there was a lack of overall goal setting in their work, to promote recovery as well as it could. They felt their role had become one of supporting patient discharges. The service had also lost some inpatient rehabilitation capacity, due to redesign of the hospital, and the physiotherapy team did not work seven days a week which meant they would not be able to offer a full enhanced recovery service.
Staff used new care plans for pressure ulcer and falls management, based on NICE guidance. The trust has also introduced an updated intravenous (IV) catheter care pathway and had adopted the Sepsis care bundle.

The service did not use a standard cognitive assessment and pathway for patients with suspected dementia, apart from the mini mental test. Although there was one bay on the trauma orthopaedic ward which had been painted to help patients with dementia orientate themselves, the trust did not have a programme for providing adaptations to support people with dementia. The trust had not adopted national guidance, NICE CG42, to help support patients with dementia.

The service participated in relevant national audits to assess practices, including the National Hip Fracture audit and the National Emergency Laparotomy Audit.

**Nutrition and hydration**

Staff gave patients sufficient food and drink to meet their needs and improve their health.

Patients told us they liked the food and there was enough provided. They commented staff provided extra tea when they asked for it.

Volunteers and healthcare assistants served patient lunches and they understood the importance of ensuring patients received both food and drink that met their specific needs. They also explained the range of specialist diets available for people’s dietary needs. For example, meals suitable for people with diabetes, or meals prepared to the consistency recommended by the speech and language therapists.

Staff reported good support from the speech and language therapists when a patient’s nutritional risk assessment raised malnutrition as a risk. We saw evidence of regular speech and language therapy input into the assessment of the dietary needs of a patient with a cognitive impairment.

We observed that staff regularly refreshed water jugs and these were placed within patients’ reach. Staff offered support to those patients who had difficulty eating and drinking independently. The trust highlighted those assessed as needing assistance by putting a red paper napkin on their tray. Volunteers told us they did not assist with meals as they had not been trained to carry out this role safely.

The trust self-assessments reported they were fully compliant with the ‘10 characteristics of good nutritional care’ (Nutrition Alliance), the British Diabetic Association guidance on menu planning, and the use of a validated nutritional screening tool to identify patients at risk of malnutrition.

Staff assessed patients’ nutritional status using a screening tool. They completed food and fluid charts for patients who were assessed as at risk. However, the food and fluid charts were not consistently completed as they did not always show totals for each day. When we asked staff about this, they could explain the actions they had taken in response to the patients’ needs.

Patients for surgery were kept ‘nil by mouth’ however there was no policy to provide guidance on fasting times.

The 2017 ‘patient led assessment of the care environment’ (PLACE) scores for food/hydration were 64.4% for Alverstone ward and 80.1% for Luccombe ward. These scores were lower than the national average of 89.7%, indicating that patients and the public had a lower opinion of the quality of food on these wards than patients in most other hospitals.

**Pain relief**
Staff assessed and monitored patients to see if they were in pain. This was part of the ‘intentional rounding’ process used by staff and was also included on the NEWS chart.

All the patients we spoke with on the wards told us they received pain relief when they needed it. Those in the discharge lounge said they understood their medicines for pain relief and when/how to take them.

**Patient outcomes**

The service did not consistently monitor the effectiveness of care and treatment or use audit findings to deliver improvements. Staff did not carry out relevant audits, or use the results effectively to improve services.

**Relative risk of readmission**

**Trust level (St Mary’s Hospital)**

From June 2016 to July 2017, the trust had a lower than expected risk of readmission for elective and non-elective admissions overall when compared to the England average.

Elective admission:

- General Surgery patients and Trauma and Orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average. These were the top three specialties for this trust based on count of activity.

Non-elective admission:

- All top three non-elective specialties for this trust (General Surgery, Trauma and Orthopaedics and Urology) had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**
Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/07/2016 - 30/06/2017))

The trust understood the reasons why urology patients had a higher risk of readmission compared with the national average. They had commissioned a ‘getting it right first time’ review of the service in 2016. The trust was not able to offer a full range of services, as it had a single consultant-led urology unit, on a 1 in 4 rota with a locum, and limited access to technologies.

Following the review, the service had received approval for investment in technology to improve the treatment of urinary tract stones. The service had good links with neighbouring hospitals for specialist treatment.

Hip Fracture Audit

This audit was based on data for the period from January 2016 to December 2016. In this audit, the trust failed to meet any of the National Standards.

St Mary’s results show one area of poor performance in comparison within the other trust; crude perioperative medical assessment rate. Although increasing from the previous year’s audit by 12.7% to 67.7%, it still falls lower than the National average of 88.7% and National Aspirational Standard of 100%.

The trust outperformed other trusts in one standard:

- The crude overall hospital length of stay was 13.4 days, which was much lower than the national average of 21.6 days.

For the remaining standards, the trust performed within expected range:

- The proportion of patients having surgery on the day of or day after admission was 70.5%, which did not meet the national standard of 85%, but was similar to the National average of 70.6%.
- The proportion of patients documented as not developing pressure ulcers was 98.3%, which was similar to the national average of 95.6%, although falling just short of the National Aspirational Standard set at 100%. The previous year’s figure was 100%.
- The risk-adjusted 30-day mortality rate was 9%, higher than the England average of 6.7%.
In the light of the audit results, the service aimed to bring forward the medical ward rounds for hip fracture patients. A plan had been proposed by the orthopaedic nurse specialist in January 2018 to improve compliance with the audit standards. The trust reported that the key barriers to improvement were perioperative assessments by an orthogeriatrician, due to vacancies, and timely access to theatre. The service recognised they needed to embed a multidisciplinary approach to improve performance and the audit had highlighted areas for development.

**Bowel Cancer Audit**

This audit was based on data for the period from April 2014 to March 2015.

In this latest Bowel Cancer Audit, the trust’s case ascertainment, at 128.7% (112 operations), was rated as “good”. The trust performed better than the National average in one of the standards; 55.9% of patients at the trust undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national average of 69%.

Of the remaining four metrics, the trust fell within the expected range:

- The risk-adjusted 90-day post-operative mortality rate was 3.5% which was similar to the National average of 3.8%, and falls within the expected range. The previous year’s figure was 5.2%.
- The risk-adjusted 2-year post-operative mortality rate was 29.9% which is higher than the National Average of 20.9%. This was an increase compared to the previous year’s report 20.7%.
- The risk-adjusted 30-day unplanned readmission rate was 16% which is higher than the National Average of 10.1%, and within the expected range.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 41.6% which is below than National Average of 50%. The previous audit's figure for this metric was 39.2%.

(Source: National Bowel Cancer Audit)

The service had developed an action plan in response to this audit, and the colorectal team were mostly compliant with the standards. The action plan provided to CQC was not dated however to show if or when actions had been completed.

**Oesophago-Gastric Cancer National Audit**

This audit was based on data for the period from April 2014 to March 2015.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the trust’s case ascertainment was estimated at >90% better than the national average of 79%. The trust’s results do not show any areas of poor performance compared to other trusts.
The trust was not eligible for the second metric in this audit; risk-adjusted 90-day post-operative mortality rate. Therefore no data has been collected.

The trust outperformed other trusts for one standard; age and sex adjusted proportion of patients diagnosed after an emergency admission. The trust scored 4% which was lower than their previous score of 15.6% and the National average of 13.7%.

The trust performed similar other trusts for the crude proportion of patients treated with curative intent in the Strategic Clinical Network. The trust score 40.1% which was similar to the National average of 37.6%.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

This audit was based on data from December 2014 to November 2015.

In the 2016 National Emergency Laparotomy Audit (NELA), St Mary’s hospital (Isle of Wight) achieved a red rating (performing significantly worse than other trusts at the 99.8% confidence limit) for two standards:

- 43% of cases had a pre-operative documentation of risk of death. This was based on 70 cases, and fell short of the National Standard of 80% and was lower than the National Average of 64%.
- 17% of high risk cases had a consultant surgeon and anaesthetist present in theatre. This was based on 45 cases and fell short of the National standard of 80% and was much lower than the England average of 82%.

This trust achieved an amber rating (performing significantly worse than other trusts at the 95% confidence limit) for two other standards in this audit:

- Crude proportion of cases with access to theatres within clinically appropriate time frames (69% compared to the 82% National Average). This was based on 45 cases and fell short of the National standard of 80%. This amber rating demonstrates that this trust performed significantly worse than the other trusts for this metric at a 95% confidence limit.
- Crude proportion of highest-risk cases admitted to critical care post-operatively. The trust scored 61% which was lower than the England average of 85% and did not meet the National standard of 80%.

The trust performed within expected range for the risk adjusted 30 day mortality (15.2% compared to the England average of 11.4%).

(Source: National Emergency Laparotomy Audit)

The trust reported that the third report of the NELA audit has shown mortality at this trust was 20%, against a national average of 10%. The findings had not improved year on year and the trust reported it was amongst the worst in the country for this audit. The poor audit results related to consultant involvement and availability and access to critical care beds. Urological services were delivered by one consultant and the service experienced issues regarding access and quality of outcomes. The clinical commission group (CCG) review in 2016 had made a recommendation to commission urology services on an in-reach basis, and this was included as
part of the wider review of acute service provision on the island. The issues had been discussed within the anaesthetic and surgical departments, and the service planned to undertake a ‘deep dive’ into the 2017 data to better understand where improvements could be made.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In the 2016/17 data, across all four procedures, a higher proportion of people reported feeling improvements after the procedures than worse, in line with the England average.

In 2016/17 performance on groin hernias was about the same as the England average for both patients reporting improvement and feeling worse off after this procedure on both measures.

There is no data available for how patients rated their improvement after varicose vein procedures because the trust does not provide vascular services.

For hip replacements, performance was about the same as the England average for patients reporting improvements after the procedure and better than the England average for patients reporting feeling worse. For both hip replacement measures, no patients reported worse after the hip replacement procedure.

For knee replacements, performance was worse than the England average. For both measures, fewer patients reported improvements compared to the England average and a higher proportion of patients reported feeling worse after the procedure than the England average.

*(Source: NHS Digital)*
As well as the national audits, the services had also carried out some local audits in the past year. There was no local audit programme, as such, but we found the trust had completed a medical record keeping audit in April 2017. The audit found two criteria met the 90% compliance level, but poor performance, less than 70% compliance, was found generally. There were widespread issues with making corrections to written records in line with good record keeping practice. It was not clear if there were any follow up audits.

There had been no theatre-specific audits, to provide assurance of safety and quality of their service. The WHO checklist audits did not include observational audits, to review behaviours.

The service had not audited VTE assessment and prophylaxis, even though a recent incident root cause analysis identified a failure in this process.

**Competent staff**

The service did not consistently make sure staff were competent for their roles.

**Appraisal rates**

From October 2016 to September 2017, 69% of staff within medicine at the trust had received an appraisal, not meeting the trust's target of 100%.

A split by staff group can be seen in the graph below:

**Appraisal Completion rates by staff group, October 2016 to September 2017**

![Appraisal Completion rates by staff group graph](attachment:image)

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff in theatres reported they had either participated in an appraisal or had one booked. Ward and department managers knew the current appraisal rates for staff and anticipated that all staff would have completed an appraisal by the end of March 2018. Following the last inspection in 2014 we required the service to offer all staff a meaningful annual appraisal. This had not been met at the time of our inspection, but managers were working towards achieving this.

Within theatres, staff had a dedicated day for training and audit each quarter. These had been used for mandatory training as well as ‘human factor’ training.
At the last inspection, we made a requirement that consultants undertake training in end of life care. The service reported that 82% of consultants and specialist doctors had completed this training in January 2018, slightly below the target of 85%.

Some staff felt there was a lack of opportunity for development, and there was a ‘fire-fighting’ attitude within the service. We found that the service had initiated a mentoring and coaching approach for student nurses on Alverstone ward, with ward-based supervisors and support from the clinical educators.

In theatres, recovery staff and band 3 support workers completed in-house competencies. They did not attend external courses, which meant there was missed opportunities for learning from external practitioners.

Staff had access to, and for the most part had completed, online training on identifying and responding to the deteriorating patient. This had been rolled out with the NEWS approach for assessing deterioration. This e-learning had been completed by all nurses on Alverstone, Mottistone and Luccombe wards and on the day surgery ward. In addition, healthcare assistants had completed the training on Whippingham ward and the day surgery ward. However, staff reported that in practice, they were learning how to complete the assessments ‘on the job’. Our observations indicated the training had not yet been sufficient to ensure they were fully competent.

Foundation year doctors told us they received good support and training, and mainly felt they had a good experience working at the trust. There was a shortage of phlebotomy staff however, which significantly impacted upon junior medical staff, as there were delays in receiving phlebotomy results for treatment changes.

Results of the 2017 trainee survey, by the General Medical Council, did not indicate any particular trends from responses, except that rotas were poorly designed.

**Multidisciplinary working**

Staff did not consistently work well together as a team to benefit patients. The relationships between the various allied health professionals, medical and nursing staff was, for the most part, respectful and professional. This was not the case in theatres however, where staff and managers told us medical and non-medical staff did not always work well as a team.

The multidisciplinary team (MDT) meetings we observed did not entirely or accurately reflect the experience, knowledge and skills of the team, as the meeting focus was on immediate discharge. For example, there was no discussion around medium term planning for successful discharge. We observed a daily huddle meeting on a ward, which was person-centred, but lacked depth and detail.

All ward staff said they received good support from the physiotherapy and occupational therapy staff, and they were integral to the MDT.

Staff reported good liaison with adult social care, but some delay (1-2 weeks) in agreeing the continuing healthcare care funding package of care.

**Seven-day services**

Overall, the trust had not addressed the requirement for seven-day services and the project to implement this had not yet been fully developed.
The service did not have access to physiotherapy services on Sundays, except for emergencies. This meant the length of stay for patients recovering from a fractured lack of femur who could otherwise have been discharged requiring physiotherapy advice for their rehabilitation and discharge.

**Health promotion**

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care. They were aware of the principles of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, the trust reported 22.2% of surgery staff had completed MCA training. This was lower than the trust target of 85%.

We observed staff seeking consent and this was done in a way that patients and their relatives understood.

Patients gave written consent for treatment prior to having an operation. This was completed pre-operatively in an outpatient clinic and verbally checked on admission. However, this last check was not done consistently by anaesthetists within theatres.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. We spoke with 14 patients and carers and received 22 comments cards. All patients told us that staff were very kind and attentive, and we consistently heard that staff were kind, friendly and understanding. We received feedback that ‘nothing seemed to be too [much trouble]’ and ‘I cannot fault the care I have received’. One person on Whippingham ward said ‘The staff are always helpful. This is one of many visits and it’s always a great experience’. Another, on Alverstone, said ‘The staff were very caring to my needs’ and a patient on Luccombe told us ‘Absolutely wonderful, amazing staff’. From St Helens we heard, ‘[the staff] were kind, caring and efficient’. We also received comments that staff coped well despite patients feeling they were overworked or under pressure.

We observed times when staff provided reassurance and engaged with patients in a positive, caring way.

Staff introduced themselves by name and explained to patients what their roles were. Staff in theatres took their time with an elderly patient who was slightly confused, forgetful and anxious. The anaesthetist explained everything that would happen several times and took time to answer all of the patient’s questions and concerns.

We saw staff tried to maintain their patient’s privacy and dignity. Patients in theatres and recovery had their dignity maintained at all times, curtains were always closed and patient’s that were anaesthetised were covered during any intervention.

Staff in the day surgery unit were aware of the risk of a lack of privacy and dignity for patients on the unit, due to the layout of the estate. To mitigate this, they screened patients with curtains, with their agreement, and aimed to arrange the theatre list to direct male and female patients into separate areas.

The trust said it was promoting privacy and dignity through its improvement project on individualising care plans.
Results of the privacy and dignity scores from the ‘patient led assessments of the care experience’ (PLACE) for 2017 showed that overall the surgical wards achieved lower scores than the national average of 83.7%. Alverstone, Luccombe and St Helens wards scored 77%, 63% and 65% respectively, whereas the score for Whippingham was in line with the national average, at 84%.

The Trust worked with iWantGreatCare (iWGC) to encourage feedback, and promoted feedback on the trust’s website. The surgery, women’s children’s health CBU received 281 iWGC reviews in October 2017, and 95% said they were likely to recommend the service. Of these, feedback showed scores of 4.91/5 for staff attitude and dignity and respect. Access to information scored 4.75/5. It was not clear how these were used to encourage improvement. We were told the iWGT feedback forms were available in paper format, via tablet devices on the wards or patients could visit the iWGC website. Posters about iWGC were on display, and we were told the trust was working with iWGC to find ways to improve patient feedback.

**Friends and Family test performance**

The Friends and Family Test response rate for surgery at the Isle of Wight NHS Trust was 24%, which was lower than the England average of 29% from September 2016 to August 2017.

A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at Isle of Wight NHS Trust.**
Friends and family test responses Isle of Wight NHS Trust.

Please note that the red, amber and green colour coding above is not a judgement of performance but merely highlights the highest and lowest scores of the number of responses received.

The lowest score was 44% for Whippingham ward in June 2017. Otherwise all wards scored over 76% in all months.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress. We had positive feedback from a patient that they were relieved that staff made provision for their partner to stay when they were very distressed about their health. They said this had helped them cope emotionally with the situation they were in.

Patients said they found staff reassuring and sensitive. We observed that staff understood patients’ social backgrounds and needs and aimed to treat them holistically. One patient, who had experienced a life changing event said they were looked after well and appreciated the support they were given. One person said they ‘were not treated like a number’ which they valued.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. We spoke with 12 patients and two relatives, and received comment cards from 22 others. They all said they understood the care they were receiving, with people adding, ‘I have been invited to ask questions’, ‘staff talk to me about my progress’ and ‘I have been given information about the medicines so I understand them’.

The hospital had cancelled elective operations at the time of our inspection, and was operating its winter plan. The trust had written to all patients affected by this to explain the situation and to give them advice on how to contact the trust if they needed an urgent reassessment of their condition.

Patients confirmed their treatment had been discussed with them and they felt able to make informed decisions.

Staff told us that relatives or carer’s support for example counselling or psychological support was organised by the hospital before the patient’s discharge.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned services with its commissioning partners and in liaison with social care partners and acute services on the mainland.

The trust had developed a specific ‘winter plan’, in preparation for an expected rise in medical and surgical emergency admissions, in partnership with the commissioners and the island’s adult social care service. This plan was based on trying to create capacity to manage the additional demand, without increasing the overall number of beds. It involved reconfiguring the use of wards and in particular, using elective surgical and rehabilitation beds to meet the anticipated rise in demand for emergency patients. To achieve this, the service had reduced the number of elective operations from mid-December, in liaison with health and social care partners and individual patients, based on patient risk.

In January 2018, the winter plan was in place, but there was some confusion and miscommunication relating to cancelled operating lists in day surgery and main surgery. In January, the government also stopped all NHS hospitals from carrying out routine operations due to a spike in winter flu. The surgical service was prioritising trauma and cancer operations in alignment with the capacity plan.

When we visited Whippingham ward, it had 27 beds, of which 23 were occupied by medical patients: these are patients who are not in hospital to have an operation. On St Helens, there were two medical patients on the 15 bedded ward. Mottistone, previously designated as a private surgical ward, had NHS patients during the winter plan as it’s remit had been changed in the autumn to reflect the current operational capacity need.

Average length of stay

Trust Level (St Mary’s Hospital)

Trust Level – elective patients

From July 2016 to June 2017, the average length of stay for all surgical elective patients at the trust was 2.8 days, which is lower compared to the England average of 3.3 days.

- The average length of stay for Trauma & Orthopaedics elective patients at the trust was 3.9 days, which is higher compared to the England average of 3.4 days.
- The average length of stay for Urology and General surgery was lower than the England average.
Elective Average Length of Stay – Trust Level

(Source: Hospital Episode Statistics)

Trust Level – non-elective patients

From July 2016 to June 2017, the average length of stay for all surgical non-elective patients at the trust was 7.0 days, which is higher compared to the England average of 5.1 days.

- The average length of stay across all three top elective specialities (General Surgery, Trauma and Orthopaedics and Urology, was also higher than the England’s average.

Non-Elective Average Length of Stay – Trust Level

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service did not fully take account of patients’ individual needs.

Bed management was a key focus for managers when we visited in January 2018. In January 2018, the government announcement that all trusts could relax the requirement to separate male and female patients on wards, due to the anticipated high demand for beds. Staff said they aimed to minimise having to resort to this, but there was a very high demand for beds across the hospital.

Performance reports showed the trust had recorded 77 mixed sex breaches in October 2017 in the day surgery unit. Options for refurbishing the estate were under debate. Trust data showed there was only one recorded mixed sex breach in the year from 1 October 2016 to 30 September 2017 on the surgical wards. This was in Alverstone ward, in December 2016, when there was an overnight breach due to bed pressures.

We spoke with 14 patients or their relatives and received comment cards from 22 patients. All said they had not experienced ward moves unnecessarily. Managers and staff told us they worked very hard to minimise any unnecessary bed moves for patients or admitting them to beds that compromised their privacy or dignity.
The trust provided data the number of times patients moved wards during their admission, for non-clinical reasons. The electronic patient transfer system had only been in place since 17 July 2017 and was used to monitor and analyse bed moves.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of ward moves</th>
<th>Number of patients</th>
<th>How many were at end of life</th>
<th>% share of all patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whippingham</td>
<td>0</td>
<td>361</td>
<td></td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4+</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luccombe</td>
<td>0</td>
<td>281</td>
<td></td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
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<td>2</td>
<td>1</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4+</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

Trust data submitted for the inspection

The trust also monitored the number of times patients were moved at night (between 10pm and 8am), as this is known to be disruptive to patients' sleep. Between 1 July 2017 and 30 September 2017, six patients had been moved onto Whippingham ward at night and two onto St Helens. The system was not set up to identify patients in their last 12 months of life. However the trust reported that no patients had been moved who were receiving ‘Priority of Care’ at the end of their lives, unless it was in their best interests, to move to an individual room. Data was not provided for Alverstone, St Helens or Mottistone wards.

The PLACE assessment for 2017 gave low scores to Alverstone ward for its support for patients with dementia or those living with a disability. The ward scored 46% for these questions, against a national average of 77% and 83% respectively. Luccombe ward results were higher than the national average for meeting the needs of people living with dementia, but both St Helens and Whippingham received lower scores than the national average.

The trust had identified that their current patient management software did not support the Accessible Information Standard, by flagging patients with a disability or sensory loss to ensure they received information in a way they could best understand it.

The trusts preoperative assessment documents for elective patients noted how the patients wished to be addressed; although we did not locate this in the emergency patients’ admission paperwork.

There was some provision for people living with dementia on the wards. For example there were ‘fidget boxes’ with items for people to handle and use. On Whippingham ward, the ward clerk had at times created an impromptu ‘café’ at her desk, for patients who were agitated. This gave patients a place to sit and interact with staff and others, which helped their wellbeing. Staff said they had good support from the memory liaison team, who met with patients and their carers and helped with strategies and guidance.

The trust used their own ‘My life, a full life’ passports to better understand the specific needs of patients. We also saw ‘This is me’ booklets in use that patients had been admitted with. There
were no special adaptations for people with dementia however, apart from one bay on Luccombe ward. Staff said they could request additional staff to provide 1:1 supervision for patients, but these requests were not always fulfilled.

The trust used a telephone interpretation service for language translation. Staff told us they used this, and did not ask family members to translate. They also had access to qualified interpreters. One ward was registering their overseas staff to be interpreters to provide a more personalised service to patients when breaking bad news.

Staff had access to an advocacy service and we saw where this had been used for a patient who lacked capacity for a safeguarding meeting.

On day surgery, staff had worked with the learning disability group to purchase a trolley chair, so that patients did not experience the stress of having to transfer to a bed for surgery. They also created lists specifically for patients with a learning disability, allocating extra time and staff to help provide reassurance.

### Access and flow

#### Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2016 to August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery (percentage within 18 weeks) was consistently lower than the England average.

From September 2016 (68%) to February 2017, there was a trend of decline in the trust’s referral to treatment time, with the lowest percentage of patients being seen within 18 weeks in February 2017 (46%), much lower than the England average of 70% for the same month. From February 2017, the trust’s performance improvement, with the percentage of patients being seen within 18 weeks increasing to 62% in August 2017, still remaining lower than the England average of 70% for this month.

(Source: NHS England)

### Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these six specialities with data recorded, three specialties were above the England average and three specialties were below the England average.

The trust performed better than the England overall for the three specialities below:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>72.8%</td>
<td>72.7%</td>
</tr>
</tbody>
</table>
The trust performed worse than the England overall for the three specialities below:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.6%</td>
<td>77.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>62.2%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>27.3%</td>
<td>74.3%</td>
</tr>
</tbody>
</table>

The risk register for surgery and theatres showed the ophthalmology backlog as a major risk, as were the inadequate facilities for ophthalmology. The backlog was caused by increased demand for follow up appointments and a shortage of medical staff. Staff in day surgery also said there were logistical issues involved and the service lacked administrative support to improve efficiency. At the time of the inspection, timescales for recruitment and addressing the backlog had not been defined.

The trust had set up a workstream to improve RTT rates. The workstream had identified many milestones required to achieve the target outcomes, with assigned accountability and timescales for completion. The service had ambition to achieve 85% theatre utilisation rates (from 79.9% in October 2017) and the RTT target trajectory by March 2018. The trust had an understanding of the referral issues behind for urology and ophthalmology. The trust had commissioned an external review of ophthalmology and had set up a project to improve referral times.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the eight quarters between Q3 2015/16 and Q2 2017/18, the trust performed better than the England average from Q1 2016/17 to Q1 2017/18. From Q1 2017/18, the trust’s performance deteriorated with a higher percentage of patients not being treated within 28 days of cancelled operation compared to the England average.

In Q3 2015/16, this trust cancelled 40 surgeries. Of the 40 cancellations 18% weren’t treated within 28 days.

In Q4 2015/16, this trust cancelled 48 surgeries. Of the 48 cancellations 10% weren’t treated within 28 days.

In Q1 2016/17, this trust cancelled 46 surgeries. Of the 46 cancellations 2% weren’t treated within 28 days.

In Q2 2016/17, this trust cancelled 74 surgeries. Of the 74 cancellations 1% weren’t treated within 28 days.

In Q3 2016/17, this trust cancelled 94 surgeries. Of the 94 cancellations 3% weren’t treated within 28 days.

In Q4 2016/17, this trust cancelled 53 surgeries. Of the 53 cancellations 4% weren’t treated within 28 days.
In Q1 2017/18, this trust cancelled 47 surgeries. Of the 47 cancellations 6% weren’t treated within 28 days.

In Q2 2017/18, this trust cancelled 36 surgeries. Of the 36 cancellations 17% weren’t treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Isle of Wight NHS Trust

Over the two years, the percentage of cancelled operations at the trust was consistently higher than the England average. The trust’s performance was worse in Q3 2016/17, with the highest percentage of cancelled operations, scoring above 3%. This trust’s performance has been improving since this point, to becoming more in line with the England average in the most recent quarter, Q2 2017/18. Cancelled operations as a percentage of elective admissions included only short notice cancellations.

(Source: NHS England)

Theatre utilisation was consistently below the 85% target. This was attributed to late starts and cancellations on the day. Main theatres had only met the target for two months between November 2016 and October 2017 and the theatre utilisation rate was 79% for April 2017 to December2017. The day surgery unit had never reached the target in that time. This would have impacted negatively on the patient referral to treatment times. The trust had recently set up a workstream to improve theatre efficiency and patient access.

The trust monitored delayed discharges. There had been 4,960 delayed discharges, against a total of 28,240 discharges in the 12 months from 1 September 2016 to 30 August 2017. This data represented a trust-wide result, and was not specific to surgery. It equated to 17.6% of discharges being delayed.
Staff told that there had been short notice cancelled operations and cancelled lists in January 2018 and this was not well communicated within the trust, causing confusion and frustration. The decision making process was not clear and there were no protocols for locking down lists.

Since the winter plan had been introduced the service had created patient standby lists for different specialties, to be able to include routine elective patients where demand permitted. The impact of the winter plan was expected to increase the number of cancelled operations and delayed discharges, due to the proportionately higher number of complex cases.

Learning from complaints and concerns

The service took concerns and complaints seriously, by investigating and learning from them, although lessons learnt were not consistently shared with staff. We had required the service to investigate and respond to complaints in a timely way, and to share lessons learnt, following the last inspection in 2014. This requirement had not yet been fully met. We were told some patient complaints meetings had been cancelled at little or no notice.

Summary of complaints

From October 2016 to September 2017, there were 52 complaints about surgery. 42 complaints were closed, and ten from June 2017 to September 2017 still remain open. The trust took an average of 50 working days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints. Three complaints took over 91 working days to close, and one from November 2016 took 152 working days to close.

A breakdown by subject matter is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment - Surgical Group</td>
<td>14</td>
</tr>
<tr>
<td>Communication</td>
<td>10</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>7</td>
</tr>
<tr>
<td>Clinical Treatment - Accident and Emergency</td>
<td>4</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
</tr>
<tr>
<td>Integrated Care (Including Delayed Discharge due to absence of a care package - see Integrated Care)</td>
<td>2</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>2</td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
</tr>
<tr>
<td>delayed discharge due to absence of a care package - see Integrated Care</td>
<td>1</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Treatment - General Medicine group</td>
<td>1</td>
</tr>
<tr>
<td>Other (Use with Caution)</td>
<td>1</td>
</tr>
<tr>
<td>Patient Care</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

Patients we spoke with said they had no complaints about their care.
The trust’s complaints process was being reviewed to improve the timeliness and quality of response, and the trust complaints policy had not been updated. The trust had carried out a ‘deep dive’ into their complaint management and in November 2017 there were eight overdue complaints within the surgery, women’s and children’s health CBU, which was an improvement (reduction) from the number in October 2017. As a result of the complaints project, the trust reported improved quality of complaint responses, with quality managers appointed to CBUs to help coordinate complaint investigations and responses. The trust recognised that further work was required to update policies, procedures, patient information and learning from complaints.

We read three complaints response letters sent by the trust, relating to issues raised by this service. The response letters appeared to answer the issues raised, provide contact details should the complainant wish to take the issue further, and were signed by an executive manager.

From talking with staff, it was not clear that learning from complaints was communicated and acted upon effectively. Discussions about complaints were not a standing item on meeting agendas for example.

**Is the service well-led?**

**Leadership**

The new leadership arrangements were not embedded, as there were newly appointed clinical and operational managers within the service, and they were still learning about the risks and challenges and how to address them.

Staff commented that the new trust and clinical business unit (CBU) leadership team seemed approachable and visible. Ward leaders said the CBU was well established and led by experienced, committed managers. Senior staff also said they had good links with the executive team and there was a new spirit of cooperative leadership.

Staff in theatres said they were confident in their managers and that patient care had improved as a result of an increased focus on quality and safety. For example, theatre staff were pleased trust approval had been given to start building the new admission area and felt this signalled a positive change for the hospital. Generally, staff were optimistic the new chief executive (CEO) had a realistic, ‘down to earth’ approach to leadership which increased their confidence. However, some senior surgical staff told us that after a “promising beginning” the relationship with the CEO was now less secure, as less had been achieved than they expected, and they thought her focus now lay elsewhere in the trust.

At ward and departmental level, we observed managers had a wide range of tasks to complete, yet because they were also often covering for staff on the wards, it was difficult to move their work lists forward. For example, tasks still to complete included implementing standard operating procedures, developing local induction packs, creating guidance information for patients and promoting staff development.

The trust had implemented a leadership development programme, which one senior nurse said was useful and illustrated a greater commitment to building an inclusive workforce.

**Vision and strategy**

A recent external review of the trust identified that it lacked a clear vision and strategy and these required development in collaboration with staff and the wider health economy.
At the time of the inspection, the surgical service was primarily focused on improving operational management and had not adopted a systematic approach to strategic planning.

Surgical services were delivered through two CBUs; the surgical, women’s and children’s health CBU and the CBU for clinical support, cancer and diagnostic services (CCDS). We were shown the operating plan for 2017 for the surgery, women's and children's health CBU. This was not clearly based on any trust-wide agreed visions and values. However, the service was creating business operating plans for 2019/20 based on a vision of ‘quality care for everyone, every time.’ These had been drafted in December 2017 for theatres and for the CCDS.

The stated values of the service were ‘we care, we are a team and we innovate and improve’. The business operating plans outlined goals, and priorities for achieving these goals. The plans were developed from the analysis of the service’s current position, as well as risks and anticipated demand levels. At department or ward level, there was no evidence staff were engaged in the service vision and values and this was an area the service leads recognised as needing further development.

The trust had established an acute scheduled care workstream, to capture identified shortfalls in the management of the services. This was given a priority to help inform overall strategy decisions.

**Culture**

The culture of the service was mixed, with many staff promoting a positive culture of valuing people and creating a sense of shared purpose. However, amongst some medical staff the behaviours and culture were not always positive. For example, in theatres, we were told there had been a failure to deal with unprofessional behaviours amongst medical staff, and senior managers had not addressed repeatedly raised concerns. This meant staff did not always feel supported or engaged. During our visit we also observed anaesthetists who were not promoting a safe environment for surgery. On one ward, we observed a doctor being dismissive towards nursing staff.

Poor behaviours were not consistent across the service or amongst medical staff. For example, we observed some excellent, collaborative working in some theatres lists. Non-medical theatre staff reported having good support from the theatre manager, and working in a culture of cooperation and teamwork. They felt confident, valued, and liked working in the unit.

Similarly, on wards, staff spoke of a supportive culture, where the patients’ needs came first. We saw that individual staff on the day surgery unit had received ‘reward postcards’ as a thank you for their contribution to the wider service.

The operational manager for the surgery, women and children’s health CBU was also the ‘Speak Up Guardian’. They told us they had observed staff were more prepared to raise issues and the new executive team supported and welcomed this approach. The number of reports had increased from nine in the first two quarters of the year, to 19 in the last quarter and this increased level of engagement was welcomed. We were told issues raised related more to inappropriate behaviour than bullying and it was an area the trust was seeking to address.

There was a strong culture of promoting quality and teamwork in the HSDU. For example, staff maintained a robust system for checking surgical instruments and had full accreditation from the Medicines and Healthcare Products Regulatory Agency (MHRA). The unit had maintained a record of zero non-compliances for two years. Staff assisted in other departments during the winter plan, to support staffing needs, for example in portering and pharmacy. Staff had gone the extra mile to maintain business continuity during a four-day period when the HSDU was out of
action, when they took surgical kits to the mainland for sterilisation. Their actions ensured operations continued.

Staff generally reported enjoying working at the trust, valuing the good teamwork of colleagues and feeling proud of the care they provided for patients. Some staff spoke of development opportunities they had received. The appraisal system had slipped but most teams expected to complete annual appraisals by the year end. There was some frustration that access to training was constrained due to winter pressures; however staff felt there was generally renewed emphasis on safety and staff skills within the service. For example, the service had recruited new practice educators to support wards with training.

**Governance**

The service did not have a systematic approach to continually improving the quality of its services and safeguarding high standards of care. There was requirement following the last inspection in 2014 that the provider must improve governance, risk management and quality measurement, to include reviewing audits and risks effectively. These parameters had not been achieved.

External reviews of in 2016 and 2017 identified problems with the trust’s governance arrangements, both at board level and at CBU level. This core service of surgery spanned the CBUs for surgery, women’s and children’s health, for surgical wards, and the CBU for clinical support, cancer and diagnostic services for day surgery and theatres.

The governance of surgery, including anaesthetists, was insufficiently robust for purpose. There was an inconsistent approach to safety, a lack of engagement of medical staff and a trend of under-performance in theatre utilisation. Governance of the service had failed to address these issues when raised by staff or when highlighted by monthly performance data. Recently, the service had set up three huddle meetings a week to review theatre lists and to escalate any under-utilised lists. It had recently started to monitor start times for individual surgeons’ lists.

Minutes of nursing, theatre and medical staff meetings showed an inconsistent approach to discussing governance matters. For example, governance had been discussed at the last two general surgical consultants meetings. There was no standard agenda for team meetings to prompt such discussions.

Morbidity and mortality (M&M) meetings were not held regularly and a backlog had built up during 2017. Minutes did not show any evidence of the discussion and two sets of minutes showed a list of case numbers, and not commentary. In December 2017, the M&M meeting was for 18 cases, and the meeting lasted one hour 10 minutes, which indicated that individual cases were not discussed in detail. Minutes did not make it clear if the relevant staff were present and there were no actions listed to prevent the recurrence or errors and adverse incidents. The approach to M&M meetings was not in line with the Royal College of Surgeons guidelines.

There were a range of business unit meetings; however the terms of reference for these were not clear. For example, the CBU leaders attended monthly fundamental standards meetings, monthly quality and safety meetings, patient safety meetings and weekly CBU meetings. For capacity and demand discussions, there were three huddles per week and during the day, there were two-hourly bed meetings to manage the winter plan. There was a lack of evidence of effective communication of decisions made at meetings, and this was confirmed by the staff we spoke with. Staff felt there was a lack of prioritisation in tackling issues. Despite this, there was a level of optimism that recent changes in senior management would lead to improved systems of governance and assurance.
The service had not used a programme of local audits to identify areas for improvement and implement changes. For example, WHO checklist audits had been done monthly, and had highlighted significant areas of non-compliance and risk, but the results had not been used to affect changes. Records audits in 2016 and 2017 showed significant omissions, including missing addressographs. When we visited in January 2018 we found this was still an issue. It was not clear that actions had been implemented to improve the quality of records.

The trust had participated in national audits. It had taken action in response to the 2016 NELA report, published in October 2017, where it had a red rating (performing significantly worse than other trusts at the 99.8% confidence limit) for two standards.

**Management of risk, issues and performance**

The trust did not have consistently effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Some staff described risks in terms of risks (current risks) and issues (potential risks) whereas others said the trust approach to risk management had been reviewed and standardised. The trust had set up a new system for recording risks (November 2017) and the CBUs managed their own risk registers. These identified and described the risks, controls, updates and actions, as well as the accountable person and action due dates. The registers we saw did not show when the risk had been added, but the trust said they were able to monitor the time taken to manage and close risks from their electronic reporting system.

The registers did not include risks identified by staff. Staff felt the increased dependence on agency and locum staff had increased risks and this was especially the case in theatres. Reliance on locum staff was not on the theatre risk register.

Staff said they raised risks at their local governance meetings, for allocating a risk rating and discussing any actions required to mitigate risks. These were then reviewed at the patient safety meeting, the patient experience meeting and the clinical effectiveness meeting (three separate meetings). The head of nursing and quality attended the patient safety meeting and the patient experience and clinical effectiveness meetings are chaired by executive representatives. This was a new process, and we were told the risks were reviewed monthly, with consideration of any overdue actions.

**Information management**

The service did not produce sufficient relevant and accurate information to support robust challenge and service improvement. This had been recognised by the new management team.

The trust reported a lack of assurance on the quality of data from theatres. However, the service expected this to improve with a new theatre dashboard, once staff were fully engaged in its application and use.

The off duty plan was not electronic which meant it was time consuming for departmental and ward managers to maintain. The patient information system did not flag patients with particular needs or risks to help staff anticipate their needs or plan their care.

Incident reporting, and the reporting of mixed sex breaches, was being promoted under the new leadership team. Systems to improve the accuracy and timeliness of reporting and review were being implemented, but these approaches were not embedded in staff practice. For example, locum staff said they did not have login access to the trust reporting system so did not report
incidents. However the trust told us locum staff did have access rights to the incident reporting system. This lack of understanding meant there was a risk locum staff would not report incidents. Service level risk registers were relatively new and still being developed.

The service provided monthly data on staffing, quality and safety for committee and board reviews. The trust board performance reports included data on patient care (safe care indicators, infection rates), patient experience (mixed sex accommodation breaches, complaints, cancelled operations, serious incidents, abuse against staff), staff data on appraisals and referral to treatment times. These were rated and showed where performance was below the target level. There was sometimes a lack of granularity in the data, such as where vacancies occur, to inform discussions and decision-making.

In addition, the service monitored top line key performance indicators in the ‘getting to good’ dashboard, and tracked these against ‘what good looks like’. Additional measures, such as those relating to the assessment of the deteriorating patient, compliance with mandatory training an appraisals and agency spend had been added to help assess performance and analyse areas of weakness.

Reviews of national audit results raised concerns over the quality of submitted data. For example, the third NELA audit showed a 100% score for timely arrival in theatres, which the trust considered unlikely.

The trust had introduced improved auditing of patient moves to help inform operational practices, using the automated bed management system. Staff reported that decisions were sometimes made about patients and where to place them, without clinical input. We were told matrons were required to intervene to promote patient safety. We observed this happening in practice. This indicated the system was not being used to best effect.

Engagement

The service had started to engage better with patients, staff, the public and local organisations, however it did not have a strong track record on engagement. Healthwatch Isle of Wight reported an improved level of engagement under the new executive team and a stronger commitment to listen and act on findings. This was confirmed by staff, who reported they felt more prepared to contribute and were more likely to be listened to. Staff recognised that engagement was ‘a work in progress’. Staff were hopeful that the new trust leadership team would support front line services more effectively, and already reported that the winter plan demonstrated a proactive management approach.

The trust had a ward recognition scheme in place, and this was being relaunched to give it more impact.

Patients were invited to complete feedback forms about their care, and we saw boxes for these on the wards. Patient feedback on the ‘I want great care’ (iWGC) reviews was reported through the monthly governance arrangements. The ‘I want great care’ patient feedback forms showed, for example, that the surgery, women’s and children’s health CBU received 281 reviews in October 2017, and 95% said they were likely to recommend the service. The board received results on the number of complaints, compliments and concerns for each clinical business unit, and concerns raised by partners in the complaints process had prompted a trust wide review into the process. This indicated an open and collaborative approach with partners.

Feedback from patients in day surgery, of long waiting times, had resulted in staggered admission times. When delays were envisaged on the day, reception staff also advised patients and their relatives/carers and gave them the options to return at a later agreed time.
The trust had carried out a Medical Engagement Score survey in September 2017 which had identified low relative engagement within the surgical and women’s and children’s health and the clinical support, cancer and diagnostic CBUs. The survey identified particular engagement issues with medical staff in anaesthetics, orthopaedics and consultants without managerial responsibility. This presented a potential barrier to improved service delivery. The trust had since adopted a leadership programme which was being led by the CBU operations manager, to address the issues raised and to work collaboratively to improve performance.

Nursing and clinical staff generally felt engaged with their leaders and described a positive relationship with the Interim Director of Nursing. Staff meetings were still held, despite the staffing difficulties and staff were encouraged to attend; however, this was not always fully possible and meetings were described as “necessarily brief.”

**Learning, continuous improvement and innovation**

The trust had not established an embedded learning culture. It had started to create the frameworks for learning from incidents, complaints and staff and patient feedback. This was not underpinned however by effective information sharing, or a robust staff development programme, with meaningful appraisals and supervisions aligned the service aims and ambitions. Staff and managers took control of their own development and this had led to inconsistencies in performance and quality across the service.

There was not an effective process for learning from deaths, incidents and external reports. There had been five unexpected deaths reported as serious incidents between September 2017 and December 2017 in surgery, women’s and children’s health CBU. There had been six requirements from the last inspection relating end of life care (including: patients must be allowed to die in their preferred place of care; all patients nearing end of life must be assessed and have an individualised end of life care plan). Two of the five unexpected deaths related to patients on end of life care, where their care had not been in line with their wishes or trust policy. This indicated that areas for improvement, identified from the previous CQC visit, had not been implemented. We also found the MRM meetings were not used effectively to drive improvement.

There were a few examples of the service offering protected time for learning and sourcing examples of good practice and innovation. For example, the hospital sterilisation and disinfection unit (HSDU) staff team ran a well organised, high quality service. The HSDU had maintained accreditation for over two years. Staff were motivated and the team had won the ‘Going the extra mile’ award in August 2017. A member of the team had also won an individual award in February 2017, for working flexibly and working additional hours in overall support of the trust. This illustrated celebration of acknowledged high performing staff.

The ward sister on Alverstone described a new model of mentorship they were piloting. Staff on the ward provided mentorship and supervised learning-in-practice for students, with the help of trust practice educators.
Facts and data about this service

The trust has 8 Critical Care beds. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, Isle of Wight NHS Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, 25.0%</td>
<td>Neonatal, 23.9%</td>
</tr>
<tr>
<td>Adult, 75.0%</td>
<td>Adult, 58.4%</td>
</tr>
<tr>
<td>Paediatric, 7.7%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England)

St Mary’s Hospital has one Critical Care ward, Critical Care Outreach and Anaesthetic Department.

(Source: Trust Provider Information Request)

The Trust’s critical care service included a six bedded intensive care unit (ICU) and a critical care outreach service. There were two neonatal critical care beds. Neonatal critical care was reported in the children and young people’s report.

The unit provided level 3 care for patients requiring one-to-one support, such as ventilation and level 2 high dependency care.

During our inspection we visited the ICU. We spoke with four consultants, eight nurses, a physiotherapist, the matron in charge, one relative and two patients. We observed care and treatment patients were receiving and reviewed four care records. On day one of the inspection there were four patients in the unit and on day two there were five patients.

Before our inspection we reviewed performance information from and about the Trust and data from the Intensive Care National Audit and Research Centre (ICNARC).

Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service had made recent efforts to ensure it provided mandatory training in key skills to all staff and made sure everyone completed it in a timely way.

The trust set a target of 85% for completion of mandatory training. Staff were expected to complete up to date training in key topics which included resuscitation, conflict resolution, end of life care, hand hygiene and fire safety.
In critical care, in the reporting year before our inspection both medical and nursing staff failed to meet the target with medical staff having 75% and nursing staff having 83% compliance overall. However, following our inspection the trust provided evidence which demonstrated that the overall compliance for the critical care team had risen to 86% whilst the outreach team had risen to 85%. Mandatory training records were held electronically and closely monitored to ensure staff knowledge was current. Staff told us there was an expectation they would keep up to date with training.

**Mandatory Training Completion by module – Medical Staff**

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>20</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>20</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>20</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>20</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>20</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>20</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>20</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>20</td>
<td>85.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>20</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>20</td>
<td>75.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>20</td>
<td>60.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>20</td>
<td>55.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>19</td>
<td>47.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>20</td>
<td>15.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>19</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff working within critical care met the trust’s target for eight out of 15 training courses listed above. The training courses with the lowest compliance rates were prevent training levels 1 & 2 (three out of 20 members of staff completed this), adult resuscitation (nine out of 20 members of staff completed this) and fire safety part 2 (11 out of 20 members of staff completed this).

**Mandatory Training Completion by module – Nursing Staff**

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>42</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>42</td>
<td>95.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Name of course</td>
<td>Eligible staff</td>
<td>Completion (%)</td>
<td>Target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>42</td>
<td>95.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>40</td>
<td>87.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Maths &amp; Medicines Calculations</td>
<td>41</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>42</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>42</td>
<td>81.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling</td>
<td>42</td>
<td>76.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>41</td>
<td>75.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>41</td>
<td>75.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>42</td>
<td>69.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>46</td>
<td>10.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>42</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>42</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>40</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff working within critical care met the trust’s target for 12 out of 22 training courses listed above.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

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 demonstrated a good understanding of how to protect patients from abuse. Most staff had completed training on how to recognise and report abuse. Staff received annual training for safeguarding level 2 children and adults.

Safeguarding Training Completion by module – Medical Staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for medical in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>20</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>20</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>20</td>
<td>45.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff working within critical care met the target for two out of the three safeguarding modules; safeguarding adults level 1 and safeguarding children level 1. Notably, there were low compliance rates for safeguarding children level 2 with nine out of 20 members of staff having completed this. Following the inspection the trust provided evidence that overall compliance for both medical and nursing staff had risen to 86% for safeguarding children level 2.

Safeguarding Training Completion by module – Nursing Staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for
Nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>42</td>
<td>88.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>42</td>
<td>78.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff working within critical care met the target for two of the three modules; safeguarding children level 1 and safeguarding adults level 1. Following the inspection, the updated mandatory training information provided showed that compliance rates for safeguarding adults had fallen, although evidence of booked training days was also provided. This provided reassurance that training was regularly monitored.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The trust had recruited a trust wide head of infection control and prevention. The new head reported that they did walk arounds in all departments to make sure they were aware of what was happening around the Trust.

The unit had three side rooms for infection control isolation purposes. Two of these did not meet Health Building notice 04-02 and therefore were not in regular use as the unit was often below full occupancy and staff opted to use the other two. Due to the age of the build there was no requirement to meet this notice. Staff were mindful of this and took a risk-based approach in making decisions about where patients were treated. There was a negative air pressure room to ensure contaminated air did not leave the room.

The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC) and so was evaluated against similar department nationally. The unit was not an outlier in infection control measures.

On the day of the inspection the unit was visibly clean. We observed equipment with ‘I am clean’ stickers detailing the date and time they were last cleaned. Individual equipment items were mostly clean and ready for use. Some equipment items stored behind curtains in two unused bays were not protected by dust covers. Although the equipment did not look dusty, we highlighted this to the lead matron. We were aware that equipment storage on the unit was being reconfigured and reorganised once the planned floor replacement had been completed.

Staff used disposable curtains to separate each bed space which we were told were changed every six months unless visibly dirty when they would be changed immediately. We saw all the curtains had been changed in the month before our inspection. Curtains were changed regularly to control the potential spread of infection.

All staff providing direct care to patients followed best practice guidelines of bare below the elbows (BBE), washing hands between each patient contact and using personal protective equipment (PPE) such as gloves and aprons.

Staff told us infection prevention and control was included in mandatory training requirements. Data provided by the trust showed 97% of nurses had completed infection control training in the last six months. This was above the trust target of 85%. The trust provided data following our
inspection which showed that as of January 2018, 100% of staff in the critical care outreach team and 96% of ward staff had completed mandatory infection control training.

ICU internal audit results for December 2017 showed hand hygiene and PPE use was 100% compliant with the audit standards being checked.

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.**

Due to the age of the build of the unit, the trust was not required to meet current best practice building guidance (Health Building notice 04-02.) Staff were aware of this and managed non-compliant areas appropriately. For example two rooms were too small. Staff utilised other areas of the ward and the two small rooms were used only when absolutely necessary. The ward included a large side room and a negative pressure room. The negative pressure room was used for patients requiring isolation as the negative pressure prevented contaminated air from leaving the room.

During the inspection we found some products, including COSHH, (Control of Substances Hazardous to Health), which posed a potential risk to patients and visitors, stored in an unlocked cupboard in an unlocked room. We informed the matron in charge and the next day, the products had been relocated to a safe storage area where they were locked away. There were plans to reconfigure the layout, design and use of storage areas following planned renewal of flooring. The COSHH products we had found had been missed during the intermediate period.

Some equipment was stored behind curtains in two unused bays. The equipment was not well organised or easily accessed. In the same area, bed linen was stored in a trolley with a curtain around it. A patient urgent transfer trolley with emergency medicines in sealed bags looked poorly organised. It was clear that the unit did not have access to appropriate storage for their equipment, due to the footprint, and we were made aware that a reorganisation program was underway. The situation was recorded on the risk register. Although not ideal, the storage of equipment was not considered dangerous. We were told by staff that new transport equipment had been ordered. This had been influenced by what the coastguard would allow in the helicopters in the case of air transfers.

We checked the resuscitation trolley and saw that it met Resuscitation Council (UK) guidelines. Records evidenced that daily checks were carried out and tamper proof seals were intact.

Medical electronic equipment was maintained by the medical electronics department. It was checked in line with ‘Managing Medical Device April 2014’ guidance from DoH. Many critical care devices were maintained under manufacturer contract.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.**

There were effective handovers and shift changes, which ensured all staff had an overarching review on the status of all unit patients before taking a detailed handover about their allocated patient.

There was a critical care outreach team who were on site and worked across the whole hospital 24 hours a day, seven days a week. The team consisted of nurses who had extensive skill and
knowledge in recognising and treating deteriorating patients. The skills of this team were being further enhanced by training to become advanced nurse practitioners. The outreach team were extremely busy (up to 1,000 calls a month) but had a key role in supporting ward staff when early signs of deterioration were detected. Staff from a range of wards across the hospital told us they valued the input from the outreach team in helping them to manage the most unwell patients.

There was a trust wide sepsis policy, with clear processes in place for pre admission sepsis screening. Critical care outreach team undertook sepsis liaison advising staff on the medical wards on management of patients with sepsis. The trust had experienced some success in improving the prognosis and outcome of septic patients. Septic patients were referred to outreach as soon as sepsis was identified. There was a clear pathway in place which adhered to guidelines. The outreach team tracked these patients and recorded their progress.

Antimicrobial stewardship meetings took place daily on the unit. These included representatives from microbiology, pharmacy, nursing and medical. This was noted as good practice as it ensured that antibiotic prescribing and medical management of patients with infections was closely monitored.

Staff completed risk assessments in relation to each patient admitted onto the unit. These included waterlow (a tool designed to assess the risk of a patient developing pressure ulcers), Malnutrition Universal Screen Tool (MUST) (a tool designed to identify adults who are malnourished or at risk of malnutrition), tissue viability and falls. If the patient was identified as being at high risk, then a separate care plan was written to address the identified risks. Waterlow was reassessed on a daily basis and this determined the intentional rounding. Intentional Rounding is a structured approach of checks carried out by nurses to check the health and wellbeing of patients. Patients could be weighed whilst lying on their bed and this helped to determine appropriate care such as pressure mattress settings and dosage of medicines.

**Nurse staffing**

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

A band 6 was rostered to be in charge of every shift, and six nurses were rostered to every shift in order to cover one to one nursing. Staff supported each other with cover for shifts where possible. Bank and agency nursing use was minimal as staff worked additional hours to cover shifts. This meant that shifts could be filled by staff who were already familiar with the workings of the ward. A health care assistant was also rostered on each shift. Nurse staffing followed national guidance. Level 3 patients were nursed on a one to one basis and level 2 were nurses on a minimum of two patients to one nurse ratio. At the time of the inspection, the unit was not full and therefore level 2 patients also received one to one nursing. The unit was well staffed for the level of activity and acuity.

The unit had previously lost key staff in a restructuring program, that took place several years ago. Senior staff told us this had really affected staffing numbers and morale at that time. We were told that two band 6 nurses had recently been recruited and that other new staff had brought a fresh approach which had helped motivate the team to improve.

There were 28 nursing staff (70%) with a post qualification award in critical care. This met the GPICS standard that “A minimum of 50% of registered nursing staff will be in possession of a post registration award in Critical Care Nursing.”

There were sufficient nursing staff to enable a robust handover. Handovers were two step, first a more general handover for the whole team. This took place in private in the clean utility area. This
was followed by a more detailed handover at the patient bedside between individual staff, this included results and current plans. Staff were allocated to individual patients to care for during their shift. Continuity of care was ensured by the maintenance of a book which nurses kept in relation to each patient. The handover process we observed had included discussions about staffing cover, equipment and training updates, medicines expired and family issues with patients.

The outreach team was led by a nurse consultant. There were three nurses working days and three working nights supported by two clinical assistants who provided a supportive role to the nurses.

From October 2016 to September 2017, the trust reported an overall vacancy rate of 10% for registered nursing staff working within critical care. Staff and patients consistently told us there was a consistency of care as regular nursing staff worked additional shifts to cover gaps in the rota.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From October 2016 to September 2017, the trust reported an overall turnover rate of 4% for registered nursing staff working within critical care.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From October 2016 to September 2017, the trust reported an overall sickness rate of 0.2% for registered nursing staff working within critical care.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From October 2016 to September 2017, the trust reported an overall bank usage of 27 shifts, and an overall agency usage of 24 shifts. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

The service had taken action to ensure there was enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The matron told us there were four intensivists, who worked a roster of one week each of day shifts. Weekends sometimes were not covered by intensivists but by anaesthetists. Nights were covered by an on call system. This did not meet GPIC standard “Consultant intensivist led multidisciplinary ward rounds within Intensive Care must occur every day (including weekends and national holidays).” However, we were told that two more intensivists had been recruited and were due to start within a month of our inspection. When in place, this would ensure that GPIC standards were met.

Staff and patients told us doctors were accessible and visible around the unit and we observed this during our inspection.

From October 2016 to September 2017, the trust reported an overall vacancy rate of 20% for medical working within critical care. This did not include the recruitment of the two intensivists who had not commenced employment at the time of our inspection.
From October 2016 to September 2017, the trust reported an overall turnover rate of 4% for medical working within critical care.

From October 2016 to September 2017, the trust reported an overall sickness rate of 0% for medical working within critical care.

From October 2016 to September 2017, the trust reported a bank usage of nine shifts and an agency usage of 138 shifts within critical care. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

Records

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

Patient records were paper based on the ward although there was an electronic discharge system. The ward round was paper based. Patients’ records were maintained in three parts; nursing notes stored at the patients’ bedside, current medical notes and previous medical notes. We noted, during the inspection, that one set of patient medical notes from the current episode of care dated 18 January 2018 had been moved to the previous medical notes file. These were therefore not readily accessible by staff should they need to be referred to whilst the patient was still under their care. This meant there was a risk of staff not having timely access to recent clinical information to support their clinical decision making.

Records included contemporaneous daily entries and antibiotic stewardship records. There was concern that some entries, which appeared to have been made by the same one doctor, in medical notes were unreadable and this meant that it was difficult to confirm that a clear record of patient care had been maintained. We were unable to read their handwriting and nursing staff we asked were also unable to. This meant there was a risk that key information could be missed as the documentation was illegible.

Medicines were part of a new electronic system and medicines records were maintained electronically as part of that system. The ward was using paper charts and transferring patients to the electronic JAC system during their stay on ICU. Staff raised that only one mobile computer was available on the unit which made keeping administration records difficult, as more than one nurse may be administering medicines at the same time.

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**Incidents**

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 appropriately applied duty of candour.

Staff told us they would report incidents to the nurse in charge, but it was their responsibility to report the incident through the system. All staff were invited to monthly mortality meetings. Mortality meetings are peer reviews of the care of patients with the objective to learn from complications and errors and to prevent repetition of any errors leading to complications.

We saw evidence of shared learning identified from incidents. In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in critical care which met the reporting criteria set by NHS England from December 2016 to November 2017. The incident type was medication incident meeting SI criteria. Staff told us that as a result of this incident, there was now a procedure in place for patients admitted with low sodium levels. Another incident resulted in a review of escalation plans to ensure that patient care was not compromised when patient demand was high.

Feedback from incidents to ensure shared learning was through handovers, staff meetings and monthly reports to staff. We saw this evidenced when a minor equipment malfunction was discussed at handover.

The outreach team also reported, investigated and learnt from incidents. For example, they had carried out a root cause analysis where there was a concern about failure to rescue, with an intention to learn from any mistakes.

The unit reported a never event in November 2016. This was a retained foreign object following a medical procedure. Never events are serious patient safety incidents that should not happen if
healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Following this never event staff described learning which resulted in revised documentation and a witness to observe and sign the procedure.

**Safety thermometer**

The service used safety monitoring results to improve the service. Staff collected safety information but it was not routinely shared it with staff, patients and visitors.

The service used safety monitoring results, although these were not publicly displayed on the ward. The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Measurement at the frontline is intended to focus attention on patient harms and their elimination. The matron reviewed the results and reported any exceptions to staff via a monthly report.

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, no falls with harm and one new catheter urinary tract infections from October 2016 to October 2017.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Isle of Wight NHS Trust**

![Graph showing prevalence rate of pressure ulcers and CUTIs](Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

With the exception of not providing follow up clinics, the service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges, the Intensive Care Society, the Faculty of Intensive Care Medicine and other relevant bodies. Policies and protocols were available on the hospital’s intranet.

In line with national guidance and best practice, patients had a rehabilitation assessment completed within 24 hours of admission to critical care service.

Senior staff told us palliative care pathways and withdrawal of care protocols, were followed. The ICU followed NICE guidance CG135 by promoting and participating in a programme of organ and tissue donation.

Patients were nursed using critical care bundles which followed national best practice. Care bundles consist of a group of three to five evidence based interventions for patients in critical care. We reviewed care pathways and plans in relation to intentional rounding, post cardiac arrest care bundle, central venous catheter care plan, body maps, arterial line insertion records. These were all compatible with national standards, practice and guidance.

Patients were safely ventilated in line with best practice. This included mechanical invasive to assist or replace the patient’s own breathing using endotracheal tubes (through the mouth or nose) or tracheostomies (through the patient’s windpipe).

The outreach team kept data on all cardiac arrests in the hospital including emergency department arrivals and also regarding ITU admissions from wards as a result of outreach interventions. Readmissions and averted admissions to ITU were also reviewed to identify learning and good practice.

The critical care outreach team followed the stroke patient’s pathway. They were bleeped either from the ambulance or the emergency department and supported the patient through the early stages. This was compliant with the national pathway. They provided follow up 24 hours later when care had been taken over by the stroke team. This process was audited due to the heavy investment of time.

Ward rounds took place twice a day and included consideration of best practice guidance.

The critical care unit did not follow GPIC standard in respect of follow up clinics “Patients discharged from ICU must have access to an ICU follow up clinic.” The service leads were aware of this shortfall and had ambition to start follow up clinics in the future. They were hoping the addition of two new intensivist posts would create capacity to support these clinics. Additionally several nursing staff were keen to get this running and a few had visited clinics on the mainland to see how other units operated.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

All patients, on admission to the unit, had their nutritional and hydration needs assessed, and their risk of malnutrition, using a national validated nutritional screening tool. We saw patients had access to dietary supplements when needed and additional dietary advice was also available, for example from the stoma nurse.

All patients had their weights recorded as part of their ongoing assessment which staff used to inform their target weights for feeding.

A speech and language therapist (SALT) was available to support patients with a tracheostomy and those with swallowing difficulties. SALT referrals from ICU were prioritised. The SALT provided instruction to staff about how to support patients with swallowing difficulties with eating and drinking. There is no nationally agreed guidance about the minimum SALT staffing levels in a critical care environment.

The unit did not fully meet the GPICS guidelines that “There must be a dietitian as part of the Critical Care multidisciplinary team.” Dietetic support was provided from the trust’s general dietetic service as and when requested by the ICU team. Whilst there was no dedicated dietitian, we saw clear evidence that patients’ dietetic needs were met and staff could access dietitians in a timely way.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave additional pain relief to ease pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients’ pain was well managed. Staff monitored patient’s pain and response to pain as part of routine observations. Staff demonstrated a good understanding about identifying pain. Patients told us they received pain relieving medicines when they required it. All patients we observed on the unit appeared to be comfortable and were not exhibiting signs of any obvious discomfort. One patient told us that a doctor had accompanied them through a procedure to ensure their pain was appropriately managed.

Pain control was reviewed and discussed during ward rounds and handovers. Staff were aware and monitored physiological responses to pain such as changes in heart rates and agitation, particularly when patients were on a reducing rate of sedation.

Staff had access to a range of pain relief administration methods such as liquid or tablets, subcutaneous injections and intravenously, including via syringe drivers. Patients could access pump controlled analgesia if appropriate, where they could control the amount of pain relief medicines they required within safely prescribed limits.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used findings to improve them. They compared local results with those of other services to learn from them.

The trust has one intensive care unit, St Mary’s Hospital, which contributed to the Intensive Care
National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. Two facilitators ensured data was regularly fed into the ICNARC system and liaised with the ICNARC network. This critical unit was within expected range for all patient outcomes declared on the ICNARC system. This meant patient outcomes were in line with other similar units when compared nationally.

The team in the unit followed the guidance in identifying a patient's potential for donation in consultation with the specialist nurse for organ donation (SNOD). They also considered any advance statements or Lasting Power of Attorney for health and welfare.

Staff across the trust screened all patients for delirium. This was in line with the Core Standards for Intensive Care Units (2013) which recommends all patients are screened for delirium. This is more prevalent in patients who are on a breathing machine, in intensive care for example. Certain conditions and chemical changes in the brain can lead to an increased risk of developing delirium.

The trust achieved equivalent to the England average in the national Lung and bowel cancer audits during 2017.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The trust’s risk adjusted hospital mortality ratio was 0.9 in 2015/16. This was similar to the National average score of 1, and meant the trust performed within expected limits. The figure in the 2014/15 annual report was 0.9.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The trust’s risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.4. The trust performed within expected limits, performing better than the England average score of 1. This was also an improvement from the trust’s score in the 2014/15 annual report of 0.9.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

All staff at every level, were observed to be skilled and competent in their role.

The Trust did not meet the GPIC standard which requires that each critical care unit has a dedicated Clinical Nurse Educator responsible for co-ordinating education and training. Senior staff told us that the post had been lost during the restructuring programme, whereby a number of staff were downgraded. Since the post had been lost, one nurse on the unit had been overseeing nurse education and training but did not have any dedicated time to do this. However, there were plans to recruit to this post in the months following our inspection.

Staff were proactively supported and encouraged to acquire new skills and share best practice. Recently recruited staff had worked hard building up fundamental knowledge. There had been a focus for learning regarding end of life withdrawal of care. Staff told us they had been booked on training programs and there were more opportunities for development. For example there had been recent ventilator and haemofiltration training. There were also opportunities for link nurses. Staff told us they shared their learning for example, nurses taught other nurses how to insert a syringe driver and their competency was then assessed.
Clinical supervision was provided for staff, and they told us they supported each other. New members of staff were assigned mentors. One member of staff told us they had four mentors, this ensured there were several people supporting them. Staff told us there was a learning culture and nursing staff appreciated medical staff input into their development.

The nurse consultant in charge of the outreach team had an appropriate level of training for the role.

From October 2016 to September 2017, 61% of staff within critical care at the trust had received an appraisal, not meeting the trust’s target of 100%.

A split by staff group can be seen in the graph below:

**Appraisal Completion rates by staff group, October 2016 to September 2017**

![Appraisal Completion rates by staff group](graph)

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Service leads demonstrated improvement since the above data was submitted. The appraisal rate evidenced on inspection by the matron was 90% of staff in ITU and 100% of staff in the outreach team had received an appraisal.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The unit had access to a dedicated physiotherapist who was present on the ward during core working hours. Staff could also access a physiotherapist on call.

A pharmacist was present on the ward every day, excluding weekends. The service did not have its own dietitian. However, from a review of patient records, it was clear that patients had had dietitian input into their care where needed. There was also access to occupational therapy services although the unit did have its own dedicated therapist. Where speech and language therapy (SALT) referrals were made by the team, these were prioritised.

Other professionals visited the ward as necessary, such as a stoma nurse.

MDT handovers took place daily, patient plans and conditions were reviewed. Present were lead consultants, medical teams, ward co-ordinator, pharmacy, nutrition and rehabilitation. This
represented a holistic view of patient care.

Seven-day services

Seven day services were not fully established across all of the multi-disciplinary teams, although action had been taken which would develop the service to meet the seven day standard.

A dedicated physiotherapist was available during core weekday working. The hospital on call physiotherapy service was available outside of these hours.

The unit did not meet GPIC standards which stated “A consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes and undertake twice daily ward rounds.” Staff consistently reported that consultants were available at weekends and attended within 30 minutes if required but they were not routinely intensivists. However, the unit had recruited two further intensivists which would ensure they could meet this standard.

Pharmacists were available weekdays which met the minimum GPIC standard. However, GPIC recommends that pharmacy services “must ideally be available seven days a week.” Staff were able to access trust wide pharmacy services at weekends as needed.

Health promotion

Patients were signposted to organisations that could support them and help them to manage their own health and wellbeing. The team appropriate referrals to health professionals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 (MCA). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The trust reported that from April 2017 to September 2017, Mental Capacity Act (MCA) training had been completed by 15% of staff within critical care. This was lower than the trust target of 85%. Following our inspection, the trust provided data which showed this had improved to 43%, for nursing staff on the outreach team, but this still meant the majority of nursing staff had not received mandatory training in this area. However, ward staff compliance rates had increased to 88% which was in line with trust targets. We found staff were familiar with the MCA and best interest decisions for patients. They told us they would seek support if they were in any doubt about a patient’s capacity to consent and how to proceed.

During the period from October 2016 to September 2017, there were six applications to deprive patients of their liberty. None of these were approved by the local authority. The trust training data did not include Deprivation of Liberty training. However, staff we spoke with, at all levels, understood their responsibilities under DoLS legislation.

Staff told us they always sought consent from patients and written consent forms were used by doctors for procedures if appropriate. For example: patients requiring surgery.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff were passionate about the care they provided. Staff were aware of the importance of providing compassionate care and the impact on the patient. One member of staff reflected “If you do it well, it’s what they remember, you become part of their story.”

Relatives described the care as “lovely.” One relative told us they had been given the direct telephone number to reach the consultant.

Patients described the care as “outstanding” and were keen to praise the staff and the quality of care they had received. One patient said “Right from the surgeon to the lady who cleans, if someone smiles it makes such a difference, it’s the impact on people’s lives.”

Staff worked hard to ensure that patients and relatives were well cared for. There was a relatives’ room for patients to wait for news about their family member. The relatives’ room had information displayed to support relatives and let them know what to expect when the entered the critical ward. For example it informed them about types of equipment which might be in use. Staff made drinks for relatives, whilst they were waiting. Before visiting their loved one, relatives were updated by a doctor or nurse in respect of their condition.

The service recognised the importance of family members for patients. Visiting hours were open, with the exception of a flexible hour long dedicated rest period each day.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Help was sought from specialist organisations in relation to emotional support for patients with specific illnesses.

Staff provided emotional support to families who were often distressed. For example, supporting family members to carry out personal care for their loved one as a final act and encouraging and supporting family at special times such as Christmas and birthdays ensuring this was a special time for both the patient and their family.

The unit also sought support for families such as offering specialist counselling for children and young people.

Staff could also make other referrals to support patients in their recovery such as psychiatric liaison, palliative care psychology and chronic pain team.

Relatives who had travelled were supported with accommodation, arranged by the team. There was also a sofa bed in the relative’s room for relatives to stay overnight.

Patient diaries were kept which helped patients understand what had happened to them on their journey to recovery.

Staff told us they stayed in touch with patients, after discharge from the unit, and that some were regular visitors to the unit.
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment that was being provided. Relatives told us that staff were supportive and understanding and went out of their way to minimise their anxiety. When patients were admitted to critical care, relatives waited in the relatives room so that medical staff could talk to them first and explain the condition and plan of care for their family member. On subsequent visits they were always updated by staff before accessing the ward.

Patients and relatives told us that staff took time to explain the care and treatment.

Staff explained how they ensured staff were involved in decisions about their care, even in the smallest way. For example, choices in flavours of fortified drinks. They wanted patients to feel in control of their own care.

Staff told us they got very involved with families. One member of staff recalled how they had spent some time with family members explaining about the withdrawal of care.

Staff followed processes to contact the Specialist Nurse for Organ Donation (SN-OD), to speak sensitively to relatives of patients about organ donation when treatment was being withdrawn.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The service took account of the needs of the local population. Service leads understood the need for a flexible service which could flex and adapt to the fluctuating demand for critical care beds.

Bed capacity of the unit meant the trust did not meet the department of health recommendations about the number of critical care beds needed to meet a local population. The department of health recommends 7.4 critical care bed availability per 100,000 population. The population of the Isle of Wight is 140,000 indicating a critical care requirement of 10 beds. However, during our inspection we heard and saw that patients were at times remaining on critical care for longer than needed, as they frequently had the available beds. This would suggest there was no significant need for any further beds.

The critical care outreach team covered all areas of the hospital and responded to all emergencies. They also facilitated helicopter transfers.

Meeting people’s individual needs

The service took account of patients’ individual needs.

The service could provide for patients with complex or additional needs. Staff told us that as they provided intensive support to patients, frequently one to one care, that they could meet individual needs with ease, as needed.

Staff said they treated each person as an individual, and said they could make reasonable adjustments to meet the needs of patients with a learning disability or living with dementia if required.

There was a range of literature available in the relative’s room to support relative make sense of
their loved one’s illness and expected recovery. This included information on post-traumatic stress disorder and other potential complications associated with recovery.

Where patients required interpreters, staff contacted switchboard where a list of all staff who were bilingual was kept. Staff were released to interpret for the patient. Staff also kept a clipboard of basic phrases and symbols which supported the communication process.

**Access and flow**

People could access the service when they needed it. However, patients stayed longer on this critical care unit than was always necessary meaning mixed sex accommodation requirements were not always met.

From October 2016 to September 2017, the Isle of Wight NHS Trust’s bed occupancy levels fluctuated below or around the England average. From July 2017, the trust’s bed occupancy percentage dropped to 17% in August 2017. This percentage increased again in September 2017 to be more in line with the England average.

This indicates, also supported by our observation at the time of the inspection, that the unit often did not operate at full capacity. There were specific criteria for admission to critical care and where these were met patients were able to access the service when they needed it.

However, there were some issues with delayed discharges back to general wards. The trust had 2,562 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 10.6%. This was higher than the National average of 5.3%, but the trust did not perform in the worst 5% of all units. This was also a decrease from the trust’s score in the previous year’s audit of 13.9%. The data is supported by our findings during the inspection. During the inspection we were aware of a patient who had been waiting six days for transfer to a ward. Despite this being highlighted at bed meetings, the Trust had not been able to find an available bed. There was no clear motivation at trust level to move patients out of the unit when they were no longer critically ill. We witnessed, and were told about, senior staffs’ behaviour at these bed meetings which did not always support the effective management of beds in critical care. Staff were aware of the impact of delayed discharges, for example, patients becoming too reliant on higher levels of care and they found these delays frustrating. The inability to step down patients had been recognised and was recorded on the risk register.

The delayed discharges impacted on mixed sex breaches. The patient who had been waiting for transfer for six days was awake, alert and able to mobilise around the unit. They were able to view members of the opposite sex from their bed. We observed this patient walking freely around the unit in front of a variety of other patients and visitors which was not in line with gender separation rules as outlined in Department of Health guidance. During the period 1 October 2016 to 30 September 2017 there were 71 mixed sex breaches for the whole Trust, 64 of these were on the ITU. This indicated a history of delayed discharge affecting mixed sex breaches. We requested further data from the Trust in relation to the length of delayed discharges from ITU but they were unable to provide this as they had not been monitoring the time period of each mixed sex breach. This meant once the breach had been declared there was no ongoing monitoring of the breach.
Adult Critical Care Bed occupancy rates, Isle of Wight NHS Trust.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

The trust had 341 admissions, of which 0.3% had a non-clinical transfer out of the unit. This was similar to other units, and the National average of 0.4%. The trust performed within expected limits, and obtained the same percentage score compared to the previous year’s audit.

(Source: Intensive Care National Audit Research Centre (ICNARC))

At the trust, 1.8% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was better than the England average of 2.5%, with the trust performing within expected range. The figure in the 2014/15 annual report was 1.6%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Staff told us that any complaints were always discussed in staff meetings and handovers. The focus was on learning not blame. The matron told us there were low numbers of complaints as they tried to resolve any issues at the time they arose.

From October 2016 to September 2017, there were two complaints about critical care. The trust took an average of 31.5 working days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints.

One complaint was related to communication, and the other about values and behaviour.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
Is the service well-led?

Leadership

Service leaders had the right skills and abilities to run a service providing high-quality sustainable care.

The critical care unit was part of the cancer support and diagnosis clinical business unit (CBU). Each CBU was led by a head of nursing, clinical director and a general manager. The unit had just appointed a new matron who had previously been the sister in charge of the ward. The unit sister post was vacant at the time of our inspection. There were three deputy sisters and five other senior nurses who provided clinical leadership.

The newly appointed matron in charge of the unit was a strong leader who fostered a positive culture. Staff told us that the matron was very supportive and they felt she had a proactive approach to development and training. We saw evidence that the matron had made significant improvements on the unit in the short time she had been there (in her capacity as senior nurse in charge prior to becoming the matron). The critical care outreach leader also instilled confidence in the inspection team and demonstrated strong leadership skills. We observed good joint leadership between nursing and medical staff.

Staff told us that the matron kept them up to date with feedback from other meetings, in a fortnightly round-up.

A staff notice board was maintained which included documents which needed to be read and signed for by staff. This ensured the matron knew when staff had accessed key information.

Vision and strategy

The service had a vision for what it wanted to achieve and plans to turn it into action.

There was no written vision or strategy for the critical care service. However, service leads described working towards full compliance with GPIC standards including setting up a follow up service as their medium term goals. Service leads also described feeling positive about the recent changes to senior leadership of the trust and were supportive of the general direction of travel for the trust which they felt was starting to broadly improve patient care.

Whilst there was no written vision, staff we spoke with shared service leads ambitions for the service. Staff talked about improving the environment of the unit, developing a follow up clinic and improving the flow through the unit. Some plans were underway, including refitting the outdated flooring which was due to happen shortly after our inspection.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We observed a positive, inclusive and collaborative culture within the critical care service.

Nursing staff said they felt supported by the senior nursing team and there were plenty of opportunities provided for professional development. They described positive experiences of mentorship and support. This was noted to be very positive given the unit had not had a dedicated practice educator following staff restructuring a few years prior to our inspection.

Staff described the matron as ‘very open.’ They all said they would feel comfortable approaching her if they needed to raise a concern. One member of staff recalled an open and informal discussion with the matron which had left them feeling valued.
Staff said that procedures within the department, such as regular debrief, made them feel safe. One member of staff said “I don’t ever feel let down.” Another member of staff told us “Doctors listen to you every time.”

Staff felt motivated by the new trust executive team feeling that the trust was making some much needed improvements to the overall culture at the hospital.

**Governance**

Local leaders used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was a system in place involving all staff and grades to review and improve the service. There were clear reporting lines from frontline nurses through to the trust board which was through the CBU leaders.

The departmental structure was clearly laid out and staff understood the hierarchy. The new matron had ensured that the Band 6 nurses had clear roles and dedicated areas of responsibility. Some provided clinical leadership and some had more operational or business led responsibilities. There were regular monthly meetings for the whole ICU department as well as separate monthly meetings for deputy sisters and clinical leads such as band 6 nurses.

Staff told us they were clear about their roles and responsibilities.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The critical care unit held its own risk register. There were three risks on the departmental risk register which were the challenges associated with delayed discharges and two environment risks (flooring and the pantry not being fit for purpose). We could clearly see how risks on the risk register were being mitigated. However, there were some risks that were not recorded on the risk register such as not being fully complaint with GPIC standards and the numbers of mixed sex breaches.

Staff were involved in the decision making and received regular feedback from their seniors, which they appreciated. Senior staff we spoke with said that historically they had not always felt that trust level managers had listened to them or responded appropriately when they had escalated risks. However, they reported this had improved in recent times. Staff said they were involved in decisions about risk. For example, a decision had been taken to replace the floor in the unit, which involved patients temporarily moving to another part of the hospital.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. However, some data was not being collated or analysed to improve the quality of care. For example, leaders were not monitoring the length of individual mixed sex breaches to reduce the impact on patients.

Service leads reviewed a range of data including ICNARC and audit (trust-wide and local) and used the results to improve the quality of the service. Recent audit results were displayed on a noticeboard in the unit. These were in relation to uniform, equipment cleanliness, MRSA screening and PPE for example. Where results fell below expectations, explanations had been recorded showing the outcomes had been investigated.
Engagement

The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service valued the views of patients and their relatives and considered them an essential part of running and developing the service. Staff used patient and relative interactions as a way of continual improvement to shape the service. There were patient representatives on the transfer/transport committees, ensuring the views of patients were heard.

Staff told us there had been some recent changes in the lay out of the department due to the fire policy. All staff had been asked how they felt about the new layout. All staff said they had been asked for feedback by senior staff nurses and senior sisters.

Feedback from care after death and bereavement service suggests the service could be further developed. The critical care service was receptive to feedback.

Staff engaged in a positive way with partner agencies where needed to enhance patient care.

Learning, continuous improvement and innovation

Innovation was encouraged and supported by the service. Staff were listened to and we were aware of changes in the department as they continually sought and researched new ideas to improve.

Staff told us they felt encouraged within the department to be innovative. They told us they had put forward a request for some protected time on the ward first thing in the morning, this would impact on the timing of ward rounds and therefore further feedback was being sought from doctors, as a potentially more effective way of working.
We inspected the maternity service for Isle of Wight (IOW) NHS Trust as an announced visit as part of the new phase of our inspection methodology. The inspection of the Maternity unit took place on the 23, 24 and 25 January 2018.

The maternity service provided midwifery led care for low risk women and obstetric consultant led care for high risk women.

- Antenatal and postnatal ward consisted of 17 rooms two 4 bedded bays and 8 side rooms. There was also a birthing suite which included two midwifery led care beds, an obstetric theatre and a day assessment unit with two chairs facilities. The trust also had a special baby care unit where Newborn babies were transferred for specialist care and this unit was inspected separately.

A community midwifery team covered the whole of the IOW and worked closely with the acute team. We did not inspect the community team; however we spoke with some midwives who worked across both sectors.

**Number of babies delivered at Isle of Wight NHS Trust by quarter.**

In the most recent four quarters, from July 2016 to June 2017, 1,121 women delivered their babies at the trust. Trends by quarter for the last two years can be seen in the graph below.

(Source: Trust Provider Information Request – Acute sites)

(SOURCE: HES - Deliveries (July 2016 - June 2017))

A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below.
A profile of the births can be viewed below.

Table 1: Profile of all deliveries (July 2016 to June 2017)

<table>
<thead>
<tr>
<th></th>
<th>Isle of Wight NHS trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>1,104</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>17</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>57</td>
<td>5.1%</td>
</tr>
<tr>
<td>20-34</td>
<td>869</td>
<td>77.5%</td>
</tr>
<tr>
<td>35-39</td>
<td>154</td>
<td>13.7%</td>
</tr>
<tr>
<td>40+</td>
<td>41</td>
<td>3.7%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td>1,121</td>
<td>608,950</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

During this inspection we spoke with 22 staff including midwives, maternity care assistants, administrative staff, cleaning staff, physiotherapists, consultant obstetrician, specialist trained doctors, the deputy head of midwifery, delivery suite midwives, antenatal and postnatal ward manager, We spoke with 7 women and their families to obtain feedback on the care they had received. We reviewed 13 women’s and baby records.

The Care Quality Commission last inspected the maternity service as part of a maternity and gynaecology inspection in June 2014. The rating for maternity and gynaecology service was good overall. We previously inspected maternity jointly with gynaecology, during this inspection we have inspected and will report on the maternity service.
Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training for staff working in the maternity unit did not always meet trust targets. Staff consistently did not meet targets and attend mandatory training modules as required for their role.

The trust set a target of 85% for completion of mandatory training. In maternity, both medical and dental staff and nursing/midwifery staff had just met the overall target of 85% with medical/dental staff being 85.5% overall compliant and nursing/midwifery staff having 86.8% compliance. However, some areas of mandatory training fell below the 85% compliance target.

Mandatory Training Completion by module – Medical and Dental Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Newborn Life Support</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>11</td>
<td>81.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>11</td>
<td>81.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>11</td>
<td>72.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>11</td>
<td>72.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>11</td>
<td>63.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>11</td>
<td>54.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>11</td>
<td>45.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical/dental staff working within maternity met the target for 10 of the 17 training courses listed above. Courses with the lowest compliance levels included prevent training levels 1 & 2 (five out of 11 members of staff completed this) and hand hygiene (six out of 11 members of staff completed this).

The compliance rate for adult resuscitation training which should be one of the core mandatory training had 63% compliance, hand hygiene at 54% and Prevent training at 45%. These were well below the trust’s target of 85%.

There was no evidence about what action the trust was undertaking to ensure compliance with mandatory training.

**Mandatory Training Completion by module – Nursing and Midwifery Staff**

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>52</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>52</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>52</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>52</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>52</td>
<td>90.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>52</td>
<td>88.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>52</td>
<td>86.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Newborn Life Support</td>
<td>52</td>
<td>86.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>52</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>52</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>52</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>52</td>
<td>82.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>50</td>
<td>82.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>52</td>
<td>78.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>52</td>
<td>75.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>52</td>
<td>51.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Load Handling</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff working within maternity met the target for 8 out of the 18 courses listed above. The training course with the lowest compliance rate was PREVENT training levels 1 & 2 (27 out of 52 members of staff completed this).
PREVENT is a government agenda to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence. Healthcare staff were well placed to recognise individuals, whether service users, patients or staff, who may be vulnerable and therefore more susceptible to radicalisation by violent extremists or terrorists. Nursing and midwifery staff had achieved 51% for level 1&2 Prevent training. This was well below the trust’s target of 85%.

We reviewed the number of nursing and medical staff trained in basic neonatal life support. Currently 80% of all registered and non-registered nursing staff held basic neonatal life support training. The trust confirmed that an action plan was in place for the remainder of the staff to complete this training. Staff told us that workload and staffing were the two main barriers in completing training.

Practical obstetric multi professional training (PROMPT) was mandatory and should have been completed by the multidisciplinary team annually. The training included recognition and management of certain conditions such as shoulder dystocia, antepartum and post-partum haemorrhage, vaginal breech birth, cord prolapse, severe pre-eclampsia, maternal sepsis, maternal collapse, management of the seriously ill woman, fluid balance, maternity early obstetric warning scores, twin birth, and record keeping and documentation. This training involved a simulation to ensure the practical application of the training.

Some staff said they had completed this training at one of the tertiary centres and a senior staff said that they were planning simulation training in house from next year. We have not received data as this was not available from the trust to enable us to assess staff’s compliance with this training. At the factual accuracy process, the trust has confirmed that most of the eligible staff had completed the PROMPT training.

Safeguarding

The trust set a target of 85% for completion of safeguarding training.

Safeguarding Training Completion by module – Medical and Dental Staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for medical/dental in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>11</td>
<td>81.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>11</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical/dental staff working in maternity met the standard for two of the safeguarding modules; safeguarding adults’ level 1 and safeguarding children level 1. There was a lower compliance rate for safeguarding children’s level 2, with nine out of 11 members of staff having completed this.

The intercollegiate guidelines for safeguarding children recommends that staff providing care to children should be trained to level 3 in safeguarding. There were no medical staff in maternity who had achieved this training.

Safeguarding Training Completion by module Nursing and Midwifery Staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>11</td>
<td>81.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>11</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>52</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>52</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>49</td>
<td>89.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>52</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff working within maternity met the standard for three of the four safeguarding modules and have a completion rate of 84.6% for the remaining one.

(Source: Trust Provider Information Request P18)

In line with the intercollegiate document on safeguarding, midwives and doctors were required to complete safeguarding children training at level 3. The requirement is staff to have over a three year period 18 hours safeguarding training, a one day face to face training, e-learning completion and annual update days providing two hours face to face. This ensured staff’s confidence and competence in identifying and acting appropriately to safeguarding concerns. Over 85% of midwives had achieved safeguarding at level 3. However there was no doctor who had achieved level 3 training in safeguarding as the trust data showed 0% compliance with this.

There were safeguarding policies and processes for referrals or raising an alert in place at the trust. Staff spoken with were able to tell us about the processes they would follow and were confident in identifying and referring a safeguarding concern. They were aware who to contact if they required any safeguarding advice and support.

Safeguarding was considered as part of the assessment of women. Safeguarding was discussed during handovers as appropriate and at team meetings. However staff told us there was no consistency on how this information was cascaded to the staff.

There was a named midwife and a Consultant lead for safeguarding in the maternity unit. The midwife lead was based in the hospital and provided advice, and support to the staff within the maternity service. We were told that the safeguarding lead attended multi-agency meetings; however there were no minutes of these and there was no established process for sharing information and learning. There was no evidence that the leads had completed safeguarding children training at level 4 as required.

The midwives team were aware of female genital mutilation (FGM) and had received training as part of their level three safeguarding. Staff told us they were not aware if any cases had been reported within the last year. They were unsure whether data was collected; although they were confident that they would report any such cases.

The process for safeguarding flags being added to the electronic system was not robust. There was a risk healthcare professionals may come in to contact with a woman or their baby and not be made aware of the safeguarding concerns as they used a different electronic system or did not have the patients’ records to hand.

There was no system in place to provide real time information of the status of each woman or baby. At risk groups of women such as homeless women, those with mental health concerns, domestic violence cases, alcohol and drug abuse cases may not be identified due to availability of
current information. The current status and action of the safeguarding concern relating to these women may be missed including those who had been discharged meaning appropriate follow up may not have been put in place.

**Cleanliness, infection control and hygiene**

The maternity unit appeared to be visibly clean. Staff followed procedures for the prevention and control of infection. They used hand gels and we observed staff cleaning their hands between patient’s contacts. Staff adhered to bare below the elbow best practice guidance in the clinical environment.

We requested to see the cleaning rota s for the birthing pool and two staff members confirmed that there were none in place. This is a high risk area and detailed cleaning procedure and records of cleaning should have been maintained.

Infection control training was part of mandatory training for all staff and data from the trust showed that medical staff had achieved 74% compliance which was below the trust target of 85%. We were not assured that there was a robust process in place to monitor compliance with mandatory training in this area.

Hand hygiene audits were completed monthly, however the results were not displayed. Hand hygiene audit showed compliance ranging between 80-100%. The unit had a process of using “I am clean stickers” to identify clean equipment and inform staff practices. We observed a number of equipment which did not have stickers on and staff told us that they should be used. This posed infection control risks as staff could not be assured that the equipment had been cleaned and was safe and ready for use.

**Environment and equipment**

There was a risk that emergency equipment was not available and ready for use. Daily checks of emergency equipment were not consistently completed in different parts of the units. Equipment in the ante-natal and post -natal wards were checked and records were kept. However the resuscitation trolleys in the labour ward did not meet with the Resuscitation Council (UK) guidelines. Records showed daily checks were not consistently carried out in line with the trust policy and procedures and this included the neonatal resuscitation equipment. There was confusion amongst the staff regarding which team was responsible to check the neonatal resuscitation trolley and this had resulted in emergency equipment not being checked. This was highlighted in the last inspection report where this emergency equipment had not been checked for 4 weeks.

The emergency resuscitation trolleys did not have tamper proof tags. This is a system used in order to identify if the equipment had been tampered with, as the seals would be broken. This, combined with the inconsistency of daily checks, posed risks as the trust could not be assured that the equipment was fit for purpose and ready for use in an emergency. We brought this to the attention of senior management during the inspection. Staff told us that the resuscitation team would be reviewing the emergency trolleys across the trust in order to ensure a safe system.

The labour ward had a birthing pool which staff said was new. We observed that the birthing pool was accessed using a stool due to the height of the pool. There was a net for the removal of mother and baby in an emergency. Senior staff confirmed that staff had not completed any training for the use of the net. There was no risk assessment for the birthing pool and emergency
evacuation drill had not been developed to ensure safe management of mother and baby in an emergency. At the last inspection similar concerns were raised regarding lifting equipment for the pool and their safety management.

During the inspection we received concerns regarding the fitness of equipment used in the operating theatres. We requested a list of equipment used in the obstetric theatres and this showed that some equipment was serviced; however this was not consistent. Eight equipment were serviced in 2017 and one in 2016 and two in 2018. The Force triad diathermy was purchased in 2009 and was last serviced in 2011. Another diathermy was purchased in 2009, there was no record of servicing according to information provided by the trust. Other equipment included cameras, videos, monitors which were purchased in 2005 and no servicing records. The trust could not be assured that equipment were maintained in line with manufacturer’s guidance to ensure they remained safe and fit for purpose.

The entrance to the maternity unit had restricted access. However staff told us they did not have adequate receptionist cover on the front desk. During the inspection we observed the reception area was not always manned. Staff on the ward used an intercom system to allow access to visitors. The unit did not maintain a visitor’s register which meant staff could not account of people in the unit and in an emergency. There was also a risk of unauthorised people entering the unit as people may enter by following others. In the labour ward, there was no facility to ensure that unauthorised people did not enter the ward as staff were unable to see who they were allowing in. This risk had also been highlighted following a peer review. The trust was looking at volunteers to staff the reception area.

There was a lack of facilities to accommodate partners on the unit and staff told us it was difficult for partners to stay overnight. Staff told us they tried to accommodate partners; however the rooms were restricted and “not ideal”. A staff member said the trust was looking at acquiring some appropriate chairs.

There was a room which had been set up for families who had experienced loss of a baby. This room was quite isolated and away from the main unit. There was a single bed and the room was impersonal and clinical in appearance although there was facility for making hot drinks. Staff member agreed that the room could be made more homely and comfortable and said the choice of less clinical bedding for example had previously been discarded by the infection control team.

There was a dedicated obstetric theatre which was easily accessible from the delivery suite. The theatres were set up to include all equipment needed for obstetric care. There was a resuscitair in the labour ward which was checked and set up ready for use. There was a resuscitair in the obstetric theatre and a second resuscitair was available in case it was needed for twin births. A resuscitair is used for warming babies and has an emergency facility if needed for resuscitation. The neonatal unit was situated close to the delivery suite and was easily accessible.

Assessing and responding to patient risk

There were procedures in place which staff followed for identifying high risk patients. These included risk assessments which were completed at ante natal stages, throughout their pregnancy and postnata lly.
We reviewed eight sets of women’s records and they contained risk assessments and care plans with detailed information to manage identified risks. Staff were able to access their internal procedures and pathways as required in order to deliver care in line with guidance.

Midwives confirmed that they followed guidelines regarding fresh eyes when reviewing cardiotocograph (CTG) which are recordings of the foetal heart rate. Misinterpretation of a CTG can be common, and therefore fresh eyes, by using a second person to review the CTG, reduces the risk of something being missed. We saw evidence of this in care records we reviewed. Staff used stickers as part of their hourly reviews. Staff told us they tried to maintain hourly checks however this was not always possible due to staffing shortage. Trust’s data showed that they had achieved 80% fresh eyes compliance as per unit guidelines in January 2018.

The maternity unit used the modified early obstetric warning score (MEOWS) for women. The MEOWS is a tool used to allow early recognition of physical deterioration in women by reviewing physiological parameters. These were completed in all eight patients’ care records which we reviewed. For babies, the Newborn early warning score prenatal, perinatal and postnatal was used. We observed during handovers, scores were discussed to include any resulting changes in management plans, for example changing the frequency of observations or requesting a review by a doctor as required.

Increasing risks associated with maternal diabetes was well managed in the unit. Record showed patient was on a sliding scale of insulin and clear instructions were in place for bolus dosage and reviews.

Staff had good awareness of sepsis recognition and we saw the recent policy and procedures and staff showed us how they accessed these. Women and their baby had their temperature closely monitored and recorded. We saw evidence of action taken for a suspected neonatal infection where a baby had a raised temperature. This was well managed and in line with the trust sepsis policy and included multi-disciplinary team input.

Patients who had emergency or planned caesarean sections were nursed in the unit. Maternity did not have a high dependency unit and deteriorating women were nursed in the recovery area. They were transferred out to the intensive care unit or externally as required. The data we received from the trust showed that no women had been transferred out to other units in the year prior to our inspection. Staff had raised concerns about the appropriateness of the recovery area as this was away from the unit and there was one midwife allocated to this area.

Women were admitted to the labour ward /delivery suite for inductions of labour where required. Inductions were discussed at handovers as staffing was shared across the unit. Women received 1:1 care during induction and we observed this was available during the inspection.

High risk patients, medically, and those with social concerns, were highlighted during the booking process by a consultant obstetrician. High risk women were referred to the antenatal staff to ensure additional screening requirements were met.

There was inadequate emergency evacuation process for the birthing pool as there was a lack of lifting equipment except for a net, and staff had not completed emergency evacuation drills. Although there was a net, staff confirmed that they had not completed training for using this equipment. These concerns were raised with the trust at the time of the inspection, as action was
needed. The trust confirmed to us that the birthing pool will be out of action until appropriate and safe emergency management procedures and staff training could be put in place. This was to safeguard the welfare of women using the birthing pool.

Arrangements were in place for women having home births who deteriorated in the community and staff would call 999. Staff told us that the midwives would also call the unit as they worked across both sectors and knew the staff. We saw evidence of this in one woman’s record who had a homebirth plan but was admitted to the labour ward due to her deteriorating condition.

Patients’ records showed that pregnant women were made aware of the importance of foetal movement and staff told us this was also discussed during antenatal care. The service followed the care bundle for reduced foetal movements programme (saving babies lives). The foetal movements were documented in the notes, if there were any concerns expectant mothers were asked to call their midwife or the unit.

Staff involved in the obstetric theatre told us they used “five steps to safer surgery” procedure. The World Health Organisation (WHO) guidelines (5 steps to safer surgery) the surgical safety checklist is guidance to promote safety of patients undergoing surgery. This sets out what should be done during every surgical procedure to reduce the risk of errors. The checklist must be read out loud, and must include all sections of the checklist including the ‘sign in’ before anaesthesia is commenced, the ‘time out’ before starting surgery, and the ‘sign out’ before any member of the team leave the operating theatre. We were unable to observe this procedure in the operating theatre as there was no surgery during our inspection.

However we reviewed six sets of women’s post -operative records following a caesarean section procedure. We found that staff did not consistently follow guidelines as the WHO checklists were not fully completed. This included the pre-op checklists were not completed and there were inconsistencies in the signing out process. We requested audit of WHO checklist which we received after the inspection. The unit carried out an audit in November 2017 which showed 70% compliance. This meant that the use of the WHO checklist was not fully embedded in routine practice. There was no action plan developed to demonstrate how the risks of lack of compliance with this would be addressed.

**Midwifery and nurse staffing**

Information is routinely requested about total numbers of planned staff versus the total numbers of actual staff on duty within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data when we requested this. This showed that the trust were not effectively monitoring planned versus actual staffing.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

There were four midwives allocated per shift in the unit. They were supported by three support workers. The maternity unit did not have a nursery nurse, they could ask for support from the neonatal intensive care if they are very busy. Staff told us that there were staffing challenges as the unit had staff on long term sickness and they used community midwives and bank to support
them. There was no ward coordinator in a supernumerary role to provide support and advice to the staff. Feedback from staff was that there was not always adequate staff to meet patients’ needs which could impact on care and this was a particular concern at night and weekends. Staff said that they had a ward clerk Monday to Friday and not at the weekends which can be very busy times.

Staff worked across the antenatal, postnatal and labour wards. There were also concerns raised with us that when there was an emergency caesarean section, for example, this impacted on staff’s availability in the unit. Midwives and healthcare assistants were taken off the ward to support in theatre which meant there was a shortage of staff on the wards. We saw there was an on call rota for nursing staff; however, staff told us this did not always work as they did not have time to ring on call when they are very busy. Staff also commented that they were discouraged to use the on call system and some staff did not feel confident to call out for extra staff as they would be questioned by their seniors/management.

Staff also raised concerns about the lack of band 7 presence on days, night shifts and at weekends. There was currently 3.4 whole time equivalent availability of band 7 on the labour ward to supervise and support. The roster showed that there were 3 band 6s and 2 bands 7s who were on call to support home births and the unit. The supervisor of midwife post had been terminated and there was only one professional midwifery advocate which did not meet with national guidelines.

Vacancy rates

From October 2016 to September 2017, the trust reported an overall vacancy rate of 0% for registered nursing and midwifery staff working within maternity.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From October 2016 to September 2017, the trust reported an overall turnover rate of 10% for registered nursing and midwifery staff working within maternity.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From October 2016 to September 2017, the trust reported an overall sickness rate of 6% for registered nursing and midwifery staff working within maternity.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
From October 2016 to September 2017, the trust reported an overall bank usage of 25 shifts, and no agency usage. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Midwife to birth ratio

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data. We have no up to date data relating to midwife to baby ratio as the last data provided from the trust was dated 2015. This suggested the trust were not prioritising the midwife to birth ratio.

(Source: NHS Digital)

Medical staffing

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data as requested.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From October 2016 to September 2017, the trust reported an overall vacancy rate of 1% for medical/dental staff working within maternity.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From October 2016 to September 2017, the trust reported an overall turnover rate of 14% for medical/dental staff working within maternity.
Sickness rates

From October 2016 to September 2017, the trust reported an overall sickness rate of 0.5% for medical/dental staff working within maternity.

Bank and locum staff usage

From October 2016 to September 2017, the trust reported a bank usage of 7 shifts and an agency usage of 118 shifts. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

Staffing skill mix

From July 2017 to July 2017, the proportion of consultant staff reported to be working at the trust were higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career</td>
<td>50%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>8%</td>
<td>43%</td>
</tr>
<tr>
<td>Junior</td>
<td>0%</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)
Consultant cover on labour ward

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data when we requested this.

(Source: Routine Trust Provider Information Request (RPIR) – P22 Consultant Cover)

Medical staffing

During the inspection we spoke with the four medical team members and we were told that overall they had adequate cover which was provided as an on call system. There were five consultants and they provided 40 hours of consultant’s cover between the hours of 08:30 and 16:30. This was in line with the Royal College of Obstetricians and Gynaecologists recommendations for the number of births within the service.

The consultant team was supported by middle grade doctors. There were six middle grade doctors; these are specialities doctors with no obstetrics and gynaecology trainees. There was one locum middle grade providing cover for a doctor on long term sick leave. The middle grades worked 12 hour shifts on a rotational basis of 4 long days and 4 nights and time off in between.

There were 24 hour consultants cover for emergency obstetric care, high risk antenatal care, and delivery suite cover. Consultants reported the on call rota was difficult as it was split across maternity and gynaecology. There was a 24 hour elective and emergency obstetric anaesthetic team available.

During the inspection staff raised concerns about the middle grad doctors who did not assist in theatres and this meant there was no learning. The middle grades did not undertake ante natal clinics.

We discussed the limited visibility of the medical team in the delivery suite and in the unit. Medical staff and midwives confirmed the medical team were not present but would attend if they were needed. Staff reported that consultants were completing only daily ward rounds, not twice daily. This was not in line with Safer Childbirth guidance.

A medical handover was completed daily. We observed a handover which was attended by the consultants, specialist doctors, and midwives. There was a high quality of discussion within this handover. Women and their babies were discussed, and the plans for the day which included any elective caesarean sections or planned inductions. The situation background assessment recommendation (SBAR) document was partially used when discussing women and their babies.

Records

The maternity unit used a paper based system for their record management. We found records were in poor conditions, a number of records were not bound and loose and included scans and blood results. The lack of a robust process of filing patients’ records posed risks of results being mislaid and lost. We noted that cardiotocograph (CTG) did not have the patients’ details in two records we reviewed.
Records also showed that consent forms were not fully completed such as examples where patients had signed the form and there was no date and the names of the patients were not printed.

Records were not being regularly audited to ensure compliance with guidelines and best practice. This did not allow for trends of good and poor documentation to be identified and action plans to be developed to improve practices and learning. The last records audit submitted by the trust in March 2018 showed that maternal notes audit observations in labour was undertaken in September 2016. This highlighted low degrees of compliance with CTG assessment such as 4 sets of records were non-compliant with hourly assessment; 2 out of 7 sets of records had the women temperature recorded 4 hourly.

We saw evidence within women’s care records of antenatal risk assessments and screening completed, to include safeguarding. A venous thromboembolism (blood clot) risk assessment was also complete in the care records seen. Patients’ observations using the modified early obstetric warning score, and foetal monitoring records were also complete, signed and dated. Staff kept detailed records of care and treatment of care provided in the unit.

Staff had access to information on patients’ care and treatment. Women were provided with handheld records. This was a medical record of care given to the woman and unborn baby during pregnancy. The records were kept by the women which meant that information was available to healthcare professionals as it tracked their pregnancy. Following birth, the mothers were provided with a red book which was a personalised child record and recorded the child’s health and development.

However, we raised our concerns with senior management at the trust as the growth chart was not pre populated and available in the women’s records. We were told that this was carried out in the scanning rooms and were kept there for audit purposes. This meant that some records of women’s care were not available as required.

Staff had access to policies and procedures which were in paper formats and also on the trust’s intranet. The paper policies should be version controlled documents; however, this was not reflected on the records. There was also no evidence of recent reviews. This posed risks of staff relying on policies and procedures which may be outdated and not reflecting current practice guidelines.

Data from the trust highlighted an incident which met the serious incident criteria, where confidential information leak/information and governance breach.

(Source: Strategic Executive Information System (STEIS))

**Medicines**

Policies and procedures were in place for the management of medicines in the unit. However, there was no internal auditing by the trust to assure them that medicines management was safe.

We looked at a random sample of medicines including controlled drugs (CDs) in the labour ward. There was an internal policy for CDs to be checked three times daily. We reviewed records for CDs checks for the months of December 2017 and January 2018. This showed no checks were carried out for 11 days between 1-24 January 2018. For December 2017; there were 12 days where the CDs were not checked. The staff had carried out daily checks on the other days. Staff confirmed that this should be done three times daily and did not know why these had been missed.

In the day assessment unit we carried out a random check of medicines and found two
medicines which had expired. We were not assured that there was a system in place for stock checks to ensure medicines were safe.

We observed medicines were stored securely in a locked room with restricted access. To access the medicines it required two staff members and finger prints recognition which reduced the risks of unauthorised access. Staff told us that the fridge temperatures were monitored centrally to ensure medicines were stored correctly and at the recommended temperature. Emergency medicines were available and kept with emergency resuscitation equipment.

A random sample of prescription records showed that these were completed appropriately.

**Incidents**

From December 2016 to November 2017, the trust reported no incidents in maternity classified as a never event. There was one serious incident relating to an infant death in early 2016 and this investigation was in progress at the time of our inspection.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

There was a process in place for reporting and recording incidents. Nursing staff said they used the internal intranet system and they told us that they were able to access this as needed.

We received serious concerns about incidents reporting by medical staff. These related to culture within the service where staff did not consistently report incidents which may be detrimental to patients’ health and well-being. Staff told us that nursing staff did report incidents but the doctors left it to the nurses to do so. These included maternal haemorrhage and birth related third degree tears. We requested data from the trust about number of incidents in theatre and we haven’t received this information at the time of submitting this draft report.

Nursing staff told us they used their internal system of Datix to report some incidents. Two staff members said that at times incidents were delayed or were not reported when the unit was very busy. This was particularly in relation to raising incidents when the unit did not have adequate staff.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Midwives told us about being open and honest when things go wrong and supporting the women. However, staff told us they had not received any formal training relating to the DoC.

There was variable understanding among staff about when DoC should be initiated such as for drug errors which staff had not escalated. Data regarding DoC as supplied from the trust showed that some part of the DoC was followed; however, we noted the verbal apology was not always followed up by a letter.

Senior staff members we spoke with were clear about their responsibilities in relation to DoC. We saw evidence of the DoC had been initiated following an incident which resulted in the death of a baby. There was clear communication with the family and included an offer of bereavement support.

We were told that learning from incidents was managed on a 1:1 basis and information. Additionally, staff said information was shared with staff on a monthly basis and through ‘staff updates folders’. Midwives told us they heard about some of the incidents which occurred;
however, this was not consistent. Staff could not tell us of changes to practices which had occurred through learning from incidents.

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in maternity which met the reporting criteria set by NHS England from December 2016 to November 2017.

Safety thermometer

The maternity unit collected safety thermometer data in relation to care provided to women. This provides a means of checking performance and is used alongside other measures to direct improvement in patients’ care.

The safety thermometer data for December 2017 which we reviewed at the time of the inspection showed there had been no fall, urinary tract infection (UTI) or venous thromboembolism (VTE) or blood clots.

The maternity safety thermometer data did not include recording blood loss over 500ml, perineal tears (tears to the area between the vagina and rectum during birth), the psychological well-being of the mother and the baby’s health scores in the first 10 minutes following birth. This was a tool used that allows trusts to focus on these types of incidents and as a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced ‘harm free’ care.

Is the service effective?

Evidence-based care and treatment

The maternity service provided care and treatment in line with national guidance and best practice such as the Royal College of Obstetrics and Gynaecology (RCOG) and National Institute for Health and Clinical Excellence (NICE).

NICE quality standards are guidelines designed to drive measurable quality improvements within a particular area of health or care. They are derived from the best available evidence and other evidence sources accredited by NICE. They make evidence-based recommendations on a range of topics, which should be used by staff as appropriate, with the aim of promoting individualised and integrated care.

The unit followed NICE QS 22 guidelines for antenatal care. This included advice on foetal monitoring and lack of foetal movements for example and what women should do. Other guidance included CG62- Antenatal care for uncomplicated pregnancies, CG190 - Intrapartum care for healthy women and babies and PH11 - Maternal and child nutrition.

The trust had achieved UNICEF baby friendly initiative (BFI) and World Health Organisation (WHO) stage 1 baby friendly initiatives (BFI) breast feeding accreditation. This is an evidence based approach to support breastfeeding by improving standards of care and support.

The maternity service had arrangement in place to achieve best practice in line with the stillbirth and neonatal death charity (Sands) - Five ways to improve care for parents whose baby dies
before, during or shortly after birth. There was a room in the main maternity unit for women and their family to allow them time and space to grieve. Parents could have a memory box with mementos of their baby such as hand/foot prints, photographs and hair lock.

Sands recommends all maternity unit staff should have access to a specially trained bereavement midwife who is responsible for staff training and support, and for monitoring policies and procedures to ensure bereaved parents receive good quality care. Staff we spoke with were unsure if there was a dedicated midwife for this role. During the inspection a member of the senior team had confirmed there was a designated bereavement midwife based in the community who provided this support.

The trust carried out an audit of their compliance with their implementation of NICE guidelines for shoulder dystocia during the period of January 2016-June 2017. The result is illustrated below.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Target %</th>
<th>Exceptions</th>
<th>Achieved %</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mothers should receive postnatal briefing before discharge and/or at follow up</td>
<td>95%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cord blood should be taken to assess acidosis in babies</td>
<td>95%</td>
<td>0%</td>
<td>70%</td>
</tr>
<tr>
<td>Neonatal staff should attend in all cases of shoulder dystocia</td>
<td>95%</td>
<td>0%</td>
<td>78%</td>
</tr>
<tr>
<td>Proper documentation of delivery process should be done</td>
<td>95%</td>
<td>0%</td>
<td>83%</td>
</tr>
<tr>
<td>Incidence of shoulder dystocia should be reported</td>
<td>95%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Shoulder dystocia proforma should be filled</td>
<td>95%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency call 2222 should be done (unless all necessary staff are already present)</td>
<td>95%</td>
<td>When all staff are already present as in cases of trial of instrumental delivery in theatre</td>
<td>39%</td>
</tr>
</tbody>
</table>

There were some good practices noted from the audit such as Shoulder Dystocia incidence was reported and the proforma was filled in all cases. An action plan was developed to address the areas of non-compliance which included documentation of delivery process and postnatal briefing before discharge and at post-natal follow up. Cord PH should be taken regardless of baby’s condition at birth, and regardless of Appearance, Pulse, Grimace, Activity, and Respiration. (APGAR) score. Staff told us that there had been some progress in using this guideline although they were not aware if a re audit had been completed.
Nutrition and hydration

Women we spoke with were satisfied with the diet and fluids provided. They said they had access to hot and cold drinks and staff were “obliging” in meeting their requests. They were offered a choice of meals and staff checked to ensure they had eaten. Women told us they were also encouraged to have plenty of fluids. There was mixed feedback from women we spoke with about the advice they were given regarding healthy diet during the antenatal periods.

Women were sufficiently encouraged and supported to breast feed their baby. The data from NHS England for 2016/17 Q4 for this trust was 65% of women breast fed their baby within 48 hours. This was similar to the England average.

It is well documented that the prevalence of breastfeeding is particularly low among very young mothers and disadvantaged socio-economic groups. Midwives told us of initiatives to encourage and support breast feeding which included breastfeeding peer support groups in the community.

Pain relief

The women we spoke with said that they had received regular pain control as needed and were satisfied with the way that pain was managed. Women were provided with information at the antenatal stage and pain control choices were offered. Care records seen evidenced that pain control was considered at part of the birth plan.

There was 24 hour anaesthetist cover and they were available for epidural pain control. Epidural pain control was set up using an infusion pump to manage women’s pain and with midwives support. There was no data on the waiting time for epidural pain relief but midwives told us this was usually timely. Staff told us they did not report as an incident if a woman was kept waiting for longer than 30 minutes which may have meant that this was not being appropriately monitored. Midwives told us they received epidural training as part of their study days.

Women had access to opioids (stronger pain medicines) and Entonox (commonly called gas and air) which were available on the delivery suite. There was a birthing pool on the delivery suite; warm water immersion could be used as a method for pain relief.

Patient outcomes

There were 1,121 babies born in the trust in the reporting period of June 2016-June 2017. The profiles of delivery methods for elective and emergency caesarean sections were similar to the England average. The trust showed a better outcome at 62% of babies born using non interventional method compared to England average of 59%.

The RCOG recommends the use of a maternity dashboard; this is a tool that can be used to monitor the implementation of principles of clinical governance. It can be used to benchmark activity and monitor performance against the standards agreed locally for the maternity unit on a monthly basis. Healthwatch is the consumer champion for health and social care and they look at patients’ experiences of health and care in England, so that they can work together to make sure that the system works for people. They carried out a survey of women using the maternity service on the Isle of Wight. The report in 2016 found there was a much higher rate of people discussing home births as an option, and a much lower rate of people discussing Co-located Maternity Unit, Stand-alone Maternity Centres, and Hospital Obstetric Units.
The trust carried out an audit of women requiring blood transfusion following major haemorrhage during childbirth. This was a retrospective audit from November 2014 to April 2016 and this followed the RCOG Green-top Guideline for Management of Major Haemorrhage. The trust scored 100% on documentation of reasons for transfusion and provision of local protocols for the management of major haemorrhage. They scored 95% for gaining verbal consent and only 92% for cases of major haemorrhage which were reported as incidents.

In the 2016 National Neonatal Audit St Mary’s Hospital’s performance was as follows:

**Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?**

The trust scored 100%, which was higher than the National average of 96%. There were nine babies born at <32 weeks included in this audit.

**Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

The trust scored 93%, which was higher than the national average of 86%.

**What proportion of mothers delivered < 30 weeks received Magnesium Sulphate.**

The trust scored 0% compared with the national average of 43%

**What proportion of babies < 33 weeks gestation at birth were receiving any of their own mother's milk at discharge to home from a neonatal unit?**

The trust scored 88%, which was higher than the national average of 59%.

**What proportion of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission?**

The trust scored 100%, which was higher than the national average of 90%.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health 2017 Annual report)

### Standardised Caesarean section rates and modes of delivery

From July 2016 to June 2017, the overall standardised caesarean rate was as expected. Both the standardised caesarean section rates for elective sections and rates for emergency sections were also as expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>ISLE OF WIGHT NHS TRUST</th>
<th>Standardised Ratio</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective caesareans</td>
<td>116.3 (z=1.1)</td>
<td>Similar to expected</td>
<td></td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>87.9 (z=-0.9)</td>
<td>Similar to expected</td>
<td></td>
</tr>
<tr>
<td>Total caesareans</td>
<td>99.9 (z=0.0)</td>
<td>Similar to expected</td>
<td></td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
In relation to other modes of delivery, the table below shows the proportions of deliveries recorded by method in comparison to the England average from July 2016 to June 2017:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>ISLE OF WIGHT NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections</td>
<td>293</td>
<td>26.1%</td>
</tr>
<tr>
<td>Instrumental deliveries</td>
<td>124</td>
<td>11.1%</td>
</tr>
<tr>
<td>Non-interventional deliveries</td>
<td>701</td>
<td>62.5%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>3</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>1,121</td>
<td>100%</td>
</tr>
</tbody>
</table>

1Includes elective and emergency caesareans
2Includes forceps and ventouse (vacuum) deliveries
3Includes breech and normal (non assisted) deliveries

The non-interventional deliveries rate (including breach and normal (non-assisted) deliveries) was similar to the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

We reviewed further data which we received from the trust following our inspection of the maternity unit. This showed the caesarean sections rates were 28% with a monthly target rate of below 24%. The spontaneous delivery rates were 29% which was above the national target of <24%.

The induction of labour rates were 30% for the month of January 2018 and 29% year to date which was above the national average of 24%. The maternity breast feeding initiation rate was 68% which was below the national target rate of >73%.

Maternity active outlier alerts

As of October 2017, the trust had declared they had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2016 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.04, which was up to 10% lower than average for the comparator group. The comparator group was 4,000 or more births per annum at 24 weeks or later.
The MBRRACE (mother and babies: reducing risks through audits and confidential enquiries) published report on confidential enquiry into maternal deaths. This is a national programme of work conducting surveillance and investigating the causes of maternal deaths, still births and infant deaths.

The Royal College of Obstetricians and Gynaecologist (RCOG) green top best practice guideline 55 states ‘bereavement officers should be appointed to coordinate services’. There was a bereavement midwife we were told who was based in the community who provided support to women and their family.

(Source: MBRRACE UK)

Competent staff

All new staff completed a corporate induction programme when they joined the trust. There was other training available to the staff relevant to their roles. This included Cardiotocography (CTG) training. This is used during pregnancy to monitor the foetal heart and contractions of the uterus. There were weekly CTG updates on the unit. However there was no formal maternity induction programme.

The statutory supervision of midwives had ceased in April 2017. Staff were not aware if a replacement programme was being considered. Midwives were able to provide support to more junior midwives; however this was not embedded in practice. Midwives told us that the supervision programme was not adequate and needed to be developed with designated experienced midwives supporting other staff. Staff told us that this may impact on the quality of care that women receive as midwives were busy dealing with their caseloads and there was no planned/ dedicated time set apart for providing support to junior staff.

The latest appraisal data for nursing staff which we received from the trust showed 49% of midwives had an appraisal to date. This was well below the 100% trust compliance rate. Staff told us the changes to staff working practices had impacted on staffing and they had lost some experienced staff when the trust had introduced working across community and acute.

Midwives told us that they worked across the units which meant they maintained their skills from antenatal, labour wards and post- natal care. There was no evidence of competency frameworks or assessments for staff within the maternity service. This did not provide assurance of staff being competent in their role or the trust was able to identify any gaps in skills or knowledge across the service. A senior staff from the management team told us the trust was looking at developing the role of a practice development midwife to support learning in the unit.

Doctors we spoke with said they felt well supported and had training and good peer support. The appraisal rate for medical staff was 91%.

Appraisal rates

From October 2016 to September 2017, 54% of staff within maternity at the trust had received an appraisal; this was not meeting the trust’s target of 100%. It is widely accepted that unsupervised experience can lead to the acceptance of lower standards of care because the trainee may not
learn correct practice without appropriate supervision. They can improve patient care/experience. Therefore, improvements in outcomes for patients are one major test of effective supervision.

A split by staff group can be seen in the graph below:

**Appraisal Completion rates by staff group, October 2016 to September 2017**

![Appraisal Completion rates graph](image)

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

<table>
<thead>
<tr>
<th>Change since 2016 survey</th>
<th>Ranking Compared with all acute trusts in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>Decrease (worse than 16)! Below (worse than) average</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>No change</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>Lowest (worst) 20%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff surveys 2017)

**Multidisciplinary working**

We observed effective multi-disciplinary working between the team such as midwives, anaesthetist, consultants and health care support staff. Staff told us they worked as a team.

The Situation Background Assessment Recommendation (SBAR) tool was used to communicate between team members and promote patients safety. The tool included standardised prompt questions to ensure the information being shared was clear and well-focused. This is an effective and efficient way to communicate important information. Midwives were positive about this tool which had improved the way they communicated information within the multidisciplinary team.
especially in an emergency situation. We observed the use of SBAR during our inspection and when reviewing care records.

The unit had access to critical care outreach sepsis liaison for advice and support as needed. Patients’ records showed that the diabetic liaison nurse had visited the unit to review and support women with gestation diabetes. There was no designated physiotherapist for the maternity unit and staff said they relied on support of staff from the surgical wards.

A community discharge summary form was completed for each woman who had given birth. This enabled the information of the birth and postnatal care to be recorded and shared with the community team. Upon discharged from the maternity unit a discharge summary was sent to the GP. The GP would follow up the woman and the baby at six weeks old.

Arrangements were in place for inter departmental transfer such as NICU and ICU as needed. Midwives confirmed that other medical teams would attend the unit to review women as requested. The sonographers were part of the maternity team and staff told us they worked well together.

The unit also relied on the HEMS team for transferring acutely ill women and babies to tertiary centres on the mainland. Staff told us there were many challenges; and we were told us some staff were not confident in making referrals to tertiary centres and this may impact and cause delays. Staff said they worked closely with the neonatal team in order to support mothers and babies.

**Seven-day services**

The maternity unit provided twenty four hour care on the antenatal, postnatal and labour wards. The consultants were available Monday to Friday from 0830 to 16:30 and provided 24 hour on call emergency out of hours. There was a middle grade doctor available to cover all the shifts. Community midwives also provided on call service out of hours. Women undergoing caesarean sections were booked during normal working hours and emergency caesareans were facilitated as needed outside of these hours.

Ultrasound scan was provided by the diagnostic department within the antenatal clinic. These were routinely available Monday to Friday 9am to 5pm. Women were booked for appointments and there was the capacity to provide urgent appointments as required.

The perinatal mental health team was available Monday to Friday from 08:30 to 16:30 and out of hours staff relied on the on call service.

**Health promotion**

Midwives told us that they encouraged women about healthy eating and women were signposted to smoking cessation support in the community. Staff were not aware of any health promotion programmes which were available to pregnant women within the trust. Staff told us there was no one leading on teenage pregnancy although they could access drug awareness clinics. We requested data from the trust relating to women who smoke referred to public health trainers for support. We had not received this data at the time of submitting the draft report.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust reported that from April 2017 to September 2017, Mental Capacity Act (MCA) training had been completed by 50% of staff within maternity. This was lower than the trust’s own target of 85%. This meant staff may not have fully understood their responsibilities when caring for women who may not have full capacity to make decisions about all aspects of their care and treatment.
The trust training data did not include Deprivation of Liberty training. We requested data for mental capacity training following the inspection which we received in February 2018. This showed that out of 80 staff, only 11 staff (14%) had completed this training which was well below the trust compliance target of 85%. Whilst it would be unusual for maternity staff to have to deprive a woman of their liberty, staff still needed to be trained in this area should this situation ever arise.

There was a variable understanding of consent and decision making requirements of legislation and guidance. Staff spoken with understood the requirement to gain consent and their responsibilities in this process. Midwives were not always able to demonstrate an understanding of best interest and decision making when required.

The women we spoke with were satisfied with the consent process. They told staff had asked for permission before proceeding with care and treatment. Records also showed consents were gained for women undergoing surgical procedures.

(Source: Trust Provider Information Return P14/P49)

Is the service caring?

Compassionate care

We observed patients were treated with care, compassion, and respect by all staff they had contact with during their visit.

Women and their relatives were all positive about the care and treatment they had received. They told us their privacy and dignity was preserved when receiving care.

Staff treated women with respect and introduced themselves and took time to explain what they would be doing. Staff checked to ensure that women preferences and comfort were considered when providing care. Partners were also treated with respect and supported as needed.

The women comments “my midwife has been great and she does make sure and give time to ask questions”. Another person said “we have been left to get on and this works well for us. We are very happy with things”.

During our inspection we observed the day assessment unit had two couches and was separated by a curtain which did not support women’s privacy. There was no facility to have private discussion about women’s care and treatment without being overheard. Staff told us the women there were usually very anxious and needed lots of support and were high risk women requiring monitoring.

Friends and Family test performance

The trust took part in the NHS friends and family test and the result from 2016-2017 survey maternity birth point result showed 92-100% satisfaction with the care they had received. There was no result for the months of July, August and September as this had not been submitted.

Friends and family test performance (antenatal), Isle of Wight NHS Trust

During the inspection staff had raised concerns about the post-natal support for women following discharge from the unit. There were very low in the range of fewer than three submissions for the Family and Friends test (postnatal) for the trust.

Healthwatch survey 2016 asked women if they felt there was enough support in the first 10 days after birth for them and their babies found that 53% agreed and 47% said there was not enough
support. The main issues raised about postnatal support were the lack of continuity in the community.

**Friends and family test performance (birth), Isle of Wight NHS Trust**

From October 2016 to September 2017, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was in general similar to the England average. For three months of this twelve month period (November 2016, July 2017 and September 2017), there were fewer than three responses recorded, and therefore the results have not been submitted to protect anonymity. For the rest of the months, the trust scored 100% consistently, higher than the England average of around 97% for this 12 month period.

**Friends and family test performance (postnatal ward), Isle of Wight NHS Trust**

From October 2016 to September 2017, the trust’s Maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. In September 2017, there were fewer than three responses recorded, and therefore the results have not been submitted to protect anonymity. Aside from this month, the trust’s result remained fairly stable between 90% and 100%. This was similar to the England’s average which fluctuated between 94% and 95%.

**Friends and family test performance (postnatal community), Isle of Wight NHS Trust**

There was no submitted data for the Family and Friends test (postnatal community) for the trust.

(Source: NHS England Friends and Family Test)

**CQC Survey of women's experiences of Maternity services 2017**

The trust performed better than other trust’s for one out of the 15 questions in the CQC Maternity Survey 2017, scoring 9.74 for “Thinking about your care during labour and birth, were you spoken to in a way you could understand?”
The trust scored about the same as other trusts for the remaining 14 questions in the CQC Maternity Survey.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>9.13</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>8.56</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same</td>
<td>9.71</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>9.36</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.17</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>8.26</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>8.59</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>Best performing trusts</td>
<td>9.74</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>8.72</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same</td>
<td>9.27</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>9.10</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>7.34</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>8.12</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same</td>
<td>9.37</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same</td>
<td>8.92</td>
</tr>
</tbody>
</table>
Staff told us the trust currently women had good consistency in their antenatal care such as having the same midwife. However this was not available for postnatal and feedback from staff and two new mothers were that they were not assured that there would be same level of consistency.

The 2017 maternity survey showed that women who did not see the same midwife for either their antenatal or postnatal care reported a poorer experience when analysed in the theme ‘compassion’.

**Emotional support**

Women were supported emotionally and socially. Staff reflected on how they would provide emotional support for women, for example for general anxieties with regards to the pregnancy and birth, mental health support or support following death or unexpected abnormality of the baby.

Women felt that they were involved in their care and treatment. They told us the staff took time to answer their questions. One woman told us the staff “understood I was a bit anxious” and took time to listen to them and provided support and gave them time. Comments included “they take time and listen to you. Another woman said “they understand and make you feel special”. Staff provided patients with written and verbal information about their care and ensured that they had support at home if needed.

Women we spoke with felt they received good transitional care between the delivery suite and postnatal ward, with lots of support for them and their new born baby. They described staff as welcoming, friendly and approachable. Birthing partners and visitors were encouraged to visit and made to feel welcome. Visiting hours within the maternity unit were between 9am and 9pm for the birthing partner and between 2pm and 7pm for other visitors. Partners were able to stay overnight and it was made clear to them that they were there as valued support to the women.

Midwives assessed and documented women’s emotional state during antenatal appointments in line with NICE quality standard (QS115). The maternity unit benefited from a perinatal mental health team who provided specialist support in assessing and managing mental well-being during the maternity pathway.

Midwives we spoke with could sensitively describe the support in place when women loss their babies. Women received the support of bereavement counselling. The hospital chaplaincy service was also available to the women and those close to them. Staff ensured that there was clear communication with the community team to offer support and cancel any postnatal appointments. Women could also be referred to the mental health crisis team as needed.

**Understanding and involvement of patients and those close to them**

We spoke with five women and their partners about their care who told us they were fully informed of their care. They told us the midwives explained the options available to them including any risks. Women said their preferences were discussed and consent gained before partners were involved. Two people told us that this was their second child and the whole process seemed more relaxed. Partners told us they felt included in discussions such as birthing plan. Women records seen also reflected birth planning and preferences were documented.
We observed women receiving care and found they were kept informed and their consent gained before any care was given. All women and partners we spoke with were complimentary about the care they had received during their antenatal periods and during their stay.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

From Q4 2015/16 to Q1 2017/18, the bed occupancy levels for maternity were consistently lower than the England average. The trust's occupancy levels varied between 32% and 40% for this time period, much lower than the England.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

The trust planned and provided services in a way that met the needs of local people.

The trust had 16 antenatal and post-natal beds and five labour rooms and a birthing pool. There was a process that staff followed to ensure that care was planned to meet the needs of people using the service. Women followed different pathways depending on their risks such as midwife and consultant led care as appropriate. Patients were offered some flexibility in choosing their appointments, inductions and some caesarean section were planned. Although women commented that the clinics did not operate at the weekends and they had to fit in between the hours of 9-5pm.
The maternity service followed the public health agenda and better births recommendations. These included increasing the number of home births, reducing the number of caesarean sections, promoting breast-feeding and reducing smoking during and birth. Between April 2017 and February 2018 the homebirths rate was 3%. Staff were not aware of initiatives to promote the reduction of smoking in pregnancy apart from signposting them to external support.

As an integrated trust, the maternity service was provided both in the hospital and in the community. Midwives delivered antenatal and postnatal care in the community. A senior staff told us that the arrangement and delivery of the services were reviewed to ensure they met the needs of the local people. This also took into account some fluctuation during the summer holidays.

The maternity unit had a day assessment unit had two beds and was used 8.30am to 5pm Monday to Friday mainly for observations. If women needed to remain for longer period they were transferred to the antenatal ward.

**Meeting people’s individual needs**

**The service took account of patients’ individual needs.**

Women’s preferences regarding where they would like to have their babies was part of the initial assessment during the early stages of their pregnancy. Midwives told us that all efforts were made to meet the individual needs and this was recorded in the women’s plans.

Women with low risk or uncomplicated pregnancies were offered midwife led care to have their babies at home or in hospital. Those women with underlying/pregnancy related health concerns were under Consultant Led Care, to have their babies in hospital. Women were supported and the risks were discussed and a staff member told us arrangements would be made as far as possible to support high risks women in the community.

Women’s mental health needs were considered in the maternity unit. Perinatal mental health problems are those which may occur during pregnancy or in the first year following the birth of a child. This is associated with significant changes in the woman’s life. Staff confirmed that they had the support of a designated mental health lead in the community. Women were assessed and referred to the mental health team as appropriate.

Women whose first language was not English were offered a translation service. We saw leaflets in the maternity unit advising people in about six different languages to ask for information to suit their needs. Staff told us that women with a learning disability were referred to the learning disability team during the early stage of their pregnancies. Staff did not know if the learning disability team would be able to attend antenatal clinics in order to support these women.

Midwives had access to the drug liaison and domestic violence support teams.

**Access and flow**

**Patients could access the service when they needed it.**

There are a number of services available to women and these included

- Midwife led antenatal clinics in local children’s centres and GP surgeries
- Consultant led antenatal clinics held at St Mary’s Hospital
- Ultrasound scanning
- Antenatal screening
- Day Assessment Unit (DAU)
- Antenatal/Postnatal inpatient wards
The maternity unit saw approximately 1,250 women annually. The monthly number of women who received care fluctuated with an increase during the summer months. In the reporting periods from January 2017 to January 2018, there were 122 babies transferred in to the neonatal intensive care unit. The trust had told us that ‘Transfers’ in included 18 repatriations from tertiary centres and any baby admitted from labour ward, postnatal wards.

We cannot report on the number of babies who were transferred to the neonatal unit from the maternity unit, as there was no data available when we requested this from the trust. During the factual accuracy process, the trust submitted some further data which showed there were 27 planned admissions and 55 unexpected admissions to the unit.

The lack of local data showed the trust did not consider the impact of internal transfer and staffing. However the trust confirmed that there was no transfer of women to the critical care unit or the high dependency unit.

Women could self-refer for maternity care or via their GP. Women were triaged and low risk women followed a midwife led pathway and high risk women followed a consultant led pathway. Multiple births would also follow the consultant led pathway at this trust.

Pregnant women must have a full booking appointment before 12 weeks of their pregnancy in line with NICE guidelines. Between April 2017 and February 2018, the trust achieved an average of 89% which was below their target of 90%.

Staff confirmed that women who did not attend an appointment were followed up. There was no system to remind women of their appointment such as by text message. If a woman did not attend an appointment in the hospital or community a second appointment letter would be sent and the community midwife informed. The woman’s record would be reviewed for any safeguarding concerns. If the woman failed to attend their second appointment the community midwife would check on the woman at their home. If parents declined or missed screening appointments the community midwife would be informed and a letter sent to parents. A record of this would be made in the woman’s antenatal notes. Staff could not tell us if the woman’s GP would also be informed.

Learning from complaints and concerns

From October 2016 to September 2017, there were five complaints about maternity. Three complaints had been investigated closed, and two from September 2017 still remained open. The trust took an average of 32.7 working days to investigate and close these complaints. This was not in line with their complaints’ policy, which stated complaints should be closed within 20 working days or 45 working days if by prior agreement for more complex complaints.

A breakdown by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment - Obstetrics &amp; gynaecology</td>
<td>3</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>1</td>
</tr>
</tbody>
</table>
The trust had a policy and procedures for dealing with complaints. Information on how to raise a concern or complaint was available to women and their relatives including referrals to patient liaison advice service (PALS).

We saw there were a number of thank you cards which were displayed and seven people we spoke with told us they were treated very well. Patients told us the staff were kind and caring and they had received appropriate care and did not have any concerns.

Staff told us they did not receive many complaints and they would try and resolve any concerns at the time they were raised. However they did not maintain a record of the concerns or complaints that were resolved at the time.

If complaints could not be resolved, these would be escalated to the management team to investigate. There was inconsistency in the way that feedback from complaints was disseminated to staff. Staff said they sometimes heard about these at staff meetings but this was not consistent.

The trust told us they did not audit their complaints and concerns and we were not assured that trends were monitored to initiate changes and learning from complaints and improve the outcome for women and babies.

(Source: Provider Information Request P55)

Is the service well-led?

Leadership

There was a fairly new but stable leadership in the maternity unit following some recent changes. The maternity unit was part of the surgery, women’s health and children directorate. The unit was consultant led but midwives played an integral part in the management of women’s care. The unit had a consultant obstetrician as clinical lead and a ward manager. There was no consultant midwife to lead or drive improvement in the service.

Support was also provided by specialist role midwives, antenatal and perinatal liaison. The team maintained regular links with their peers in the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) care partnership region. The deputy head of midwifery attended a bi monthly regional meeting to network with other maternity units in the region. However midwives told us that communication was poor and information sharing was the’ big challenge ‘that the trust needed to address.

Some community midwives worked across the acute sector although midwives said that these were staff at band 6 only. It was not evident how senior staff worked across community and the wards in order to share practices such as joint team meetings. Staff described the leadership as approachable but felt and there was a lack of visibility of senior management in the unit. Staff told us the lack of bands 7 impacted on how care was managed. There were also concerns about the development of the professional midwifery advocate. The education team in maternity would consist of one professional midwifery advocate, the midwives told us they were not aware how this role would help in the development of education within the unit.

Vision and strategy

There was no formal or written strategy for maternity care at this trust. Service leads shared the vision for the maternity unit which was to develop the service; although management told us this was a long term prospect. The strategy was in the development stage such as promoting home
births and drive normalisation of births. Staff told us they were not aware of the vision for the unit; however they were committed in delivering good quality care.

**Culture**

Midwives and the support workers said they worked well as a team and supported each other. We observed positive relationship between the team and they were supportive and respectful to each other.

Staff told us that there was a ‘bullying culture’ and they were discouraged to raise concerns at local level. They did not always feel respected or valued and other staff attitudes and behaviour were not addressed when these were raised with senior management. Other staff said that there were some small positive changes and it would take a while to change the culture. Staff felt isolated from the main trust; although a senior manager told us the relationship was improving. Some staff told us that changes were not well managed as band 6 midwives started rotating from community to acute. They felt that management was reluctant to listen to their concerns. Other staff told us they had raised concerns and this had a negative impact including staff were seen as “trouble makers”.

Senior management promoted an open door policy and they told us staff were encouraged to raise any issues with them. They were committed to promote a culture of continuous improvement.

**Governance**

The trust could not evidence a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were policies in place to support the local governance of the organisation. These key policies provided staff with guidelines and processes to follow. Such policies included risk management, incident reporting, information governance, medicine management. Staff were aware of their line of reporting and accountability. However access to policies was not always available or staff could not access these as required.

The governance arrangements were not embedded as it was not evident how feedback from meetings was used to support practices and learning. The maternity service leads took part in the monthly quality, risk and patient safety group who reported to the quality assurance committee and to the board. The forum reviewed risks, clinical audit, safety alerts, infection control and complaints. However the process and communication from board to floor was not consistent as the flow of information was poorly managed. Doctors and midwives told us that although there may be some work being undertaken at ‘senior level’, this did not filtrate down to the staff who were responsible to deliver the care.

We requested and received last four team meeting minutes which included records management and update on sepsis training. The unit was also trialling access to tea and coffee for partners as staff had identified that at busy periods this was difficult to manage.

The trust process for auditing third and fourth degree perineal tear was not developed and there was no evidence that this was monitored in order to safeguard women and there was learning from these to improve practices. We requested data on this and the information we received in March 2018 showed the last audit was carried out in 2011. There was no data provided by the trust for post-partum haemorrhage (PPH) . This is defined as the loss of more than 500 ml or 1,000 ml of blood within the first 24 hours following childbirth.
Management of risk, issues and performance

Governance processes were not effective at identifying risks and improving safety and quality of services provided.

Maternity unit had a risk register which had been developed in the past three months and there were five risks identified. Risks such as resuscitation trolleys which were not tamper proof and risk assessments, staff training and appropriate evacuation of woman and child had not been previously identified. Three risks had been identified as moderate, one as major and one catastrophic. These included staffing, IT accessibility in the community and unauthorised access to maternity due to lack of cover at reception.

Community midwives had poor IT access and connectivity issues which staff said had been raised continuously with the trust. This had high impact on women as the community midwives had no access to women’s results. Midwives told us that currently not all community hubs had access to Trust’s systems. These included risks of results being unavailable leading to substandard and unsafe care for women. Some of these risks had been added to the risk register and a business case was being developed to purchase mobile phones. In the interim, there were no action plans in place in order to mitigate these risks.

The trust had major incident arrangements which the maternity service formed part of. Staff told us they had not received specific training on major incidents.

Following proposal from NHS Resolution formerly ((NHSLA) the trust proposed in March 2017 to have standardised national reviewing process. In January 2018, the trust improvement plan showed they were working to develop regional measures and part of SHIP collaborative governance meeting were in place. This included a review of regional still birth and working towards a standardised review tool.

Information management

The unit did not have an audit plan and a senior manager told this was being developed. Although there were some audits undertaken, such as infection control, falls, UTIs and blood transfusions, there was no system to evidence action taken when these fell below the expected expectations.

Following the inspection we received the trust’s maternity quality dashboard which showed the trust collected data on a variety of activities including number of babies delivered, ventouse and forceps deliveries, planned and emergency caesarean section rates. The dashboard contained clinical activities; it did not include information such as midwife to baby staffing ratio, complaints and other risks such as incidents. There was no information on how the trust benchmarked with other trusts locally.

Engagement.

There was a process for seeking patients’ feedback through the friend and family test, and this was monitored. Patients were encouraged to provide feedback about their care and also through the trust’s website and Facebook. The result of this survey showed mothers were satisfied with their care. The maternity unit had reviewed feedback from women using the service and had recently introduced some changes allowing birth partners or fathers to stay overnight in the unit. Although we were told that the facilities were inadequate to accommodate these people.

There was no evidence on how the maternity unit engaged with birth partners or fathers to seek their views and experiences of care provided. There was a lead midwife providing bereavement
support for women and their family in the community. Staff were unable to tell us if there was a bereavement group and type of support which was available to them.

Patient feedback on the ‘I want great care’ (iWGC) reviews was reported through the monthly governance arrangements. However, we have not been able to assess how the maternity unit used this information, as we have not received the requested information from governance meetings.

The Maternity survey was undertaken as part of the Southampton, Hampshire Isle of Wight and Portsmouth (SHIP) and published in February 2018. This found that women were satisfied with information they received and were supported. However it also found that women’s preference for midwife led care would be unlikely due to staffing and may not provide real option. Birthing partners and fathers said they got their information from other expectant parents, classes (National Childbirth Trust (NCT) & NHS) and on-line. Birthing partners and felt they were mostly included in the discussion. Mothers found that opportunity for discussions were inconsistent and this was mainly due to the midwives being rushed and lack of time and staffing pressures. The survey also highlighted that over 30% of respondents said that they saw three or more midwives throughout their pregnancy. This did not meet with guidelines which state that pregnant women should be cared for by a named midwife throughout their pregnancy.

Summary of all Key Findings for Isle of Wight NHS Trust (acute sector)
Change since 2016 survey Ranking, compared with all acute trusts in 2017

| KF1. Staff recommendation of the organisation as a place to work or receive treatment | No change | Lowest (worst) 20% |
| KF4. Staff motivation at work | No change | Lowest (worst) 20% |
| KF7. % able to contribute towards improvements at work | No change | Lowest (worst) 20% |
| KF8. Staff satisfaction with level of responsibility and involvement | No change | Lowest (worst) 20% |
| KF9. Effective team working | No change | Lowest (worst) 20% |
| KF5. Recognition and value of staff by managers and the organisation | No change | Lowest (worst) 20% |
| KF6. % reporting good communication between senior management and staff | No change | Lowest (worst) 20% |
| KF10. Support from immediate managers | No change | Lowest (worst) 20% |
| KF2. Staff satisfaction with the quality of work and care they are able to deliver | No change | Lowest (worst) 20% |
| KF3. % agreeing that their role makes a difference to patients / service users | No change | Lowest (worst) 20% |
| KF32. Effective use of patient / service user feedback | No change | Lowest (worst) 20% |
The NHS staff survey 2017 reflects the findings across the whole trust. Feedback from the staff echoed some similar themes such as support from immediate managers was inconsistent. Staff did not feel empowered to raise concerns about practices which may impact on women. Although patients’ survey feedback was used to make effective changes, they said progress was slow. Staff felt valued by their immediate leads and were complimentary about peer supports and working with the multidisciplinary team.

**Learning, continuous improvement and innovation**

The maternity service was developing opportunities to improve learning for midwifery staff. Training and further learning had included CTG package and developing the breast feeding accredited programmes. However the unit did not have any mechanisms in place in order to fully support learning and innovations.
Facts and data about this service

We inspected Isle of Wight NHS Foundation Trust gynaecology services on an unannounced visit at St Marys Hospital as part of the new phase of our inspection methodology. We did not look at the effective, caring or responsive domains as this was a focused inspection looking specifically at the safe and well led domains.

The gynaecology services form part of the surgery, women’s and children’s health clinical business unit at St Marys Hospital, which is the main site for the Isle of Wight NHS Trust.

The gynaecology service forms part of the surgery division at the hospital and we were not able to separate gynaecology-specific data from the data provided about the overall surgical services. Therefore some data will be reflective of the whole surgery services.

The gynaecology service at St Marys Hospital provides emergency inpatient treatment, elective (planned) inpatient treatment and day case surgery. Outpatient services are also provided at the site and included colposcopy, hysteroscopy, oncology, urogynaecology, oncology, fertility and minor procedures.

St Marys Hospital has four main theatres with two additional theatres within the day surgery unit (DSU). There were no specific gynaecology wards. Gynaecology patients requiring surgery were admitted to general surgical wards, most commonly St Helen’s ward.

During the announced visit, we visited the following areas/departments:

- Main operating theatres
- Gynaecology outpatients department
- St Helens Ward

During the inspection visit, the inspection team:

- reviewed eight sets of patient records
- looked at performance information and data about the trust
- spoke with 28 members of staff at different grades including consultants, doctors, nurses, operating department practitioners (OPDs), theatre and outpatient department managers.
- met with consultants, matrons, director of the surgery division, medical director and the director of nursing.

The Care Quality Commission last inspected gynaecology services in 2014 when gynaecology was rated as part of the maternity and gynaecology core service. The service was rated as good.

Is the service safe?

Mandatory training

Although the trust provided mandatory training in key skills to all staff, not all staff had been able to attend, and the level of compliance was below the trust’s target.

The hospital provided a programme of mandatory training and updates for staff including...
infection prevention and control, health and safety, adult resuscitation and equality and diversity. The trust’s target of 85% compliance with mandatory training was met in seven of the 18 selected modules for medical and dental staff and 13 out of 25 for nursing staff. Areas of poor compliance were paediatric and adult resuscitation, hand hygiene, fire safety (part two extinguishers) and conflict resolution refresher (medical staff). Staff on St Helens ward (where gynaecology patients were admitted) had achieved 84% compliance with their mandatory training.

A breakdown of compliance for mandatory courses between April and September 2017 is shown below:

**Medical and dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load Handling</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>36</td>
<td>94.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>36</td>
<td>91.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>35</td>
<td>91.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>35</td>
<td>91.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>36</td>
<td>88.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>35</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>36</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>36</td>
<td>72.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>36</td>
<td>69.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>35</td>
<td>68.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>34</td>
<td>67.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>36</td>
<td>63.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>36</td>
<td>63.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>36</td>
<td>61.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>33</td>
<td>54.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>35</td>
<td>54.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>36</td>
<td>25.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load Handling</td>
<td>2</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>127</td>
<td>99.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>127</td>
<td>99.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>83</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>83</td>
<td>96.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>127</td>
<td>96.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>125</td>
<td>96.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>77</td>
<td>94.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Course</td>
<td>Staff</td>
<td>Compliance</td>
<td>Target</td>
<td>Completion</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------</td>
<td>------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>127</td>
<td>93.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>127</td>
<td>91.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>127</td>
<td>91.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>127</td>
<td>90.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>127</td>
<td>90.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>127</td>
<td>81.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>127</td>
<td>72.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>126</td>
<td>72.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling</td>
<td>110</td>
<td>69.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>118</td>
<td>67.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>127</td>
<td>64.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Maths &amp; Medicines Calculations</td>
<td>125</td>
<td>64.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>61</td>
<td>57.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Newborn Life Support</td>
<td>12</td>
<td>33.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>110</td>
<td>30.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>36</td>
<td>22.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>120</td>
<td>7.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff were not always given the time to attend training. Training was provided both face to face and electronically. Staff we spoke with reported they felt the training was informative and enjoyable, however, they would prefer less electronic based learning and more face to face learning.

Responsibility for attending training was held by the ward, outpatient and theatre managers. Managers would access an electronic record which would list each staff member and whether they were compliant or non-compliant with training. However, there was no flagging or alert system for the individual staff members or the managers and awareness of compliance was reliant on the manager regularly and manually accessing the system.

**Safeguarding**

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

The trust had processes and practices to keep both adults and children safe from abuse. Staff had awareness and knowledge of who to contact if they had any safeguarding concerns and knowledge of the trust’s safeguarding policy. The outpatient department manager said the safeguarding team were very accessible and supportive and provided advice and support as required.

Safeguarding has three levels of training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people. The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses between April and September 2017 for registered nursing staff and medical staff in surgery is shown below:

Medical and dental staff
### Name of course  
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>36</td>
<td>91.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>36</td>
<td>80.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>36</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

### Nursing staff

### Name of course  
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>127</td>
<td>84.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>127</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>114</td>
<td>63.2%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff on St Helens ward (where gynaecology patients were admitted) had only achieved 4% compliance with safeguarding adults level 2 (1 staff member out of 24), 13% compliance with medical devices theory and 58% with Mental Capacity Act. Completion of training in the Mental Capacity Act across the trust was also only 30% for nursing staff.

Due to training in safeguarding falling below the trusts target of 85% there was a risk staff would not identify people at risk of abuse and take appropriate actions.

Staff also had access to an E-Learning package available on the Local Safeguarding Children Board website, for additional information and training.

Staff had good awareness of the different types of abuse and the signs to look out for. This included female genital mutilation (FGM). Staff received training in how to safeguard patients in regards to FGM as part of the safeguarding mandatory training. A plan was in place for this training to become stand alone to improve knowledge and awareness.

### Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. Staff used control measures to prevent the spread of infection and practice was audited to monitor performance.

The operating theatres, gynaecology outpatients and wards were visibly clean tidy and well maintained. Patient bed spaces, consulting rooms, waiting rooms and staff areas were dust free and visibly clean in hard to reach areas including beneath beds. We found ward, bed spaces, theatres and the gynaecology outpatients area to be well organised and clutter free.

Furniture was clean and in good condition, fully wipe able and fully compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment. Staff used an ‘I am clean’ sticker when equipment had been cleaned after use.

Ward based cleaning was carried out by domestic staff. A domestic staff member was assigned to each ward and worked from eight am to three pm with an additional domestic staff member available on call out of these hours. Compliance with cleaning was ensured by weekly cleaning audits. These audits were carried out by the domestic supervisor with a target of 95% compliance. Results were displayed on the main corridor outside of the ward. We reviewed St Helens ward most recent audit result and found they were 95% compliant.
Gynaecology outpatients was cleaned by a regular domestic staff team. The manager had not had a replacement for their regular domestic staff member when they moved to a different role. This meant the department was not cleaned as regularly as it should have been. The manager reported this to the senior domestic supervisor who had the department thoroughly cleaned and ensured a replacement domestic staff member was allocated to the department. Following this, the manager was pleased with the cleanliness of the department.

Staff had a good knowledge of infection control processes. We observed all staff groups bare below the elbow and actively gelling their hands before and after contact with patients in line with the National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3). Hand gel facilities were also available and clearly signposted in all departments we visited.

Data provided by the trust showed that all ward staff groups had achieved over 85% compliance with infection prevention and control (IPC) training. However, compliance with hand hygiene training was lower, with surgical medical staff at 54.3%, well below the trust target of 85%.

Hand hygiene audits were carried out each month on the wards or departmental area. The wards carried out their own self audits and the IPC team validated the results by re-auditing areas that had failed the target 90%. Results for April 2017 to December 2017 showed that self-audits of the Day Surgery ward and St Helens ward all achieved the 90% target. Main theatres failed the audit most months. The IPC team observational hand hygiene audits found St Helens ward failed to achieve the target. The IPC audit results for hand hygiene and environment found St Helens failed to reach the target 90%, however the Day Surgery Unit scored 100%. The IPC follow up audits had recently been postponed due to staff shortages in the IPC team. It was not clear whether wards had been tasked to pick up this shortfall in the audit programme.

Waste was managed safely. We saw bins used to dispose of sharp instruments, such as needles, were not filled above the safe level before being replaced. Lids were closed to avoid accidental injuries or spillages.

**Environment and equipment**

Most premises were suitable and well maintained. Equipment was readily available and any repairs were dealt with promptly.

The service had suitable premises but their systems did not provide assurance that equipment was regularly serviced and maintained. There was safe provision of resuscitation equipment with the resuscitation trolleys being easily accessible and staff knew where they were stored. Trolleys were checked regularly with records we looked at showing checks were carried out daily. However, the trolley contents were not locked with a breakable seal which meant that medicines or equipment could have been used or tampered with since the trolley was last checked.

Equipment and consumables were not all within their expiry date and we were not assured the appropriate systems were in place to identify all equipment that needed servicing. Responsibility for checking and the servicing of equipment was a shared responsibility of the medical devices team and the ward or department who contacted external servicing teams. However, the medical devices team relied on a single spreadsheet which had to be manually assessed to identify equipment that was due servicing or checks. Also, not all external services reported the checks they had undertaken to the medical devices team. The service could not therefore be assured that all equipment that needed servicing or checked would be identified.

Equipment was stored safely. Products deemed as hazardous to health were in locked cupboards or clinical rooms or rooms that were only accessible to authorised staff.
Emergency equipment was readily available. There was piped oxygen and suction equipment in each ward at the bed space as well as call buttons in the event of an emergency. We looked at three oxygen cylinders on St Helens ward and found them to be secured safely and within their expiration date.

Systems were in place to ensure access to theatres and other areas were limited to specific staff. Access to the operating theatres was via a keypad system.

There were no kitchen facilities in the gynaecology outpatients department for staff to make a drink. There was a limited facility comprising of a fridge and kettle in the early pregnancy unit office. There was no dedicated rest room so staff used the early pregnancy office for their breaks. This was not suitable as staff may have to use the office to make sensitive and confidential telephone calls meaning staff had nowhere to take their breaks. This meant staff may not have been taking adequate rest breaks during their shifts which could have affected their ability to deliver patient care.

There was only a water cooler available in the patient’s waiting room. There was no access to a hot drink or snack.

Assessing and responding to patient risk

The National Patient Safety Agency five steps to safer surgery World Health Organisation (WHO) checklists were not being followed correctly to ensure patient safety was not compromised.

The five steps to safer surgery checklists were not being followed correctly as part of the World Health Organisation (WHO) surgical safety checklist in operations we observed. The purpose of the checklist is to check all safety elements of a patient’s operation before proceeding. The trust had made a video about the WHO checklist and its importance. It was not clear if staff had to sign to say they have seen the video or if it was to be used in training sessions. We did see it being used as part of the staff briefing meeting in the day surgery unit which led nursing staff raising concerns that the medical staff do not and will not participate and comply with the WHO safety checks. We observed two WHO surgical safety checklists happening. Both were thorough and all staff were engaged. Staff told us registrars were generally present with the consultant for the WHO checklist procedure. Middle grade doctors often arrived after the WHO checklist had been completed. Sometimes they were asked to scrub and assist without having attended the WHO checklist process at all.

The trust provided us with the six most recent monthly WHO checklist audit reports. These showed that in main theatres, sign in was completed in full on only 42% of the 255 forms audited and the sign out only 29%. Non-compliance was primarily caused by no anaesthetist signatures on the sign in and no surgeon signatures on the sign out. In day theatres, there were some omissions, but overall compliance was higher.

NHS England published national safety standards for invasive procedures (NatSSIPs) in 2015, to reduce the number of patient safety incidents related to invasive procedures, in which surgical ‘never events’ could occur. NatSSIPs were not yet embedded in practice.

Theatre staff in the main operating theatres and in the day surgery unit did not see the operating lists until the day of surgery and because there was no consistent form of daily safety brief it was not always clear if there had been last minute changes to the operating list or if particular equipment was/ was not available. There was no communication with the bookings team which meant sometimes more equipment was needed than was available. For example on one day, three operating theatres needed the same piece of equipment and there were only two in the trust. This had led to tensions between the surgeon and theatre staff.
A theatre support worker (TSW) was sent to collect the first patient on the operating list during the daily safety brief. This meant if there was a change of order on the list the TSW could bring the wrong patient to theatre. We were told this had happened but had not been reported as an incident therefore there was no evidence to support a change in procedure. This system also meant the TSW had missed all or part of the safety brief and any relevant information about patients or other important issues.

Staff completed and updated risk assessments for each patient. They did not always keep clear records as they did not carry out the surgery safety checks consistently. Gynaecology services were effectively using a system for monitoring acutely ill patients. The trust had implemented and was using the National Early Warning Score (NEWS) system for the monitoring of adult patients on wards and in the operating theatres. In all patient records we reviewed where patients had undergone surgery the early warning score charts had been completed and used appropriately.

Comprehensive risk assessments were carried out for patients in line with national guidance. These were carried out both pre operatively and post operatively to highlight those who may need additional support. We reviewed six care records which showed appropriate risk assessments and actions were taken. This included patients at risk of falls, pressure ulcers and additional nutritional needs.

Intentional rounding was also used to look for emerging risks and concerns. Intentional rounding ensures patients who may be higher risk are regularly reviewed to ensure any changes or emerging risks are noticed early and acted on before an incident can occur. We saw records of intentional rounding being carried out in the patient records we reviewed.

Daily safety briefings and board rounds were undertaken to highlight any patient that may be deemed at risk on St Helens ward and in the gynaecology outpatients department. In the operating theatre’s there was a daily safety brief and a weekly safety briefing meeting in the day surgery unit. We attended a safety briefing and found it to be informative, professional and with patient safety as the priority. Staff were encouraged to report incidents using the electronic reporting system to ensure concerns were highlighted. New policies and/or policies under review were discussed, for example, uniform policy.

Some systems were in place for patients post discharge. On discharge, patients were provided with the ward number or directed to the 111 service, their GP or the emergency department if they had concerns out of hours. However, there was not a 24-hour emergency helpline available for discharged patients post discharge. Also, due to operational pressures, patients with post-operative complications would need to attend the emergency department rather than present directly to the ward.

In the gynaecology outpatients department there were information and advice leaflets readily available to patients. Patients were given details of who to contact out of hours if they had had a minor procedure in the outpatients department and had a problem once they were home.

**Nurse staffing**

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Staffing levels in the gynaecology outpatients department had been reviewed in August 2017. However staff described an increased workload with extra clinics and longer clinics and no extra staffing.
The trust monitored safe staffing levels and reported when staff levels dropped below 95% (amber rating) and 90% (red) and used regular bank and agency staff to fill vacant shifts. The trust used an acuity tool and introduced a safe staffing approach in October 2017. There was a high vacancy rate in theatres and staffing levels in theatres was added to the service risk register in January 2018.

Some recruitment had been successful, with three new staff on the day surgery ward, following the safer staffing review. We were told that gynaecology outpatients department had recently recruited a whole time equivalent nurse. This brought the department up to their allocated staffing numbers. However clinic times and therefore number of patients seen had increased but staffing levels had not been reviewed to meet the growing demand. This meant staff in the department were often not able to attend mandatory training or have appraisals within the required timeframes. The manager had raised the issue but felt it was low priority. Staff described the recruitment processes as “very slow” and “not fit for purpose”, and told us of known vacancies not being recruited to for many months.

Theatres were staffed in line with the Association for Perioperative Practice (AfPP) recommendations for safe staffing. The department had carried out a recent staffing review which identified a need for 15 additional whole time equivalent registered staff. Whilst on the winter plan, with protected time for emergency admissions, there was less pressure on theatres and the staffing was sufficient. Recruitment and retention plans were in development, but the high level of vacancies were likely to impact on the capacity of the service.

From October 2016 to September 2017, the trust reported an overall vacancy rate of 33% for qualified nursing staff working within surgery.

Data showed that in December 2017, St Helens ward had a 28% vacancy rate (7.2 staff). Although bank and agency staff were used, there were between 20 and 25 unfilled shifts on the surgical wards during the month.

During the inspection we observed ward staff, theatre staff and gynaecology outpatient department staff were very busy.

From October 2016 to September 2017, the trust reported an overall turnover rate of 5% for qualified nursing staff working within surgery.

From October 2016 to September 2017, the trust reported an overall sickness rate of 4% for qualified nursing staff working within surgery.

Within theatres, there had been increased levels of sickness in January 2018, and this was attributed to theatre staff working additional day and night shifts in different areas of the hospital, to support the winter pressures.

We inspected when the hospital had introduced the ‘winter plan’, to support increased non-elective demand. This meant there were medical patients on surgical wards and this impacted on the staffing needs of the wards. We observed that ward staffing was reviewed throughout the day by the matron and the site management team. There was a high reliance on bank and agency staff, and permanent staff were moved to work on different wards or departments on a daily basis to manage the risk.

The theatre departments relied on bank and agency staff, and overtime.

Bank and agency staff were not always available to fill gaps in staffing. In December 2017, St Helens ward achieved less than 90% fill rate for nurses and healthcare staff on day shifts and less than 90% fill rate for healthcare staff on night shifts.
To minimise the risks associated with a high dependency on agency staff, some wards used agency staff on a long term basis.

Arrangements for handover at shift changes ensured people were kept safe. Nursing staff told us handover meetings always happened. In the gynaecology outpatients department the handover (which included all trained nurses and healthcare assistants) set the scene for the day so staff knew in which clinics they were working and if there was any information they needed to know for example patients who may need extra help and support.

**Medical staffing**

The service did not always have enough medical staff with the right skills and experience in all areas, to keep people safe from avoidable harm and to provide the right care and treatment.

 Consultants and doctors carried out appropriate timely ward rounds. Staff we spoke with reported that consultants would review their patients on the day of their operation and would attend the daily ward rounds. Staff also reported that the registrars and consultants were responsive to their needs and contactable when needed for advice or guidance.

 Consultants and doctors were available for all their allocated clinics and the early pregnancy unit in the gynaecology outpatient department. They were also available for emergency gynaecology surgery.

 Staff we spoke with said there was adequate consultant presence at the weekends within surgical services. During the day a designated consultant was on site and on call, this nominated individual was then contactable via phone out of hours. A nominated consultant would be on call over the weekend and would attend ward rounds. We saw a selection of consultant duty rota. They detailed who was to cover which area, when cover was required and if a person was attending training. If a clinic needed to be cancelled this was detailed in red to ensure action was taken.

 From October 2016 to September 2017, the trust reported an overall vacancy rate of 15%, an overall turnover rate of 19% and an overall sickness rate of 1% for medical/dental staff working within surgery.

 In the same reporting period, the trust reported a bank usage of 13 shifts and an agency usage of 1,116 shifts within surgery.

 The theatre team were dependent on locum anaesthetists and reported difficulty recruiting to posts, and a national shortage.

 We were not able to speak with any junior or middle grade doctors working in gynaecology services during our visit as they were all very busy. There was no specific rota for the gynaecology specialty doctors (middle grade) clinics as they provided labour ward cover. Three of the six specialty doctors undertook clinics. The clinics were cancelled for labour ward cover, annual and study leave.

 As of July 2017, the proportion of consultant staff reported to be working at the trust was lower than England average and the proportion of junior (foundation year 1-2) staff was higher.

 Staffing skill mix for the whole time equivalent staff working at Isle of Wight NHS Trust...
The service broadly operated a pattern of 1 in 6 on call rota, with consultants on site during normal working hours and relieved of elective commitments during their on call week. Due to the numbers of consultants involved, the rotas differed within different specialties, with consultants in urology for example having a 1:4 and for gynaecology emergencies a 1:5 on call rota. The service was subject to an acute services review across this and neighbouring trusts, and medical vacancy rates and hospital facilities would be considered in this review.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care, but the service had failed to ensure that medical records displayed the patients name or patient number on each page.

Records were a mixture of paper and electronic based. We reviewed eight sets of patient medical records and found there was a good approach to the completion of both the electronic and paper records.

Patient records were legible, timed and dated. Of the eight sets of records we looked at, seven all had the name and grade of doctor looking after the patient clearly recorded as well as a clear diagnosis and management plan documented.

We saw gynaecology outpatient staff completed records for patients attending clinics and the early pregnancy unit. Consultants dictated letters following consultations that were typed up and sent to the patients GP. All but one of the consultants checked and signed their dictated letters before they were sent out.

The trust monitored and audited documentation about patients care and treatment.

We were told that patient records did not always include individual addressographs. The service’s audit of nursing notes for all wards including St Helens, in December 2016 also identified omissions in addressographs, patient names and NHS/Isle of White (IOW) numbers on notes. The audit found higher compliance with completed care plans and risk assessments (over 95%), but low rates of infection control risk assessments and patient involvement. Compliance with best practice was rated as low, at 50%. The action plans to improve this situation had not been completed at the time of the inspection.
A trust wide medical records audit in November 2017 also showed low compliance with attaching addressographs on patient notes, with a year on year reduction from just above 15% to just over 5% compliance. The audit found that only about 25% of notes had the patient name on each page and only 10% displayed the NHS or IOW patient number. This created a risk of records not being linked to the correct patient notes. There had been improvements year on year on documenting assessments, diagnoses, reviews and medical history. The report concluded that compliance with the Royal College of Physicians’ guidance was poor, at 54%.

Patients seen in the early pregnancy unit and then transferred to the ward or operating theatre did not always have an addressograph label on their medical notes as there were no means of printing them in the department.

**Medicines**

The service did not always follow best practice when prescribing, giving, recording and storing medicines. Patients did not always receive the right medication at the right dose at the right time.

There were no medications used or stored in gynaecology outpatients department. This section refers to St Helens ward and operating theatres only.

On St Helen’s Ward, medicines were not always managed safely and systems did not always ensure patients received the right medication.

Medicines were not stored appropriately. The trust had audited medicine storage and had proposed new locks for treatment rooms. In theatre 1, intravenous fluids were stored in an open access room.

Medicine fridges on all wards were locked and the trust had completed monthly audits of fridge temperatures and showed 100% compliance.

The trust had audited treatment lockers for patients’ own medicines, and had identified areas of non-compliance with security.

Medicines and medical devices were not checked consistently. Controlled drug (CD) balance checks were not always undertaken. Balance checks are important in ensuring CDs are managed appropriately. The CDs in theatres were checked twice daily, however there were gaps in the sign sheets and it was not clear if the checks had not been done because theatres had not been in use on those days. CD waste was managed appropriately.

On St Helens ward and in gynaecology outpatients the resuscitation trolley was checked twice a day in line with trust guidelines.

The emergency drugs on the resuscitation trolleys were not stored in tamper-evident containers, as recommended by the Resuscitation Council (UK). This meant they might not be available in an emergency as the drugs could be removed without being noticed.

Pharmacy audited patient medicines on wards each month. They reviewed the allergy status documentation, medicines reconciliations, and warfarin patients with raised International Normalised Ratios (INRs). In 2017, staff consistently documented patient allergies. Timely completion of medicine reconciliation (within 24 hours) was variable, with wards generally failing to achieve 95% compliance, and often achieving less than 70%. This meant there was a risk patients were not receiving their correct medicines. The audit template included opportunities to audit venous thromboembolism (VTE) preventative treatment, but these had not been completed.
Emergency blood supplies were available and major haemorrhage protocols were in place in theatres. The theatre fluid store was well organised.

A daily pharmacy service provided discharge medicines for patients discharged from the ward, helping to reduce delays in discharge. The pharmacy team spoke with patients to give them advice about their medicines when they were discharged.

**Incidents**

The service did not manage patient safety incidents well. Staff recognised incidents but did not always report them appropriately. Managers did not therefore investigate incidents and were not able to share 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 trust had recognised that it had not managed patient safety incidents well and had taken action to review incidents more promptly and to encourage reporting of incidents. This approach was not yet embedded in practice and improvements could not yet be identified.

Between 1 February 2017 and 31 January 2018 the trust reported no serious incidents which met the reporting criteria set by NHS England for gynaecology services.

The service carried out root cause analysis (RCA) on serious incidents. The surgery team had reviewed a sample of these, during their surgery inspection and one listed planning, communication, failure to carry out a robust WHO checklist and the absence of clear protocols. Some of these delivery problems were observed during our gynaecology visit, especially relating to completion of the WHO checklist, which indicated that learning had not always been shared effectively.

There had been 14 gynaecology related incidents reported on the trusts electronic reporting system between 1 February 2017 and 31 January 2018. All the incidents were investigated but it was not clear if learning had been shared with relevant staff.

Staff we spoke with said they did not report all incidents and did not receive feedback when they did. We heard of numerous examples of incidents that should have been reported. We were therefore not assured that appropriate risks were always identified and that incidents would not be repeated.

The trust had recently taken steps to improve the review of and learning from incidents. The head of nursing and quality attended the twice weekly clinical review meetings, set up in June 2017, to review incidents of moderate harm and above. The trust patient safety committee reported on the timeliness of reporting serious incidents and the actions taken forward for learning.

Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.

Staff had good awareness of the regulation. Staff we spoke with from different levels of the organisation had had an understanding of duty of candour, when they would use it and the actions they would take.

There was not sufficient evidence to show if any agreed actions or learning identified from the trusts morbidity and mortality (M&M) reviews were followed and led to any improvement in the gynaecology services.
The trusts morbidity and mortality (M&M) meetings were not held regularly and a backlog had built up during 2017. Minutes of these meetings did not show any record of the discussion and just listed the case numbers. In December, the M&M meeting was for 18 cases, and the duration of the meeting was one hour 10 minutes, indicating an average discussion time per case of less than four minutes. Minutes did not make it clear if the relevant staff were present to discuss the cases listed. There were no actions recorded or escalated to prevent the recurrence or errors and adverse incidents. This approach to M&M meetings was not in line with the Royal College of Surgeons guidelines and did not protect patient safety.

Safety thermometer

The service did not always use safety monitoring results well. The trust collected safety information but did not always share it with staff, patients and visitors. Therefore, managers did not always use this information to improve the service.

Avoidable patient harm data was collected and reported using the NHS Safety thermometer tool, however this information was not clearly displayed on St Helens ward. Staff were not familiar with recent trends indicated by the safety thermometer and patients and visitors would not know the safety record of the ward or department they were visiting.

The safety thermometer was used to record the prevalence of avoidable patient harm. This included pressure ulcers, falls with harm and certain infections. It also provided immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination. Data collection took place one day each month, and data must be submitted to NHS Digital within ten days of the suggested data collection date.

Data from the patient safety thermometer on St Helens Ward reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections in the last month. However, staff reported that although they submitted this information on to a trust wide database they received no feedback on results or actions required if performance fell. We were therefore not assured that there was the oversight needed to address safety concerns and prevent patients coming to harm.

Is the service well-led?

Leadership

Managers at all levels in the trust did not all have the right skills and abilities to run a service providing high-quality sustainable care.

There was a lack of consistent management of gynaecology services, to promote the provision of high quality, sustainable care. Clinical business unit leads understood challenges to quality and sustainability. However, there had been a lack of action in place to address these challenges. Leaders and staff reported that there was a lack of support given for service improvement ideas and this had a negative impact on the service and care staff could provide.

Staff told us that the senior management team were not visible and approachable. Staff we spoke with reported they had not met or seen the new director of nursing or chief executive.

Managers in the gynaecology services had different line managers as they sat in different specialities. They said their managers were approachable and generally supportive. Staff working in the operating theatres, the day surgery unit, St Helens ward and the gynaecology outpatients department all said their immediate line managers were visible and supportive.
Vision and strategy

The service as a whole or gynaecology service did not have its own vision and strategy for what it wanted to achieve or workable plans to turn it into actions developed with involvement from staff, patients, and key groups representing the local community. A recent external review of the trust identified that it lacked a clear vision and strategy and these required development in collaboration with staff and the wider health economy. At the time of the inspection, the service was focused on improving operational management and had not adopted a systematic approach to strategic planning.

Gynaecology services were delivered through the surgical, women’s and children’s health clinical business unit (CBU). The operating plan for 2017 for the surgery, women’s and children’s health CBU did not reflect trust-wide agreed visions and values. However, the service was creating business operating plans for 2019/20 based on a vision of ‘quality care for everyone, every time.’ These had been drafted in December 2017 for operating theatres. The stated values of the service were ‘we care, we are a team and we innovate and improve’. The business operating plans outlined goals, and priorities for achieving these goals. The plans were developed from the analysis of the service’s current position, as well as risks and anticipated demand levels. At department or ward level, we did not find staff were engaged in the trust vision and values and this was an area the service leads recognised as needing further development.

Culture

Managers across the trust did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff did not always feel supported, respected and valued. There was not a positive culture or common sense of purpose amongst senior staff which led to inconsistency in leadership approaches.

Staff we spoke with reported varying levels of support. Most spoke of the positive working relationship between staff members. However, there was sometimes a lack of support from leaders.

The trust did not celebrate success or award staff for their work. However in the February 2018 e-bulletin, distributed by the trust, staff were being encouraged to nominate colleagues for the NHS70 awards launched by NHS Improvement and NHS England.

There was some evidence of team working and cooperative, supportive and appreciative relationships among staff, however this did not extend to more senior staff. We heard of incidences where difficult relationships between senior staff had impacted team meetings. The trust were aware of the difficulties and had implemented a number of strategies to improve some working relationships.

The Wessex Deanery (a Deanery is responsible for coordinating postgraduate medical and dental education within a given region, to standards that are set by the General Medical and Dental Councils. Deaneries are each advised by a Specialty Training Committee (STC), which includes Consultants) had received reports of an environment that was not conducive to a good learning experience. As a result the Deanery had withdrawn medical students from working in obstetrics and gynaecology from December 2017. The trust were aware of the ongoing issues of difficult relationships within the obstetrics and gynaecology consultant team and had identified strategies to help resolve the issues.

Staff were encouraged to undertake professional development opportunities. Staff told us they had been able to access role specific training to enhance their skills. The gynaecology oncology nurse
specialist told us about role specific training and networking opportunities that were available to them. They felt meeting with other nurses in similar roles was an opportunity to share experiences and learning that would benefit patients on the island.

**Governance**

The trust did not have a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were not effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services. There was a lack of effective arrangements to facilitate sharing of information from ‘board to ward’ and ‘ward to board’. Staff we spoke with were unaware of the decisions being made at board level. They also reported they knew how to raise concerns with their managers or matrons but they did not feel that change always occurred following this.

Staff at all levels were clear about their roles and understood what they were accountable for and to whom.

The gynaecology service did not have a systematic programme of clinical and internal audits to monitor quality and operational processes. We were told an internal audit was carried out to show a staff member how often they were late in starting their clinics and how long patients had waited as a result. The staff member was shown the data and had since not been late in starting their clinics. The gynaecology services took part in trust wide audits for example handwashing, infection control and cleaning audits.

There was a monthly gynaecology risk meeting chaired by a consultant gynaecologist and obstetrician. In this meeting all near misses and ‘low level’ incident were discussed. For example two sets of notes in a consulting room could easily have led to the consultant writing in the wrong notes. This was discussed at the meeting and a decision made to ensure only one set of notes was to be in a consulting room at any time. Attendees at the meeting included the theatre manager, the head of midwifery, ward manager and all grades of medical staff. We did not see any minutes of these meetings. It was not clear if the spreadsheet containing details of ‘low level’ incidents was shared with the risk manager or anybody else from the trust senior management team in order for learning to take place.

**Management of risk, issues and performance**

The trust did not have an effective system for identifying risks, planning to eliminate or reduce them, and to cope with both the expected and unexpected. There were no gynaecology risks on the local risk register at the time of our inspection. Staff were unclear about what was on the risk register and their role in adding to the register and mitigating risk.

The trust had set up a new system for recording risks (November 2017) and the CBUs managed their own risk registers. These identified and described the risks, controls, consequences, updates, actions required and due dates and the accountable person. The registers did not show when the risk had been added, meaning it would be difficult to know how long the risk had been an issue.

There were no gynaecology risks on the local risk register at the time of our inspection. Staff we spoke with were unclear about what was on the risk register and their role in adding to the register and mitigating risk. It was clear in discussion with staff that incidents were not reported using the
trusts electronic reporting system therefore issues were unlikely to ultimately included on the risk register. For example, in operating theatres when the correct equipment was not available.

The operating theatres risk register had two risks recorded. They were flooring that required replacement and theatre staffing levels. The non-compliance with the WHO surgical safety checklist was not on the risk register. It was evident staff were not clear about how to access and use the risk register to highlight patient safety issues.

The day surgery unit had a weekly safety briefing. This did not ensure new risks or safety issues were discussed and managed on a daily basis.

Staff on duty in the gynaecology outpatients department had brief safety meetings twice a day. Any patient safety issues, staffing issues, equipment problems and general updates were discussed.

**Information management**

The trust did not collect, analyse, manage or use information well to support all its activities, using secure electronic systems with security safeguards.

The service was not producing relevant and accurate information to support robust challenge and service improvement. This had been recognised by the new management team.

The duty rotas were electronic meaning it was time consuming for departmental and ward managers to maintain. The patient information system did not flag patients with particular needs or risks to help staff anticipate their needs or plan their care. However there was system in gynaecology outpatients that identified vulnerable people.

Staff were being encouraged to report incidents under the new leadership team. Systems to improve the accuracy and timeliness of reporting were being implemented, but not yet embedded in practice. Service level risk registers were relatively new and still being developed. Staff in the gynaecology service knew of their local risks but were not aware if they were on a departmental risk register.

The trust had introduced improved auditing of patient moves within the hospital to help inform site management teams.

There was no performance dashboard available for this service so service leads were reliant on manually checking a range of available data to assess the quality and performance of their service. There were no agreed key performance indicators recognised for this service.

**Engagement**

The trust were beginning to engage with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. Staff reported that the trust’s new senior team were more engaging with staff and were hopeful that they would be supported to address issues and make improvements where required.

Staff engagement was limited. Staff we spoke to reported engagement was limited to a quarterly feedback form. Some concerns were expressed that this was not anonymised and that they were unaware of action taken from this feedback.

However most staff felt engagement with them was improving and were hopeful that the new trust leadership team would recognise issues within individual services and listen to staff about how they thought improvements could be made. We saw the February 2018 e-bulletin sent to all staff
and volunteers. It contained news and information for staff including encouragement to complete the “Getting to Good” survey (designed to help the trust look at ways to improve care and services for the benefit of patients and staff). It also included details about how to join the Getting to Good Staff Engagement Advisory Committee and dates for the “Getting to Good” Leadership and Culture Workshops for medical staff.

Patients were invited to complete feedback forms called “Did you get great care today”. Patient feedback from completed forms was reported through monthly governance meetings. The ‘I want great care’ patient feedback forms showed, for example, that the surgery, women’s and children’s health CBU received 281 reviews in October 2017, and 95% said they were likely to recommend the service. Of these, highest engagement was shown by St Helens ward and ophthalmology. We saw December 2017 results displayed in the gynaecology outpatients department. They were all positive with most people extremely likely to friends and family if they needed similar treatment.

The trust had carried out a Medical Engagement Score survey in September 2017 which had identified low relative engagement within the surgical and women’s and children’s health clinical business unit. The survey identified particular engagement issues with medical staff in anaesthetics and consultants without managerial responsibility.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.

The trust had not yet established or embedded a learning culture. It had started to create systems for learning from incidents, complaints and staff and patient feedback. Staff and managers took control of their own development and this had led to inconsistencies in performance and quality across the service.

There was not an effective process for learning from deaths and incidents. Systems were being developed but at the time of the inspection we heard about a number of incidents that had not been reported as such and therefore no learning had come about.

Some gynaecology staff had protected time for learning and sourcing examples of good practice and innovation by for example networking with regional colleagues to discuss and share good practice.
Services for children and young people

Facts and data about this service

The trust has 13 inpatient paediatric beds across one site.

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute tab)

The trust had 1,773 spells from August 2016 to July 2017.

Emergency spells accounted for 97% (1726 spells), 0% (0 spells) were day case spells, and the remaining 3% (47 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, August 2016 and July 2017, Isle of Wight NHS Trust.

Total number of children’s spells by Site, Isle of Wight NHS Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary's Hospital</td>
<td>1,773</td>
</tr>
<tr>
<td>This trust</td>
<td>1,773</td>
</tr>
<tr>
<td>England total</td>
<td>1,098,341</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

The Isle of Wight hospital provides services for children and young people living in the Isle of Wight. The trust shares its care with other NHS trusts to cross-provide children and young people specialist services such as oncology aged from 2 weeks old to 18 years.

We visited the children and young people services over three days during our announced inspection.

The children’s unit consists of:

- The children’s ward has 13 beds including 10 rooms and a bay of three beds.
- One of the rooms was able to accommodate children who had been detained under section 136 of the mental health act.
• The day unit has six beds and is not open every day. The unit is used to see oncology children, day surgery, predominantly teeth extractions, allergy testing and blood taking.

• Children’s outpatient clinic has three consulting rooms.

There is also a community children’s nursing team based on the children’s ward and provided nursing and medical support within the local area. Children are cared for in other areas of the hospital for example theatres, adult outpatients, and the emergency department.

We also inspected the neonatal Intensive Care Unit (NNU) which detailed:

• Level 2 Neonatal Unit. 9 cots including intensive care, high dependency beds and special care as well as staffing the transitional care unit within the maternity department.

Patients, and parents or carers, can access paediatric specialist services via their GP, and the emergency department. There is also open access for an identified group of chronic patients who have direct access to the ward using their ‘Yellow Passport’.

The paediatric department at St Mary’s hospital is set up to care for babies, toddlers, children and adolescents. The neonatal ward also has capacity for level 2 patients (with its own intensive care and high dependency beds). The neonatal ward is situated adjacent to the maternity unit and a door separates the post-delivery area where the transition ward is situated.

The children’s ward has separate bays for younger children and adolescents where possible. There is one high dependency bed on the unit and the day surgery unit can be used as extra bed spaces when the demand is high.

Paediatric Surgery services are delivered at St Mary’s Hospital. Elective referrals are accepted for children over 1 year of age, and emergency admissions for paediatric surgery patients are accepted within the competency of the on-call surgeon and availability of paediatric trained anaesthetists who accepts the patient. Paediatric surgery is routinely undertaken on day case lists but can be supported on main theatre operating lists as required with paediatric trained anaesthetists.

The children’s outpatient department is situated adjacent to the paediatric ward.

During our inspection, we spoke with 25 members of staff including consultants, junior medical staff, nurses from band five to band eight, administration and domestic staff. We spoke with one patient and seven family members visiting patients plus we received four CQC ‘tell us about your care cards’. We reviewed seven sets of patient records and medicine charts.

Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff although their systems did not appear robust enough to ensure everyone completed it. Staff told us it was their responsibility to ensure they were up to date with training and managers oversaw the training rates.
Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

In services for children and young people, both medical and dental staff and nursing staff failed to meet the target, with medical/dental staff having 83% and nursing staff having 81% compliance overall.

Mandatory Training Completion by module – Medical and Dental Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>10</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>10</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>10</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>10</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>10</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>10</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>10</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>10</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>9</td>
<td>77.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>New-born Life Support</td>
<td>9</td>
<td>77.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>10</td>
<td>70.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>10</td>
<td>70.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>10</td>
<td>70.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>10</td>
<td>60.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>10</td>
<td>60.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>10</td>
<td>60.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>10</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>10</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical/dental staff working within services for children and young people met the trust’s target for seven out of 18 training courses. Courses with the lowest compliance rates included adult resuscitation (six out of ten members of staff completed this) and prevent training levels 1 & 2 (six out of ten members of staff completed this).

Mandatory Training Completion by module – Nursing Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>41</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>41</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>41</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing staff working within services for children and young people met the trust's target for 13 out of 23 training courses. Courses with the lowest compliance included medicines management – competency assessment (five out of 40 members of staff completed this) and prevent training levels 1 & 2 (20 out of 41 members of staff completed this).

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We were told staff worked hard to ensure their mandatory training was completed. A computer system was used to monitor mandatory training, at the time of inspection the neonatal unit (NNU) was at 80% completed, and the children’s unit was at 76%. This was below the trust’s target of 85% however, the trust had acknowledged the low compliance rates and it was detailed on their risk register.

Staff we spoke with had completed mandatory training, which included the range of topics listed above. Staff received an email reminder when their training was due and staff discussed expired training reminders in appraisals.

Staff monitored their own training requirements using the trust electronic staff database; this helped them maintain compliance with training. Delivery of mandatory training was both face-to-face and online. Managers had oversight of the training using the electronic database and we saw evidence of discussion about mandatory training requirements in the clinical business units (CBU) quality, risk and patient safety monthly meetings minutes.

We saw evidence of a structured induction programme all staff completed when they commenced employment, which included mandatory training. Staff we spoke with reported they completed mandatory training yearly; although figures above show not all staff were completing their training. This did not give assurance staff fulfilled the trust’s requirement for mandatory training.

Staff we spoke with were aware of the sepsis policy and training sessions were included within handover and the bi monthly team meetings. Following a meeting during the inspection period,
staff reported posters were being produced to display as reminders regarding sepsis identification around the ward.

The NNU staff (nursing and medical) linked with staff from across the neonatal network and attended clinical days to share best practice.

The NNU risk register identified there was a lack of documentation of continued professional development (CPD) records to demonstrate nursing staff competences, which could affect the ability of nursing staff to provide safe effective care to the babies.

Following the trust commissioning an external review of the NNU, the review identified gaps in nursing staff, which meant the trust could not spare enough staff to attend refresher training and observations on the mainland. This posed a risk of staff not having up to date nursing and observation skills.

Prevent training was a newly introduced module to the mandatory training and minutes of the leadership weekly meeting evidenced three members of the leadership team would undertake the training and then share the training within the teams. This could account for the low compliance rate.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

**Safeguarding Training Completion by module – Medical and Dental Staff**

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for medical/dental in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>9</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>7</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>9</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>10</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical/dental staff working within services for children and young people met the trust’s target for all four safeguarding modules.

**Safeguarding Training Completion by module – Nursing Staff**

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for nursing staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>41</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>41</td>
<td>90.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nurses working within services for children and young people met the trust’s target for two out of the four safeguarding modules; safeguarding children level 1 and safeguarding children level 2.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

In March 2014, the Royal College of Paediatrics and Child Health published the Safeguarding Children and Young People: roles and competence for health care staff, Intercollegiate Document. The document defines the level of child safeguarding training that is required for various staff groups. The trust policy stated, in line with this document, all staff working in children and young peoples (CYP) services should receive children’s safeguarding training as appropriate to their role as part of their mandatory training programme.

We were informed the current safeguarding completion rate for children’s safeguarding at level three was 85%, which met the trusts target. Level one was 93% and level two was 71% for the trust which did not meet the trusts target of 85%.

Embedded within the level two children safeguarding courses is ‘The Think Family approach’. The think family approach is a needs led approach and provides support that is more effective for families and helps to prevent unnecessary problems arising. It is believed the well-being of children and their families is best delivered through a multi-agency approach with different services working effectively together.

A named nurse, midwife and doctor for safeguarding children and young adults was available for assessment and advice to ensure the trust fulfilled its safeguarding legal obligations. The NNU liaised with the named nurse for midwifery. The safeguarding team offered supervision to the nursing staff upon request. This ensured support and supervision was available as part of staff development.

Safeguarding processes were robust. Children on a child protection plan, under the care of the local authority or required additional support were flagged clearly on the electronic records system which mitigated the risk of staff being unaware of concerns around the family. The children’s safeguarding professional reviewed the alerts and alerts would stay on the system for one year.

Safeguarding was included in all assessments on the children’s unit and NNU. Any disclosures were communicated to the safeguarding named nurse within working hours or to the multi-agency safeguarding hub (MASH) outside of hours and added to the system.

A member of the safeguarding children’s team attended the emergency department, the children’s ward and NNU daily to review where there may be child protection concerns and to offer advice.

The trust had not developed some key policies for keeping children safe. For example, there was not a protocol for children and young people who might abscond or are abducted, however, there was a missing person’s policy and whilst this did include children and young people, the policy did not describe procedures regarding if a baby, child or young person was removed from the ward or absconded. There was also no evidence of restraint policies and staff reported a trust wide policy was in development. In the event of a child or young person, absconding or being
abducted staff told us they would inform the nurse in charge and call hospital security. This did not assure us the children’s and NNU wards had robust systems in place to respond to an abduction or absconder.

Safeguarding policies and procedures were clear and staff we spoke with showed a comprehensive understanding of safeguarding issues for example, female genital mutilation which is included in the level 2 children’s safeguarding training and child sexual exploitation. The trust worked in partnership with the local safeguarding children boards (LSCB). The trust did not have a chaperone policy and did not provide any chaperone training.

An electronic records base which the community team recorded safeguarding concerns was accessible in a read only format by the inpatient unit thus ensuring the sharing of safeguarding information was robust.

Any children who failed to attend an appointment were followed up using the trust protocol which detailed if children on child protection plans, looked after children or child in need plans did not attend, they were followed up by the department and the health visitor/school nurse were contacted.

Any child or young person who presented with self harm or drug medication overdose was automatically referred to the Child and Adolescent Mental Health Services (CAMHS) who liaise closely with the safeguarding team. Children and young people admitted to the ward under the care of the CAMHS team were not discharged until a full review had been completed.

On arrival in both areas staff asked to see, the inspecting team’s identification.

**Cleanliness, infection control and hygiene**

Most of the service controlled infection control risk well.

**CQC Children’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.93 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and young People’s Survey 2016, RCPCH)

The children’s department reported no cases of Clostridium difficile or Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia (blood stream infection) cases between January 2017 and December 2017.

We reviewed patient areas across the children’s and NNU wards as well as dirty utility areas and treatment rooms. All areas were visibly clean and we saw cleaning was in progress. Most patients and relatives were satisfied with the level of cleanliness on the wards.

Infection prevention and control standard operating procedures and policies we reviewed were current and accessible on the hospital intranet. This assured us the units were following local procedures to prevent the spread of infections.

We observed most staff adhered to the infection control policies, including ‘bare below the elbows’, hand hygiene, long hair tied up and appropriate use of personal protective equipment such as gloves and disposable aprons. However, on two occasions we observed a member of staff examining patient’s genital areas and then assessing the patients suck reflex without washing their hands in between. They were also seen to be wearing jewellery with stones which is an additional infection control risk. We raised our concerns to the sister and matron at the time of inspection.
Hand hygiene audit results for the children’s unit and NNU were between 70% and 100% compliant. We did not see evidence of how staff used the results to improve hand hygiene.

The NNU was 100% compliant with Peripheral Venous Access Device (PVAD) practice and the children’s ward was between 80-100% compliant. Again, we did not see evidence of plans for improvement in compliance on the children’s ward.

Staff had received infection control and prevention training as part of their mandatory annual training with an attendance rate of 97.6% for nurses and 70% for doctors, which is lower than the trusts target of 85%, and there was a link nurse for infection control on the children’s ward. Staff we spoke with were aware of where to access information on infection control and how to contact the infection control team.

There were a sufficient amount of side rooms across the children’s unit to isolate patients who were at risk of or spreading infections, however only two of the side rooms contained ensuite toilets so children with infection risk would have to use commodes.

Signs outside the side rooms alerted staff and visitors of infection transmission risks, and advised the use of aprons and gloves where appropriate.

Hand sanitiser gel was available at each entry and exit point and around the ward. We observed signs displayed on the ward to remind staff and visitors to use the hand sanitiser gel. All hand sanitiser gel dispensers were out of reach of small children as a safety precaution and we observed staff using the hand sanitiser.

We observed staff would clean all equipment and the patient areas after discharge. Patient area’s that had been cleaned displayed a laminated sign, which stated when the area was last cleaned. The children’s ward and NNU had an area for storing cleaned machinery and a green tag displayed the date and time it was cleaned. Therefore, the unit was taking steps to prevent the spread of infection.

The play team identified all toys were washable and told us toys that had been with a child or young person with a known infection were deep cleaned after use. There was no evidence of soft toys in the playroom; however, at the entrance to the children’s unit stood a life size teddy bear, which could subsequently pose an infection risk if it was not cleaned effectively. However, we saw evidence of a cleaning schedule for both the bear and the uniform it was wearing.

The day ward had a designated area for children having chemotherapy to protect them from the risk of infections. This was seen to be good practice.

Feeding equipment such as babies bottles were single use and where sterilising tanks were used this was seen to be changed daily.

**Environment and equipment**

Most of the service had secure suitable premises and equipment and looked after them well.

The children’s ward was a safe, secure and age appropriate environment, which featured child friendly decoration themes and interactive floor projections. The Children’s unit had a large play area with outside area’s accessible and the children’s outpatients had a dedicated play area within the waiting room.

Both units had access to beds, cots and bassinettes for smaller babies. The transport incubator on the NNU was outdated and the unit was in the process of purchasing a new one. This meant due to its size the current incubator was unable to travel on the helicopter transfers so the retrieval teams from other providers had to provide their own incubators.

Within the children’s outpatient department, the weighing scales and height measure were behind the front door. Staff explained they would stop people entering the department whilst they were weighing, as there was confidentiality as well as a safety risk. A member of staff demonstrated
this whilst weighing a patient.

Equipment in the resuscitation room on the children’s ward included a blood gas-monitoring machine, appropriately charged resuscitation equipment, controlled drugs stored appropriately within the room and a medicines fridge and cupboard. This ensured all equipment, medication and blood analysis equipment was available in the same room if a resuscitation event was to occur.

In the children’s unit, the scales and height measure were in an open environment, which potentially breached confidentiality as other patients, and families may be able to hear the height and weight of the patient. This did not assure us of patient confidentiality.

Staff used the intercom button to allow entry and would greet visitors at the entrance. All staff wore appropriate identification and were seen to greet visitors to the ward area and ask them to sign in to a visiting book. However, the neonatal unit did not have reception staff, which posed a risk of unauthorised entry.

Staff were aware of the importance of checking the identification of all visitors entering the unit.

In the operating department, the anaesthetic room and waiting area did not have child friendly decoration. There was a dedicated children’s recovery area, however recovery nursed children and adults with only curtains to separate them. This could expose children to possible frightening sights and sounds. This did not follow the recommendations from the Guidelines for the provision of anaesthetic services (GPAS) 2016. All theatre equipment was appropriate for use with children and young people. This followed GPAS recommendations.

On the children’s unit, the sluice door was not lockable. It also had a low handle making it easily accessible to young children when shut. Lockable cupboards within the sluice room were unlocked and contained cleaning materials such as detergent tablets. This posed a risk for unauthorised children and young people to access these areas. We raised this concern with staff at the time of inspection.

Doors in the children’s unit did not have hinge protection which posed a trapping hazard for young children’s fingers. The door to the medicines room was lockable with a combination lock but was a slow closing door which posed a risk for unauthorised entry as well as a finger trapping risk for young children. Staff reported they had requested the estates department review the door on numerous occasions but the estates department advised it did not require changing. Staff reported they could not remember when the door combination lock was last changed which posed a risk for unauthorised entry. The children’s unit did not identify this risk on their risk register.

Parents were encouraged not to bring hot drinks on to the unit without being in a cup with a lid to reduce the risk of spills. We observed staff carry hot drinks on trays to reduce the spill risk.

Both milk kitchen doors on the children’s unit and the NNU were not lockable. This posed a risk of unauthorised access and possible deliberate contamination of breast milk, which was stored in the fridge. The fridges in both milk kitchens were also unlocked.

Where possible, accommodation of patients with autistic diagnosis, sensory, behavioural or mental health needs was in a cubicle specifically designed for safe detainment of children or young people under section 136 of the mental health act. The cubicle was accessed with a key fob and could be locked for the safety of the young person. However, within this specified room we noted the window blinds were a ligature risk and raised this immediately with staff. This did not meet the standards of the section 136 mental health act. Staff arranged for removal of the blinds. This did not assure us the ward was adhering to the trusts priority of “eliminating ligature points where possible and management of the risk where not.” However, we did not see any ligature assessments.

The units were well equipped with equipment such as syringe drivers and intravenous pumps.
Estates and the ward housekeeper oversaw the ordering, repair of equipment, and ensured it was charged and quality tested before use. The ward housekeeper communicated any concerns with the ward sisters.

Bins for the safe disposal of sharps were available in secure areas. All bins we inspected were correctly labelled with a date of opening and signed as per trust policy. None were filled above the maximum fill line.

Emergency trolleys and equipment were sited in accessible locations. We saw evidence on the children’s unit all trolleys were stocked, checked twice every day, and emergency equipment was charged and fit for purpose. On the previous inspection in 2014 it was noted the outpatients department did not record daily checks of the emergency equipment. During this inspection, we observed written evidence staff checked the emergency equipment daily for the last two months.

In the NNU, we noted staff should be checking the emergency trolley twice a day but out of the 24 days in January, we saw evidence staff had signed to say they had checked eight times. This did not assure us the equipment contained in the trolley would be in date and fully stocked.

Waste management, including those for contaminated and hazardous waste was in line with national standards and the trusts policy. We observed dirty linen bagged appropriately and stored in a dirty utility room.

Staff reported the internet connection was not always reliable and often staff would not be able to access their emails, which could pose the risk valuable patient information may not be received in a timely manner.

Mattresses on the children’s unit were checked every Monday (“mattress Monday”) for damage, wear and tear and replaced where necessary. This also reduced the risk of infection spread.

There was no specific area for adolescents although staff told us they would try to accommodate adolescents in rooms or in the larger bay area on the ward.

**Assessing and responding to patient risk**

Assessment of risks to children, young people and families were assessed, monitored and managed appropriately.

In the CQC Children and Young People’s Survey 2016, the trust scored 8.13 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.78 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

**CQC Children and Young People’s Survey 2016 questions, safe domain, Isle of Wight NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.93</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>8.13</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>Were you given enough information about how</td>
<td>0-15</td>
<td>9.78</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>
your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Staff on both units completed observation charts, which included a version (which met with the relevant standards) of the paediatric or neonatal early warning system (PEWS and NEWS). The PEWS or NEWS scores were used to monitor babies and children to ensure early signs of deterioration or sepsis was recognised.

We saw evidence PEWS and NEWS scores were recorded alongside the vital signs consistently and documentation demonstrated appropriate action when required. However, we saw evidence through audit of poor documentation of escalation following a high PEWS score, which would not assure the children’s unit staff consistently recognised a deteriorating child. Staff discussed this in the children’s unit team meeting and staff were encouraged to improve their documentation of escalation processes.

The Royal College of Nursing recommend at least one member of qualified staff on the children’s unit has an advance paediatric life support qualification. Staff we spoke with confirmed and evidence was provided of there always being one member of staff each shift with an advanced paediatric life support (APLS) qualification. Two members of staff also held the qualification to teach APLS.

The children’s ward regularly cared for children and young people who had self-harmed or with other mental health issues. The child and adolescent mental health team (CAMHS) would liaise closely with the children’s team to ensure the correct care and supervision provided kept the young person safe. However, overnight and at weekends, the CAMHS service was not available and the adult mental health team would advise. Mental health specialist nurses would provide one to one care for the detained children in the absence of a specialist CAMHS unit. In a five-year period staff reported, they had had two young people detained under section 136 of the mental health act.

The children’s unit used one of the rooms as a high dependency bed although the unit did not have commissioning to provide high dependency care. Children who required non-invasive ventilation and very close monitoring of their condition were cared for in this room.

The children’s unit had a resuscitation room, which had clear protocols and transfer arrangements for children who needed to be ventilated or required transfer for treatment on a specialist unit. Most children would stay in the resuscitation room or operating theatres to await retrieval by specialist retrieval teams. The adult critical care unit was able to offer care for young people using either the critical care staff or staff from the children’s ward. The children’s medical team would care for the children whilst they were on the critical care unit.

For children requiring surgery, we observed pre-operative safety checklists were completed. We also observed the World Health Organisation (WHO) ‘5 steps to safer surgery’ checklist was completed which reduce risks associated with surgery. We saw the theatre paperwork included the PEWS tool and used post operatively to identify any early deterioration in the child’s condition. We saw evidence anaesthetists had undergone advanced paediatric life support training and intensive life support training.

The children and NNU unit were introducing the sepsis outreach team, a multidisciplinary team who will be responsible for reviewing children and young people with confirmed sepsis at four hours and 12 hours to ensure their treatment is sufficient.
Nurse staffing

The service did not have enough staff with the right qualifications, skills, training and experience, which may affect the ability to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

There was currently one band seven sister paediatric trained nurse, seven band six paediatric trained nurses, 15.36 whole time equivalent (WTE) band five’s paediatric and adult trained nurses, 5.9 WTE band fours nursery nurses plus one band four play specialist on the children’s ward.

Staff on the children’s unit told us nursing staff were at full complement currently, and we saw evidence staffing met the RCN guidelines for staffing, but the neonatal unit’s nursing staff did not meet the British Association of Perinatal Medicine (BAPM) standards or the RCN guidelines for safe staffing.

The NNU encompassed the use of Badger net (a neonatal audit tool to capture staffing levels) to assess acuity requirements. On the neonatal ward, there was one supernumerary advanced nurse practitioner, one supernumerary band seven neonatal nurse, 8.51 whole time equivalent (WTE) band six neonatal nurses/midwife, 1.8 WTE band five neonatal nurses and 4.93 WTE band four nursery nurses. This did not meet the BAPM standards, of 26.59WTE nursing staff on the NNU. The current nursing vacancy rate was 9.33 WTE. The Royal College of nursing guidelines state for children’s wards there should be a recommended minimum ratio of 70:30 of qualified to unqualified staff, but ideally 80:20, and recommend for specialist units this should be higher. Following an inquest into a neonatal death, the trust identified and recommendations were made to increase staffing levels as they were below national guidance in the NNU and recorded this risk on their risk register. There was one band six and three band five staff due to commence in February 2018.

Some staff had undergone additional training, for examples, on both units, there were three advanced nurse practitioners and two nurses were qualified to teach advanced life support.

It was identified the children’s unit did not have a formal tool to assess the acuity of patients and required staffing levels. RCN guidance states there should be a ratio of one nurse to three patients for children under the age of two years, a ratio of one to four for patients over the age of two years, during the day and night shifts, and an experienced band 6 should be on duty over the full 24 hour period. The guidance also stated, ‘the standard for a general inpatient ward should reflect the age of the child as well as acuity. Hospitals should therefore use a proven methodology to assess acuity of patient care that clearly reflects the needs of children, not adults. In the absence of any formal validated acuity/dependence tool for children staff told us they used their professional judgement. However, staff told us they were aware of the need for an acuity tool and were approaching another NHS trust to benchmark their service.

Electronic rota’s were reviewed on the children’s unit and staffing levels were as planned providing the minimum 70:30 ratio of qualified to unqualified staff. The Royal College of Nursing guidelines for children’s wards recommend there should be a minimum of two registered children’s nurses at all times in all inpatient and day care area’s and at least one nurse per shift in each clinical area trained in advanced children’s life support. We saw evidence in the last two months each shift had the required number of registered children’s nurses with the correct advanced life support skills.

There was band six or seven senior nurse cover for 24 hours a day over a seven-day week on
the children’s ward. Depending on staffing levels, the band six or seven would be supernumerary and be available if required to attend resuscitation calls in the emergency department.

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 8% for registered nursing staff working within services for children and young people.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Staff told us the children’s ward was now at full complement of staff and the NNU was working hard to recruit more nurses.

**Turnover rates**

From October 2016 to September 2017, the trust reported an overall turnover rate of 0% for registered nursing staff working within services for children and young people.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Although the turnover rate for nursing staff was 0%, the trust reported difficulties in recruiting permanent nursing staff due to the location of the trust.

**Sickness rates**

From October 2016 to September 2017, the trust reported an overall sickness rate of 6% for registered nursing staff working within services for children and young people.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

From October 2016 to September 2017, the trust reported an overall bank usage of 120 shifts, and an overall agency usage of 18 shifts. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Staff on the children’s unit reported a low use of bank and agency staff as they fill vacant shifts from within by either swopping shifts or doing overtime. Rotas’ we reviewed evidenced this. The ward sister monitored the hours worked to ensure the staff were not working excessive hours.

NNU staff reported they used bank staff and more recently agency staff to cover sickness and annual leave. They said they used bank staff familiar with the NNU but staff we spoke with were unable to describe how bank and agency staff maintained their skills. This did not assure us of the trust used competent agency and bank staff.

**Medical staffing**

The service did not have enough staff with the right qualifications, skills, training and experience, which may affect the ability to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 9% for medical/dental staff working within services for children and young people.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
The current staffing was: seven established consultant posts with five substantive filled posts and one covered by a locum. There was still one vacant post. Seven established middle grade posts with four current vacancies. Three of the vacant posts were filled with doctors from overseas but the recruitment process was delayed whilst the new doctors awaited their visas.

A consultant of the week had overview of children on both units and consultants would often cover the middle grade vacancies, which could affect the consultant’s ability to fulfil their own job plans.

Some medical staff felt they were not supported by their consultants and would often not get regular breaks. During inspection, it was noted the morale of medical staff appeared to be very low. This could affect the quality of care provided to the children and families on both units and could also be attributable to the 30% medical staff turnover rate due to working environment, lack of support and development opportunities.

Consultants had a 1:6 on call rota. Consultants on call were split over Monday - Thursday and Friday - Sunday. Consultants were required to be on site from 8am – 5pm and then on call from home during out of hours. Consultants were relieved of their elective commitments, cover shared amongst the medical team during their on call week, and at the weekend; the consultants came in to do a ward round both Saturday and Sunday.

Between the hours of 8pm and 8am, there was no provision of direct medical care with sole responsibility for both the NNU and children’s unit. A registrar covered the children’s unit, NNU and the emergency department. There was one middle grade doctor on site for the nights and weekends covering both neonatal, paediatric and emergency department, which is further likely to be a risk in emergencies.

A junior doctor would manage an emergency until the senior medical support was available. Consultants were on call overnight however all consultants are within a 20 minute drive to the unit. This was not in line with the Paediatric intensive care standards (PICS) and could affect the quality of patient care and clinical outcomes. The duty consultant or middle grade registrars were able to offer specialist advice (by telephone) 24 hours day, seven days a week.

Following a NNU peer review by another NHS trust, and given the limited out of hour’s medical rota, there were concerns this could seriously compromise the ability to deliver specialist intensive care to babies on the island. Therefore due to the unavailability of medical staff being sufficient to meet BAPM guidelines the trust agreed to introduce a tier 3 level of working. Which meant recruitment of junior doctors, GP trainee’s and advanced paediatric and neonatal practitioners. At the time of inspection, these posts were not filled.

Handovers took place twice each day and were led by a consultant paediatrician. We were unable to observe a handover to assess its effectiveness.

**Turnover rates**
From October 2016 to September 2017, the trust reported an overall turnover rate of 30% for medical/dental staff working within services for children and young people.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**
From October 2016 to September 2017, the trust reported an overall sickness rate of 0.8% for medical/dental working within services for children and young people.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

From October 2016 to September 2017, the trust reported a bank usage of 79 shifts and an agency usage of 135 shifts within services for children and young people. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As of July 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.

Staffing skill mix for the 10 whole time equivalent staff working in Children’s services at Isle of Wight NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>58%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>32%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior</td>
<td>0%</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of children and young people’s care and treatment. Records were clear, up-to-date and available to all staff providing care.

The children’s unit were trialling being paper light which meant using electronic records rather than relying on paper records. Feedback from staff was they felt it was unsafe as there were a mix of patients who had both electronic and paper records. Staff also noted in the clinical business unit minutes that since July 2017 they could not see letters properly on the electronic records system for paper light patients since July. This posed a risk vital information about the child or young person’s condition could be missed.

We observed records in the children’s unit to be stored securely in a locked notes trolley however, on the NNU unit the notes trolley remained unlocked in an area not manned by staff resulting in the risk of unauthorised access and a compromise of patient confidentiality.

Access to electronic records was password protected and permissions were required for staff to access records relating to their professional discipline. Computers we observed during the inspection were locked, password protected, and we observed them to time out so the screens locked if they were unattended.
The community specialist nurses maintained patient confidentiality and safety by not taking records out on visits and would return to the base to complete records.

We reviewed seven sets of medical notes and found these were legible, signed and dated. Paper records were standardised across the units and were multidisciplinary. Medical staff wrote in separate records to the nurses but both were reviewed on ward rounds. All disciplines had access to current and comprehensive information on each patient.

There were care plans for specific care pathways such as respiratory, orthopaedic and trauma and head injuries referred to within the documentation. The care records covered relevant assessments of care needs, risk assessments and were patient centred and personalised. Included were daily evaluation records of whether the patient’s health and emotional needs had been met.

The admission sheet placed at the front of the notes, detailed any safeguarding risks, name of GP, health visitor and social worker. It also detailed the patient’s school or nursery. All admission sheets reviewed were fully completed. These helped to ensure all staff could easily identify safeguarding risks. This information enabled staff to communicate with the GP’s or health visitors where necessary.

The electronic paper records (EPR) would show an alert if a patient was on a child protection plan, was a looked after child or if there had been previous concerns. The community team’s notes were available to read only on the electronic record system. This ensured all staff were aware if a child was at risk and could liaise with the relevant multidisciplinary teams to make a safe plan of care. However, some staff told us if they did not access the electronic records system regularly, the system would lock the staff member out, which could compromise vulnerable children’s safety.

Audits of the quality of record keeping identified issues to be actioned for improvement. For example, evidence of PEWS scores escalation were low and therefore discussed in team meetings with information sharing ideas on how to improve the recording of action taken following a high PEWS score.

We saw notes of children with long-term conditions who had a ‘yellow passport’, which allowed them open access to the ward, were stored securely on the ward for ease of access when they were brought directly to the ward via ambulance.

**Medicines**

Overall the service prescribed, gave, recorded and stored medicines well. However, we found some expired medicines on the children’s ward had not been disposed of in a timely way.

Medicines and controlled medicines (CD’s) were securely stored within the electronic pharmacy system which was accessed with fingerprint access for both fridge and cupboard medicines. To access the CD’s two nurses fingerprints were required. The electronic pharmacy system recorded the removal of medication and fed back to the central pharmacy. This ensured both units had sufficient stock.

The central electronic pharmacy system monitored most fridge temperatures. However, we observed one fridge did not have recordings of temperatures, which could result in medicines having a reduced shelf life.

We found three syringes of insulin infusions for newly diagnosed diabetics that were out of date. We raised this issue with staff at the time of inspection and staff returned the syringes immediately to pharmacy and replaced the same day. Some vials of insulin were past their six week from
opening expiry date. These were immediately disposed of. This indicated staff did not effectively review the patient and wards medicine fridge for out of date medication.

We observed staff checking CD’s and staff reported the process for reporting missing CD’s was as per the trust protocol.

We spot-checked the expiry dates of medicines, including open liquid medicines across the children’s unit and NNU, and most were all in date.

We did not see evidence staff recorded the temperatures of the treatment room routinely, even though thermometers were in situ across the service. This could mean medication may be stored above the recommended temperatures rendering their shelf life to be reduced.

Staff consistently completed medicines charts with the child or babies allergies, weights and the person prescribing clearly identified. Nursing staff checked all medication against the date, time, patient and correct dose. Two members of nursing staff checked all medicine and upon review of 10 medicines charts, all medicines were given on time.

A ward pharmacist visited the wards daily to review the prescription charts and order any additional medication. Take home medications were dispensed in a timely manner and staff reported there were no delayed discharges due to the waiting for medicines.

Excess medication kits were available on both units for the disposal of unused or excess Medicines. This would prevent unauthorised access to medicines left in intravenous lines. This practice followed trust guidelines.

The units investigated medication-prescribing errors and then took appropriate actions to reduce the risk of similar occurrences happening. The pharmacy department discussed medicine incidents on a monthly basis and reported to the appropriate clinical business unit with their findings. However, we did not see evidence of any medication errors for the children’s unit or NNU.

Incidents

The service managed patient safety incidents well and responded appropriately to significant events

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for services for children and young people.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in services for children and young people which met the reporting criteria set by NHS England from December 2016 to November 2017. This was in relation to a confidential information leak/information governance breach meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))
Staff demonstrated they were aware of how to report incidents and access the online reporting system. Staff reported either they received feedback from incidents face to face or through email however, staff were unable to provide examples of feedback they had received.

The duty of candour (DoC) is a regulatory duty relating to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good knowledge of the DoC and, senior staff we spoke with were clear about their responsibilities in relation to the DoC.

Staff described an incident where the patient received the wrong medicine and DoC was applied which ensured openness, and transparency was adhered to. Senior nursing staff ensured the parent was aware of the outcome of the investigation. This demonstrated appropriate use of the DoC.

Application, discussion and documentation of DOC was evident in the route cause analysis reports reviewed.

The children’s service held monthly mortality and morbidity meetings to learn lessons from clinical outcomes and drive improvement for quality. It was unclear how learning from these meetings was disseminated to the unit’s staff.

National patient safety alerts were discussed in the clinical business units monthly Quality, Risk & Patient Safety Group and then disseminated down to the ward sisters to discuss with staff via email or in face-to-face ward meetings. They were also contained in the trusts ’10 minute team brief’, which was emailed to staff. We observed three months’ worth of the minutes.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from October 2016 to October 2017 for children’s services.

(Source: NHS Digital)

The above data details the results from a non-specific paediatric safety thermometer, which therefore did not provide an accurate snapshot of safety analysis. However, for the last two months the children’s and NNU unit had used a specific paediatric safety thermometer and the data shows 0% of early warning signs did not need to be escalated, 10% of the early warning sign observations were not complete, and from November 2016 – January 2018 90% of care was harm free.
Is the service effective?

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

We reviewed trust policies including safeguarding, the Thames Valley and Wessex Neonatal Network (TVNN) therapeutic hypothermia (cooling) and TVNN noise and light policy. The policies were up to date and based on national policy and guidelines including the National institute for Health and Care Excellence (NICE) guidelines and the Royal College of Paediatrics and Child health (RCPCH). However, the nasogastric tube (NG) teaching pack for parents was not based on the latest guidelines. When opened a warning appeared that the policy required a review however it could still be viewed. This could result in staff following an out of date policy and providing unsafe care. The trust has reported in the routine provider Information request “The Clinical Nutrition Nurse Specialist has reviewed the national patient safety agency (NPSA) alert relating to Nasogastric tube insertion and competency. However, guidance within the policy was not up to date. We did observe a NG feed in process, which followed NICE guidelines, which could indicate communication with staff regarding the change of policy, but not updated on the electronic system.

The trust had system and processes in place to monitor compliance with NICE guidelines. A review of documents showed the trust had assessed themselves against NICE guidelines for spasticity (87% compliant), Cerebral palsy assessment (86% compliant), Baseline assessment tool for End of life care for infants, children and young people with life-limiting conditions: planning and management (100% compliant) and child maltreatment (100% compliant). Overall 72% of guidelines were fully compliant and 28% partially compliant. Action plans were in place and we saw evidence of regular review in the clinical business units (CBU) quality, risk and patient safety minutes.

Policies were available to all staff on the electronic intranet system and staff demonstrated they knew how to access them. Discussions about NICE quality standards and guidance happened at monthly CBU governance meetings and we reviewed three months of the meetings minutes, which documented reviews of NICE guidance.

Evidence based Care pathways for the management of children presenting with specific conditions such as epilepsy were in place. This was to ensure staff applied a consistent approach to the child’s management and was in line with NICE guidance.

The neonatal unit (NNU) was applying for baby friendly accreditation status with BLISS (for babies born premature of sick) following a recent audit and were awaiting an accreditation visit. Bliss is a charity, which supports volunteers to enter neonatal units and support parents of ill or premature babies. The Bliss Bay Charter is an accreditation scheme which measures against seven standards which identify the level of family centred care provision within a unit.

We saw the trust had not undertaken a ‘You’re Welcome’ audit, which is the Department of Health (DH) ‘Quality criteria for young people friendly health services’. These criteria set out principles to help commissioners and service providers to improve the suitability of NHS and non-NHS health services for young people.
All children and young people displaying severe depression, thought to be at risk of suicide or a first episode of psychosis were routinely referred to the Child and Adolescent mental health Services (CAMHS). Suitably experienced professionals provided care.

All staff handovers we observed were effective and routinely referred to the psychological and emotional needs of patients as well as their relatives/carers.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health.

Patients were able to request the meals they would like and religious and cultural dietary needs were accommodated.

Staff supported mothers to breast feed their babies. There were fridges and freezers available in both units for the storage of breast milk, for those mothers who needed to express their milk. Staff on the unit were educated in breast feeding guidance, so they were able to help mother’s wishes to breast feed. Staff also knew how to use the breast pumps so again they could help the mothers understand how to use them.

The NNU did not have a specific breast milk expressing room for mothers with babies in the bays; however, there was adequate space for the curtains to be pulled round to ensure their privacy whilst expressing. A family room was also available however multiple families could use this.

Staff asked children and their parents or carers about eating and drinking preferences, appetite and ability to feed as part of the admissions process. For infants this included what milk was normally consumed, how much and how often.

There was dietetic support for both units and there was a diabetic nurse specialist to support patients with diabetes when required.

**Pain relief**

We reviewed completed children’s pain assessment charts in the nursing care plans and saw staff reviewed the patient's pain relief for effectiveness and made changes if necessary. However, there were no specific paediatric pain guidelines available however; the play specialist was available to provide distraction therapy. Generic pain relief guidelines were available on the trusts intranet. The unit was currently in the process of rewriting the pain management guidelines. This would provide effective guidance for pain management, which was not yet in place.

Staff told us about the use of pain assessment charts; however, from information we were told their use was not effective, which did not assure us pain assessments were robust. For younger children staff used ‘Smiley face’ charts by matching the child’s face to the chart as well as asking the parents for their views of younger children’s pain. This was not the correct use of the chart.

Staff on the children’s ward used the disability distress assessment tool (DisDAT) for children with developmental conditions who were nonverbal by means of providing them with a passport type booklet as the tool. The tool helps to identify the source of distress, e.g. pain, in people with severe communication difficulties.

Medicines records showed clear prescribing of pain relief and clear administration documentation with the time, route and dose of the medicines administered.

Staff told us a play specialist was available to assist the medical and nursing teams, as required with distraction techniques during painful procedures. At the time of inspection, we did not observe any painful procedures happening and therefore could not assess the techniques used.
The children’s unit used local anaesthetic cream for children to reduce the pain from invasive medical procedures such as venepuncture.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them.

**Paediatric diabetes audit 2015/16**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%).”

The data below shows in the 2015/16 diabetes audit the trust performed within expected range compared to the England average at a 95% confidence limit.

The proportion of patients receiving all key care processes annually was 54.2% which, although higher than the England average of 35.5%, was not significantly better than other trusts. This was also higher than the previous year’s score of 38.5%.

The average HbA1c value (adjusted by case-mix) at the trust was 67.7, which was within the expected range and similar to the national average of 68.3. The previous year’s score was also within expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 63, similar to the England average score of 65. This was a clinically significant improvement from the previous year’s score of 69.

*(Source: National Paediatric Diabetes Audit 2015/16)*

**Emergency readmission rates within two days of discharge**

The data shows from June 2016 to May 2017, there were no emergency readmissions after elective admission at this trust among patients in the under one age group and no speciality at the trust had six or more readmissions in this period.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust name</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
</tbody>
</table>

No speciality at the trust had six or more readmissions

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialities with the highest volume of readmissions and only those specialities where six or more readmissions recorded are shown in the table.
The data shows from June 2016 to May 2017, there was a higher percentage of under ones readmitted following an emergency admission compared to the England average and a similar percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (June 2016 to May 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Isle of Wight NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.6%</td>
<td>475</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (Month Year to Month Year)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Isle of Wight NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.9%</td>
<td>1,265</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From July 2016 to June 2017 the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple admissions for diabetes.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (July 2016 to June 2017)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Isle of Wight NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-17</td>
<td>*</td>
<td>12</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-17</td>
<td>10.5%</td>
<td>19</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td>1-17</td>
<td>*</td>
<td>11</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)
National Neonatal Audit Programme (NNAP)

In the 2016 National Neonatal Audit, St Mary’s Hospital performance was as follows:

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

There were 11 babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to your unit for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window*; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

There were 93 first episodes of care that were eligible for inclusion in this audit measure for your unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 100% of the eligible episodes; this was above the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Are rates of normal survival at two years comparable in similar babies from similar neonatal units?

The results below include all of the infants that your unit is deemed to be responsible for entering follow up data for in 2016. It is recognised not all eligible infants will have reached a suitable age for two year follow up until the audit year has finished. Results are updated each quarter to give units an indication of their progress towards completing the follow up data for these babies. Follow up data for these infants can be recorded at any neonatal unit, but the results for the infant will always be assigned to the unit of final neonatal discharge unit.

There were 5 babies born at < 30 weeks born between July 2013 and June 2014 who have been assigned to their hospital for two year health assessment based on their final neonatal discharge. Data was entered for 60% of the babies assigned to their unit, whilst nationally data was available for 61% of babies born at < 30 weeks born between July and June 2014.

What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?

There were 28 babies born < 32 weeks in this hospital who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies, 6 were identified as having Significant BPD.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

An additional area identified via the NNAP was that of breastfeeding rates. Results showed an above average compliance with this measure as compared with similar neonatal units nationally.

The children and young people’s (CYP) service was regularly reviewing the effectiveness of sepsis management through local audit. Results reviewed show effective sepsis management for children and young people across the inpatient and NNU unit.

The Neonatal unit (NNU) has been involved in peer review from other NHS trusts and were making improvements as a result. This included increased staffing levels and the recommendation to reduce from a level two NNU to a level one special care unit due to the low number of babies requiring the level 2 care. This change would come into effect in April 2018.
The service was on a journey to achieving level two accreditation for the UNICEF baby friendly initiative (BFI). A midwife was the lead for the BFI initiative and worked closely with the NNU.

**Competent staff**

The service made sure staff were competent for their roles however; there were often situations where staff could not access additional training due to a lack of funding and staffing.

**Appraisal rates**

From October 2016 to September 2017, 73% of staff within services for children and young people at the trust had received an appraisal, not meeting the trust’s target of 100%.

A split by staff group can be seen in the graph below:

**Appraisal Completion rates by staff group, October 2016 to September 2017**

(Source: Trust Provider Information Request P46)

All staff we spoke with had had an appraisal and we saw evidence of an appraisal system in place to ensure all staff received an appraisal on the children’s unit.

All staff we spoke with told us they considered the appraisal system to be beneficial and effective to their personal and professional development. Learning needs of staff were identified through their annual appraisals. However, staff told training needs were not always accommodated stating a lack of funding was the reason given by management.

Nursing staff we spoke with knew where to access help with revalidation and told us there was good support from their peers and managers for completing this.

All staff new to the organisation underwent a corporate induction in addition to a local induction when they joined the trust. The local induction included mandatory training and equipment, ward and medicines familiarisation over a period of six months.

We saw within staff break areas staff had access to information to support continued professional development (CPD), such as information on revalidation and forthcoming CPD training days and events.

Across both services, all staff had some specialist knowledge and the right skills to treat children, young people and their families. Four staff had undergone additional training for example, the advanced nurse practitioners course and there was one the children’s ward and one in NNU. In
addition to this, two nurses were qualified to a level to enable them to teach advanced life support to the teams. This additional knowledge and skills helped to support staff with their clinical knowledge and development.

Some nursing and medical staff in both units had undertaken children and adults basic life support and some had undertaken the advanced children’s life support. Staff we spoke with confirmed this. Rotas we reviewed showed there was always a member of staff with the advanced children’s life support qualification on duty.

Newly qualified medical and nursing staff had a mentor and completed a competency framework however; neither unit had a clinical facilitator or nurse educator, which could limit the development opportunities for newly qualified nurses. However, there was a preceptorship programme for newly qualified staff.

Surgeons and anaesthetists had appropriate training and competence to handle emergency surgical care of children such as appendectomies however, theatre nurses did not undertake any children’s competency training. The trust were yet to introduce these. This did not assure us theatre nurses had the necessary skills and knowledge to care for children during procedures and in recovery.

Staff in critical care were not paediatric trained and had not completed any children’s competency training, however, children over 16 years requiring intubation would be transferred to critical care. Off island transfers for critical care for patients under 16 years would be transferred by the most appropriate transfer: Southampton retrieval team/paramedic ambulance/air ambulance and would be accompanied by appropriately trained nursing staff where necessary. Specialist community nurses were knowledgeable about Epilepsy, Asthma, Oncology and end of life. Following the admission of children with specialist conditions, the community nurses were able to provide the ward nurses with additional education, knowledge and support.

Following findings from a recent coroner’s inquest, the unit developed NNU nursing competency packs with the support of the regional operational delivery network. The competency packs would be introduced to all unit staff this year. The trust’s lead paediatric nurse in conjunction with the ward leadership team would oversee this process and new starters in the NNU would be supernumerary for six weeks and have allocated mentors. This ensured all nursing staff had the same baseline set of skills and knowledge.

Staff on the NNU told us the unit regularly used bank and agency staff were but were unable to describe how bank and agency staff maintained their skills. This did not assure us all bank and agency maintained their competencies to care for neonates.

Medical staff we spoke with reported good relationships with specialist paediatricians in other NHS trusts. They were available to speak with via Skype or the telephone to discuss individual patient’s requirements. This would help support staff in providing children and young people with the right care.

Nursing staff we spoke with on the NNU reported they did not receive clinical supervision however, the trust had recently employed a lead for clinical supervision and the children’s ward and NNU were involved in a clinical supervision pilot scheme. The trust had identified this as an area that required further development.

Upon review of patient’s notes, we noted a paediatrician had seen or discussed the child or young person’s case before discharge was completed. This was in line with the Facing the Future Standards.
Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

There was an appropriate range of multidisciplinary staff providing care and treatment to patients on the children’s unit and NNU, including paediatricians, children’s physiotherapists, pharmacists, dieticians, speech and language therapy and a play specialist. The play specialist was only available to work Monday to Friday across the children’s unit and NNU. There were no schoolteachers and if children required to stay longer than a week, school would provide additional work for the child to complete. Other areas of the hospital that required specialist paediatric advice were able to access the senior children’s nurse on duty.

Staff told us the hospital had a good relationship with the local retrieval service. This service effectively managed the transfer of sick children and babies to intensive care units in other hospitals.

The child and adolescent mental health service (CAMHS) team provided training to the children’s unit about the care of young people sectioned under part 136 of the mental health act. They also provided training in self-harm, and eating disorders and provided outreach support. The ward had good links with the community CAMHS link who visit the ward regularly following a referral of a child or young person.

Staff reported the neonatal unit had good links with the perinatal health professional that specialised in maternal mental health conditions, and could refer mothers to these professionals when there was a concern with their mental health.

We attended a ward round on the NNU and saw clear communication between the parents, medical staff and nursing staff. We saw clinical staff explain all aspects of the treatment for each baby seen.

The psychology department meets with the community nurses on a monthly basis to feedback any concerns regarding children they are working with.

Multidisciplinary team meetings were held to discuss children with cancer, which included the consultant, nurses and community nurses and an outreach nurse from the mainland. These meetings happened monthly with the aim of ensuring effective information sharing about the child’s treatment plan, with the aim of providing a consistent approach to meeting their needs.

Community nurses with training in end of life care for children provided an on call 24 hour service to all staff caring for children at the end of their life. If necessary, they would liaise with the local adult hospice for further support or advice or with the primary NHS trust. The family was able to use one of the hospices special rooms, which enabled the parents to spend time with the child once the child, had passed away.

Paediatric consultants told us following admission of a child for surgery with further medical concerns a joint review took place with the surgical or orthopaedic teams for the benefit of the child.

Staff reported the children’s unit, accident, and emergency unit staff relationships had been historically strained. However, during this inspection, staff reported the relationship and communications had improved and felt the service provided had subsequently improved and was more effective for the children, young people and their families. This resulted in streamlined care as children moved out of the accident and emergency department quicker than in previous years.
An administration team who would produce clinic letters, answer telephone calls, and arrange appointments supported the clinical teams. GP’s, health visitors and school nurses received discharge letters with information regarding the child or young person’s admission.

Upon visiting the radiology outpatients, department staff told us they do not communicate with the children’s ward and were not aware of the availability of the play specialist to help during procedures.

The safeguarding lead for children told us there was good multidisciplinary/interagency working when dealing with safeguarding issues. This would enable good communication within multidisciplinary teams and ensured information regarding safeguarding concerns were shared with the appropriate services.

Transitional care for young people into the adult services was limited which could affect the emotional and physical wellbeing of young people as moving from children’s to adult services is a major transition. However, we noted young people up until the age of 18 were cared for within the service and saw evidence of effective management of the diabetes transition service, by utilising a joint adult and paediatric clinic. Young people suffering from renal disorders transitioned over to services on the mainland due to the Isle of Wight not having renal services available.

**Seven-day services**

The neonatal and paediatric wards were open 24 hours a day, seven days per week and medical and nursing staff provided care.

The outpatient and day surgery ward were open Monday to Friday only and the community nurses worked Monday to Friday but were available on call for end of life patients.

There was 24-hour medical cover with medical presence over the weekend seven days a week on both units with access to radiology support at weekends and an on-call pharmacy outside normal working hours. Children’s consultant job plans covered weekends. This was in line with the RCPCH recommendations.

The neonatal transport service and children’s retrieval service operated by different NHS trust ran over a 24-hour period seven days a week.

The CAMHS service only operated on a 9-5 Monday to Friday basis. When children or young people with mental health concerns required admission over the weekend, they would have to wait until Monday for review for discharge by the CAMHS team. This could lead to unnecessary hospital stays.

**Health promotion**

The service effectively promoted and empowered service users to manage their own health, care and wellbeing to maximise their independence.

Within the children’s outpatient department, there was a wealth of health promotion information available for children and families. This included a topic board, which detailed head lice treatment.

Within the children’s wards and the NNU there was health promotion information displays for parents and children.

Within the NNU, there were posters actively promoting breast-feeding and its benefits.

Parents on both units were encouraged by the staff to care for their babies or children independently but provided support where necessary.

The community nursing team were able to support families when planning for end of life care.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported from April 2017 to September 2017, Mental Capacity Act (MCA) training had been completed by 6.7% of staff in services for children and young people. This was lower than the trust target of 85%.

The trust training data did not include Deprivation of Liberty training

(Source: Trust Provider Information Return P14/P49)

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

When asked the CYP service reported their current completion rate for mental capacity Act training was at 28%. Only 10 staff members out of 35 had completed it.

Staff told us they obtained consent from children, young people, and their parents/carers prior to commencing care or treatment. We observed the community nurses had completed consent to treatment forms and we observed a community nurse gaining consent to treatment from both the patient and their carer.

For children under the age of 16, the young person’s decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises some children may have sufficient maturity to make some decisions for them. Staff undertook a competency assessment based on the Gillick competence to ensure the child was able to fully understand the consent process. If they were assessed not to be competent, only a person with parental responsibility was able to give the consent.

Staff we spoke with showed an understanding of consent and complications around children and consent. All staff described how they would ensure the child was the centre of discussion around consent and how they always gave children and young people choices when they accessed the service.

At the time of inspection, we were unable to see any completed consent forms due to there not being any surgical lists running.

Staff on both units we spoke with reported they had training on the Mental Capacity Act and deprivation of liberty and all staff were aware of policies on the intranet.

We observed staff discussing treatment and care options available to babies for example a member of staff discussed the best route of feeding a baby undergoing phototherapy treatment (treatment to reduce jaundice). The discussion involved the mother to decide if she wanted to breast feed her baby or try with a cup feed to ensure maximum exposure to the phototherapy lights.

Other CQC Survey Data

CQC Children’s Survey Data

The trust performed about the same as other trusts for the five questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. The trust did not score in the question about staff playing with the patient in hospital.
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.56</td>
<td>About the same as other trusts</td>
<td>E3</td>
</tr>
<tr>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>8.68</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>8.58</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>9.06</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>7.83</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP No Score</td>
<td>No Score No Score</td>
<td>No Score</td>
<td>E4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

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

Compassionate care

Staff cared for children and young people (CYP) with compassion.

CQC Children and Young People’s Survey 2016

The trust performed better than other trusts for one question, and about the same as other trusts for the remaining nine questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, compassionate care, Isle of Wight NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>9.22</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.86</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.55</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>
Do you feel that the people looking after your child were friendly?  
0-7 adults: 9.41

Do you feel that your child was well looked after by the hospital staff?  
0-7 adults: 9.34

Do you feel that you (the parent/carer) were well looked after by hospital staff?  
0-15 adults: 8.89

Was it quiet enough for you to sleep when needed in the hospital?  
8-15 CYP: 5.89

If you had any worries, did a member of staff talk with you about them?  
8-15 CYP: 8.28

Do you feel that the people looking after you were friendly?  
8-15 CYP: 9.14

Overall, how well do you think you were looked after in hospital?  
8-15 CYP: 8.84

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Carers and children we spoke with were positive about the individual care and attention staff paid to them at the hospital.

We observed staff engaging with children and their families. We saw compassionate and caring interactions and staff were skilled in talking to and caring for children and young people.

Parents/carers and children comments included:

- “Really brilliant kept me updated”
- “Everything was great I loved the Lego”
- “Friendly staff, relaxed atmosphere – good toy selection”
- “All staff have been polite – shown empathy and understanding. Very clean and hygienic. All needs met to high standard”
- “All staff we have come into contact with has been attentive and caring. Facilities have been clean and tidy”

During our inspection, we saw children and families of multi ethnicities, treated with dignity and respect at all times by staff. Staff respected the adolescent’s viewpoint and adolescents were placed in cubicles or with their peers out of respect for their need for privacy and an acknowledgement of their growing independence and maturity.

We saw doctors and nursing staff introduce themselves to families and curtains were drawn to maintain patient dignity.

Both units participated in the ‘I want great care’ survey and scored five out of five stars for if users would recommend for their friends or family to use the service consistently over the four months we reviewed. The clinical business unit as a whole scored 4.88 out of 5 stars with a response
rate of only 57 patients. 98.7% of patients were likely to recommend the hospital to friends or family.

Staff reported if parents were unable to stay with their children they would ensure if workload permitted a nursery nurse would stay with the child in their parent/carers absence.

**Emotional support**

Staff provided emotional support to CYP to minimise their distress.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for one question, and about the same as other trusts for the remaining four questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, emotional support, Isle of Wight NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.38</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.59</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.13</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>9.78</td>
<td>Better than other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>8.39</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016)

There were a range of clinical community nurse specialists employed to support children and their families. The parents we spoke with were highly complementary of the community nurse specialists.

We observed staff responding to both the child and families emotional needs in a positive and reassuring way. Staff cared for patients with compassion and the service displayed many letters and cards of thanks mentioning the emotional support provided by staff. These letters highlighted staff were dedicated to their role to ensure children and their families’ emotional needs were met.

A child psychology service was available for children with long term or complex conditions, which would aid in addressing the child or young person’s emotional needs.

The community nursing team had links with the local hospice team who are able to signpost parents and families for bereavement counselling if required.

We observed staff in the NNU were compassionate and particularly welcoming to parents and made parents feel at ease at a very stressful time.
Mothers on the NNU were encouraged to have skin-to-skin contact to promote bonding with their babies.

A practice of maintaining parenting diaries on NNU helped staff identify specific support parents needed to help them bond and care for their baby.

**Understanding and involvement of patients and those close to them**

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for 21 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

### CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, Isle of Wight NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>8.94</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.72</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.03</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.52</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.74</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.41</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>9.18</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.44</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.51</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>9.36</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>0-15 adults</td>
<td>8.23</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Question</td>
<td>0-7 adults</td>
<td>8-15 CYP</td>
<td>8-15 CYP</td>
<td>8-15 CYP</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>----------</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0.7</td>
<td>8.57</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8.15</td>
<td>9.18</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8.15</td>
<td>8.18</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Did you feel able to ask staff questions?</td>
<td>8.15</td>
<td>9.18</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Did the hospital staff answer your questions?</td>
<td>8.15</td>
<td>9.18</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8.15</td>
<td>6.19</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12.15</td>
<td>No Score</td>
<td>No Score</td>
<td>C2</td>
</tr>
<tr>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8.15</td>
<td>No Score</td>
<td>No Score</td>
<td>C2</td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8.15</td>
<td>No Score</td>
<td>No Score</td>
<td>C2</td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8.15</td>
<td>8.27</td>
<td>C2</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Transitional care services in diabetes and renal disease empowered adolescents and parents with information regarding moving into adult services and supported them emotionally to make decisions about their future care.

Parents were encouraged to be involved in the care of their babies and children as much as they felt able to. Parents were encouraged to visit and spend time with their children by staff and there were open visiting times in place on the children’s ward.

Parents told us staff kept them well informed throughout their child’s treatment. Staff told us parents were welcomed in to the anaesthetic rooms and recovery areas of the theatre department although we did not observe this due to a lack of theatre activity during the inspection.

Children and parents we spoke with felt they had been involved in care and decisions made around their child’s treatment. Parents and children were positive about the care received.

Due to the children’s ward accepting patients aged 16 to 18 years old staff told us the young people were given the opportunity to talk with the doctors unaccompanied without consent of the parents if they were deemed competent. This ensured the young person was involved and understood their treatment choices.
Is the service responsive?

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

Service delivery to meet the needs of local people

The trust did not plan and provide services in a way that met the needs of local children and their families.

CQC Children and Young People’s Survey 2016

The trust performed better than other trusts for four questions, and about the same as other trusts for 10 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

The trust did not score for three questions.

CQC Children and Young People’s Survey 2016 questions, responsive domain, Isle of Wight NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>10.00</td>
<td>Better than other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>9.04</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>9.57</td>
<td>Better than other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>3.02</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>8.02</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
<td></td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>8.39</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.83</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.77</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.75</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>8.69</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>8.12</td>
<td>Better than other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>6.66</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>Description</td>
<td>Source</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td>--------------------------------------</td>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>7.81 About the same as other trusts</td>
<td>R2</td>
<td></td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>9.33 Better than other trusts</td>
<td>R2</td>
<td></td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>R3</td>
<td></td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>R3</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

The children’s ward catered for children up to the age of 18 years old. Children aged 16 years to 18 years were given the option to be cared for in an adult ward dependant on bed availability. However, one patient we spoke with reported they were not given a choice and were referred directly to the paediatric service. The patient reported they would have preferred to be seen in an adult environment.

There was no evidence of planning of outpatient clinics to meet the specific needs of children. Only the ophthalmology clinic had a separate child friendly waiting area for children. Most clinics did have some toys but we observed radiology and maxiofacial clinic had nothing available at all for children. Within fracture clinic, children’s plaster cast application was done in a non-child friendly environment and children would share the treatment room with an adult. In addition, staff reported they did not contact the play specialist to help with distracting children during clinical interventions. Children waiting alongside adults were at risk of exposure to distressing adult conversations.

There was not a specific area of the children’s unit for adolescents although staff reported the service was looking at ways to develop this during the 2014 inspection, but we observed limited progress. Four cubicles were used primarily for adolescents within the children’s wards designated area separated from main body of the ward.

There were many quiet areas in both units, which could be used if a parent or child was to become distressed or where bad news could be discussed. All staff we spoke with identified how they would use these areas in the above situation.

The Royal College of Surgeons 2013 recommend children and young people’s outpatient appointments occur in dedicated children’s outpatient sessions. If an outpatient clinic is mixed, children’s appointments should be grouped together at the beginning or end of the clinic and the environment should allow for separation from adult waiting areas. We observed in all clinics where children were seen apart from ophthalmology, that children and adults appointments were held together.

During the inspection in 2014 it was identified there was more than one pathway for children requiring urgent medical treatment which posed the risk of children not being attended to in a timely manner. During this inspection there were now clear pathways. Children arriving in ambulances were taken directly to accident and emergency. Some children who held a ‘yellow passport’ for a long term condition were admitted directly on to the ward (after calling the ward in advance to ensure safe staffing numbers).
The environment in both the children’s wards and the neonatal unit (NNU) met the needs of babies, children and young people and their families. Parents on the children’s unit were able to stay with their child on a pull down bed beside the child’s bed.

NNU parents were encouraged to stay with their baby and there were no restrictions to visiting. Two of the rooms in the unit had sofa beds for the parents to stay and the unit had an overnight room for babies and their parents/carers who are close to discharge home.

There was a parent’s kitchen and family room outside of the children’s unit and within the NNU. Hot drinks were available for the parents to help themselves. In the NNU, parents had a specified area for eating and drinking away from the cot side.

There was a lack of available WIFI within the hospital, which both parents and children commented to us would be helpful so they could stay in touch with their families, as they did not receive phone signals in parts of the hospital. There was however a pay phone available on the children’s and NNU unit.

Paediatric epilepsy plans were coordinated with a specialist centre on the mainland for support as the cohort of patients in the children’s unit is too small to necessitate a local service.

There were plans to reduce the number of paediatric beds to 10 and to open a paediatric assessment unit to enable children periods of observation in a child friendly ward environment instead of accident and emergency.

Meeting people’s individual needs

The service took account of patients’ individual needs.

A room on the children’s ward was available to facilitate adolescents with mental health concerns or who were detained under section 136 of the mental health act. This dedicated area was lockable to prevent access to the ward but had access to the room from the outside. However, within this room we observed a ligature risk of some blind cords. This concern was raised at the time of inspection.

Children with sensory or learning disabilities could be placed in a cubicle if due to their additional needs they were unable to cope with the open ward environment. The play specialist also had an interest and was the point of contact for children with learning disabilities as well as there being a lead nurse in the trust for patients with learning disabilities.

Clinic appointments were available for children with complex needs and multiple diagnoses in the children’s outpatients’ clinic however; there were no multidisciplinary clinics, which meant this group of children might have to attend several different appointments on different days.

Within the paediatric team there were consultants with an interest and knowledge in ASD who ran clinics. The trust had costed up two models of care for children with a possible diagnosis of ASD to take forward to the clinical commissioning group (CCG);

a. A waiting list initiative to address the 147 waiting list from the previous provider and the anticipated 140 referrals that have accumulated since they ceased providing the service

b. A NICE compliant service model to meet the demand of 400 referrals and 200 assessments. This paper was going to be discussed at the CBU leadership board.

The ASD service the CCG wished to commission was an assessment and diagnostic service and the trust were in discussions about developing a whole life pathway that meets the needs of island residents which will include post diagnostic support in the future with the CCGs support. In the meantime children have to travel to the mainland for their ASD diagnosis.
The CCG asked the Mental Health CBU to evaluate whether it could provide a service to a) clear this backlog and b) to provide an ongoing service. The CCG agreed a financial envelope for the backlog but the Mental Health CBU have confirmed they cannot source agency staff to provide this service and do not currently have the in house skills or capacity to undertake the work. There is no agreed service specification for the ongoing service itself or formal agreement for the Trust to deliver it.

The children’s unit detailed pictures of items such as toilet or shower etc. so parents/children with learning disabilities or families who do not have English as their first language were able to identify these items.

Staff were able to access interpreter services for patients whose first language was not English. Staff could book interpreters for face-to-face meetings or over the phone.

We saw a range of information leaflets on the intranet in plain English for parents across the units including Head injury, respiratory syncytial virus (RSV), hernia repair and adenoidectomy. At the beginning of the leaflet, there were details in multiple languages advising on how to get the information in the leaflet translated.

Educational needs of the children were met by support of the individual child’s school.

All children and young people admitted to the children’s unit with mental health concerns were referred to the CAMHS team. However the CAMHS team only operated Monday-Friday and there was no access to child mental health support during the weekend. A business case produced found there were not enough children admitted over the weekend to justify the CAMHS team covering weekends. Out of hours support was covered by the adult mental health team.

Parents visiting the NNU or children’s unit for prolonged periods of time were offered a discounted parking and discounted meal vouchers. The trust provided meals for mothers who were breast feeding.

Parents were provided with equipment whilst their child was staying at the ward. For example, milk formula and bottles were provided. Staff had access to a wide supply of baby clothing. Breast pump machines were available for parent use.

The parent’s toilets on the NNU were mixed sex and there were no shower facilities within the NNU. Mothers would have to use the maternity unit’s facilities, which meant leaving the NNU.

We observed call bells responded to on the children’s ward by the nursing team in a timely manner. However, on the NNU, we observed a period of time where monitors, which registered the baby’s heart rates and oxygen saturations, were alarming but there were no staff available to attend to them.

**Access and flow**

**Neonatal Critical Care Bed Occupancy**

From September 2016 to August 2017, the trust has seen neonatal bed occupancy at 0% for all months apart from April 2017. In April 2017, the neonatal bed occupancy was at 50%. This was lower than the England average across every month.
Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

There were multidisciplinary networks supporting the early discharge of children such as the community nursing team.

GP's could refer children direct to the children's ward following contact with the paediatric registrar, which avoided a wait for children in the accident and emergency department. GPs had access to an advice line run by registrars Monday to Friday. GP’s could also refer children in to urgent outpatient clinics.

Discharged children from the children’s unit received open access for one week, which meant the child could return to the ward if they were to become unwell. Parents were reassured if their child was to become unwell again they could bypass the need to visit their GP or the emergency department.

The service operated a “Yellow Passport” policy for specific patient groups. This offered parents/carers the reassurance should the condition of their child deteriorate at any time, they could report directly back to the children's unit without the need to go via the emergency department.

The community nursing service provided care available Monday to Friday 9am to 5pm. Children at the end of their life could access an on call community nurse 24 hours Monday to Friday. For children not at the end of their life they would need to call the ward for advice for attend the ward for medical treatment.

The units used Skype, a video conferencing service to discuss patient conditions with specialist teams on the mainland whilst the child or young person was an inpatient. This enabled a responsive and quick outcome for any changes required in children’s treatment.

The national neonatal audit programme (NNAP) for 2016 demonstrated the unit achieved 100% compliance for consultation with parents by a senior member of the neonatal team within 24 hours of admission.

Patients and family members within the outpatient department reported they felt they did not wait long for referrals, or for specific appointments.

Learning from complaints and concerns

Summary of complaints
From October 2016 to September 2017, there were nine complaints related to services for children and young people. Five complaints were closed, and four from June 2017 to September 2017 still remain open. The trust took an average of 38 working days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints.

A breakdown by subject matter is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment - Psychiatry group</td>
<td>2</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Treatment - Obstetrics &amp; gynaecology</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Treatment - Surgical Group</td>
<td>1</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Patient Care</td>
<td>1</td>
</tr>
<tr>
<td>Trust admin/Policies/Procedures including patient record management</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

There was guidance about how to raise concerns or complaints in patient advice and liaison service information (PALS) leaflets, which was available across the units.

Children, young people, parents and carers were encouraged to complete the trusts “I want great care” questionnaires and there were child friendly versions to provide feedback regarding the care they received on both units. We saw the response rate to these monthly were quite low with December receiving 10 responses for the children’s unit.

Staff were encouraged to respond to and resolve concerns raised by parents at an early stage. Parents told us when concerns were raised, staff addressed these immediately.

Staff told us shared learning from complaints was on an individual basis or in team meetings; however we did not see any evidence of this in the team meeting notes we reviewed.

At the time of inspection, staff we spoke with were unable to give an example of changes to practice that had arisen from a complaint. This did not assure us the feedback from complaints was discussed at ward level.

Is the service well-led?

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

Leadership

There was a designated matron for children’s inpatients, community, day surgery and the neonatal unit (NNU). However, their role also covered head, neck, and adult (including private) surgery, which meant the matron’s time was not dedicated to children’s services. The matron was responsible for managing quality assurance and we saw evidence of a strong visible clinical
leadership by the matron, however; some staff felt the matron was doing too many roles to be supportive of their service. The matron reported in to the clinical business unit lead.

Both units had ward sisters who staff reported were approachable. Sisters we spoke with told us they ran an open door policy for staff.

Some staff we spoke with would have appreciated visits from the executive team especially during the changing times. Staff were unaware whether the executive team were aware of the impact service changes within the children’s department and NNU would have on families such as the reduction of inpatient beds to form a paediatric assessment unit.

The named nurse for children safeguarding reported in to the designated nurse for the clinical commissioning groups. This potentially created a conflict of interest whereby the designated nurse was involved in commissioning the services the named nurse would provide.

Discussions we had with the senior management teams across the service, demonstrated leaders who were patient focused and committed to improving services.

Staff we spoke with reported band six nurses to be approachable, supportive and encouraged staff engagement. Across the services, most staff told us, the matron and senior nurses were visible and supportive and many band seven staff had an open door policy.

All staff knew their strategic manager (operations manager) and some staff were aware of members of the trust executive leadership team particularly the director of nursing.

Staff told us the chief executive of the trust emailed weekly bulletins to update staff on hospital news.

Staff we spoke with were positive about the skills, knowledge and experience of their immediate managers and felt well supported.

**Vision and strategy**

The chief executive was reviewing the structure of the trusts clinical business units (CBU) which will affect which business unit the children’s ward and neonatal unit (NNU) were situated under. Staff on the NNU reported they felt removed from maternity being in a separate business unit and staff on the children’s unit were unsure why there were not grouped with the emergency department.

At the time of our inspection, a clinical services review was in process, which was commissioners led. This had led to some uncertainty about all services at St Mary’s hospital with the possible option all inpatient beds would move to the mainland. This caused uncertainty and stress amongst the nursing staff and families.

Staff knew how their work contributed to the wider vision of the trust and they were aware of the trust values. However, the children’s and NNU did not have a vision or robust, realistic strategy in place to deliver good quality sustainable care. However, all levels and disciplines of staff were enthusiastic about where their clinical business unit wanted to be.

**Culture**

Most managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service displayed an open culture of learning and reflection. This included listening to, empowering, and involving children, young people their families and staff. Staff were aware of and were working towards the trust values of “Quality care – everyone, every time”.
There were positive working relationships and cohesive team working between the nursing, medical, allied healthcare professionals, play staff, administrative team and housekeeping staff. Medical staff respected the views and professional opinions of the nursing staff and children’s experiences were seen as the main priority.

Staff described a ‘no blame’ culture and told us they were encouraged to report clinical incidents. There was a proactive culture in learning from incidents and sharing information but staff we spoke with were unable to evidence the changes made as the outcome of incidences. This did not assure us investigation and learning from incidents were robust enough or shared effectively.

Staff were encouraged to undertake annual appraisals. Staff we spoke with said they would be confident to raise a concern with their managers and were confident appropriate investigation measures were in place.

Most staff felt valued and were proud of the service, patient outcomes and parent feedback. They told us they felt supported to provide high-quality care. Most of the staff we spoke to felt it was a good trust to work for but felt they were so busy there was no opportunity for further development and others reported due to financial restraints further development was not available.

The ward sisters had some oversight of their service although neither we spoke with were able to give precise staffing figures. Staff reported the ward sisters communicated well with the team.

Staff we spoke with were not aware of the freedom to speak up guardian however, they were aware there was someone in the trust available to talk to if they were experiencing bullying.

Staff worked collaboratively in teams and most expressed a view they readily helped other areas when they were under pressure. However, some nursing staff expressed they were uncomfortable working in the emergency department due to a lack of knowledge and expectation to care for adults. The ward management were supporting staff by providing additional training to support g staff to feel more confident to work in the emergency department.

Staff told us previously they had felt the trust leadership did not address or acknowledge issues within the children and young people’s service; however, staff now reported this was changing and felt the trust showed more acknowledgement of the CYP service.

Staff we spoke with described a process when in the event of a local incident or the requirement to break bad news staff could choose how and when the unit should contact them. A “bad news spreadsheet” was developed and updated as required.

**Governance**

The service did not appear to use a systematic approach to continually improving the quality of its services.

The children’s unit and Neonatal unit were part of surgery, women’s health and children clinical business unit (CBU).

The Matron attended monthly clinical governance meetings, which reviewed the outcome of any audits, complaints or incidents. However, staff reported they were often not aware of any outcomes of audits or incidents but they were informed of complaints.

Across both units at service level, there were a range of quality initiatives such as audits and parent satisfaction questionnaires to assess the effectiveness of the service however learning and implementing changes from the results was not evident. Audits included the Bliss Baby charter audit tool and the diabetic audits.
All staff we spoke with were clear about their roles and understood what and whom they were accountable for or to.

The sisters for both units were responsible for overseeing sepsis management. The children’s unit were utilising the resources from the trust sepsis team to ensure children with sepsis were managed effectively and in a timely manner. However, there were no visual reminders for staff regarding the signs of sepsis and treatment required.

We reviewed three months’ worth of the monthly CBU meeting minutes, which discussed staffing risks, finance, contracts and any other business. The Matron, consultants, the community nursing team and the paediatric secretaries, attended these meetings.

The CBU held weekly team meetings, which discussed finance, the 18-week performance, winter plans, scrutiny requests, business cases, quality issues, incidents and actions and staffing. This information fed in to the 10-minute team brief which was emailed out to staff. The 10-minute brief was a summary of key information discussed at the meeting.

Leadership meetings held monthly discussed business cases, quality updates, and patient stays over 21 days, learning and education, directorate performance – finance, human resources and RTT. The matron attended the meetings and fed back to the CBU’s weekly meeting.

Both units held monthly staff meetings were they discussed complaints, documentation, reminders regarding patient care, updates on new paperwork and presentations of any completed audits. We reviewed three months of minutes and found each meeting discussed similar.

The children’s safeguarding team met regularly with the safeguarding steering group, where the director of nursing attended and the lead for children’s safeguarding from the local authority. Policy renewal or writing was discussed as well as other items at this meeting.

**Management of risk, issues and performance**

Most areas of the service had effective systems for identifying risks, planning to eliminate or reduce them, and coped well with both the expected and unexpected.

Service risks were fed up to the trust level risk register. The executive team reviewed the risk registers and fed down to the clinical business unit (CBU) managers who fed downwards to the team leads. The current risks were medical and nursing staffing on the NNU.

The patient safety working group met monthly and looked at incidents with minor harm over previous weeks with Ward Sisters/Matrons. Staff explained this included a review of the incidents, decisions as to whether appropriate documentation of harm was completed, and lessons learned. The executive team held regular quality meetings for discussing serious incidents.

The NNU service used their dashboard to update the nursing and medical team through monthly team meetings, which ensured all staff were aware of areas requiring improvement. This dashboard fed up to board level to provide an oversight of the NNU’s performance levels.

It was clear the service had taken steps to address some of the issues identified during our previous inspection such having one pathway for children requiring urgent medical treatment.

There were no current risks on the children’s ward risk register which was reflective of what we observed during inspection, however risks on the NNU were detailed as two-tier medical cover for NNU was insufficient to meet national standards and nursing staffing levels and competencies were insufficient and did not reach the BAPM’s requirement for safe levels of staffing. Staff we spoke with were aware of their services risks, which indicated managers shared information appropriately.
Currently the risks for the NNU were discussed weekly between the children’s ward sister, matron and director of nursing. Recruitment of additional nursing staff was agreed at these meetings. This ensured the unit understood any new risks as they arose and whilst staffing levels were increasing, the unit was able to mitigate any new risks.

A decision following the identification of medical staffing not reaching the BAPM’s requirement was the introduction of a three-tier model, which would include eight posts of GP trainees/junior, doctors/advanced neonatal nurse practitioner or emergency nurse practitioners.

There were mechanisms for measuring quality and escalating risks within children’s and NNU services. Members of the clinical governance team had responsibility for reviewing local guidelines to ensure they were reflective of current national guidance. Three sets of meeting minutes we reviewed demonstrated this.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Ward management were responsible for cascading information upwards to the trust management team. We saw information shared during clinical governance meetings; however, there was no assurance ward management shared information such as learning from incidents as widely as it could have been.

The NNU used their local service dashboards, which covered incidents, complaints, staffing and key performance indicators to ensure staff were aware of areas requiring improvement. The dashboard was discussed during team meetings and was displayed on the staff room notice board.

Staff we spoke with were aware of information security and knew where to report possible Information Technology (IT) breaches. All staff knew not to open unfamiliar attachments in emails and received regular reminders from the IT team regarding possible cyber-attacks.

All staff across the service we spoke with were confident in the use of the IT system to report incidents, complaints, and appraisals.

Staff had access to the equipment and information technology needed to do their work. However, in some area’s access was difficult due to connectivity issues to access their emails effectively. This could result in vital patient information being missed.

IPADS were used to gather patient feedback which proved especially popular with the young people.

**Engagement**

The service engaged well with patients, staff, the public to plan and manage appropriate services, and collaborated with partner organisations effectively.

Feedback from children, young people and parents was actively sought through surveys and action was taken in response. For example the ward had a tree on the wall where children, parents and staff were able to write on a leaf with their suggestions or compliments. All comments were of a positive nature.
The NNU unit displayed a parent feedback board which displayed positive comments from parents who had a baby on the unit. There was also a tree etched in to the window and for a fee, parents could add their family on to the window. This helped raise funds for the NNU unit.

Staff on both units attended ward meetings and the minutes were circulated via email. Staff were encouraged to look at the intranet to keep up-to-date with hospital policies. Communications were posted on the staff information board in the staff rooms and emails circulated including the 10 minute team brief.

Staff had access to up-to-date information about the work of the trust. Information was available through the intranet, email bulletins and newsletters. Patients and carers had access to up-to-date information about the work of the trust through the trust’s website.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Innovation and ideas from staff were actively encouraged. We were given an example where the play therapist had recognised the need for visual signs to be used across the unit for children and families with learning difficulties or English as their second language.

Because of the location of the trust, there were difficulties in appointing junior doctors. To overcome this problem, advanced nurse practitioners were appointed across both units. However, problems arose when the advanced nurse practitioners were required to work across the medical and nursing rota, which caused some confusion with unrealistic expectations from the medical team when the ANP was working on the nursing rota. We observed on the NNU the ANNP was taken out of the unit and used during the ward round which placed the NNU at risk due to decreased nursing staff. The trust were planning to increase the number of ANP’s to mitigate this risk.

The NNU developed an action plan, which detailed the introduction of improvements following the inquest into the neonatal death. More staff were recruited and plans were in place to encourage staff to attend the advanced nurse practitioner course. The trust identified a need for a dedicated junior level doctor or registrar to be on duty 24 hours covering NICU with plans for the advanced neonatal practitioners to fill this gap. The previously used NICU Stabilisation/Transitional Care Sheet was not effective in recognising a deteriorating baby and implementation of a Neonatal early warning signs (NEWS) sheet, which empowered staff to escalate concerns earlier. Review of the transfer policy of neonates ensured nursing staff were proactive in early contact of the tertiary centres and transport team.

An oncology shared care network for managing children with cancer enabled families to be supported and treated closer to their homes. It also enabled access to the best possible advice for these families. The children’s unit was a level one paediatric oncology shared care unit which could offer care to visitor to the island.

The trust recognised the need for a paediatric assessment unit to try to decrease the numbers of children requiring overnight stays. Plans had been agreed to reduce the number of beds on the ward by one and open an area of the children’s’ ward as an assessment unit. The existing nursing team would staff the unit. Long-term ambitions were to move the children’s unit closer to the emergency department.

During the 2014 inspection, to ensure sufficient nursing numbers the trust would adopt the practice of ‘growing their own ‘specialist nursing staff. The children’s ward had recently employed two
general adult nurses who were working with the Wessex wide children’s competency handbooks to ensure they had the correct skills to care for children and young people.

Rotational posts were available for staff, which included the children’s unit, NNU, community nurses and accident and emergency. These ensured staffs had a well-rounded experience and were multi-skilled when caring for children and young people of all ages. Staff would complete competency workbooks and given mentors for each rotation placement to ensure their competencies were achieved.

The children’s and young people’s service were part of a network within the Wessex region, which met every three months. The network was able to share policies and updated guidance to ensure a consistent approach across the Wessex region to treating children.
End of life care (EoLC) encompasses all care given to patients nearing the end of their life and following death. Patients received care in any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services.

The definition of end of life includes patients who are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean they are expected to die within 12 months
- existing conditions that put them at risk of dying if there is a sudden acute crisis in that condition
- life-threatening acute conditions caused by sudden catastrophic events.

The Isle of Wight NHS Trust provides EoLC to patients across all clinical areas who have a variety of conditions including cancer, stroke, cardiac and respiratory disease and dementia. The hospital does not have a dedicated ward for EoLC. It also provides EoLC to some patients in the community.

The Isle of Wight NHS Trust has a high length of stay for people who die in hospital, with the highest percentage of death from dementia in England. The trust spends more on end of life care than the national average (Results of monitoring of funding for end of life care 2010 to 2011: PCT returns on SPC spend in 2010/11. Results of monitoring of funding for end of life care 2010 to 2011). Public Health England Fingertips data (2018) revealed that fewer patients die in hospital compared to the national average.

The commissioners have a contract with the hospice for palliative and EoLC services for residents across the Isle of Wight. The hospice provides the hospital with a hospital palliative care team comprising of a specialist consultant, a nurse team lead, one staff nurse and one end of life discharge coordinator. These individuals provide advice, assessment, and treatment to patients nearing the end of their life across all clinical areas within the hospital. The trust has appointed one end of life facilitator to support ward staff to deliver care to patients at the end of life and a lead clinician on EOLC, who is also the trust lead on frail and elderly patients. The trust has also appointed a senior operational manager with operational responsibility on end of life care.

Two palliative care doctors who are employed by the hospice and work at the hospital support the hospital palliative and end of life team. Whilst the hospital palliative care team and the palliative care doctors are employed by the hospice, and therefore not being inspected, their role within the trust was integral to the delivery of end of life care. As such, they are referred to throughout the report.

We requested the trust to provide us with the number of referrals the hospital palliative care team (HPCT) received for the period August 2016 to July 2017 and the number of referrals in that period were of patients diagnosed with cancer. We did not receive this data from the trust. The trust reported 637 deaths from August 2016 to July 2017. (Source: Hospital Episode Statistics (HES))
The hospital palliative care team were available five days a week, from 8.30am to 4.30pm, Monday to Friday. An on-call specialist palliative care team based at the hospice provided specialist palliative care support to medical and nursing staff out of hours and weekends.

The end of life care service was previously inspected in November 2016 and received an overall rating of ‘Requires Improvement’.

We completed an announced inspection of the end of life care service on 23, 24 and 25 January 2018 with an unannounced night visit on 5 and 6 February.

During this inspection, we visited some inpatient wards including stroke, elderly care, respiratory, general medicine, oncology, general surgery and the medical assessment unit. We observed patient care and viewed care records. We noted the care and records of patients identified nearing the end of their life. We spoke with patients, relatives, mortuary technicians, the chaplain, porters, staff in the bereavement centre and staff based on wards including nurses, doctors and an occupational therapist. We also met with the district nurses, team leaders and locality leads.

In total, we spoke with 47 staff members. We looked at policies and procedures and reviewed performance information about the trust.

### Is the service safe?

#### Mandatory training

The service provided mandatory training in key skills to all staff. However, it did not make sure everyone completed it. The trust did not follow the national standard for end of life care training, as end of life care training was not mandatory.

At the last inspection in 2017, the trust was required to ensure it monitored the mandatory uptake of end of life care training across all specialities. At this inspection, we found this had not occurred.

The trust set a target of 85% for completion of mandatory training. In end of life care, the trust told us that eligible nursing staff met the trust’s target with 85% overall compliance rate. However, medical/dental staff did not meet this target with having a 63% compliance overall. We were not provided with the definition of “eligibility” with regard to nursing staff as nurses provided end of life care across the hospital.

**Mandatory Training Completion by module – Medical and Dental Staff**

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
There was only one reported medical/dental staff who worked within end of life care within this period. This member of staff completed 10 out of the 16 training courses listed above. The team told us this was an oversight and the individual would complete their training. The trust did not include two palliative care doctors who also worked in the hospital. We asked for clarification on the rationale for not including them. The trust did not respond to this request.

Mandatory Training Completion by module – Nursing Staff

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>14</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>14</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>14</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>14</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>14</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>14</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>11</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>14</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>14</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>14</td>
<td>78.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>14</td>
<td>71.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>14</td>
<td>71.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Load Handling</td>
<td>3</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Maths &amp;</td>
<td>14</td>
<td>57.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Topic</td>
<td>Number Required</td>
<td>Compliance (%)</td>
<td>Completed?</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>People Handling</td>
<td>2</td>
<td>50.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>2</td>
<td>0.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>14</td>
<td>100.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>14</td>
<td>100.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>14</td>
<td>100.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>14</td>
<td>100.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>14</td>
<td>100.0%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

We were not provided with the definition of “eligibility” with regard to nursing staff as nurses provided end of life care across the hospital. Nurses working within end of life care met the trust’s target for 15 out of the 22 training courses listed above. Training courses with the lowest compliance rates include medicine management – competency (zero out of two members of staff completed this), people handling (online) (one out of two members of staff completed this) and medicine management – maths & medicines (eight out of 14 members of staff completed this).

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Nursing staff within end of life care met 15 out of 22 mandatory course completion targets in the last financial year.

The specialist palliative care team had received specific training such as the five priorities for end of life care. However, the “End of life care policy: care of the dying adult” identified a mandatory e-learning requirement for groups of clinical staff. The trust did not set a target for compliance.

The trust reported the level of completion for all clinical staff as below.

<table>
<thead>
<tr>
<th>Date (As of date below)</th>
<th>Staff group</th>
<th>Number required</th>
<th>Number achieved</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 February 2018</td>
<td>Medical and dental consultants</td>
<td>91</td>
<td>69</td>
<td>76%</td>
</tr>
<tr>
<td>5 February 2018</td>
<td>EoLC e learning junior doctors</td>
<td>76</td>
<td>41</td>
<td>54%</td>
</tr>
<tr>
<td>5 February 2018</td>
<td>EoLC classroom junior doctors</td>
<td>76</td>
<td>33</td>
<td>43%</td>
</tr>
<tr>
<td>5 February 2018</td>
<td>Either EoLC classroom or e-leaning</td>
<td>76</td>
<td>60</td>
<td>79%</td>
</tr>
<tr>
<td>5 February 2018</td>
<td>Nursing and midwifery registered</td>
<td>498</td>
<td>379</td>
<td>76%</td>
</tr>
<tr>
<td>5 February 2018</td>
<td>Additional clinical staff</td>
<td>299</td>
<td>217</td>
<td>73%</td>
</tr>
</tbody>
</table>

The above data highlighted poor rate of uptake of end of life training that was mandated both by the National Care of the Dying Audit of Hospitals (NCDAH) 2014-2015 across all staff groups and also by the trusts’ policy across all clinical staff groups.

**Safeguarding**

Most staff had training on how to recognise and report abuse and understood how to protect patients from abuse. However, they did not always recognise safeguarding issues or work with external agencies on investigations relating to end of life care.
The trust set a target of 85% for completion of safeguarding training.

Safeguarding Training Completion by module – Medical and Dental Staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for medical/dental in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>1</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust required medical and dental staff to attend all three modules. The one medical/dental member of staff who worked within end of life care attended only two out of three safeguarding modules. The trust did not include two palliative doctors who also worked in the hospital. We asked for clarification on the rationale for not including them. The trust did not respond to this request.

Safeguarding Training Completion by module – Nursing Staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>14</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>14</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>14</td>
<td>78.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nurses working within end of life care met the trust’s target for two out of the three safeguarding modules; safeguarding adults level 1 and safeguarding children level 1.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust did not provide safeguarding adult level 2 training data for any of the above groups of staff.

Trust staff were up-to-date with trust wide safeguarding policies and procedures. These were accessible to staff via the trust’s intranet site. Staff within the hospital palliative care team and on the wards were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children. They were aware of the referral process to the safeguarding team.

However, there was no evidence that staff were able to apply this knowledge. None of the staff we spoke with could recall a recent safeguarding incident that related to patients in receipt of end of life care. There were no reported safeguarding concerns pertaining to patients who received end of life care between 1 January 2017 and 31 December 2017. Between the period 22 May 2017 and 10 January 2018, local nursing homes reported four safeguarding alerts to the local authority. These related to the care provided by the trust for end of life care patients. The local authority has
the power under section 42 of the Care Act 2014 to make enquiries or cause others to do so if it believes an adult had experienced or was at risk of abuse or neglect. The local authority asked the trust to investigate these cases. At the time of the inspection, we had not received a report from these investigations, and the end of life team were not aware of them.

**Cleanliness, infection control and hygiene**

The end of life care service controlled infection risk well. They used control measures to prevent the spread of infection.

We inspected end of life care facilities provided for the use of patients and their families, which included interview rooms, the chapel, patient visiting rooms, the bereavement service meeting room, and the viewing suite in the mortuary complex. All areas were visibly clean, tidy and well maintained.

Patient and staff representatives conduct patient led assessments of the care environment (PLACE) and national guidelines set out the areas of the hospital to be reviewed each year. These self-assessments are undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. In 2017, St Mary’s Hospital scored 99.1% for cleanliness, which was above the England average of 98.4%.

The mortuary fridges were visibly clean and we saw that mortuary staff followed infection control procedures. The mortuary complied with all the regular audits they undertook. The mortuary had produced guidance on how to provide care to people after death, this included actions to reduce the risk of spread of infection. This was documented in the trusts’ mortuary policy and policies, and this included the wearing of gloves, aprons and the use of body bags.

Personal protective equipment (PPE), for example, gloves and aprons, was available for use by staff in all relevant areas. Porters used gloves and gowns when they transferred a deceased person from the bed to the trolley in the wards. Porters removed the PPE during transit and disposed of them in the ward. They replaced the PPE on arrival in the mortuary if required.

Ward staff we spoke with were aware of the procedures and knew how to minimise infection risks when they performed ‘last offices’ procedures. The term last offices related to the care given to a body after death. This process demonstrated respect for the deceased and focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements.

The trust developed policies and procedures that ensured that after death, the health and safety of everyone that met the deceased person’s body were protected. Porters confirmed they had received appropriate training and their supervisors undertook regular checks. This ensured they adhered to the trust policies and procedures. We spoke with a supervisor who confirmed they conducted these regular checks.

**Environment and equipment**

The service had suitable end of life care equipment and looked after it well.

Appropriate equipment was available to meet patient needs such as syringe drivers. The trust used nationally recommended syringe drivers to deliver consistent infusions of medication to support patients with complex symptoms. Equipment was stored and accessed through a central equipment library. Syringe drivers were maintained and used following professional recommendations. We checked two syringe drivers during the inspection, and both had been serviced and were in working order.
Staff had access to all other equipment for patients at the end of their lives, including pressure relieving mattresses and air cushions. These were readily available through the equipment library. Staff told us they could readily access equipment both in and out of hours to support patients. Each ward had sufficient moving and handling equipment to enable patients to be cared for safely. District nurses told us equipment required at people’s home was available within 2 hours of making the request.

There was a mortuary at the hospital. The environment surrounding the mortuary was tidy. There were no signs throughout the hospital to direct visitors to the mortuary. However, staff at the main reception directed relatives if asked. The mortuary had a secure entrance and CCTV equipment to prevent inadvertent or inappropriate admission to the area. The inside of the mortuary appeared clean and uncluttered. There were 30 spaces available in the mortuary, which included a bariatric fridge to support the care of bariatric patients. The mortuary fridges recorded the temperature of the fridges on a daily basis. The fridges were alarmed with alerts directed to the reception staff should the temperature fall outside the normal range. All fridges were locked, and keys were held in secure locations.

Assessing and responding to patient risk

The trust did not have effective processes for identifying, assessing and responding to all patients nearing the end of their life. Ward staff did not complete and update risk assessments for each patient at end of life. They did not always keep clear records and escalate concerns when necessary.

Both, the 2014 and 2016 CQC inspections identified the lack of safety processes for early recognition of the patients nearing the end of their life as a priority. In response to the 2014 report, the trust identified the use of the AMBER care bundle (AMBER- Assessment, Management, Best practice, Engagement, Recovery uncertain) as a safety system. The AMBER care bundle is an approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live.

The AMBER care bundle was implemented and communicated to staff in June 2016. At the unannounced inspection in November 2016, staff we spoke with told us they were aware of the AMBER care bundle approach to managing the care of patients who were at risk of dying in the next few months, but it was not yet ‘embedded’ into practice.

In September 2017, the trust abandoned the AMBER care bundle and adopted another new safety system titled “thinking about uncertainty, talking about the future.” However, most junior doctors, nurses on the wards, healthcare assistants, district nurses, and consultants we spoke with were not aware of this new safety system. They were not aware of how this new system worked nor had they had any training on this. We reviewed 15 records, and we found patients’ increased needs were not identified or addressed in any of them.

Appropriate systems were not always in place to recognise and manage patients whose condition was deteriorating. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. The trust’s National Early Warning Score (NEWS) guidance required a “NEWS” sticker to be completed and added to the patient’s medical records if their NEWS score indicated a possible deterioration in their condition. However, across most wards, we saw undated NEWS stickers in patients’ records. There was no record of actions taken
in response to the patients’ condition. We found eight records where there had been a change in the patients’ condition and this had been recorded, but there was no record of action taken.

In 15 records reviewed, only five patients had risks such as falls, malnutrition and pressure damage assessed and appropriately completed. For example, we saw the Malnutrition Universal Screening Tool (MUST) used to determine malnutrition risk and the Waterlow tool to evaluate patients’ risk of pressure ulcers evaluated and completed in only five patients.

However, the hospital palliative care team (HPCT) assessed and responded to risk appropriately, when patients were referred to them. They carried out comprehensive risk assessments. There was a triage system for HPCT referrals. The HPCT clinical nurse specialists held daily review meetings. They discussed patients seen, allocated new referrals and reviewed their workload.

**Nurse staffing**

The end of life service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The hospital palliative care team (HPCT) staff were employed by the hospice and provided to the trust. The team consisted of one team lead (1.0 whole time equivalent) and two Band 7 clinical nurse specialists (1.8 whole time equivalent staff). The staffing levels were above National Institute of Health and Care Excellence (NICE) guidelines. There was one end of life discharge co-ordinator. As part of a new model of care, the hospice had appointed a staff nurse to work across the wards. They were due to commence this role shortly.

General nursing staff provided care and treatment for patients who required end of life care with support from the HPCT and the end of life care facilitator nurse. There were 15 end of life care champions across the trust, with most wards having at least two. There were also ‘end of life champions’ in the community.

**Medical staffing**

The end of life service did not have enough consultants. The staffing levels were below the National Institute of Health and Care Excellence (NICE) guidelines.

Medical staffing in the HPCT included one dedicated 0.5 wte consultant. This consultant supported the community and the hospital. Two senior grade doctors from the hospice also supported the HPCT. On average, they visited the hospital 2-3 times a week and more frequently if required. The staffing levels were below the National Institute of Health and Care Excellence (NICE) guidelines. The guidelines recommended there should be a minimum of one consultant to 250 beds. The trust has 246 beds. The trust was in the process of recruiting one extra whole time equivalent consultant.

**Records**

Staff did not keep detailed records of patients’ care and treatment. Records were not clear and up-to-date.

The care records and individual care plans we looked did not follow the trust policy. In the medical notes of patients approaching the end of their lives, there were not always clear descriptions of their conditions and of the rationale behind the decisions to stop active treatment.

We reviewed 25 priorities of care individualised care plans. These were not always written in a way that kept patients safe from avoidable harm. The majority had some sections missing, and staff had only fully completed three of the 25 we reviewed.
Records within the mortuary were maintained appropriately. We saw staff completed mortuary records following trust protocol that provided an audit trail.

The trust policy on the use of do not attempt cardio pulmonary resuscitation (DNACPR) stated the DNACPR decision could be made by a doctor ST3 or equivalent or above, specialty or associate specialist or registered nurse (Band 6 or above who had achieved the required competencies). A consultant / GP must verify these decisions within 72 hours, or before discharge, whichever was the sooner.

Medical records were stored in lockable cabinets. The cabinets were locked when we visited the wards, which reduced the risk of people who did not have appropriate authority accessing the notes.

There was a system for GPs to be informed that a person had been identified as requiring EoLC as this information was included in the care summaries sent to them on discharge. The care summaries also included any medication changes. A similar communication was sent with the patient to the care home if appropriate. However, patients GPs did not always receive the discharge care summaries to ensure continuity of care within the community. As a result, instructions relating to changed care needs may not get actioned in a timely way. We were told relatives regularly phoned the local 111 service requesting help from the community practitioner when patients ran out of medicine because the GP did not have the updated information on discharge.

**Medicines**

The service did not consistently follow best practice when prescribing, giving and recording medicines. Patients did not consistently receive the right medication at the right dose. Most staff were not trained in safe administration of medicines via syringe drivers. There was no structured training for their use and not all staff had completed their competencies.

There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. The trust had guidance on anticipatory prescribing / just in case medication at end of life. Anticipatory medicines were prescribed to control key symptoms such as agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may occur as an individual reaches the end of their life. The policy had been ratified in January 2017 and was due for review in January 2019. There was an Island wide approach to anticipatory prescribing. The palliative care consultants jointly employed by the trust and the hospice developed guidelines for ‘Palliative care prescribing.’

Medicines were readily available to patients requiring treatment for palliative and EOL care.

We reviewed the medicines administration records of over nine patients who were receiving a range of medicines. We found doctors prescribed these pre-populated medicines, doses and frequency via protocol on the trust electronic prescribing and medicines administration system.

We found nine patients had been prescribed pre-populated variable medicines doses and were administered the highest prescribed doses. The nine cases where nurses had administered the highest dose were highlighted to the senior sisters on the wards. We were told that as they were experienced nurses, they would know if the dose was too high and as such, they would administer a lower does within the prescribed range.

We raised our concerns about the frequent selection of the highest dose for administration from these variable dose ranges. We identified one occasion when a patient received the highest dose
of a medicine on two separate occasions, which resulted in the patient being heavily sedated. This could be a sign and symptom of an overdose. Our concerns were investigated and although no issues were identified, the prescribed dose was halved as a precaution.

The pharmacy department undertook a review of the prescribing frequency and dose administered of one medicine within the end of life prescribing protocol. This review identified that over the previous three months, 14 patients were prescribed medicines via the end of life prescribing protocol. One medicine was administered on 21 occasions. On 18 (86%) occasions, patients received the highest dose and on three (14%) occasions, they received mid-range dose for the same indication. The lowest dose being for a different end of life symptom. The review did not look at the symptom treated or the effect on the patient.

We asked nine nurses about variable doses and only two knew how to administer and record the lower dose. Most told us they would administer the prescribed dose (the highest dose).

As these patients were nearing the end of their life, it was not possible to assess the impact of them receiving higher than required levels of these medicines. This issue was raised with the trust executive team on the same day.

There was no structured training for the use of syringe drivers. Most staff did not receive training in syringe driver administration. Staff were required to undertake competency assessments, as per policy, before setting up syringe drivers. We found not all staff had completed their competencies. For example, staff used syringe drivers after they had been shown how by another staff member. Two nurses confused the syringe drivers with intravenous medications. We spoke with two Foundation 1 (F1) and Foundation 2 (F2) doctors and they told us they did not have training as such but used the British National Formulary (BNF) or guidance on the intranet. The F1 and F2 doctors were able to find the information on the intranet. We spoke with eight nurses and most had not received any formal training to use syringe drivers. One member of staff had worked in the trust for over 15 years and had not received any training on syringe drivers. They were not aware whether what they were doing was correct. They had copied the process from observation of other staff.

One senior nurse told us that they had completed their train-the-trainer course provided by the hospice. The senior nurse was not aware of any competencies to demonstrate staff were safe and trained to use the syringe driver. We found another member of staff training other staff on the ward. They had not completed the train-the-trainer programme at the hospice to have the competence to deliver training to others.

**Incidents**

The service did not manage patient safety incidents well. Staff did not recognise incidents and did not report them appropriately. Managers did not always investigate and share lessons learned with the whole team and the wider service.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events within end of life care.

Source: NHS Improvement - STEIS (01/10/2016 - 30/09/2017)
(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in end of life care that met the reporting criteria set by NHS England from December 2016 to November 2017. This incident type was treatment delay meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

At our last inspection, we told the trust they must ensure learning from incidents was cascaded and shared. We found this had not happened. Staff told us learning from the serious incident mentioned above had not been shared with them at ward level.

During this inspection, we found staff understood the incident reporting system and trust policy. Nursing and medical staff were aware of the need to report incidents such as patient falls, pressure ulcers, equipment errors, and medicines errors. But there was still inconsistency in the level of detail in the reporting of patient safety incidents that related to end of life care.

Staff told us they were actively encouraged to report incidents, including those related to end of life and palliative care. However, we found that staff did not always report incidents which meant opportunity for learning was missed. For example following a recent incident where staff could not access the correct equipment for a patient. This was not reported as an incident because the patient had not incurred any harm.

When reported, incidents were investigated and learning was sometimes shared at ward level but senior leaders did not have an overview of incidents specific to end of life care, due to the way incidents were categorised. The end of life working group was not aware of the incidents relating to end of life care. This meant opportunities to identify themes in end of life care incidents across the trust were missed. Staff could not collate end of life incidents to identify trends/themes as they were reported under service type i.e. cancer care, surgery, equipment. Staff were also not aware as to which incident would classify as an end of life care incident. For example, we asked whether incidents such as the unavailability of a syringe driver would be considered as an incident. Staff were unsure about whether the shortage of equipment should be reported as an incident.

Incidents that should be classified and related to end of life had not been identified in the trust end of life care policy. In the absence of such information, end of life incidents could be underreported. We found no evidence of systems in place to discuss and review end of life incidents to ensure learning was disseminated across the trust.

Mortality and morbidity reviews took place monthly as part of the medical clinical business unit (CBU). We were told that sharing learning from mortality reviews was a priority for the trust during 2018. However, learning from the mortality and morbidity meetings was limited. Staff did not review in detail patients’ care and treatment. For example, summary notes of these meetings showed that staff did not review routinely medicines or symptoms of each patient to improve future patient outcomes. The trust told us the meeting notes were circulated to all the medical doctors. The next step was to ensure wider dissemination of the learning to other CBUs.

Mortality and morbidity reviews also took place in the community. Staff found them very useful and informative. The community teams designed a form that prompted discussions of medicines and the symptoms of each patient. We saw processes set out to share the learning across the community.

The end of life care team told us that they intended to use the community form as a template throughout the acute trust. We were not given a start date for this implementation.

The trust board minutes of February 2018, detailed two investigations had been initiated in relation to an inappropriate transfer of patients at the end of their lives. These investigations were still on going.
Staff we spoke with were aware of the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. Staff knew what duty of candour meant and could describe their responsibilities relating to it. Staff did not share any examples of how they applied the duty of candour. We did not review any notes where the duty of candour was applied.

Is the service effective?

Evidence-based care and treatment

End of life care policies and procedures were based on national guidance and evidence of its effectiveness. Managers did not always check to make sure staff always followed guidance and best practice in care and treatment.

The trust had a newly revised care planning tool called priorities of care individualised care plan (PoC) which replaced the Liverpool Care Pathway. The implementation of the tool began in 2015 and the newly revised version was re-launched in April 2017. The tool was in the process of being embedded across all wards in the hospital. The PoC was in line with the recommendations published in June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), National Institute for Health and Care Excellence (NICE) guidance QS13 ‘End of Life Care for Adults’ and NICE CG140 ‘Opioids in Palliative Care’.

The trust completed an internal audit that assessed compliance with NICE guidance in March 2017. The results were that the trust was 100% compliant to the following:

1. QS13 that defined clinical best practice within end of life care for adults
2. NG31 which covered the clinical care of adults (those over 18) who are dying during the last 2-3 days of life and the National Framework for end of life care.

However, managers had no assurance systems in place that confirmed staff followed the guidance. For example, the baseline assessment for QS13 states that people approaching the end of life were offered spiritual and religious support appropriate to their needs and preferences. The internal audit stated the hospital clergy proactively visited wards and offered spiritual support to all patients and those close to them. However, staff on various wards confirmed the hospital clergy only attended patients upon their request. The chaplain also confirmed this.

The trust conducted an audit that assessed the presence of the priorities of care individualised care plan in the records of patients who died in hospital. The results were as follows: In April 2017, 49% and in October 2017, 78% of the patients who died in hospital had the document in their records. While there had been some improvement in the presence of it, there was not sufficient assurance that staff consistently followed guidance and completed the document appropriately.

Staff told us they had repeatedly informed the EoLC nurse facilitator there was no clarity as to who initiated the personalised priority of care plans. The end of life care policy stated this was a multidisciplinary decision. However, in most cases, we found there was significant variation in staff understanding of the word “multidisciplinary.” Some thought it only applied to doctors. Staff told us that locums rarely initiated the plan. We spoke with three locum doctors and they had not received training in end of life care and did not know when and how to initiate the use of the document, with one doctor telling us the document was initiated by nurses.
Mortuary policies were up to date, evidence based and relevant to the service they provided. Ward staff, mortuary staff, and porters were aware of these policies, could describe the procedures followed and equipment used. Standards of practice for the mortuary were based on national guidelines.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

There were systems in place to ensure patients received enough food and drink. Nutrition and hydration were included in the daily assessment in the priorities of care nursing care plan. Medical staff were aware of the General Medical Council (GMC) guidelines for nutrition and hydration in end of life care. Nurses made referrals to the dietitian, who visited the wards to assess and support the patient with their nutrition needs. Staff used Malnutrition Universal Screening Tool (MUST) when they assessed patients’ at risk of malnutrition. Our review of 15 records showed patients’ nutrition and hydration needs were met. There were examples of what patients had eaten at various times of the day. If a patient was prescribed liquid dietary supplements, these were recorded.

**Pain relief**

Staff did not assess and monitor patients regularly to see if they were in pain. They did not support those unable to communicate using suitable assessment tools.

There were no assessment tools in place to help assess and monitor patients’ pain relief needs, and there were no tools in place for those people who had difficulties in communicating. Staff relied on patients’ requesting pain relief or by their non-verbal behaviour or by observing their eyes to manage their pain.

Though a recognised pain assessment tool was not in use, nurses reviewed patients’ pain and its control regularly. Syringe pumps were used to give a continuous dose of pain relief. However, there was no holistic pain management plan in place. The EoLC team told us they had not implemented the Faculty of pain medicines’ core standards for pain management.

We did not observe any patients in pain during our inspection. However, the results of the bereavement questionnaire confirmed that 13% (17/131) disagreed with the statement that their relative/friend was free from pain and other symptoms.

**Patient outcomes**

Managers monitored effectiveness of care and treatment provided to patients in receipt of end of life care, but this was limited. The service did not use the findings to improve outcomes for patients. The effectiveness of care for patients was poor if not cared for by specialist teams. There was limited comparison of local results with those of other services to learn from them.

The trust participated in the National Care of the Dying Audit of Hospitals (NCDAH) 2014-2015. The results were published in March 2016. The trust performed better than the England average for three of the five clinical indicators. For the remaining two indicators, the trust performed worse than the England average. These were:

Is there documented evidence that the patient was given an opportunity to have concerns listened to? The trust scored 42% yes, much lower than the England average of 84% yes.
Is there documented evidence that the needs of the person(s) important to the patient were asked about? The trust scored 46% yes, lower than the England average of 56% yes.

(Source: Royal College of Physicians)

A baseline audit undertaken by the EoLC team at the end of 2017 demonstrated the trust continued to perform poorly in the following areas:

1. Identification that people were dying sooner and referral to the end of life care facilitator
2. Referral for spiritual support
3. Completion of priorities of care individualised care plans
4. Daily updates
5. Evidencing that symptom relief had been offered.

The results of the NCDAH 2016 results and the trust baseline audit results from 2017 were highlighted as a comparator:

<table>
<thead>
<tr>
<th></th>
<th>National Result 2016</th>
<th>Trust result 2016</th>
<th>Audit results in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients recognised that they were in the last days of life</td>
<td>83</td>
<td>92</td>
<td>95</td>
</tr>
<tr>
<td>Patients with documented evidence that there was in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care (PoC).</td>
<td>66</td>
<td>92</td>
<td>58</td>
</tr>
<tr>
<td>Documented evidence that the person had the opportunity to have their concerns listened to.</td>
<td>84</td>
<td>42</td>
<td>63</td>
</tr>
</tbody>
</table>

While the trust had improved and there was documented evidence that the dying person had the opportunity to have their concerns listened to, it still fell below the England average. The trust had worsened its performance regarding an individualised plan of care for the dying patients in the last 24 hours of life.

Based on this baseline audit, the end of life operational group planned to review service performance. They had identified some outcomes they wanted to monitor, however there was no overall plan in place at the time of inspection.

Outcomes were much better for patients if they were referred to the EOLC and HPCT teams. Trust audit of 41 case notes showed:

<table>
<thead>
<tr>
<th>% of patients</th>
<th>% Patients cared for by EOLC and HPCT</th>
<th>% patients cared on the ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients NOT recognised that they were in the last days of life</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Patients with NO documented evidence that there was in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an</td>
<td>5</td>
<td>16</td>
</tr>
</tbody>
</table>
individual plan of care (POCP).

Patients NOT asked about referral to chaplaincy support 73 26

Patients whose capacity was NOT assessed 0 84

Patients and the next of kin who were NOT given daily updates 32 45

Patients where NO preferred place of care and death identified 4 37

Patients NOT able to die in preferred place of care 18 11

At inspection the trust was unable to provide us with information about the percentage of people who were seen by the palliative care team within 24 hours and whether patients died at their preferred place of death. The trust told us they had put in place systems to collect this information and had not obtained enough data for analysis.

No audit had taken on the completion of priorities of care individualised care plan. The trust had implemented a bereavement survey. The service was unable to highlight the improvements made as a result of the bereavement survey. The format of the results provided to us gave little assurance of an overall improvement in the service. For example, from July 2017 to the end of October 2017, the trust gave out 95 surveys and received only nine responses, a response rate of 9%. From November 2016 to the end of October 2017, they gave out 447 surveys and received just 53 responses, a response rate of 12%. However, the trust analysed the data as an overall cumulative result of 193 responses from April 2015 when it began the survey until 31 October 2017. There was no information on what actions had taken place in response to the results.

Referrals to the specialist palliative care team

The trust did not provide us with the number of hospital palliative care team (HPCT) referrals received for the period August 2016 to July 2017. We requested this information and further information about patients diagnosed with cancer. We did not receive either set of data from the trust.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not always appraise staff’s work performance and hold supervision meetings with staff to provide support and monitor the effectiveness of the service.

Appraisal Completion rates by staff group, October 2016 to September 2017
The trust did not meet the target set for appraisal of healthcare scientists, nursing and midwifery and administrative and clerical. There were no plans in place that ensured all staff had met the target set.

Staff received little training in identifying people in the last 12 months of their life. We reviewed the training content and considered it inadequate in helping staff to identify patients in the last 12 months of their life.

The local hospice provided training for all community staff including the community practitioner. All staff told us the training was comprehensive and provided them with confidence. A few staff had recently moved from the acute hospital to the community and told us that the training they received enabled them to make the transition effectively with renewed confidence.

The trust had 15 end of life care champions whose role was to offer support to staff with end of life care training. All these champions completed a 40-minute mandatory online training programme per year. To ensure this group of staff were adequately trained, the end of life care lead nurse had initiated a 1.5 hours per month training programme titled “End of life champions training” for all the champions of the trust. However, the champions were expected to participate, support and train staff in end of life care within their individual environments, they were not mandated to attend the monthly end of life champions training sessions. As a result, there was inadequate attendance by this group. Some wards did not send their champions to these training sessions. Staff told us the knowledge of the end of life champions was very basic.

The table below highlighted attendance and representation from the wards. Student nurses had been excluded from the list of attendees.

<table>
<thead>
<tr>
<th>Date of training</th>
<th>% Number of attendees</th>
<th>Wards represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 September 2017</td>
<td>10%</td>
<td>A nurse from Colwell ward, Appley ward and Intensive Therapy Unit (ITU)</td>
</tr>
<tr>
<td>3 October 2017</td>
<td>14%</td>
<td>1 nurse from the coronary care unit, Appley ward, ITU</td>
</tr>
</tbody>
</table>
Wards, where patients received end of life care, included the newly opened Compton ward (opened in January 2018) did not have any member of staff attend. Luccombe and Alverstone where patients nearing the end of their lives were sometimes treated had no member of staff attend.

Having different training programmes for the same service across the Island resulted in variation in practice. The hospice staff trained community teams over three days. The hospital staff only had an e-learning programme. They were to be supported by end of life champions, many of whom did not attend the monthly end of life training sessions.

To decrease the variation in practice, the local hospice, subject to the signing of an agreement between themselves and the trust, had agreed to provide a 3-day classroom based programme of learning, with a further 2 days of shadowing care provided by the hospice. At the time of the inspection, this agreement had not been signed and hence the training not begun.

The specialist palliative care team, all of whom came from the hospice, had received in-depth training programmes. All of them were aware of the five priorities for end of life care. They were up-to-date with their knowledge base. For example, two nurses told us of the changes to the national care of the dying audit in hospital (NCDAH) and the transitioning to the national audit for care of end of life.

The hospice staff supervised the ‘end of life champions’ in community services. They supervised them collectively in palliative care, syringe driver use and medicines. These meetings were held monthly. They discussed the patients’ priorities of care and individualised their care plans.

Within the hospital palliative care team, staff received good support for professional development. This included an active professional development team who supported staff with training and organised in-house education initiatives. Nurses were required by their regulatory body to have their practice re-validated every three years and nurses told us they had been supported to ensure they would be assessed and their National Midwifery Council revalidation dates identified.

Staff on various wards told us they had good out of hours access to palliative care nurses.

The chaplaincy service had recruited trainee volunteers at the time of the inspection and were in the process of designing a training course. This training course included listening skills, communication, loss and grief, an understanding of being a patient, and knowledge in equality and diversity. Chaplaincy staff and volunteers were competent to support patient’s spiritual and religious needs.
Porters and healthcare assistants received a one to one, training induction to ensure they understood and were competent in mortuary procedures.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other health care professionals supported each other to provide good care. However, there was not always appropriate referral and information sharing when patients were discharged from hospital.

The service held multidisciplinary team meetings. There was effective communication between the end of life care team and other services within the hospital, for example the medical services caring for older people. The lead clinician for end of life care was also the lead clinician for frail and elderly people.

However, despite good communication, there was not always multidisciplinary input in the priorities of care individualised care plan used across the trust.

We found there were clear processes for the transfer of care from hospital to community services including care plans and medication. However, there were a few instances where the service discharged older people late at night even when they had complex needs and lived alone. We also heard of incidents where a patient with palliative care needs had not been communicated to community nursing services. On occasions the crisis team provided emergency support for end of life care patients where discharge referrals had not been made by the wards.

We found five instances where essential information about older people with complex needs was not communicated to members of the community health team on discharge because the two information systems did not interface. The handover to the community practitioner from the district nursing teams lacked structure. This resulted in the community practitioner having little or no information about the patients who sometimes called 111 for assistance.

The hospital palliative care team discussed caseloads at weekly multidisciplinary meetings. During these meetings, the team discussed diagnostic challenges, management options and any other pertinent issues relating to their current patients. As a result, increased needs could be identified and acted upon.

The chaplaincy team, the HPCT and the hospice worked together to provide the necessary support when supporting bereaved relatives out of hours.

**Seven-day service**

The service met the NICE guidelines for a seven-day service.

The hospital palliative care team provided a Monday to Friday 8.30am to 4.30pm face-to-face palliative care service at St Mary’s Hospital. One cancer nurse specialist, who also had expertise in palliative care, was on duty at the hospice on Saturday and Sunday to see inpatients with complex needs and any urgent new referrals. This met the recommendation from the NICE guidelines for ‘End of life care for adults’, which stated, “Palliative care services should ensure provision to visit and assess people approaching the end of life face-to-face in any setting from 9am to 5pm, seven days a week”. The trust had an agreement with the hospice to ensure end of life care phone support was available 24 hours a day.

Mortuary services were available 8.30am to 4pm Monday to Friday with on-call cover out of hours. The bereavement service was available to assist families with viewing between 9am to 3.30pm. The chaplaincy service provided a 24 hour seven days a week on call service.
Health promotion

The trust lacked systems to identify people in the last 12 months of their lives who could need extra support.

The trust did not have a system in place to identify people in the last 12 months of their lives and as such had not developed ways to identify the support they or their carers may need.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not understand how and when to assess whether a patient had the capacity to make decisions about their care. They did not follow the trust policy and procedures when a patient could not give consent.

The trust had a do not attempt cardiopulmonary resuscitation (DNACPR) policy, along with a new ‘ceiling of treatment and resuscitation decision record’ (CoTRDR) for recording these decisions. The CoTRDR form combined the DNACPR and ceiling of treatment decisions into one form, it identified the escalation status of patients who were not for resuscitation.

At the last inspection, the trust did not provide any training data for any staff group in respect of the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS). There was no training information provided on this inspection.

Decision specific mental capacity assessments were not always undertaken when staff completed DNACPR forms.

The do not attempt cardiopulmonary resuscitation forms (DNACPR) forms were stored at the front of the patients’ notes. This meant the forms were easy to find. However, we found that there were at least three different DNACPR forms. One form had on it AMBER care bundle under the section optimal supportive care. The trust did not use this anymore, but had a new system titled “thinking about uncertainty, talking about the future.” There was no reference to this new system on the form.

We reviewed 61 DNACPR forms and found the following:

- 98% of DNACPR records were found immediately at front of notes.
- 98% of the forms had been dated when signed.
- 94% had the identified the level of treatment clearly stated.
- 94% clearly identified the rationale for clinical decisions.
- 33% (18) patients were recorded as having questionable capacity.
- 0% of these 18 patients recorded as having Mental Capacity Assessment /Best Interest decision.

Eighteen patients (33%) were recorded as having questionable capacity, however none had any record of Mental Capacity Assessment /Best Interest decision within their notes. Sixteen out of these 61 forms (26%) indicated relatives had been informed but as there was no record of Mental Capacity Assessment, it was not possible to assess if this was in line with this policy. The trust policy stated that family/carers of a patient who had capacity should not be involved in resuscitation considerations without patients consent.
Doctors did not carry out all the necessary assessments. We did not see evidence in the notes for 18 patients that the doctor who carried out the decision used the two-stage test to identify the patients who did not have capacity.

26 (43%) of the patients' medical records or treatment escalation plan included a summary of communication about DNACPR with either the patient or their relatives.

We asked the trust to provide us with the last two DNACPR audits and the action plans. The trust provided us with the raw data of the audits undertaken in July 2017 and January 2018 with no corresponding analysis. We did not undertake any analysis of their data. The data collected did not identify what time forms were signed. The trust had not analysed the data to identify outcomes from the audits. Therefore they had not gained assurance that the practices were correct or identified areas where improvements were required.

Is the service caring?

Compassionate care
Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Feedback from patients and those close to them was positive about how staff treated them. Staff understood and respected patient’s personal, cultural, social and religious needs. All staff had access to multidisciplinary care records, which provided a care plan, and specified the patients’ wishes. Staff took the time to interact with patients and those close to them in a respectful and considerate manner. Staff responded in a compassionate, timely, and appropriate way when people experienced discomfort or emotional distress.

We undertook a short observational framework for inspection, known as a SOFI. This is a tool developed with the University of Bradford’s School of Dementia Studies and used to capture the experiences of people who use services who may not be able to express this for themselves. During the period of observation, we saw two members of staff supported a patient as they changed a patient’s bedding. The individual was called by their name. Throughout the process, they informed them what was going to be done. When they were being cleaned, they were informed that the water would feel a bit cold initially. Throughout the process, the shutters were down to maintain their privacy. However during another period of observation in a different ward, we observed one person came to check on the patient at the end of their life. They did not speak with them. They did their observations and left.

The mortuary staff and porters told us they did not have any concerns about the way ward staff cared for patients shortly after death. There was a last offices policy which described the care given to a body after death. The process demonstrated respect for the deceased and their religious and cultural beliefs, as well as health and safety and legal requirements. Nursing and health care support workers received training on last offices and told us they felt confident in performing procedures respectfully. We observed the mortuary staff handling bodies in a professional and respectful way.
Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff understood the impact that a patient’s care, treatment or condition had on their wellbeing and those close to them. Relatives told us how the hospital palliative care team had provided them with emotional support. Emotional, psychological and bereavement support and advice for families was an important part of the service provided by the hospital palliative care team. We saw some ‘thank you’ cards in the teams office thanking staff for supporting the patient and their families “at such a difficult time”. A relative said how after visiting the patient, they always had a member of staff reach out to them extending emotional support.

We saw patients were offered appropriate and timely support and information to cope emotionally with their care, treatment or condition. The chaplaincy team provided spiritual support to patients and relatives of all or no faiths. The team communicated with families offering last rites, where appropriate. Staff shared examples of how the hospital chaplain attended as and when needed in order to meet the needs of the dying patient and their relatives.

Priorities of care individualised care plan (PoC) were in place for most patients who were in their last days or hours of life. The PoC specified patients’ wishes regarding end of life care. Records we reviewed on the wards indicated that most patients’ preferred place of care and place of death were documented. We saw, and relatives told us staff provided care in line with patient wishes.

The bereavement office supported relatives by providing information, support and guidance on funeral arrangements, assisting with viewings of the deceased and facilitated the donation of tissues for transplantation. The bereavement office had a publication for the bereaved families containing a contact number, information regarding bereavement support, how to stop junk mail, a bereavement questionnaire and other essential information.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients and relatives told us that staff spent time talking to them. They did not feel like they were being a “burden.” We saw evidence that demonstrated patients were kept actively involved in their own care. Conversations with relatives were clearly documented. Patients and their relatives we spoke with told us staff communicated with them so they could understand their care, treatment, and condition. They felt they could ask staff questions about their care and treatment. A patient told us how they had requested some information that would have helped them in making a decision. They told us a staff member explained the information and checked later during the day if they had any further questions.

Staff ensured that patients could take the time they needed to say goodbye to their relative. One relative told us how a member of the chaplaincy department supported them. However, staff on the wards told us the chaplain team was small and there were not able to be proactive. Staff arranged visits, both in and out of hours, for relatives who wished to view the deceased.

We reviewed 15 patients’ notes and saw evidence that demonstrated patients were kept actively involved in their own care. Conversations with relatives were clearly documented. Patients and their relatives we spoke with told us staff communicated with them so they could understand their care, treatment, and condition.
Is the service responsive?

Service delivery to meet the needs of local people

The trust did not plan and provide services in a way that met the needs of local people.

The trust planned and delivered services in a fragmented manner without consideration of people’s needs and preferences. The local clinical commissioning group commissioned the hospice to provide end of life and palliative care for all the residents on the Island that included those who received their care in the hospital and the community. In April 2017, the trust asked the hospice to design a service to meet the needs of local people and develop a corresponding action plan. The outcome was a model of care (joint venture) for end of life care partnership between the trust and the hospice. Both the trust and the hospice had the document since July 2017.

In August 2017, the hospice began the implementation of parts of the action plan to meet the needs of local people. The hospice identified 44 key action points and each action point had been rated as ‘red’ (not started), amber (in progress), and green (complete). There were 30(82%) rated as ‘red,’ 7 (9%) rated as ‘complete’ and 7 (9%) rated as ‘in progress.’ The hospice began to implement some of the action points. For example, they employed a discharge coordinator to help the dying patient discharged to their preferred place of care.

However, at the end of November 2017, the hospice halted the implementation of these because the trust had not signed the joint venture despite a number of requests from the hospice. As of 22 February 2018, 37 key action points remained outstanding. As a result, the progress towards the provision of services to meet the needs of local people stopped.

Staff delivered end of life care in most wards and were supported by the hospital palliative care team and the end of life care facilitator. Staff told us they tried to allocate side rooms to patients who were receiving end of life care, to offer quiet and private surroundings for the patient and their families. However, patients at the end of life often had to be cared for on open wards, as the use of single rooms were prioritised for patients who required isolation. The hospital did not have designated overnight accommodation facilities on site for relatives, however, wards provided recliner chairs for those who wished to remain at their relative’s bedside.

There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. Reduced parking fees for relatives of patients receiving end of life care could be arranged, to enable relatives to spend the maximum amount of time with their relative.

Meeting people’s individual needs

The service did not meet the individual needs of all patients.

The mortuary service had a policy to deal with deaths of those from different faiths and cultures. We heard some examples of how they responded to a variety of situations with sensitivity. For example, we heard how the trust responded to the local Jewish community’s needs to ensure documentation needed to help with the registration of death was handled with speed. The bereavement service fast tracked processes to ensure burial could take place quickly for people who required swift funerals for cultural and religious reasons.

However, the trust was unable to fully identify the needs and preferences of different people using their services. The trust did not have access to voluntary and community groups to ensure these groups complemented the existing staff. The end of life care team informed us that they had tried
to represent patients on their working group. They told us there were no groups available that the trust could access.

Some ward staff told us they contacted the hospital palliative care team to address the needs for end of life care for disadvantaged groups, for example, travellers, people where English was not their first language or lesbian, bisexual, gay and trans-gender. Most staff highlighted this as a gap in meeting people's individual needs on the wards. Nurses on the wards told us when they did not have enough staff; they struggled to provide extra support or supervision to people with a mental health condition, learning disability, or dementia.

There was no designated ward for patients who were nearing the end of their life. Staff tried to allocate side rooms to patients nearing the end of their life, to offer quiet and private surroundings for the patient and their families. However, they told us often patients nearing the end of life were cared for on open wards, as the trust prioritised the use of single rooms for patients who required isolation.

At inspection, the trust did not provide CQC with the number of hospital palliative care team (HPCT) referrals received for the period August 2016 to July 2017. We requested this information and further information about patients diagnosed with cancer. We did not receive either set of data from the trust.

**Access and flow**

People could not access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with good practice.

The hospital did not have any designated beds for end of life care patients. However, the trust had good links with the hospice. Transfers to the hospice were subject to the availability of a bed. The trust was required to inform the hospice by 4.30pm about the need for a patient to be transferred there. There were processes in place to allow urgent overnight transfer of patients to the hospice. Patients were regularly transferred at weekends.

To ensure patients were not transferred for non-clinical reasons, the trust introduced a blue ribbon system. If a patient had a ‘blue ribbon’ on their record, the decision to transfer the patient from one area to another had to be authorised by the executive director and the decision discussed with the dying person’s family. There were many examples staff gave us of this working in practice. However, when we undertook an unannounced inspection of the trust, we saw that the information regarding which patient had ‘blue ribbon’ was out of date by 72 hours. We highlighted this to the nurse in charge who corrected the information.

There had been no audit of the prioritised of care individualised care plan (PoC). Therefore the trust could not assure itself that people could access care and treatment in a timely way.

The service did not collect data to evidence how many patients were supported to die in their preferred place of death. A process to assist the trust with identifying patients who only had a few months left to live had only been recently developed (November 2017).

Patients identified as requiring palliative care such as symptom control were referred to the hospital palliative care team by individual consultants or ward staff. The team carried bleeps for urgent referrals. At the time of the inspection there was no information on what percentage of patients were seen within 48 hours. The trust submitted the data to CQC in March 2018 for the period January 2018 to March 2018. The data highlighted that all patients were seen within two days of being referred.
There was a rapid discharge process in place. There were a few delays in discharge to the preferred place of care due to lack of community care packages. These delays increased particularly when patients required two carers more than twice a day. However, there was no data to identify how frequently this happened.

Porters told us that they were able to respond promptly to requests to transfer deceased patients to the mortuary. We spoke with ward staff who told us they did not have concerns about response times.

There was an on-call rota at weekends to support members of the local community, including police and funeral directors, which enabled access to the mortuary at weekends.

**Learning from complaints and concerns**

The service did not treat concerns and complaints seriously. They did not investigate them and learned any lessons from the results and shared these with staff.

The trust did not collate complaints information based on end of life care. The end of life care operational group requested this information from the complaints department at the September 2017 meeting. The matter remained outstanding at the January 2018 meeting. We spoke with Patient Advisory Liaison Service (PALS) who told us they had never received any concerns from patients or relatives regarding end of life care. As complaints and concerns relevant to the receipt of end of life care were not identified, opportunities for learning were missed and the organisation had no oversight of themes.

**Is the service well-led?**

**Leadership**

Managers at most levels in the trust did not have the right skills, abilities, and knowledge to run a service providing high-quality sustainable care.

At the time of the inspection, the acting director of nursing and quality was the executive lead for the trust for end of life care. While they understood the end of life care issues within the trust and were active and visible to staff, they were unable to move the strategic agenda of the joint venture within the organisation forward. The trust board had appointed a non-executive director in August 2016 to be the non-executive lead for end of life. The individual’s term ended in July 2017. The trust had recently (January 2018) appointed another non-executive member to have responsibility for EoLC. This person understood their role and had experience of working as a non-executive member of the board of the hospice.

The end of life operational group did not have the necessary experience, knowledge, capacity, or capability to lead end of life care at the trust. At the last inspection in November 2016, we identified a need for further integration with the hospice to enable improvement in the planning of end of life care. At this inspection, they had made some progress at a basic operational level. For example, the hospital bereavement service and end of life care facilitator offered Mountbatten Bereavement Service follow up. However, we found the trust had not undertaken any substantial steps towards integration at a strategic level.

At the last inspection in November 2016, we identified a need for further integration with the hospice to enable improvement in the planning of end of life care. At this inspection, they had made some progress at a basic operational level. For example, the hospital bereavement service and end of life care facilitator offered Mountbatten Bereavement Service follow up. However, we
found the trust had not undertaken any substantial steps towards integration at a strategic level. The trust charged the hospice to present a draft model on how, if they were leading on this project, they would re-design the service. The trust leadership reviewed the draft proposals for improving service delivery from the hospice. To implement these proposals, the trust and the hospice both agreed that a joint venture partnership document was designed which developed the community and trust end of life service. Two new groups were established to take this joint venture forward: An executive group who signed the joint venture proposal and a trust end of life care operational group that would operationally take forward the proposals for implementation.

In October 2017, the trust cancelled the meeting set up to sign the joint venture. In November 2017, the end of life operational group ratified an “End of life care policy: care of the dying adult.” The hospice was not consulted and this policy disregarded the proposals set out in the joint venture.

On 30 November 2017, the hospice informed the trust that until the joint venture partnership agreement had been agreed and signed off; it would not be taking any future planned developments forward. By this time, the meeting to agree and sign the joint venture had been cancelled twice. As of 20 February 2018, we had not been made aware of any meeting planned to take this forward.

It was not clear why there was reluctance from the executive team to put the plan that it had co-created with the hospice into action. It was also not clear why the end of life operational group ratified a policy that disregarded the proposals set out in the joint venture. There was a disconnect between the strategic aspirations of the senior leaders and delivery of end of life care by middle managers.

The trust lead clinician did not have a job plan in place for their role in leading end of life care. A job plan is an annual prospective agreement between the trust and the consultant that describes the objectives to be achieved by the consultant and supported by the trust.

In the community, district nurses provided care to patients nearing the end of their life. There were three locality leads; each had a team member responsible for the overall management of district, and community nursing that also included end of life care. There was some confusion about the end of life care leadership in the community. During our inspection, some staff were not aware of an end of life care lead. After our inspection, we received documentation that showed there was a designated community end of life care lead.

There was confusion amongst most ward staff as to who led on the delivery of end of life care on the wards. Most thought it was the palliative care consultant and their team. A few thought it was the end of life nurse facilitator. On the documentation provided, it was mentioned that the lead was the end of life nurse facilitator. This was only well known on some of the wards.

At a local level, the hospital palliative care team and the end of life care nurse facilitator worked hard to provide good end of life care. They aimed to provide and maintain end of life educational sessions across the hospital and when appropriate, discharge the patients to their preferred place of dying.

**Vision and strategy**

The trust did not have a clear vision for what it wanted to achieve or workable plans to turn any vision into action with involvement from staff, patients, and key groups representing the local community. An Island wide strategy for end of life care had previously been developed but this had not yet been adopted.
The trust reported their end of life strategy outlined five principles that underpinned all workforce developments. These were:

- Choices and priorities of the individual were the centre of planning and delivery.
- Effective, straightforward, sensitive, and open communication between individuals, families, friends, and workers underpinned all planning and activity. Communications reflected an understanding of the significance of each individual’s beliefs and needs.
- Delivery through close multidisciplinary and interagency working.
- Individuals, families, and friends to be well informed about the range of options and resources available to them and to be involved with care planning.
- Care was delivered in a sensitive, person-centred way, taking account of circumstances, wishes, and priorities of the individual, family, and friends.

The trust stated that the above principles were echoed in other documents that guided national standards and were the cornerstone of what they wanted to achieve. The trust principles reflected most of the guidance included in the “Transforming end of life care in acute hospitals—How to guide” published by NHS England. However, the vision did not include an identification model to recognise a dying person. The importance of this identification was highlighted in two previous CQC inspections.

The trust end of life care policy ratified by the end of life working group in November 2017 stated the priorities were as follows and were the current benchmark of standards the trust should achieve:

- The identification that a person may die in the next few hours or days.
- Sensitive communication to take place between staff and the dying person.
- The dying person and their family are involved in important decisions about treatment and care.
- The needs of the family and other identified as important to the dying person are actively explored, respected, and met as far as possible.
- An individual plan of care, which included food and drink, symptom control and psychological, social, and spiritual support, was agreed, co-ordinated, and delivered with compassion.

There were no workable plans to turn vision into action. We reviewed the minutes of September and two meetings held in October of the end of life operational group and there was no mention of the joint venture in these meetings. The first time this item was on the agenda was at the January 2018 meeting.

The end of life vision and policy lacked consistency. For example, the vision failed to recognise the importance of identifying that a person may die in the next few hours or days. The policy ratified by the end of life working group failed to take into account how the trust should further integrate the relationship between themselves and the hospice.

An Island wide strategy for end of life care had previously been developed but this had not yet been adopted across the island.
The end of life operational group decided in September 2017 that it would be mandatory for end of life champions to attend monthly updates. However, we found the policy agreed in November 2017 by this group stated that attendance by the end of life champions was not mandatory.

**Culture**

Managers across some parts of the trust did not promote a positive culture that created a sense of common purpose based on shared values.

At our last unannounced inspection in November 2016, staff told us that organisational culture did not encourage integrated team working across different parts of the palliative care service and end of life service. The hospital palliative care team was accountable to the hospice. The end of life care nurse facilitator was accountable to the trust. The hospice and the acute services that provided end of life care were seen as separate entities rather than cohesively working to improve patient outcomes for end of life care patients.

At this inspection, we found there was no sense of common purpose between senior and middle management to improve end of life care. For example, the senior leadership team had been working on a joint venture between the trust and the hospice while the end of life operational group had already agreed on an end of life care policy.

Most staff members were not aware of this end of life care policy or what it meant for their role. For example, the policy stated, matrons were to undertake regular audits to ensure their clinical area was compliant with the policy. These were not happening.

However, we observed a positive culture of care amongst some staff groups that included the portering service, the mortuary, the chaplaincy, and the bereavement centre. We found these staff groups demonstrated enthusiasm and passion to deliver good end of life care. For example, we observed the portering staff transport a deceased patient from a ward to the mortuary with respect and dignity. The staff who worked in the bereavement office showed empathy and support to the bereaved families. They followed up with phone calls of support for families after the funeral. We also heard of cases where staff looked up the dates of the deceased patients’ funeral in the local newspaper, with the aim of attending to provide support to the family. The highly dedicated mortuary staff provided exceptional service to meet the needs of people in the local community. The chaplaincy, despite their low numbers, provided pastoral care to patients and their families at any time of the day or night.

**Governance**

The service did not use a systematic approach to continually improve the quality of its services and it did not safeguard high standards of care.

Whilst the role played by the hospital palliative care team and the palliative care doctors was central to the delivery of end of life care in the trust, there was not a service level agreement with the hospice.

There were no effective structures and no systems of accountability to support the delivery of the strategy. In September 2017, the trust end of life operational group proposed its terms of reference. Their overall purpose was to ensure the implementation of the Island strategy for end of life care within the trust and its links to and from the community. The terms of reference made no mention of the joint venture with the hospice. It also did not mention whom this group would report to. The meeting held on 16 October 2017 agreed the terms of reference.
It was not clear how the end of life operational group gained assurance about the quality of end of life care provided at ward level. There were no arrangements in place to identify wards or services that provided ‘good’ end of life care. A review of the minutes did not identify the governance process on how data and information from the wards or departments reached this group. For example, data on risk and complaints were items on the agenda for two consecutive meetings with no information available.

The end of life care policy identified that all reports from audits were presented at the monthly end of life operational group and were fed back to the Isle of Wight NHS Trust and the hospice board. However this board did not exist as it was part of the joint venture yet to be established. When this anomaly was highlighted to the end of life team, we were told that this part of the governance structure was “aspirational.”

We spoke with two matrons who were not aware of this change to their role to ensure staff were supported to deliver good end of life care. Clinical leads were responsible for ensuring compliance with this policy. However, there were no established tools that enabled them to monitor compliance to deliver good end of life care.

At the time of the inspection, the trust did not have enough support from NHS Improvement (NHSI) to help embed the end of life care agenda. There was, until August 2017, a full-time service improvement lead from the NHSI seconded to the trust and who led the end of life agenda and the joint venture proposal. In September 2017, NHSI appointed a new service improvement lead. They spent half of their time at this trust and half of it at another. From the end of February 2018, NHSI were due to appoint a specialist advisor in end of life care to the trust. The specialist advisor’s sole focus would be the end of life agenda. It was planned that they would work for two days a week for three months to enable the joint venture between the trust and the hospice to begin.

Most staff were aware that the acting director of nursing was the board lead on end of life care. The trust told us the senior responsible clinician was the consultant in medicine and care of the elderly and they had been in this role since 2016. They worked for the trust 0.8wte and were responsible for the frail and elderly patients. We requested their job plan that identified the work they were supposed to do in end of life care and who were they accountable to. The trust told us the job plan including end of life had not been agreed. It was yet to be agreed whom the individual would be accountable to for the work in end of life care.

**Management of risk, issues and performance**

The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The management of risk was not understood. There was no system to learn from incidents which related to end of life care because the trust did not routinely collect this information.

There was variation in the locality leads understanding the purpose of the risk register, in the community. Some thought to place certain risks on the risk register was “naming and shaming” staff. For example, we were told that there was lack of access to education and training for staff in a locality and we found there was a reluctance to record this on the risk register. For two years, a risk had been identified about a GP practice. There had been a reluctance to place this practice on the risk register because it would be considered as “naming and shaming” GP practices. Only after an adverse incident occurred to a patient from that GP practice were they placed on the risk register.
There was a hospital risk register, but it did not identify any risks that related to end of life care. Some staff told us that the lack of identification of patient’s patients close to the end of their lives earlier “worried” them. The end of life team did not voice this concern.

There were no arrangements for the identification and management of risk. There was a section in the Quad report titled “What is our stakeholder activity in the next two weeks.” This section was blank. Throughout the other documents reviewed, there was no mention of the pending joint venture with the hospice.

The trust and the community end of life care teams had different formats of mortality review. This resulted in variation in understanding the reasons why patients died.

The assurance systems were not comprehensive and performance issues were not appropriately escalated. The trust had a programme work stream titled Quad report. In this report, end of life care for the period 1 November to 24 November 2017 was rated as ‘green’ because some items within the programme of work had been completed. However, the important development of “The End of life care policy: care of the dying adult” was not highlighted in this document.

There was no alignment between the clinical and internal audits to monitor quality. The end of life working group had established a list of audits that it monitored. We found none of the identified audits to monitor the quality of the service were listed in the policy.

There were no systems to identify where actions should be taken. The trust did not monitor quality measures such as complaints, incidents in end of life care, or uptake of training as a measure of assurance. The trust did not have clear and effective processes for the management of risk and performance of end of life care at the board level.

**Information management**

The service did not collect, analyse, manage and use information well to support all its activities, using secure electronic systems with security safeguards.

The service had not collated any specific information under each of the five domains e.g. safe, effective, caring, responsive and well-led for end of life care.

The information used to performance manage and improve delivery of quality care was embryonic. The trust had not established information about quality, the operation, and the finances of end of life care across the Island. For example, the joint venture was appropriately costed; the end of life care policy (for example the cost of matrons doing audits) was not costed.

The trust did not act upon the few performance of measures it reported. When considering the bereavement survey, the trust reported performance to the board cumulatively, from April 2015 to October 2017. As a result, the board would have been unable to challenge and improve performance. This deficiency in the reporting system was also highlighted at the last CQC inspection.

**Engagement**

The service did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services, and did not collaborate with partner organisations effectively.

Some parts of the service responded to what people said. The district and community nurses were involved in engaging with bereaved relatives. For example, they visited the deceased home to collect equipment and while doing so, they supported the bereaved families and signposted them appropriately to any services, if required. The bereaved were also supported when they picked up the death certificates.
However, at the 2016 unannounced inspection, we found there were no corresponding action plans, that identified actions to be undertaken by the trust because of the results of the bereavement surveys. We found the same in 2018. The survey took place, but it was reported on a cumulative basis, and there was no action plan that addressed areas for improvement.

There was minimal engagement with staff. The trust had identified end of life champions to embed good end of life practice. We previously highlighted their lack of attendance at these monthly meetings as an example of minimal engagement.

**Learning, continuous improvement and innovation**

The service was not fully committed to improving services by learning from when things went well and when they went wrong. The trust did not promote any innovation in end of life care.

The trust had made little improvement to end of life care services since we last inspected. Most of the hospital ‘must do’ actions that related to end of life care had not been fully implemented. For example, there was no executive framework that monitored the quality, risk, and performance issues within end of life care. We found there was no monitoring of the rapid discharge system.

However, the trust had the individualised priorities of care plan as a standard document that was used for patients nearing the end of their life throughout the Island. All services (ambulance, acute, community and district nurses) used this one form across the Island.

The joint venture between the trust and the hospice had begun to develop improved ways of working. The senior leaders that conceptualised the joint venture realised that significant progress in end of life care could only be made and sustained through collaborative and cooperative efforts between people who were part of statutory bodies, voluntary organisations and community groups. However, this had not yet been implemented.

We asked the trust to provide examples of three latest dashboards for end of life care they presented to the trust board regularly. A dashboard is a document providing summary information about the performance of a service. The trust response was “They do not have a mortality specific dashboard.” We concluded that the trust lacked understanding how they monitored the performance of end of life care.

The trust was involved in an improvement programme with NHS Improvement. The improvement programme included enabling end of life patients’ direct admission to wards to avoid prolonged waits in the emergency department.
Outpatients

Facts and data about this service

The Trust’s outpatient services for adults are mostly provided at St Mary’s Hospital. The Outpatient Department and Fracture Clinic provide outpatient clinics for medical and surgical specialties based at St Mary’s and for teams who visit the hospital from the mainland. In addition clinical speciality clinics are run from different areas in the hospital.

Outpatient clinics are mainly coordinated within the Outpatient Appointments and Records Unit (OPARU). Although some clinics are coordinated by the clinical specialties located throughout the hospital. There are consultant, nurse or allied healthcare professional-led clinics.

The trust has five Clinical Business Units (CBU). Outpatient services mainly functioned within the Clinical Support, Cancer and Diagnostic Services CBU. However some sat within the Surgery, Women’s and Children’s Health CBU and the Medicine CBU.

There is a separate children’s main outpatient department, which is reported on under the acute children and young people core service. However, some children were seen in regular outpatient clinics dependent on specialty including Ear, Nose and Throat (ENT) and ophthalmology.

During this inspection we visited the following areas;

- The main outpatient department,
- Fracture clinic,
- Chemotherapy unit,
- Maxillofacial unit,
- Pre-assessment unit,
- ENT,
- Physiology,
- Cardiology outpatient unit,
- Respiratory unit,
- Laidlaw diagnostic and rehabilitation unit,
- Outpatients and home parenteral infusion therapy (OHPiT) unit,
- Diabetes services,
- Asthma and Allergy clinic,
- Pathology laboratory,
- Haematology clinic,
- Phlebotomy unit,
- Podiatry unit,
- Eye department,
- The outpatients appointments and medical records unit (OPMRU).

We spoke with 19 patients and relatives, 48 members of staff including administration staff, managers, doctors, nurses, allied healthcare professionals, healthcare assistants and
volunteers. We looked at patient waiting areas and clinical environments, policies and procedures and information provided by the trust.

**Total number of appointments compared to England**

The trust had 192,417 first and follow up outpatient appointments from August 2016 to July 2017. The graph below represents how this compares to other trusts.

![Graph showing total number of appointments compared to England](image)

(Source: HES - Outpatient)

**Number of appointments by site**

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from August 2016 to July 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary’s Hospital</td>
<td>211,415</td>
</tr>
<tr>
<td>This Trust</td>
<td>211,421</td>
</tr>
<tr>
<td>England</td>
<td>104,581,336</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from August 2016 to July 2017. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Isle of Wight NHS Trust from August 2016 to July 2017 by site and type of appointment.

(Source: Hospital Episode Statistics)
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. Compliance with mandatory training was generally good in outpatients but was below the trust target of 85% for some modules.

Mandatory Training Completion by module – Medical and Dental Staff

Medical and dental staff were aligned to other services in the trust and did not work directly for outpatients. Therefore their mandatory training data will be reported under the services they worked in.

Mandatory Training Completion by module – Nursing Staff

In outpatients, nursing staff did not meet the trust target of 85% with 81.5% compliance overall.

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Maths &amp; Medicines Calculations</td>
<td>4</td>
<td>75.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>5</td>
<td>40.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>5</td>
<td>40.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>5</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff working within outpatients met the target for 10 out of the 21 modules listed above.
Modules with the lowest compliance rates included medical management – competency assessment (zero out of five members of staff completed this), adult resuscitation (two out of five members of staff completed this) and prevent training levels 1 & 2 (two out of five members of staff completed this).

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Data supplied was from April 2017 – Oct 2017 therefore there were still several months of the financial year for mandatory training courses to be completed. However when we looked back at data supplied from the trust for financial years 2015-2016 and 2016-2017 it was seen that mandatory training was not always completed by all staff for every module.

There was no mandatory training in the management/understanding of patients living with mental health conditions, learning disabilities, autism or dementia. This meant that staff were not trained in the awareness of meeting the potential needs of complex patients.

Mandatory training was provided in different formats including as part of the induction process for new starters, face to face classroom training and e-learning. Staff told us training was easy to access via ward computers or their home computers. Nursing and allied health professionals we spoke with said that time was given to them to complete their training; however, some staff members found it easier to complete the courses at home as this had less impact on their work time.

Staff we spoke with knew how to access mandatory training and explained how the hospital computer system would flag up any outstanding training or updates that were required.

Senior staff explained how they monitored their staff’s mandatory training compliance and would email staff if training was required. This was confirmed by team members we spoke with.

Safeguarding

The trust set a target of 85% for completion of safeguarding training.

Safeguarding Training Completion by module – Medical and Dental Staff

Medical and dental staff were aligned to other services in the trust and did not work directly for outpatients. Therefore their safeguarding training data was reported under the services they worked in.

Safeguarding Training Completion by module – Nursing Staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>5</td>
<td>40.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Nursing staff working within outpatients met the standard for two out of the four safeguarding modules; safeguarding children level 1 and safeguarding children level 3. There was poor compliance for safeguarding children level 2 with two out of five members of staff having completed this.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff at all levels in all the outpatients clinics we visited, knew how to recognise and report safeguarding issues. Staff were able to demonstrate to us how to access safeguarding policies and procedures on the trust’s intranet and who to contact in the trust if they had a safeguarding concern.

Information on safeguarding issues including financial abuse was displayed in waiting areas so patients and visitors could see. The information included who to speak to within the trust or how to contact the council safeguarding team for advice.

Female genital mutilation (FGM) was included in the Level 2 Safeguarding Children Training. This training, which was delivered to all clinical staff, had a section on FGM, explaining what it was and how to refer any concerns. However, there was poor compliance with this safeguarding module.

Cleanliness, infection control and hygiene

In general the service controlled infection risks well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Infection prevention and control (IPC) was discussed at the Clinical Business Units weekly and monthly meetings. We saw evidence of this in the minutes from these meetings.

Whilst some areas of outpatient services were dated in appearance, the environment and equipment in the majority of outpatient areas we visited were visibly clean and uncluttered. Domestic staff were present in the departments during our inspection. However, the kitchen in the Laidlaw diagnostic and rehabilitation unit had failed an infection prevention and control audit and a health and safety inspection and had been deemed unfit for purpose. The unit had submitted a business case for funding for the kitchen to be refurbished but were still waiting to find out the outcome. The kitchen was still being used in the meantime.

We saw cleaning schedules displayed in the chemotherapy unit that showed regular cleaning had taken place.

All staff we saw in outpatients areas were bare below the elbow in line with trust policy. This was to promote more effective hand washing and prevent long sleeves from touching patients to reduce the spread of infection. Personal protective equipment (PPE), such as gloves and aprons, were available for staff in all areas where it was necessary. We saw staff using PPE appropriately.

Hand sanitiser gel was available at the entrance to outpatient areas. Hand washing facilities and hand sanitiser gel was available throughout the outpatient areas and we observed staff using
these. Outpatient departments collected infection prevention and control (IPC) data in the form of hand hygiene audits and infection control audits and we saw evidence of this. Results from these audits were discussed at the Clinical Business Unit meetings and if results were low an action plan put in place.

We saw weekly environment audit paperwork from the main outpatient department. This involved checking each area for cleanliness, tidiness and any broken equipment needing repair. It also included making sure information on the notice boards was up to date. Any problems would be noted and ticked or initialled when completed.

Staff in the Respiratory Unit told us they informed the infection control team when new equipment had been purchased to make sure they had the correct cleaning procedures in place. We saw manuals in the respiratory unit on how to clean reusable equipment.

We saw the use of ‘I am clean’ stickers in the chemotherapy unit. Equipment was labelled and dated so staff knew the items were clean and ready for use.

Although there were no designated waiting areas for patients with communicable diseases, senior staff informed us that these patients would be seen in a separate treatment room, which would be deep cleaned after use. Trust policy for dealing with patients with infectious conditions needed to be isolated and the deep cleaning requirements after their appointment.

We saw confidential waste bins, sharp bins and battery disposal bins throughout the outpatient departments.

One of the blood spillage kits, used to clean spillages, in the general pathology department had contents that were out of data, with the expiry date of the disinfectant absorbent granules being March 2017 and March 2013. We raised this at the time of the inspection and it was removed from the area. This meant the service could not be assured the kit would work effectively in the event of a blood spillage. The blood spillage kit in the phlebotomy clinic area had all its contents in date when checked.

**Environment and equipment**

Outpatient services were provided in designated clinical areas. Not all outpatient services had suitable premises. Equipment was looked after well.

The buildings in the South block of the hospital, where many outpatient clinics were held were not purpose built and had been converted into clinical areas. Many of the buildings required regular maintenance from the hospital estate team. In addition many of the outpatient services throughout the hospital had out grown their current location.

Some waiting areas were excellent, for example the chemotherapy unit had a spacious waiting area with appropriate chairs and tropical fish tanks to help make the area a calm and tranquil.

However, many of the waiting areas in specialist outpatient clinics were in corridors outside consulting rooms with limited seating and no space for bariatric patients, mobility scooters or wheelchairs. Access to the phlebotomy services was down the corridor where the haematology
Clinic patients waited for their appointments. This corridor became congested and difficult to manoeuvre along especially for patients with mobility problems.

We saw sufficient seating areas in the clinics we visited, except the Eye Department. However we were told this was not always the case when clinics got busy. The main outpatient department had been recently redesigned to allow for a waiting area for the Diagnostic Imaging Service. This meant they had lost a large area of their waiting room and where the reception desk had been moved meant that reception staff could no longer see the outpatient waiting area or the clinic area. This caused problems as the reception staff were isolated from the clinical team. A panic bell had been attached to reception so staff could call to alert other outpatient staff if they needed assistance or felt unsafe. In addition, reception staff could no longer see the outpatient patients in the waiting area, meaning they could no longer look out for distressed or deteriorating patients.

We had concerns with the waiting area in the Eye Department. Although this area was clean, tidy with good furniture for elderly patients, the area was not big enough for the volume of patients seen in this department and did not fit with the flow of the clinics. The patient population is mainly elderly, with many patients in wheelchairs and the waiting room struggled to accommodate this.

The Fracture clinic and ENT unit had well-arranged play areas for children. However the Eye department, although it had a children’s play area, children were only taken to this area after eye drop treatment had been administered and not prior to treatment.

The main outpatients department told us they had funding for new flooring and seats, to include bariatric seating and these would be arriving in the next month.

Both the Chemotherapy and Out-Patient and Home Parenteral Infusion Therapy Units (OHPIT) were spacious, light and airy. The chemotherapy unit had treatment bays with curtains that could be drawn for privacy and both units had chairs that reclined and beds available. There was room for friends and family to sit.

Blood samples from round the hospital were taken to a second window by the reception of the phlebotomy clinic. Samples are handed over to the phlebotomy clinic receptionist and recorded if necessary and then stored in open blood carrying boxes until full and then taken to the pathology laboratory. Urgent blood samples were sent to the Pathology laboratory via a pod system. The area the samples were kept in, although not accessible to the general population, was accessible to hospital staff. When we inspected, staff did come in and out of the room regularly and a school children tour of the pathology services came into the room to store their coats and bags. This was not best practice and blood samples were not secure from tampering.

Equipment was looked after well by staff. We found equipment to be stored appropriately and neatly, corridors were free from equipment consumables were in date and electrical equipment had evidence of electrical safety testing.

There were maintenance systems in place and staff could tell describe how to report issues on the hospital computer system. When staff were asked how quickly repairs were dealt with they said it varied. More specialist equipment, such as the equipment used in the Respiratory Unit, were maintained under service contracts with the manufacturer.
We review documentation in regards the Eye department’s laser equipment. We saw the recommended actions from the Radiation Protection Committee last audit in 2016 and process made by the Eye outpatient department. The conclusion from the laser safety committee was that although process had been made the overall laser safety culture still required improvement.

We inspected resuscitation equipment in clinics and saw that daily checks had been undertaken. Trolleys throughout the trust were not locked and did not contain any anti-tamper tags. This meant the contents of the trolleys were easily accessible and staff could not be assured that equipment was still in situ following checks being completed. The paediatric resuscitation equipment located in the David Hide Asthma and Allergy Research Centre but used by all outpatient services running from the South Block buildings, was only checked on the days when there were children being seen in the Centre. This was unsafe practice as the paediatric equipment could be needed at any time not just when clinics were running.

Assessing and responding to patient risk

The service planned for emergencies and staff understood their roles if one should happen.

Staff could tell us how they would respond if a patient became clinically unwell in an outpatient area. Staff would monitor them, check their vital signs and request emergency assistance from the emergency care team and we were given examples by staff when this had happened. If a patient required hospital admission following review and treatment by the medical emergency team, transfer was arranged either to a ward or to the accident and emergency department depending on the nature of the patient’s illness.

We saw evidence of clinical staff in the chemotherapy unit and the out-patient and home parenteral infusion therapy (OHPiT) unit using the national early warning scores (NEWS) whilst patients were having treatment. NEWS is a chart used to quickly determine the degree of illness of a patient. It is based on six patient observations, breathing rate, amount of oxygen in the blood, blood pressure, heart rate, level of consciousness and temperature and it used to help recognise a patient whose condition is deteriorating.

There was a clear process in outpatient services to check the identity of the patient by using name, address, date of birth and GP surgery. We observed staff obtaining this information from patients that attended for appointments.

Emergency equipment was available in the event of emergency. Staff working in outpatients where required to complete mandatory basic life support (BLS) training. However this mandatory had not been completed by all members of staff.

We saw Sepsis pathway posters in some of the outpatient departments.

Staff did not receive mandatory training in the Mental Capacity Act and seemed unaware where to go for mental health support if they were concerned about risks associated with a patient’s mental health.

Whilst inspecting in the main outpatients department we observed a patient become loud and aggressive. Clinical staff had the appropriate skills and training to assess the situation and calm the patient.

Staff in the Outpatient and Home Parenteral Infusion Therapy (OHPiT) unit were sometimes
required to work alone. To keep staff safe they carried a safety device which when activated would signal both the hospital switchboard and the police. The device had been tested and worked well.

**Nurse staffing**

There were no agreed national guidelines as to what constitutes ‘safe’ nurse staffing levels in outpatient departments. Staffing levels and skill mix were planned on the number of clinics and patients attending. Nurses were flexed to provide cover within the other outpatient clinics.

The trust although asked did not provide whole team equivalent (WTE) figures for nursing staff working in outpatients.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 8% for registered nursing staff working within outpatients.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From October 2016 to September 2017, the trust reported an overall turnover rate of 14% for registered nursing staff working within outpatients.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From October 2016 to September 2017, the trust reported an overall sickness rate of 1% for registered nursing staff working within outpatients.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

From October 2016 to September 2017, the trust reported an overall bank usage of 13 shifts, and no agency usage. The data supplied by the trust did not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Staffing was planned on a daily basis to meet the needs of the clinics running that day.
At the time of our inspection, nursing staff met the needs of patients. Agency and bank staff would be used if vacancies needed to be filled. Bank staff were generally known to the department and had completed a local induction, which we saw evidence of.

Clinical services in Outpatient departments were provided by outpatient nurses, clinical nurse specialists, healthcare assistants and other allied healthcare professionals.

The senior nurse in the main outpatients department provided staff to outpatient clinics and other outpatient services, such as the gynaecology and ENT clinics. Senior nursing staff would meet each day to discuss the staffing levels and to move staff around the service to ensure clinics had the right level of staff if possible.

The senior nurse in outpatients expressed frustration in having to staff other clinics in the outpatient services, especially when some of the clinics, like the ones in the ENT department, did not sit in the same Clinical Business Unit as outpatients. The senior nurse felt that the lines of responsibility become confused in these circumstances and could leave the main outpatient department short staffed.

When evening clinics ran in the main outpatient department there was no receptionist and clinical staff had to look after arriving patients and work their clinical duties. We were told this was not always ideal, as there was a lack of supervision for patients potentially putting their safety at risk and it made chaperoning duties in clinic difficult.

Clinical specialities such as cancer care and ophthalmology had nurses with specialist skills exclusively working in those departments/clinics.

**Medical staffing**

There is no data submitted about medical/dental staff working in outpatients. The trust mapped their staff to core service by cost centre. The trust said that none of these cost centres have any medical/dental staff in them. This means medical/dental staff working within outpatients will be on the budgets from other core services. Therefore, this data will be picked up, but in a different core service instead.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Medical and dental staff were aligned to other services in the trust and did not work directly for outpatients. Therefore their vacancy, turnover and sickness rates were reported under the services they worked in. Due to the way the trust reported on medical and dental staff there was no data on the amount of bank and locum staff used in outpatients.

All clinics were staffed by doctors from the relevant speciality, either from the Isle of Wight NHS trust or by visiting consultants from trusts on the mainland.

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to staff providing care.

A mixture of record management systems were used across outpatients to record patients’ care and treatment. The majority of outpatient services although using both paper and electronic
systems were predominately paper light, meaning that electronic documentation was used rather than written notes.

We were told by clinical staff that for first appointments in clinics the full set of notes would be requested from the Outpatient Appointments and Record Unit (OPARU). For subsequent follow up appointments patient information would be obtained from the electronic computer system.

The majority of medical staff in outpatients used the electronic computer system; this provided a range of patient centric information and past medical history including outpatient visits, hospital and emergency department admissions, pharmacy information, diagnostic results and access to the GP summary record.

Following appointments, if there was any paper based patient information, this would be scanned by outpatient staff onto the electronic computer system so patient information was easily accessible to all medical staff.

In the year before the inspection, the trust reported 0.11% of patients seen as outpatients did not have their full medical records available. We were told that if records were not available the medical clinician would be alerted and it would be their decision whether to postpone the appointment.

Staff in the OPARU showed us the systems they used to manage appointments, records and collect clinical data. Electronic patient information was only available to authorised people, and computers and computer systems were password protected.

**Medicines**

Arrangements for managing medicines in the outpatient services were mostly suitable to ensure patients were kept safe from avoidable harm.

The medicines prescribed from the outpatient clinics used to be collected by patients from pharmacy using an internal form. However, due to high workloads in the pharmacy department patients were now given a FP10 prescription to take away. The exception to this was medication required by oncology patients, which could be collected from the hospital pharmacy.

Medicines were stored securely. Drug cupboards across the outpatient departments were locked and the registered nurse coordinating the relevant clinic held the keys. No controlled drugs were kept in the main outpatient departments.

Medication fridges were locked when not in use and within the correct temperature range, which was checked daily and records we saw confirmed this. When we asked what would happen if fridges went out of range we were told by clinical staff that they would contact pharmacy for advice.

We saw during our inspection that FP10 prescription pads were stored in locked cupboards and used appropriately.

We observed a pre-chemotherapy screening process taking place and being double checked by trained nurses before chemotherapy was administered, ensuring the right person received the right medicine.

Staff in the Out-patient and Home Parenteral Infusion Therapy (OHPiT) unit used an electronic
system to see where patient prescriptions were in the system, such as pending or dispensed.

Within the ophthalmology service staff told us that most patients required their eyes to be dilated before doctors assessed their eyes. Some, but not all the doctors prescribed eye drops to dilate the patient’s eyes. Patients new to the service and that healthcare assistants or nursing staff anticipated would require their eyes dilated would either, be reviewed by a doctor and the eye drops prescribed or reviewed by a nurse and the eye drops administered via a patient group direction (PGD). A PGD allows specified healthcare professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. If a patient was attending for a follow up appointment and the doctor had not prescribed eye drops for the current appointment but their eyes had been dilated at previous appointments, healthcare assistants would administer the same dilating eye drops that had been used in the past at this appointment. Healthcare assistants we spoke with felt this was working and making decisions above their grading.

Nursing staff in the eye department gave us an example of when they had triaged an urgent patient and this had required a discussion with a senior doctor. The doctor had requested via a verbal order that the patient was ‘double dilated’ on arrival. The nurse had recorded this in the patient’s notes. However the exact eye drops and strengths had not been specified. Therefore, we were not assured that medicines for dilating eyes were administered against a patient specific direction.

When we reviewed the trust’s documentation on medicines used in the ophthalmology department, there were PGDs in place for eye drops and eye ointments stating that only qualified nurses band 5 and above, or nurses with the ENB 346 ophthalmic course qualification or equivalent competencies could supply/administer ophthalmic medicines. We felt that it was unlikely that working practices in the eye department put patient’s safety at serious risk; however it was felt that the governance and documentation around prescribing and administering ophthalmic medicines was not robust or best practice.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in outpatients which met the reporting criteria set by NHS England from December 2016 to November 2017. This incident was categorised as a treatment delay meeting SI criteria.
The trust had an incident reporting policy. No figures were supplied by the trust in regards to the number of incidents reported in outpatient departments.

Staff had a good understanding of what to report as an incident. They all understood their responsibility to raise concerns and felt confident to report them.

There was an electronic reporting system to allow staff to report incidents. However some clinical staff said due to lack of computers it could be difficult to actually report an incident. A senior nurse in the main outpatient department explained she had the responsibility for reporting incidents onto the main system for the team.

Senior staff throughout the outpatient services told us they provided feedback from the incidents reported and any learns learnt back to their teams. However, staff we spoke with could not recall any incidents that had occurred in outpatients. We saw from the minutes of the Clinical Business Unit weekly and monthly meetings that incidents were discussed at this level. Although when we reviewed the minutes of the last three outpatients department monthly staff meetings, we found no evidence of any learning from incidents, even where the incident occurred in other areas. The minutes did contain reference to the morning handover meetings and how important it was for staff to attend them. We had been told by senior staff that this was where learning from incidents occurred.

Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Currently duty of candour is not part of the trust’s mandatory training. Although we were told this was due to change in the near future. However, outpatient staff we spoke with were aware of and able to explain the duty of candour.

### Is the service effective?

#### Evidence-based care and treatment

Care and treatment was provided in line with national guidance. Staff in outpatients demonstrated how they could access trust policies and guidelines on the trust’s intranet.

Senior nursing staff showed us National Institute for Health and Care Excellence guidance (NICE) that they followed in the chemotherapy unit.

The pre-assessment clinic had a newly designed pre-assessment integrated care pathway booklet for collecting the relevant medical information before surgery. It had been in practice for the last few months. It included venous thromboembolism (VTE) assessment, nutritional
assessment and dementia screening. However, we were told by medical staff that no formal dementia screening was completed. No audit had been carried out to see how efficient the new booklet had made the preoperative assessment.

**Nutrition and hydration**

Water was available in most outpatients waiting areas and we observed volunteers offer hot drinks to patients waiting in the respiratory clinics.

Vending machines were situated at various points round the hospital and there were two shops and a café in the main hospital reception area for light refreshments.

Although there was no formal process in place staff would make sure they got their patients meals if they had very long delays for patient transport.

**Pain relief**

Patients were not routinely assessed for pain in the outpatient departments, as this was not generally a clinical risk. Pain would be assessed by the consultant as part of the presenting condition and captured in the patient notes accordingly.

There was a chronic pain service run by the trust which consisted of specialist doctors, nurses, physiotherapists and psychologists.

We observed consultants in the maxillofacial outpatient clinic discussing post-operative care and pain relief with a patient.

**Patient outcomes**

Clinical audits were not routinely conducted within outpatient services. This meant there was not full oversight of patient outcomes across specialties.

The respiratory service had conducted an internal audit of compliance with NICE guidelines for continuous positive airway pressure (CPAP) for treatment of obstructive sleep apnoea/hypopnoea. This highlighted the key areas of success and concern. There was an action plan for the department following the results of the audit.

**Follow-up to new rate**

From August 2016 to July 2017,

- The follow-up to new rate for St Mary’s Hospital was similar to the England average.

**Follow-up to new rate, Isle of Wight NHS Trust.**
Competent staff

Generally the service made sure staff were competent for their roles.

Senior staff in outpatient services told us how staff competencies were assessed. New and bank members of staff would be offered a mentor for support, given time to complete their mandatory training and induction packs to help orientation to the unit. We saw team meeting minutes of the main outpatient department that showed staff training needs were discussed.

Staff in the main outpatient department told us they were supported to attend training and development was encouraged. The senior nurse in outpatients had recently attended a manager training course.

Staff in the respiratory unit told us about the weekly training sessions that were carried out in their department. The unit also displayed the respiratory physiologist’s qualification certificates in the unit for patients to see.

Appraisal rates

From October 2016 to September 2017, 53% of staff within outpatients at the trust had received an appraisal, not meeting the trust’s target of 100%.

A split by staff group can be seen in the graph below:
Appraisal Completion rates by staff group, October 2016 to September 2017

(The hospital’s appraisal policy stated that all staff were required to have an annual appraisal. The trust had an electronic appraisal form. Administration staff we spoke with said the form was more geared towards clinical staff, they found the form difficult to complete and thought it did not fit their appraisal needs.

Medical and dental staff were aligned to other services in the trust and did not work directly for outpatients. Therefore their appraisal completion rate is reported under the services they worked in.

Multidisciplinary working

Staff at different grades and skills worked well together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Nursing staff had good working relationships with visiting consultants from the mainland. They explained in detail how they would contact them if needing advice and information in regards to a patient when the consultant was no longer on the island. These systems had be used and found to be robust.

We saw both nurse-led and healthcare professional-led outpatient clinics supported by consultants.

Nurses in the outpatient services reported good working relations with the hospital pharmacy team. Chemotherapy nurses stated that pharmacy were flexible in their approach to ensure patients could start their treatment on time.

We saw good multidisciplinary working in the Asthma and Allergy clinics. The service offered one-stop clinics where patients could see the consultant, specialist allergy nurses and the dietitians at one visit.)
The Podiatry outpatient clinics combined the services of a multidisciplinary team (MDT) when assessing and treating their patients. The MDT called upon the services of doctors, nurses, GPs, biomechanics, orthotists and physiotherapists.

**Seven-day services**

The outpatient departments mainly operated on a Monday to Friday basis. The phlebotomy services started at 07:30 and finished at 4pm Monday to Friday.

In some specialities, where demand required and there were staff available, additional clinics were sometimes held in the evenings.

The Outpatient and Home Parenteral Infusion Therapy (OHPiT) unit provided a seven day service.

The cardiology outpatient department were discussing running an additional echo cardiogram diagnostic service on a Saturday due to demand. However, it was dependent on the recruitment of additional staff as currently there was not enough to expand this service.

**Health promotion**

Patients we spoke with told us they were involved in their care. They felt information was explained by staff in ways they could understand. They felt they were involved and supported in the decision making process of their treatment.

We saw a range of health promoting leaflets and posters displayed in all the outpatient departments we visited encouraging health promotion this including information on alcohol awareness and how to stop smoking.

We saw that leaflets and booklets were available and given to patients. We observed a doctor in the Laidlaw diagnostic and rehabilitation unit select a certain leaflet from the display to give to their patient.

The main outpatient department had a patient board especially relating to health promotion, with useful information, including details of aerobic classes, drop in cafes, details of self-help groups and details of societies such as PSP, Parkinson, epilepsy and multiple sclerosis.

They also had a specialist board where they highlighted a certain health area; this was about cancer awareness when we conducted our visit.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff and patients we spoke with told us consent was always obtained prior to treatment. We observed nurses obtaining verbal consent from patients in the chemotherapy unit prior to starting treatment and a consultant obtaining written consent from a patient in the maxillofacial outpatient clinic.
Mental Capacity Act and Deprivation of Liberty training completion

There was no mandatory mental capacity training and staff seemed unsure of their responsibilities in respect to the mental capacity act. Staff told us if they were worried about a patient they would seek advice from senior team members.

No Deprivation of Liberty Safeguarding applications had been made by outpatient departments in the last 12 months.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff throughout outpatient services put patients at the centre of what they did. During the inspection we saw pleasant interactions between staff and patients. Staff spoke with patients and relatives in a kindly manner, using supportive language.

Staff maintained patient’s privacy and dignity. We observed receptionists speaking to patients in an attentive and polite manner in all outpatient areas we visited. Every attempt was made to ensure these conversations were not overheard by other people in the waiting area. In the busy pathology reception, they asked patients to wait behind a line a little way from the main desk and only approach the desk when they were called. This gave patients booking in more privacy when talking to reception staff. We also observed the pathology receptionist, helping a patient to put his coat on and offering to call a porter to help transport him back to the front of the hospital.

Staff had an understanding and compassionate approach to supporting patients. Staff told us of a range of methods they used to support patients, the phlebotomy clinic had a ‘fast track’ system where vulnerable patients and patients with needle phobias had a quiet area to wait and would be seen quicker.

We saw many examples of compliments that outpatient departments had received from patients about the kindness and compassion displayed by staff. Cards and comments that staff had been given by patients and their relatives were displayed on notice boards throughout outpatient departments.

We spoke to 19 patients and relatives during our inspection, many had used the service for a number of years. Parents and relatives were positive about their experiences of care. We heard that staff were kind and caring and that communication was clear, open and empathetic. Examples included;

- Staff are excellent
- I am always treated with dignity and respect
- The staff are very nice, respectful and polite
• In 20 years, I've had nothing but praise for the hospital
• Staff were brilliant, smiles and polite, makes me feel relaxed

The NHS Friends and Family Test (FFT) is a feedback tool that gives people that use the service the opportunity to provide feedback on their experience. The FFT provides a mechanism to highlight both good and poor patient experience. The trust did not take part in the FFT but used the iWantGreatCare (iWGC) scheme to gather feedback. During our inspection we observed that iWGC feedback forms were available in the outpatient departments. Patients could either put completed forms in the box provided or complete the form online. The trust did not provide any results for the outpatients iWGC scheme.

We saw notices in the main outpatient department and chemotherapy displaying positive patient feedback, it was dated with the month but not the year so it was unclear how up-to-date this information was.

**FFT results for outpatient services Jan 2017 – Dec 2017.**

Of the FFT returned the percentage of people that would recommend the service can be seen below. The trust had a target of 90%. The table below shows the results broken down by month. The response rate, which was the percentage number of people who completed compared to how many were eligible to complete the FFT was unknown.

<table>
<thead>
<tr>
<th>Outpatient areas</th>
<th>Response rate</th>
<th>N/A</th>
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</tr>
</thead>
<tbody>
<tr>
<td>% Recommended</td>
<td></td>
<td></td>
<td>Jan 17</td>
</tr>
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**Emotional support**

Staff provided emotional support to patients to minimise their distress.

The hospital had a chaplaincy team who were on call 24 hours a day, seven days a week, who could provide listening and emotional support if requested by patients. The hospital also had a chapel and a multi-faith room that provided a solace and spiritual space for all.

There was emotional support available to patients who had received a diagnosis of cancer. Patients received an orientation visit to the chemotherapy unit, where they could ask questions and get a greater understanding of the unit and what their treatment would entail. Patients also had access to hospital psychologists. We were told patients often took advantage of this and found it extremely helpful at a difficult time.

We were told by staff in outpatient services that a room would be available if bad news had to be broken to patients. The senior staff in the main outpatient department told us about the daffodil room, which was where patients in their department could go to if so needed.
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

All the patients and relatives we spoke with across the outpatient departments said they felt actively involved in decisions about their loved ones care and treatment. Examples included:

- Definitely involved in decisions
- Very clear when explaining something medical
- Staff do know about my care
- Staff made me feel part of the decision
- The consultant explained things in simple terms

Patients told us they had received enough information before their appointment to prepare them for clinic.

We observed staff keeping patients updated when clinics ran late and explaining the cause of the delay.

We observed patient consultations in the outpatient services and saw each patient was treated with care and respect. Good explanations of procedures to be carried out were given and there was time for patients to ask questions. We saw post-operative risks identified and discussed with patients and treatment plans put in place to reduce these risks.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The trust ran clinics by both in-house consultants from the IOW trust and visiting consultants from trusts on the mainland. This meant patients did not have to travel away from the island to see their consultants. Patients, especially elderly patients, told us how much they valued this service.

During our inspection, some clinics were delayed or cancelled due to visiting consultants being unable to travel to the island due to bad weather conditions and the cancellation of ferries. Outpatient staff were honest with patients and explained the situation and offered to rearrange appointments where required.

The majority of outpatient clinics were appropriate and patient centred. There was suitable seating with access to toilet facilities and water dispensers. On the day of our inspection, excluding the eye department, areas were not overcrowded. There was enough seating for patients, although we were told this was not always the case.

There were no separate waiting areas for patients who found busy waiting areas distressing.
We were told by staff that they would try and find an empty clinic room if so required but this would depend how busy the department was that day.

There were no separate waiting areas for children in the majority of clinics. However, the fracture clinic and eye department had a play area for children. The plaster room in the fracture clinic was a large bright space but there were no posters or décor in any of the bays that would have made a bay child friendly.

During our last inspection in 2016 it was noted that the Laidlaw Diagnostic and Rehabilitation Unit was not purpose built. Patients waited and received treatment infusions in a ‘café style’ public environment on upright armchairs. We saw it was impossible to retain the patients’ privacy if they had a reaction or collapsed. In the corner of the same area, staff completed patients’ weight checks and observations with no privacy screening.

When we returned on this inspection the area where patient’s weights were checked had been screened off to give patients privacy. However the environment where patients received their infusion treatment had not changed. The staff had been proactive and carried an audit of service uses to see if patients were happy with the current arrangement and if they felt their privacy and dignity had been comprised. Of the response rate for patients who completed the survey was 100%, all indicating they were happy with the current arrangements although they did receive negative comments about the chairs. The service was in the process of buying two reclining chairs.

It was not known how many patients had decided to have their treatment in other mainland hospitals rather than use the current arrangements in this unit. The service had also been trying to find areas to relocate to, there were talks about the service being carried out in the Outpatient and Home Parenteral Infusion Therapy (OHPiT) unit and a business case was put into the space utilisation group to find a new area for the service. However, at the current time the service remains at the Laidlaw Unit.

Many of the staff and patients we spoke with described difficulties parking, many told us they would arrive well before their appointments in order to be able to park their cars. The trust had just introduced automatic number plate recognition into some of the hospital car parks. We found the instructions on the new system inadequate and we observed many visitors to the hospital confused. St Mary’s has an elderly population and many patients in this age group told us the buttons on the machines, where you needed to enter the car registration number, was too small and difficult for them to read or operate.

Signposting in the hospital was good and patients told us it was easy to find the outpatient department they required. Volunteers could be found at the main reception desk at the entrance to the hospital and we observed them advising and taking patients to the right clinical areas. We also observed staff asking patients/visitors if they needed help if they were looking lost in the hospital corridors.

Patients we spoke with were happy with the appointment letter they had been sent before attending the hospital. Patients also told us they were sent text reminders about their outpatient appointments.

There was limited information on how to get to the hospital via public transport on the trust’s
Senior staff in the main outpatients department explained that they would only book patients into evening clinics if they could access the hospital.

The ophthalmology outpatient area was cramped for the volume of patients that attended clinics. Due to space limitations, especially for patients in wheelchairs, clinic doors were left open. This did not respect patient's privacy and dignity.

**Did not attend rate**

From August 2016 to July 2017,
- The ‘did not attend’ rate for St Mary’s Hospital was lower than the England average.

The chart below shows the ‘did not attend’ rate over time:

**Proportion of patients who did not attend appointment, Isle of Wight NHS Trust.**

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

The service took account of patients individual needs, they planned and provided services in a way that met the needs of the people.

Patient transport services were available to those patients that met the eligibility criteria based on the department of health guidance. Not all clinics had easy access or enough space to fit wheelchairs in. Hoists where available if patients required them, and staff had the training to operate them. High-back chairs with arms were available in most outpatient waiting areas to accommodate older patients or those with mobility issues. Bariatric chairs were not available but we were told the main outpatient department’s waiting area was soon to be getting them.

The majority of outpatient clinics had a receptionist where patients could book in when they arrived. There was a mixture of information presented to patients when entering the different outpatient services, some clinics had photo boards of key members of staff, some had a list of
which consultants were running clinics that day, some had information on clinical staffs uniforms. However, there was no standardisation across all outpatient clinics on what information should be on display to the patients.

Patients were allocated appointment lengths based on the need of the appointment. However, we were told that appointments did not always run to time. When discussing this with patients we were constantly told that they didn’t mind if appointments overran and it meant they had to wait longer. They explained to us it just meant that doctors were giving patients the time they needed and they saw this as a positive thing.

Although translation services were accessible across the outpatient services there was no information displayed to let patients know this. The main outpatient department had a poster about this service but it was behind the reception desk and not visible to patients. The Out-Patient and Home Parenteral Infusion Therapy (OHPiT) unit had a patient information leaflet about their service. On the first page they had printed in several common languages found on the island, advice on what to do if English was not your first language. Most staff were aware how to access the translation services but had never needed to use them.

The trust had a chaperone policy which was available on the trust’s webpages. We spoke with staff who understood the importance of chaperones and they explained they provided them on request or would offer their services. We saw posters in outpatient areas offering chaperone services. We were told by all patients we spoke to that a chaperone had been offered to them.

In the respiratory unit we observed a member of staff writing individual instructions for a patient on how to use and maintain the non-invasive ventilation equipment they had recently be given.

Patients from the chemotherapy unit were given information cards to keep in their wallets. These cards included their hospital details and who and what number to telephone for advice or in an emergency. They also contained adverse symptoms to look out for and information for other healthcare professionals.

The Outpatient and Home Parenteral Infusion Therapy (OHPiT) unit offered a service which provided intravenous (IV) therapy for patients. Previously these patients would have had to receive the IV therapy as an inpatient. If certain criteria were met, treatment was delivered in an outpatient setting so reducing the need for patients to be admitted to hospital. This has freed up approx. 2000 bed days per year on the hospital wards.

**Access and flow**

People could access some of the outpatient services when they needed it. Waiting times from referral to treatment were in line with good practice for most of the outpatient specialities.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From September 2016 to August 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways was in general similar the England overall performance. There was a trend of improvement from September 2016 (89%) to December to 2016 (93%).

The latest figures for August 2017 showed 91% of this group of patients were treated within 18
weeks versus the England average of 89.6%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Isle of Wight NHS Trust.**

![Graph showing referral to treatment rates](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

The five below specialties performed above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>99.6%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>97.4%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Other</td>
<td>94.2%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>93.5%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>88.9%</td>
<td>87.5%</td>
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</table>

The six below specialties performed below the England average for non-admitted RTT (percentage within 18 weeks).

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<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>90.5%</td>
<td>93.9%</td>
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<tr>
<td>Geriatric Medicine</td>
<td>82.8%</td>
<td>95.6%</td>
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<tr>
<td>Thoracic Medicine</td>
<td>78.7%</td>
<td>89.0%</td>
</tr>
<tr>
<td>ENT</td>
<td>78.4%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>77.5%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>67.1%</td>
<td>84.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – incomplete pathways**

From August 2016 to July 2017, the trust’s referral to treatment time (RTT) for incomplete pathways met the 92% for two out of the 12 months in this time period; June and July 2017. The trust’s performance was also in general worse than the England average until May 2017 where the trust’s performance had improved.

From January 2017 to July 2017, there was a trend of improvement in the trust’s performance from 84% to 92%. July 2017 was the best performing month for the trust, meeting the standard, with the trust’s referral to treatment time for incomplete pathways at 92%, higher than the England average of 90% for the same month.
Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Isle of Wight NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Nine specialties performed above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>99.7%</td>
<td>92.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.7%</td>
<td>91.7%</td>
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<tr>
<td>Oral Surgery</td>
<td>96.9%</td>
<td>88.0%</td>
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<tr>
<td>Rheumatology</td>
<td>96.8%</td>
<td>94.7%</td>
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<tr>
<td>Thoracic Medicine</td>
<td>94.2%</td>
<td>92.3%</td>
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<tr>
<td>Other</td>
<td>93.0%</td>
<td>91.4%</td>
</tr>
<tr>
<td>ENT</td>
<td>90.1%</td>
<td>88.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>87.9%</td>
<td>86.8%</td>
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<tr>
<td>Neurosurgery</td>
<td>89.9%</td>
<td>82.6%</td>
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Six specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

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<thead>
<tr>
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<td>95.2%</td>
<td>96.5%</td>
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<tr>
<td>Urology</td>
<td>85.9%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
<td>82.1%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>80%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>87.2%</td>
<td>91.3%</td>
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(Source: NHS England)
Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust met the 93% operational standard for patients being seen within two weeks of an urgent GP referral across the whole time frame from Q3 2016/17 to Q2 2017/18. The trust’s performance was also consistently higher than the to the England average for these time periods. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Isle of Wight NHS Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The trust was also consistently performing better than the England average. The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Isle of Wight NHS Trust

(Source: NHS England – Cancer Waits)
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed better than the England average and met the 85% operational standard in the first quarter Q3 2016/17. There has been a general trend of decline from this quarter through to Q1 2017/18, where the trust performed similar to the England average but lower than the 85% operational standard. The trust performance has remained at this level through to Q2 2017/18.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Isle of Wight NHS Trust

![Graph showing cancer waiting times percentage](image)

(Source: NHS England – Cancer Waits)

Percentage of patients seen in outpatients without the full medical record being available

As of April 2017 the trust reported 0.11% of patients seen in outpatients without their full medical record being available.

The trust reported that they mitigate against this by alerting the clinician to seek advice on next step, such as to postpone consultation or continue with appointment if relevant history is available on the trust’s electronic computer system. Cancellation of appointments rarely happened due to medical records being unavailable as invariably all previous letters and results were available on the trust’s electronic computer system. On occasion visiting plastics consultants did not have the required notes and there was a delay in patients being seen as relevant letters/information was faxed over.

(Source: Provider Information Request (OPD3)).

From Jan 2017 until Jan 2018 2169 clinics in total had been cancelled. Out of the 2169 clinics cancelled, 1528 (71%) was because there was no consultant available. This broke down as; 32% consultant on annual leave, 11% consultant on study leave, 8% unavailable, 8% consultant on sick leave, 7% consultant attending a meeting, and the remaining 5% was due to consultant audit day, on call or in theatre.

When talking with staff from the Outpatient Appointment and Records unit (OPARU), who provided an integrated outpatient booking service for the consultant-led clinical services, they said clinics were usually cancelled due to a lack of consultants and this was especially true for the ophthalmology clinics. We were told by cardiology outpatient staff that they struggled to fill the current clinics available due to reduced staffing levels in their department. Senior staff were looking at ways to increase staffing levels within the department with the possibly of introducing
an apprenticeship scheme to help with long-term staffing.

The outpatient service did not measure the number of patients who were not seen within 30 minutes of their appointment time.

Tracking lists of patients waiting for appointments were monitored by the OPARU team and reviewed at weekly planning meetings. If waiting times were going to exceed hospital targets the OPRAU staff would try and organise additional outpatient clinics. However this was not always possible due to the lack of consultants to run these clinics. They currently had a project ongoing to try and reduce the ophthalmology follow-up appointment backlog, although with limited clinic times and a lack of consultants it was different to make an impact on the list.

When we visited the phlebotomy clinic during our inspection there was only a short waiting time as the clinic was not busy. Patients took a ticket and waited to be called for their blood test. Staff told us waiting times in phlebotomy varied depending on how busy the clinic was and how many phlebotomists were on shift. There was a process to fast track vulnerable and phobic patients.

One-stop clinics were only seen in the breast, urology and ENT outpatient services. A one-stop clinic is a clinic where patients can be seen and all diagnostic tests would be carried out on the same day and in the same area of the hospital. In some specialists, for example dermatology, patients could also be treated, even if this involved a minor operation. This means that patients would only need one visit to hospital.

We were told by staff in some of the outpatient services that the trust was about to start a ‘choose and book’ appointment booking system. This would mean GPs could directly book appointment for their patients at the time of referral. This would hopefully result in shorter waiting times and less missed appointments as patients would be actively involved in the booking stage of their outpatient appointments.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which was shared with staff. However the trust did not respond to complaints in a timely manner.

Staff in the outpatient services told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. Conflict resolution training was part of the mandatory training. If the problem could not be resolved by the team, staff told us patients would be given contact details of the Patient and Liaison Service (PALS).

The PALS office had a visible presence within the main entrance of the hospital. Information regarding PALS, the services they offered and how to contact them was displayed in prominent areas in the outpatient departments. We saw leaflets on PALS which patients could take away to read at home.

Outpatient departments displayed ‘Help us do Better’ posters, which explained and gave details of all the ways patients could make complaints. This included information on how to obtain free independent advice from the seAp Advocacy and details on the Health Service Ombudsman.

Outpatient staff told us that feedback from complaints and concerns were discussed at the
monthly team meetings, during daily face to face catch ups and in handover sessions. The respiratory outpatient team said they had a book were feedback about complaints was recorded.

Senior staff told us that that incidents and complaints were discussed at the main outpatient department monthly meeting. We reviewed the minutes of the last three meetings and found that there was no set agenda and no evidence of learning from incidents or review of complaints. The minutes did contain reference to the morning handover meetings and how important it was for staff to attend them. We had been told previously by senior staff that this was where learning from incidents and complaints occurred.

Summary of complaints

From October 2016 to September 2017, there were 20 complaints about outpatients. 18 complaints were closed, and one from July 2017 and one from September 2017 still remain open. The trust took an average of 38.7 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints. Two complaints took over 61 working days to close, and one from February 2017 took 150 days.

A breakdown by subject is shown below:

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<thead>
<tr>
<th>Subject</th>
<th>Total</th>
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<tbody>
<tr>
<td>Communication</td>
<td>6</td>
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<tr>
<td>Patient Care</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Treatment - General Medicine group</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Treatment - Surgical Group</td>
<td>2</td>
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<tr>
<td>Trust admin/Policies/Procedures including patient record management</td>
<td>2</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
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</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The Operations Division of the trust was split into five Clinical Business Units (CBUs): surgery, women’s and children’s health; clinical support, cancer & diagnostic services; medicine; ambulance, urgent care & community services; mental health & learning disabilities. Each CBU had a management structure in place and clear lines of responsibility and accountability.

Outpatient services and the Outpatient Appointment and Records Unit (OPARU) sat in the clinical support, cancer and diagnostic services CBU. However, speciality outpatient services sat in the surgery, women’s & children’s health CBU and the medicine CBU.
Each CBU was managed by a head of operations with support from the operations manager/head of services, assistant operations managers and a head of nursing & quality. Each CBU also had a clinical director and matrons or lead nurse specialists, who were responsible for the delivery of the services.

When we spoke with the senior staff in the main outpatient department and fracture clinic we were told that the operations manager looking after them had been seconded to a different department and the service was currently being managed by the operations manager of the diagnostic services. There had been no matron post in outpatients department and fracture clinic since the department had been restructured and the day to day management of the team was by the two band 6 nurses. The Outpatient Appointment and Records Unit (OPARU) was also managed by the interim operations manager.

It was clear there was a good working relationship between the interim operations manager and the senior outpatient nurses. However, with no matron post and no specialist operations manager the interests of the main outpatient department was not represented at the CBU level. Specialist outpatient services, such as the chemotherapy unit and the Outpatient Home Parenteral Infusion Therapy (OHPiT) unit had direct representation at the CBU meetings.

At clinic level throughout the outpatient services, we did not see senior managers or matrons present. However the senior nursing staff who managed the day to day running of the outpatient clinics were spoken highly of by their teams, who found them supportive and approachable.

Staff we spoke with knew there had been changes in the executive team and that the chief executive had recently become a substantive post. Although they commented that many of the executive team were still interim posts. We found mixed opinion about the effectiveness of the current executive team amongst staff working in the outpatient services. Nursing staff seemed more positive than the doctors we spoke with.

**Vision and strategy for this service**

The trust were currently undertaking acute service redesign work, to consider how hospital based service needs of the Isle of Wight residents should be provided now and in the future to ensure safe, good quality and affordable care.

The trust had an integrated business plan and a clinical strategy (2014/2015 – 2018/2019), which set out the trust’s direction for the next five years. It outlined how the trust would deliver on hospital activity, quality and finance.

The trust’s vision was to provide ‘Quality care for everyone, everytime’ this was underpinned by five strategic imperatives: excellent patient care; work with others to keep improving our services; a positive experience for patients, service users and staff; skilled and capable staff; cost effective, sustainable service.

At the Clinical Business Unit level, there were business operating plans (FY1019 & FY2020) which described the service responsibilities and deliverables and key issues/challenges to delivering the clinical services in line with local health needs and financial constraints.
At a more local outpatient department level, the main outpatient department had a service plan FY2017. This described where the service wanted to be. However, it was unclear how this fed into the business operating plan for the CBU where the outpatients department sat.

In the main outpatients department we saw a poster outlining the departments ‘mission’ statement. Which was to provide the highest possible standard of patient care in a safe, comfortable and caring environment, to maintain out patients privacy and dignity and offer a seamless service throughout the patients journey.

Staff knew how their work contributed to the wider vision of the trust and they were aware of the trust values of ‘we care … we are a team …we innovate and improve’. However, due to the many changes that how occurred at the trust in recent years, the uncertainty of the acute service redesign work and what impact this would have on staff working at the hospital, staff were worried and unsure of the hospital’s actual vision and strategy moving forward.

**Culture within the service**

The majority of staff we spoke with felt supported, respected and valued in their working environments. Staff confirmed that they felt able to be open and transparent, reporting adverse events and incidents in a way which helped improve things within the service. Senior staff told us they promoted an ‘open door’ and a ‘no blame’ culture in the teams

Outpatient services worked throughout the hospital in different locations. Staff working within these services described good teamwork amongst their colleagues and how they often felt their teams were like family.

Clinical staff also told us they were proud of the service they provided across the outpatient departments.

However, some consultants we spoke with felt that their professional views were not listened to and there had been no improvement in culture since the appointment of the new chief executive in May 2017, We were told about doctors raising concerns about safe staffing levels but their worries being dismissed by the board due to lack of funds for additional staffing.

As per NHS guidelines the trust had appointed a Freedom to Speak Up Guardian whom staff could talk to in confidence if they had concerns. Staff we spoke with were not aware of the freedom to speak up guardian; however, they were aware and told us about the anti-bullying team who worked across the trust.

**Governance, Risk Management and Quality Management**

It was unclear if the outpatient services had robust, well-established and effective governance process.
Each clinical business unit (CBU) held weekly meetings and monthly quality and leadership meetings. Depending in which of the CBUs the outpatient service was in, determined where the governance, risk management and quality management was discussed for that specialist outpatient service. For example, the main outpatients department was discussed at the clinical support, cancer and diagnostic services CBU meetings whereas the ophthalmology outpatient service was discussed at the Surgery, Women’s health and Children’s Health CBU meetings.

We reviewed three months of minutes from the relevant CBU meetings and found that key quality issues of safety, risk, clinical effectiveness and patient experience were discussed. However, meetings were not consistent in their agendas and there was no standardisation between CBUs. In one set of quality, risk and patient safety group meeting minutes we reviewed, risk was not on the agenda.

The trust had five risk registers; ambulance risk register, mental health risk register, community risk register, hospital risk register and corporate service risk register. The corporate service risk register captured more overarching trust risks that would impact on the trust’s ability to deliver services such as the inability to attract, recruit and retain staff. There was also a trust risk management strategy and policy document, which described how risk was managed in the organisation.

Patient risks in the outpatient services irrespective of which CBU they came under were recorded on the hospital risk register. However, when we reviewed the risk registers we saw that the Laidlaw diagnostic and rehabilitation unit had risks recorded on both the hospital and the community risk register. When risk was identified in the outpatient services, it would be discussed at the relevant monthly CBU quality, risk and patient safety group and if needed placed on the hospital risk register. Risk management would be managed at the CBU level unless the rate reached a certain criteria or was thought to be of high enough risk to be place on the corporate risk register. These types of risk would then be escalated up via the corporate governance and risk subcommittee.

It was unclear how services identified risk, although we did see some evidence of risk being discussed in the minutes of the CBU quality, risk and patient safety group meetings. Some of the problems staff had told us about during the inspection did appear on the risk register, such as the outpatient eye department being inadequate to meet the service requirements, the ophthalmology follow-up outpatient backlog, the number of cancelled appointments and the non-tamper proof emergency trolleys. It was also difficult to see from the risk register and information in CBU meeting minutes if risks were being reviewed regularly.

We saw little evidence of outpatients quality of services being discussed at the relevant CBU quality meetings and it was not a standing item on the agenda. However, we were told that fortnightly RTT specialty meetings focused on outpatient measures such as DNA rates; referral to treatment times; cancer waiting times and clinic booking backlogs. Only issues for escalation would be raised at the relevant CBU meeting. The Outpatient Appointments and Records Unit (OPARU) department held regular meetings to discuss the above measures and provide an action plan to improve outcomes. This was fed up to board level to give them an oversight of outpatient performance indicators.
Public and staff engagement

The service generally engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The trust encouraged public engagement. They offered the iWantGreatCare scheme for the public to feed back their comments and help improve the outpatient services. They could do this on a paper form found in the outpatient departments or via the ‘contact us’ tab on the hospital website where patients could leave electronic feedback about their hospital experiences.

The trust had a website where the public could assess much information about the hospital including information about the trust and the outpatient clinics and services. The latest hospital news, charity news and when the trust had been in the media was also available. The public could also find on the website details about how to get involved or the support the trust, whether that be attending public meetings, joining a patient participation group or finding out details of self-help groups.

However, not all the information was available or kept up to date, for example the current survey for patients to complete about their experience of the trust’s cancer services had the closing date for completion of the 24th December 2015.

The trust also kept the public updated on social media.

The trust took part in PLACE (Patient-led assessment of care environment) assessments. These were annual appraisals involving local people called patient assessors who go into hospitals to assess how the environment supports the provision of care. Areas looked at include cleanliness, food and hydration, privacy, dignity and wellbeing, condition appearance and maintenance, dementia, and disability. Results from this assessment were published by the NHS health and social care information centre. The results from the 2017 survey saw results that were above the national average in two of the eight categories, cleanliness and condition appearance and maintenance.

The trust took part in the NHS staff survey and used the results to tackle and measure issues or themes raised by the staff. In the 2017 survey, the responsive rate of staff completing the survey was 44%.

The trust provided information on their intranet pages and produced a newsletter and sent emails to keep staff updated on current and future plans and hospital information. It was the individual’s responsibility to read the information supplied. Outpatient staff we spoke with didn’t always have access to computers to read emails regularly and said it was easy to miss newsletters. We were told that the new executive team had organised face to face staff meetings to discuss changes occurring in the hospital but staff commented that it was always easy to leave their clinics to attend meetings.
The trust ran the Isle of Wight annual awards scheme to give recognition to staff and volunteers who had given exemplary service. These awards acknowledged individuals and teams who had made a significant contribution to the patient experience on the island.

**Innovation, improvements and Sustainability**

Many staff we spoke with had ideas of how they could improve their area of the outpatient services.

For example, the Outpatient and Home Parenteral Infusion Therapy (OHPiT) unit were an ambitious team with many plans to grow and develop their service. The unit was about to take patients from the Medical Assessment Unit (MAU) and the Laidlaw diagnostic and Rehabilitation Unit. They had also put in a business plan to expand their service and become the centralised intravenous (IV) therapy across the trust. This meant that all IV services taking place at the hospital would run out of the OHPiT unit. The unit already provided all the IV administration training for the trust.

The main outpatient department had many ideas to improve their service for patients, from centralising all outpatient clinics throughout the trust to running one-stop clinics.

However outpatient staff we spoke with felt that the trust’s financial status, staff shortages, space issues and the interim nature of the executive board was potentially hindering improvements being carried out or piloted. Therefore some staff felt it was difficult to get their ideas listened to.

The David hide Asthma and Allergy Research Centre, was internationally renowned for its research into childhood asthma, allergic diseases and prevention of allergy. The centre also housed the Isle of Wight NHS outpatient service. There was a close working relationship between the research and clinical services provided by the centre. This helped to develop better understanding of the disease area and medical outcomes for patients.

The podiatry outpatient’s team told us about how they had close links with universities and offered placement and training opportunities for students in their department. University students would carry out their research for their final year projects in the unit. This meant that the podiatry team were involved in international research and were ‘leading the way’ in podiatry services. Recent projects included ways to prevent the reoccurrence of pressure ulcers and better ways to measure for orthoses. The podiatry department had submitted a business plan to carry out podiatry surgery, however that had not been approved by the trust board.

The haematology department had started running nurse-led clinics between visits to the haematology clinicians. This still gave support to the patients but allowed the haematologists to reduce their clinic lists and waiting times.

The main outpatient department did not have a training budget for staff. However, the senior nurse had found innovating ways to give learning and development training to the team by using the close working links with other teams in the trust and external organisations. Meaning talks and training sessions had been arranged for the staff. We saw details of these in the monthly
meetings minutes including ECG and aseptic non touch technique training. The senior nurse also told us of talks that had been arranged with PALs and the hospital link champions for diabetes and dementia.

Recruitment in many of the specialities outpatient departments had become challenging. Services were therefore looking at ways to redesign the workforce without comprising patient care and safety and to maintain the services sustainability. We were told about introducing band 4 associate practitioner roles in the main outpatient department and the cardiology outpatient team adopting the practice of 'growing their own' specialist staff and offering apprenticeship roles.
The diagnostic Imaging department provided a comprehensive service for the Isle of Wight at St Mary’s Hospital NHS trust. The hospital provided the following diagnostic services: Magnetic resonance imaging (MRI), computed tomography (CT), ultrasound, mammography and plain film x-rays. There was a limited interventional radiology service provided which undertook, for example, biopsies and drainage of abscesses, ascites, and pleural effusions. Some nephrostomies were performed when a radiologist was available; otherwise, the patients would go to one of the mainland NHS trusts.

Each clinical area was managed by a lead radiographer and supported by radiographers, and radiology department assistants (RDAs). Student radiographers also supported the service in some areas. There was a service manager in post who was accountable for radiology services overall. Radiology was part of the clinical support directorate; the service supported outpatient clinics as well as inpatient wards, emergency department, GP referrals.

A full diagnostic imaging service was available between 9am and 5pm Monday to Friday, excluding Bank Holidays. An out of hours emergency service was available 24 hours a day, seven days a week for x-ray plain film imaging and CT (computed tomography) scans.

The main department consisted of three new digital X-ray rooms, two of which had enhanced software to perform image pasting and dual energy radiology, and one digital fluoroscopy room. There was also a small satellite department in the ‘north hospital’, which provided general radiology and included an orthopantogram (OPG) machine, to provide a scanning dental x-ray of the upper and lower jaw.

A computerised tomography (CT) service was provided consisting of two 128-slice scanners. CT scanning provides high-resolution imaging for oncology, cardiovascular neurological and acute care. The standard operating hours were between 8.30am – 5.00pm, Monday to Friday. Staff provided an on-call service 365 days of the year between 5pm and 8am Monday to Friday and 24 hours over the weekend for urgent emergency scans, that cannot wait until normal opening hours. St Mary’s Hospital provided magnetic resonance imaging (MRI); the scanning system was installed at the end of 2000, and was situated at the far end of the main department. Magnetic Resonance Imaging (MRI) is a scanning technique, which produces very high quality pictures of various parts of the body without using X-rays. The use of MRI can provide quick, early and accurate diagnosis. Radiographers were available for scanning appointments between 8am and 8pm by request Monday to Friday, and on Saturday mornings.

An ultrasound service operated Monday to Friday between 9am and 5pm in two rooms within the main radiology department, and staff operated a portable ward service for in-patient scans each weekday. General ultrasound scans, for example, abdominal, pelvic, transvaginal and venous ultrasound for deep vein thrombosis (DVT) were carried out.

The mammography unit offered a symptomatic service as part of the breast cancer two week wait guidelines and participated in the national breast-screening programme. The screening element of the provision did not form part of our inspection.
Throughout the radiology department, the trust had invested in state of the art technology allowing the most up to date imaging techniques to be captured digitally, and stored on a picture archive communication system (PACS). This allowed Consultants to view the images throughout the hospital on a computer terminal.

Specialist imaging was contracted from mainland providers.

The department performed the following number of examinations per month during the year January to December 2017.

- Computerized Axial Tomography: 793
- Diagnostic Ultrasonography: 1054
- Fluoroscopy: 135
- Magnetic Resonance Imaging: 450
- Plain Radiography: 3644

This is the first CQC inspection of diagnostic imaging at St Mary’s Hospital. We carried out our inspection from 23 to 25 January 2018.

During our inspection, we spoke with 3 patients and relatives, and 15 members of staff, including radiologists, radiographers, department assistants, students and health care support workers. We viewed eight patients’ examination records and observed staff delivering care.

**Is the service safe?**

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

During our inspection, the staff we spoke with were clear about their obligations to complete all mandated training. However, the data provided by the trust showed that there was some poor compliance for some clinical training, for example adult and paediatric resuscitation.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training.

In diagnostic imaging, both allied health professionals and additional clinical services staff failed to meet the trust’s target, with allied health professionals having 83% and additional clinical services having 82% compliance overall.

**Mandatory Training Completion by module – Allied health professionals**

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:
Allied health professionals working within the diagnostic imaging service met the trust’s target for 13 out of the 22 training courses listed above. Training courses with the lowest compliance rates included prevent training levels 1 & 2 (16 out of 41 members of staff completed this) and people handling (23 out of 40 members of staff completed this).

### Mandatory Training Completion by module – Additional Clinical services

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>41</td>
<td>41</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>26</td>
<td>40</td>
<td>65.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>32</td>
<td>41</td>
<td>78.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>37</td>
<td>40</td>
<td>92.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>36</td>
<td>40</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>41</td>
<td>41</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>40</td>
<td>41</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>39</td>
<td>41</td>
<td>95.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>36</td>
<td>40</td>
<td>87.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>41</td>
<td>41</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>32</td>
<td>41</td>
<td>78.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>34</td>
<td>41</td>
<td>82.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>35</td>
<td>40</td>
<td>87.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>22</td>
<td>35</td>
<td>62.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>16</td>
<td>41</td>
<td>39.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>37</td>
<td>41</td>
<td>90.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>41</td>
<td>41</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>20</td>
<td>40</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>40</td>
<td>41</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>40</td>
<td>40</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling</td>
<td>23</td>
<td>40</td>
<td>57.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Additional clinical staff working within the diagnostic imaging department met the trust’s target for 13 out of the 23 training courses listed above. Training courses with the lowest compliance rates included prevent training levels 1 & 2 (ten out of 30 members of staff completed this) and people handling (eight out of 13 members of staff completed this).

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

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 trust set a target of 85% for completion of safeguarding training.

Safeguarding Training Completion by module – Allied health professionals

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for allied health professionals working within diagnostics is shown below:

Allied health professionals working within diagnostics met target for two out of the three safeguarding courses; safeguarding adults levels 1 and safeguarding children level 1. There was a low compliance rate for safeguarding children level 2 with only 20 out of 40 (50%) members of staff having completed this.
Safeguarding Training Completion by module – Additional clinical services

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for additional clinical services staff working within the diagnostic imaging service is shown below:

Additional Clinical Services

![Completion (%) and Target (%)]

<table>
<thead>
<tr>
<th></th>
<th>Completion (%)</th>
<th>Target (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>58%</td>
<td></td>
</tr>
</tbody>
</table>

Additional clinical service members of staff met the trust’s target for two of three training courses; safeguarding adults level 1 and safeguarding children level 1. There was a low compliance rate for safeguarding children level 2 with seven out of 12 (58%) members of staff having completed this.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding training was mandatory for all staff; all clinical staff working within the diagnostic imaging department were expected to achieve level 2 training. Staff we spoke with were able to describe scenarios that would alert them to potential safeguarding issues for both adults and children. We saw information on safeguarding on noticeboards and in public areas with relevant contact numbers. However, low levels of compliance for level 2 training did not assure us that staff would act appropriately, and with confidence should a case present itself to them.

The intercollegiate document ‘Safeguarding children – Roles and Competencies for Healthcare Staff‘ published by the Royal College of Paediatrics and Child Health 2014, states that: ‘all clinical staff working with children, young people and/ or their parents/carers, and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person; where there are safeguarding/child protection concerns’ should be trained in safeguarding for children level one, two and three. The manager acknowledged there were no staff involved in the care of children who were level 3 trained in safeguarding during our inspection, so asked the forensic leads within the team to undertake level 3 training for child protection, which they were happy to book and undertake when the opportunity arose.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Control measures to prevent the spread of infection were available to them.

The majority of staff had received training on infection control, but they did not meet the trust target of 85% at the time of our inspection with radiographers achieving 83% and other staff groups at 80%.

We saw posters in waiting areas and other communal areas advising patients and visitors to gel their hands. We observed hand sanitiser units throughout the department but staff we observed
did not consistently use these as they left and re-entered the x-ray rooms. All the staff we observed in the clinical areas were ‘bare below the elbow’ in accordance with the national institute for clinical excellence (NICE) guidance. The trust provided eight samples of hand hygiene audits undertaken taken in the radiology department between January 2017 and January 2018, all of which showed that staff achieved 100% compliance. There were adequate supplies of personal protective equipment (PPE) including gloves and apron dispensers.

The clinical areas were visibly clean. It was not clear if regular environment audits occurred because the trust did not provide the data requested; we saw an audit dated June 2016 only. A review of the cleaning activity undertaken by radiology staff in February 2017 showed that the cleaning activity was not being documented as well as it could be and not on a daily basis. “There is still much to be done to achieve better results for our department” was the comment made by the auditor in the report.

We saw clinical rooms had facilities for the disposal of clinical waste and sharps. Waste management was handled appropriately, with separate colour coded arrangements for general waste, clinical waste and recycling. Clinical bins had foot pedal operated lids and were not overfilled.

We observed staff cleaning equipment after use; there was an appropriate level of decontamination equipment in place for transvaginal probes in ultrasound procedures, and we saw robust decontamination processes in the mammography department. Staff wore aprons and gloves before giving personal care to patients during interventional procedures and these were changed in between patients.

Environment and equipment

Radiology areas lacked space for waiting in-patients and outpatients; this was particularly evident during our inspection when in-patients attended the department in their beds. Staff told us that waiting areas were particularly lacking in capacity when fracture clinics were taking place.

Patient dignity could not be maintained at all times, due to the cramped waiting conditions; for example there was not a separate area for beds and at times, we observed four beds in the waiting area along with the outpatients.

Clear signage was visible for ‘controlled areas’ within the department. A controlled area is one designated to assist in controlling and restricting radiation exposures of patients and staff. Magnetic resonance imaging (MRI) equipment and devices were clearly labelled within the MRI environment. This was in accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) (2015) recommendations. We noted the warning signs were working correctly at the time of the inspection.

The staff undertook daily quality assurance checks for all the diagnostic imaging equipment. These are mandatory checks based on the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation Medical Exposures Regulations 2000 [IR(ME)R] regulations to protect patients against unnecessary exposure to harmful radiation. Any trends or increases in exposure were reported to the radiation protection supervisors (RPS) for investigation. Each of the clinical modalities had a designated, trained radiation protection supervisor (RPS) as required by IRR99.

Risk assessments were in use; staff were seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation. Staff wore appropriate personal protective equipment. We saw staff wearing lead aprons during interventional procedures.
The medical physics department at another NHS trust supported diagnostic imaging staff by providing radiation protection services. This team included a radiation protection advisor (RPA) as required under [IRR99], and medical physics experts (MPEs) as required under IR(ME)R. The medical physics team provided scientific support to diagnostic imaging departments in a number of areas. This included monitoring specialist radiology equipment, monitoring staff radiation doses and providing guidance on the various specialist regulations surrounding the use of imaging equipment. The RPA was available by phone at all times.

Staff ensured there was ongoing equipment maintenance and they displayed service stickers to show when the next service was due.

At the time of our inspection, all the equipment was in good operational order and an equipment replacement programme was itemised on the local risk register.

Resuscitation equipment was immediately accessible on highly visible resuscitation trolleys. Staff checked the resuscitation equipment against a standard contents diagram daily. The emergency trolleys were not tamper evident; review of the trust risk register showed the use of non-tamper evident emergency trolleys had been identified as a risk, with the requirement that staff must check the trolleys twice every 24 hours to ensure all equipment was on the trolleys was in date and that the defibrillator was in working order.

We saw that cleaning materials were stored securely in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances which are hazardous to health.

Assessing and responding to patient risk

IR(ME)R requires a number of procedures to be in place within every department that uses ionising radiation. These cover a wide range of patient safety features such as patient ID, checking pregnancy and dose recording. During the inspection, we found that the staff had a good understanding of the regulations and we saw that procedures pertaining to the activity in each room were accessible for reference.

The RPS in each area had a responsibility to ensure staff followed local rules and adhered to radiation protection procedures in the department. The local rules summarised the key working instructions intended to restrict exposure in radiation areas. Staff we spoke with knew who their RPS was and could contact them for advice. The RPSs were available to give advice when needed to ensure patient safety and minimise radiation risk.

Dose reference levels (DRLs) were displayed in all x-ray rooms. The employer’s procedures under IR(ME)R were up to date and we saw local rules were available for all staff to follow in the imaging areas.

We saw some comprehensive risk assessment documentation completed by the external radiation protection team, but local risk assessments for imaging rooms were minimal with limited detail on specific hazards or the level of risk applicable.

The diagnostic imaging department had guidelines to ensure that staff asked female patients of childbearing age if they were, or might be pregnant. There were signs in waiting areas and x-ray rooms reminding patients to inform staff if they may be pregnant. Staff we spoke with were aware of the importance of checking the pregnancy status of female patients.

We saw the staff follow the World Health Organisation (WHO) ‘Five Steps to Safer Surgery’ checklist effectively in the department. This checklist was designed to prevent avoidable harm,
and used for patients undergoing invasive procedures within the department. In St Mary’s Hospital, this would include, for example biopsies, pleural effusions, drainage of abscesses and ascites,

There was a list of authorised referrers available to staff, but we did not find evidence that clinical audits were being undertaken within the service to ensure that the referral requests for an x-ray or other radiation diagnostic test, for example by non-medical referrers or GPs was made in accordance with IR(ME)R.

Staff told us of the action they would take if a patient became unwell or distressed while waiting for, or having a scan. They said this depended on the specific situation and gave us examples that indicated they would take appropriate action, for example, if a person fainted or panicked. Staff would also accompany patients to the emergency department, which was close by, if they became unwell and required medical attention.

In the interventional radiology (fluoroscopy) unit, the service has developed a bespoke post to meet specific requirements. The advanced practitioner /radiographer had undertaken further training as an ‘acute clinical care nurse’ to allow her to provide appropriate patient care during interventional radiological procedures. This provided nursing support for two sessions per week to make clinical assessments and complete clinical observations of the patients and complete documentation accordingly, prior to and post the procedure.

We saw excellent procedures and documentation in place in the scanning departments relating to avoidance of acute kidney injury (AKI) due to contrast-induced nephropathy (CIN). A strict procedure was followed which detailed the necessary training required for the administration of contrast media through a peripheral cannula by radiography staff. Oxygen and suction were available and a medical doctor available should a patient react in an adverse way to the contrast media.

We saw that the contrast media was correctly stored in the CT scanning rooms. However, this was not the case in the general x ray room, where the medicines cupboard was unlocked and there was no key available to lock it. We were not assured that there was a checking process in place to ensure that the contents were in date, or that a stock rotation process was in place.

There was a Computerised Radiology Information System (CRIS) and a Picture Archiving and Communication System (PACS) in place. The CRIS contained all the clinical details relating to the patients’ imaging history and PACs, which meant that images could be viewed by the reporting radiologists from outside of the department including their own homes. This meant that urgent reports could be obtained in a timely manner.

One radiologist explained that they had set up a flagging identification on the CRIS, which ensured that patients presenting with suspicious lesions on their images were allocated to the next available multidisciplinary team meeting to escalate further action.

The trust ‘Imaging Examinations Policy for the Requesting, Justification and Reporting of’ (14 February 2017) detailed the management of reporting in the trust; in particular ‘the consultant in charge of the patient has responsibility for ensuring that any person interpreting an unreported radiological investigation is qualified to do so.’ We did not see any evidence that there was specialist training in place for non-radiologists to carry out such interpretations. Data supplied by the trust informed us that for theatre fluoroscopy and for in-patient and out-patient plain film examinations, a radiologist did not routinely report. We did not see evidence of any quality monitoring of the clinicians to test their competence before they were allowed to review the images. There was no monitoring of the accuracy of the reviews, and no monitoring of the impact
of this decision on patients’ health. There were no audits or records kept of the number of these images that had been reviewed and this was not referred to on the hospital risk register.

National data showed that between April 2017 and August 2017 the trust performed better than the England average for reporting timescales in all modalities except for chest x-rays. Staff told us that some reporting was outsourced and there was a selection process in place for this. The senior radiologist expressed some concern about the quality of this reporting but we were not aware that there was any benchmarking against the quality of in-house reporting.

**Staffing**

**Allied health professionals staffing**

CQC routinely request this information within the universal ‘provider information request spreadsheets’: for completion within a standard template.

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

**Radiographer staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

At the time of our inspection, there were 43 radiographers in post, 23 of whom worked part-time hours, which meant there was a compliment of 34.12 whole-time equivalent (WTE) staff. Sixteen radiology department assistants supported the radiographers, which was 11.12 WTE. We were told that there were no vacancies at the time of our inspection.

**Medical staffing**

The lead radiologist told us that there were six radiologists in post, two of whom worked part-time hours. The service had recently been interviewing and had offered posts to two candidates and one associate post but at the time of our inspection acceptance was not confirmed. We were told that even with these three, the service would still be two radiologists short. Radiologists were able to attend multidisciplinary meetings (MDMs) but were not sufficient in number for a deputy when absent. There was no cover for the gynaecology MDM.

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 4.4% for allied health professionals working within the diagnostic imaging department.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

From October 2016 to September 2017, the trust reported an overall turnover rate of 4% for allied health professionals working within diagnostics.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

From October 2016 to September 2017, the trust reported an overall sickness rate of 3% for
allied health professionals working within diagnostics.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Records

Staff kept appropriate records of patients’ care and treatment.

The staff we spoke with in the diagnostic imaging department had a good understanding of patient confidentiality and data protection and had attended information governance training. We saw the receptionist demonstrate this by double checking patients details when they attended.

Staff were generally able to access patient information such as diagnostic imaging records and reports, medical records and referral letters appropriately through electronic records. Detailed patient identification data was entered onto the computerised radiology information system (CRIS) including doses of radiation for each image undertaken. This ensured that robust imaging records were captured and stored for each patient. Patients’ images were held securely on the patient archiving communication system (PACS), which was accessible across the trust. The electronic systems were password protected.

Administrative staff scanned paper radiology requests (mainly from GPs) into the system.

Staff received training on these systems as part of the departmental induction. We observed staff recording information relating to patients’ examinations on CRIS including doses, pregnancy checks.

Radiology reports were generated and stored on the PACS; this allowed for timely reporting, and as patients’ previous imaging data was always available, appointments were not cancelled due to lack of clinical information.

Medicines

The service generally prescribed, gave, and stored medicines well. Patients received the right medication at the right dose at the right time.

Patient group directives (PGDs) were in place to allow non-medical staff to prescribe and administer contrast media in CT and MRI. A patient group direction allows some registered health professionals (such as radiographers) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. Doses and strengths were recorded on the patient’s radiology records.

Radiographers trained in intravenous (IV) cannulation, were authorised to administer specific IV drugs and contrast media in the CT scanner. The radiographers watched a television monitor to check for signs of extravasation (when IV injections burst a vein and the contrast leaks into the surrounding tissue). We observed staff recording contrast and dose info on electronic system.

According to the hospital medicines policy 'all pharmaceutical products must be stored in access controlled (secure key or automated) cupboards / drug refrigerators with the exception of: medicines incorporated into emergency kits e.g. emergency boxes, intravenous infusion fluids, sterile topical fluids, and medical gases. We found this to be the case in the scanning areas but not in the main x ray department where we saw an unlocked cupboard and there was no key available.
Incidents

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for diagnostic imaging.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in diagnostics, which met the reporting criteria set by NHS England from December 2016 to November 2017.

The breakdown by incident type for diagnostic imaging is detailed below:
- Diagnostic imaging incidents, including delay in meeting SI criteria (including failure to act on test results). With one (50% of total incidents)
- Screening issues meeting SI criteria with one (50% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Incident management in the diagnostic imaging department was poorly developed. We were told ‘we don’t get many’ and ‘we don’t even get minor patient related incidents’. In contrast to this, we were also told ‘However, patients never come down from the wards with their notes, but staff manage this themselves, but do not record it on the incident reporting system.’

We were told that incidents were not discussed with staff generally.

We were told about two serious incidents reported in 2017 one of which was a radiation incident reported under IR(ME)R.

The first occurred within the ultrasound service; the report identified the failure by one of the sonographers to recognise a serious clinical event and escalate accordingly. The subsequent investigation and actions were thoroughly carried out; and identified a number of organisational contributing factors. The ensuing recommendations formed an action plan and arrangements for sharing stated that; ‘Trust to share summary of findings regarding this review with other diagnostic disciplines so that similar questions regarding quality assurance of diagnostic modalities can be considered.’

The second incident related to misidentification of a patient:

The Operator failed to undertake the complete identification procedure and as a result, the wrong in-patient was x-rayed. Later that evening, the error was identified and the correct patient was x-rayed. The patient who received an unintended abdominal x-ray had recognised learning difficulties.

We were provided with the investigation report for this incident, which included just one recommendation ‘All staff are required to re-read and sign off knowledge and acceptance of the IR(ME)R procedures’

The ensuing actions were ‘The radiographers in question have been reminded that it is their
professional responsibility to ensure the correct patient ID prior to imaging as per IRMER procedures, and not to assume correct patient will be necessarily brought to department.'

At the time of our inspection, we asked seven radiographers of mixed grades in the general imaging area about learning from serious incidents and none of them were able to tell us about any serious incidents. In particular, they were unable to recall anything about any incident involving an unintended exposure of a patient in their department and thought perhaps 'it must have occurred in CT.'

We saw the most recent annual radiation protection audit undertaken by the radiation protection advisor (RPA) for the service (October 2017). The report documents that there was no single forum for sharing learning from errors and incidents. The report also identified that 'incidents under IRMER are reported using paper slips (for near-miss referral errors) and electronically for actual incidents. This is acceptable but is not generating as many incident reports as would be expected.' This suggested there was under-reporting of incidents under IR(ME)R.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. The trust had a ‘Being Open Policy’, which incorporated the details of DoC, but did not require that training for clinical staff was mandatory.

The diagnostic imaging service had a procedure for reporting a radiation incident of accidental radiation overexposure to a patient; this document does not refer to the DoC. The report, which followed the misidentification of a patient, did not refer to the DoC either. There was no reference to training for staff relating to the DoC. We were not assured that staff would recognise when the DoC would be triggered; we were not made aware of any local arrangements in place for ensuring that patients were kept informed of incidents, investigations, or their outcomes.

Is the service effective?

Evidence-based care and treatment

The service was subject to the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. We saw local policies reference this legislation and guidance.

There was a named radiation protection advisor (RPA) whose role was to advise on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R regulations.

The report of the RPA undertaken in October 2017 identified that there were infrequent and scattered audits carried out to assess the implementation of IR(ME)R. Audits for non-medical referral activity, ID checks (as part of privacy and dignity audit) and reject analysis were identified. This was insufficient to demonstrate assurance of compliance in this area. They recommended a regular audit programme covering all IR(ME)R procedures was required.

We saw an internal quality audit programme for 2017, but when we asked for them, the service failed to provide any completed audit reports.
National diagnostic reference levels (DRLs) were displayed in the imaging areas. DRLs are typical doses for examinations commonly performed in diagnostic imaging departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly or when the technique is poor. Staff audited radiation dose levels and we saw evidence of this. The radiation protection supervisors (RPSs) were aware of the new radiation safety legislation due to take effect in 2018 and the necessary steps to take for compliance. Relevant standard operating procedures were available for all imaging tests and the department provided a number of protocols that were in use following our inspection. However, these did not refer to any evidence base or pathways based on national institute for clinical excellence (NICE) and Royal College guidelines. Protocols and systems of work for activity in the MRI scanner were particularly detailed.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. The imaging department was located near to refreshment outlets, but during our inspection, we did not see any patients waiting for long periods, that may require food or drink during their time in the department. We saw data from the 2017 ‘patient led assessment of the care environment’ (PLACE) scores for food/hydration for the whole hospital, but not a specific score for the diagnostic imaging department; this was in line with national average at 89%, which meant that 89% of people asked were happy with this provision.

**Pain relief**

Pain relief (analgesia) and local anaesthetics were available for patients who needed this during procedures. In interventional radiology staff monitored patients’ requirements for pain relief and would administer pain relief on the occasions it was required. Interventional radiology is a medical sub-specialty of radiology using minimally invasive image-guided procedures to diagnose and treat diseases.

**Patient outcomes**

The service had not always monitored the effectiveness of care and treatment in order to use the findings to improve patient outcomes.

At the time of our inspection, the imaging department had begun working towards gaining Imaging Services Accreditation Scheme (ISAS) accreditation. ISAS auditors carry out checks on the quality of the service provided and instigate continuous improvements to ensure patients receive a high quality service. The service manager had appointed a quality manager to support this work and they envisaged that they could be ready within approximately 18 months.

There was no evidence that the department participated in local audits, national audits, benchmarking or peer review.

Radiologists held discrepancy meetings on a regular basis, reviewing imaging reports. These complied with the standards from the Royal College of Radiologists for Learning from Discrepancies meetings (LDM). Radiologists and registrars attended these meetings where discrepancies in reports were subject to discussion. They said that good open discussion took
place, data was anonymised, and meeting records held. The hospital provided discrepancy-
meeting notes for the ultrasound service only.

We saw some evidence that radiography staff collated data for reject analysis. Sometimes a
radiographer finds that an image they have taken is unusable and has to be taken again. Reject
analysis looks at the percentage of reject images for each body part and type of image. This is
used to learn lessons and improve technique and to reduce the reject rates in future. It was not
clear what outcomes or learning staff in this department achieved as a result of the data collection.

**Competent staff**

From October 2016 to September 2017, 41% of staff within the diagnostic imaging department at
the trust had received an appraisal, not meeting the trust’s target of 100%.

All staff administering radiation were appropriately trained to do so. Those staff that was not
formally trained in radiation administration were adequately supervised in accordance with
legislation set out under IR(ME)R.

The radiation protection advisor reported that operators and practitioners had documented training
records, which cover continuing professional development. However, they reported that this was
not adequate, as they did not fully describe the competency of individual staff in each area. They
recommended that a training matrix describing broad areas of practice against staff names be
used to track which staff can carry out which duties under IR(ME)R.

New staff were expected to go through the comprehensive induction programme; this ensured
they gained competencies for their job role in all modalities of diagnostic imaging.

Continual professional development was promoted in the department; one member of the
radiography team had undertaken a further degree in acute clinical care to support the
interventional radiology work and there were a number of radiographers trained or in training for
reporting competence.

Junior staff told us they were well supported by the senior team and they had good opportunities
to gain competencies in a broad range of examinations.

Radiology department assistants (RDAs) were utilised in the x-ray department. These members of
staff did not have a degree in diagnostic imaging, however had undergone relevant training in the
department practice, and told us they were very much integrated into the team of qualified staff.
A student radiographer told us that placements in this department gave her better opportunities to
see a wider range of procedures than they did in other departments where they were placed.

The trust had a policy not to report inpatient or outpatient plain films. Radiologists were not
reporting on these images unless specifically requested to do so. This meant that the images were
seen and reviewed by the referring doctor. We were not assured that non-radiologist reviewers
were competent to review images as they may have had limited radiology training. We were not
aware that there was a program in place to audit non-radiologist image reviews.

**Multidisciplinary working**

Staff in different teams worked together to benefit patients. Doctors, nurses and other healthcare
professionals supported each other to provide good care.
Radiologists were fully participating in cancer multidisciplinary team meetings (MDMs) except for gynaecology; though there was not enough capacity for cross cover each other during absence. The physical footprint of the imaging department was small, but there was a sense of silo working, with standards of practice in the CT and MRI areas evidently more disciplined. We saw good team working between radiographers and radiologists in the mammography unit. There was a multidisciplinary one-stop breast clinic, where patients could access consultations, diagnostics, results and clinical nurse specialists in one appointment. There was evidence of good working relationships between the imaging department and the radiation protection team who were located at another NHS trust on the mainland.

**Seven-day services**

The service generally made sure patients had access to the main diagnostic services seven days a week.

A full diagnostic imaging service was available between 9am and 5pm Monday to Friday excluding Bank Holidays, with some services available into the early evening. For example, staff operated the MRI scanner between the hours 8am and 8pm daily and on Saturday mornings. An out of hours emergency service was available 24 hours a day, seven days a week for x-ray imaging and CT (Computed Tomography) scans. CT reporting outside of the main department opening hours was outsourced to an external company.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The department provided data for the numbers of radiographers accessing training in the Mental Capacity Act 2005. This data identified five eligible members of staff, of which four had completed the training. It is not clear why so few radiographers were expected to complete this training. No data was provided for other staff in radiology. We observed staff discussing procedures with patients and taking verbal consent for procedures. Patients we spoke with told us they knew what procedure they were having and that staff always asked for consent before proceeding.

Deprivation of liberty training data was not provided by the trust.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff showing kindness, compassion and appropriate humour during patient interactions. There was a good sense of caring and staff were motivated to deliver patient centred care.

We spoke with three patients attending the department during the inspection. They were all positive about the care they had received. We were told that the staff were very kind and friendly. One patient told us they always had a good experience whenever they needed to attend for x-rays.

Patients at reception were spoken to respectfully and dealt with efficiently; staff at reception greeted all patients well, and we observed staff informing patients if there was a delay in their appointment.
Patients told us that the information they received about their appointment was good, so they were aware of what to expect when arriving. Results of the National Cancer Patient Experience Survey published in July 2017 showed that 91% of patients at this trust received all the information they needed about the test, compared with 94% nationally.

There was limited confidentiality around the reception desk where reception staff asked patients their name, date of birth and address in front of other visitors.

Results of the privacy and dignity scores from the 'patient led assessments of the care experience' (PLACE) for 2017 showed that the 77.6% of people attending the hospital, when asked said that they felt they were treated with privacy and dignity, this reflected the national picture but we did not see a specific score for the diagnostic imaging department.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Patients told us staff were professional and supported them well to minimise their distress. This was particularly true in the MRI scanning unit, which some patients found claustrophobic and noisy, and staff had to reassure them constantly. Staff had good awareness of patients with complex needs and gave examples of how they would deal with individuals presenting as anxious or with challenging behaviour.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. Patients felt involved with their care and knew what to expect.

We spoke with one patient and their relative who said they were well informed about their care. This was particularly evident in mammography where some patients were on the two-week pathway and had symptoms of disease. 79% of patients said they were given a complete explanation of the test in the National Cancer Patient Experience Survey published in July 2017, which was in line with the national score. Staff explained results in an understandable way, ensuring patients understood the procedures, and could make informed decisions about their care.

We observed staff communicating in a way that people could understand and was appropriate and respectful.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people.

All of the diagnostic radiology areas provided an extended day, on-call and/or a seven-day working pattern. This enabled patients to be seen at times to suit their needs.

Additional evening and weekend sessions were set up to manage demand. The imaging department was located very close to the emergency department and offered a 24-hour service for them.

Patients received clear appointment letters, explaining the purpose of their diagnostic test, what they needed to bring, and how they needed to prepare. All of the patients we spoke with told us they received useful information to help them plan their visit.

The interventional radiology (IR) service was limited; complex procedures were referred to larger departments on the mainland.

The department offered a walk in service for general radiography and dental imaging.
There was a variety of style of chairs within the waiting areas to cater for a range of needs. Complex paediatric cases requiring radiology were referred to the specialist unit at another NHS acute trust.

**Meeting people’s individual needs**

The service took account of patients’ individual needs.

The trust used a telephone interpretation service for language translation. Staff told us they used this, and did not ask family members to translate. They also had access to qualified interpreters.

We were told that the trust used their own ‘My life, a full life’ passports and ‘This is me’ booklets to better understand the specific needs of patients living with dementia. We did not see any patients in the imaging departments with specific needs during the inspection, but staff were able to tell us of the support given for patients with a learning disability or dementia.

The patient waiting areas were cramped and not particularly person centred, with no separate area for in patients in their beds. This meant it was difficult to fully segregate male and female patients who had changed into hospital gowns while waiting for their examination.

There was a facility within the computerised radiology information system (CRIS) to flag specific need of patients such as those with a visual impairment or learning disability. This helped staff ensure they had the capacity to support such patients more fully.

Staff told us that they had never been asked to provide a chaperone, but felt that they were able to accommodate such a request with the support of the wider team, should this be required.

There was a broad range of written information available to patients about diagnostic imaging procedures and aftercare. For example ‘Examination with Barium Contrast A: Barium Swallow’, ‘after computerised tomography (CT) (With contrast)’ and ‘having an Ultrasound Scan of the Kidneys and Bladder.’ We were not aware if any leaflets were available in other languages.

**Access and flow**

**Patients could access the service when they needed it.**

**Diagnostic waiting times (percent waiting 6+ weeks)**

From September 2016 to August 2017, the percentage of patients waiting six plus weeks to see a clinician was lower (better) than the England average for 11 out of the 12 months. From May 2017, the percentage of patients waiting six plus weeks progressively increased from 0.0% to 2.3% in August 2017 and to 2.9% in September 2017. This score in August 2017 was similar to the England average. Despite this increase in recent months, the trust performed on average better than other trusts for this 12-month period. From May 2017, however the wait for diagnostic imaging tests is increasing and presenting a trajectory, which is higher (worse) than the national average.

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This Trust England Avg.
Their GPs, hospital consultants and other practitioners such as nurse practitioners referred patients to diagnostic imaging services. The administration team on the departments’ designated system made all appointments. Patients could call and change the appointment if required in each of the imaging modalities.

The most recent national data available to us, provided by all trusts, showed that patients waiting over six weeks for a diagnostic imaging test in this radiology department scored worse (2.9% waiting more than six weeks) than the national average (2.0% waiting more than six weeks) as at September 2017. This was an increase on the percentage of patients waiting for the same tests in September 2016, which was 0.5%.

The diagnostic imaging service did not monitor how long patients waited for examinations once they arrived in the department. However, during our inspection we saw patients did not wait long before they were called in to see the clinician for their appointment. The staff told us however, that days when there was a fracture clinic-taking place, this did affect the rest of the service and wait times in the department increased. They did not formally monitor this.

**Report turnaround times**

The trust detailed the performance indicators for report turnaround times within the ‘Imaging examinations, policy for the requesting, justification and reporting of’

We received data from the trust detailing the local key performance indicators (KPIs) for report turnaround times set out by modality:

<table>
<thead>
<tr>
<th>Modality</th>
<th>In Patients</th>
<th>Outpatients</th>
<th>Emergency Department</th>
<th>GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT and MRI Reporting turnaround times for:</td>
<td>24hrs</td>
<td>10 working days</td>
<td>12 hours</td>
<td>10 working days</td>
</tr>
<tr>
<td>Plain film Reporting turnaround times for</td>
<td>immediate clinical assessment to notify clinician that a Radiologist report will only be generated if requested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 working days</td>
<td></td>
<td>10 working days</td>
<td></td>
</tr>
<tr>
<td>Fluoroscopy reporting turnaround times for</td>
<td>24hrs</td>
<td>10 working days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients</td>
<td>10 working days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In order to mitigate the risk of delays to image reporting, the trust outsourced some reporting to an external company. The percentage of the total examinations outsourced was 12% (01/04/2017-31/10/2017)

- Routine = 9%
- OOH = 3%

Qualified radiographers supported reporting of images:

- 0.4 WTE reporting radiographer for cold plain films
- 0.4 WTE reporting radiographer for cold MRI

We were told that there were two reporting radiographers in training 2017/18 with two more to follow in 2018/19 to facilitate 7 day hot reporting GP and emergency department plain film; and a business case to increase necessary radiographer backfill to support the reporting radiographers is being reviewed by the organisation.

The hospital reported that as at November 2017, there were 552 unreported examinations but these were within local KPI's. There were also four MRIs in patient examinations outside local KPI of 24 hours and one plain film chest examination outside local KPI

**Learning from complaints and concerns**

From October 2016 to September 2017, there were four complaints about the diagnostic imaging service. All four complaints were closed. The trust took an average of 24.5 working days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints. No complaints took over 45 working days to close.

A breakdown by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>2</td>
</tr>
<tr>
<td>Admissions and discharges excluding delayed discharge due to absence of a care package</td>
<td>1</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Staff told us that they receive very few complaints, which meant they were able to deal with them quickly. For example, one patient complained about the cleanliness in the toilet so staff were able to get a cleaner to attend to this straight away. When complaints were received the team enlisted the support of the PALS team where necessary and the service manager told us that feedback was given to the specific clinical team involved and share with the wider team at monthly team meetings. Staff we spoke with were unable to tell us about any complaint they had received, and patients we spoke with were very happy with their care.
Is the service well-led?

Leadership

Diagnostic imaging sat in the ‘clinical support business unit’ (CBU) within the trust.

The leadership team were well established. The service manager had been promoted to the post four months prior to our inspection but had been the lead radiographer for general imaging prior to that for a number of years. The previous manager had taken a promotion and maintained a higher-level business unit role with continued responsibilities for the radiology service. The clinical lead radiologist had been employed at the trust for ten years; he told us that he felt well supported by the clinical lead for the business unit with whom he had an established working relationship. The clinical lead had not met the trust chief executive who had been in post for nine months.

The service manager had embarked on the process for Imaging Services Accreditation Scheme (ISAS) accreditation and seconded a quality lead to the department to lead on this process. This was designed to provide a structured process for developing and establishing quality improvements. However, during our inspection we observed some frustration amongst staff in general X-ray who were keen to engage with the inspection and were frustrated by the reorganisation of electronic files in preparation for ISAS, which meant they were unable to locate documentation, which supported their work, for example hand hygiene audits, patient identification check audits.

The team of radiologists was small and under established, but they continued to attend most of the multidisciplinary meetings (MDMs) and provided continued support to their non-radiology medical colleagues for image reporting whilst supporting the radiography team to develop reporting skills.

The clinical leads for the CT, MRI, and Breast Imaging were established leaders that provided clinical and professional leadership by supporting and appraising junior staff and we saw evidence of their leadership skills during our visit. We saw they ensured that processes and procedures were in place to keep people safe, and protocols had been developed to support the provision of evidence based practice. All the imaging leaders were visible during our inspection and staff told us that they felt well supported by them.

At the time of our inspection, the service manager was also leading for the outpatient service.

Vision and strategy

We did not see a formal written strategy for the diagnostic imaging service. At the time of the inspection, the diagnostic imaging service was primarily focused on managing demand and working towards accreditation; staff we spoke with understood this. A strategy was in place to manage any image reporting backlogs by outsourcing, though we were told that this was costly and unsustainable. We saw evidence that the department was proactive in the future planning and development of radiographers. This was particularly notable in the area of radiographer reporting and advanced practice.

Culture

Staff, throughout the department were confident about the service and care they provided for patients. They told us that a high quality of service and good patient experiences were their priorities. Student radiographers we spoke with echoed this. We observed staff were considerate,
helpful and unhurried in their interactions with patients. Staff ensured patients understood the procedure they were undergoing and explained each step before it was carried out. However, staff worked in cramped conditions, which was a particular concern because of the lack of space for optimum patient confidentiality and patient dignity. In each modality, we observed that staff supported each other and established staff and junior staff interacted well with the radiology team.

Most staff told us they felt respected, valued and were treated fairly, with equal opportunities for training, development, and career progression. However, in one area staff told us that they felt that the chronic shortage of radiologists had resulted in a lack of direction and leadership from the available radiologists.

Almost all the staff we spoke with felt there was a positive working culture and a good sense of teamwork. They said that when the department was busy, they were flexible and kept the service functioning as smoothly as possible. Staff felt involved, and were keen to improve systems and processes to ensure patients received the best care and most established staff took on lead roles, for example in developing the IT systems; infection control; personal protective equipment audit.

Staff said they supported each other and that the manager and consultants were supportive. They also said the lead radiographers were hands-on and staff felt well supported by them. Student radiographers were positive about the training they had received; they felt part of the team, and they were exposed to a wider range of learning opportunities than at other training placements. They told us they would apply to work in the department should the opportunity arise.

Governance

The service did not have a robust or systematic approach to continually improving the quality of its services and safeguarding high standards of care. The trust had introduced reviewing of some images by non-radiology clinicians, but we did not see evidence that the guidelines issued by the Royal College of Radiologists (RCR) were followed; as there was no training programme in place to ensure that non-radiologist reviewers were competent to undertake the role. The issues surrounding the safety of this change were not audited.

There were twice yearly meetings of the hospital radiation protection committee (RPC) which were attended by the radiation protection advisor (RPA) for the service and by the local radiation protection supervisors (RPSs). The committee’s function was to have oversight of compliance against a number of radiation protection legislations. The lead radiologist for radiation protection chaired the meetings, which were attended by the hospital assistant director for health safety and security. These were deemed productive meetings and actions for service improvement, and quality assurance were identified.

We saw from minutes that the service manager (or one of the modality leads) attended the quality and safety committee; we were told that issues from that committee were escalated to the trust safety committee.

We saw minutes and actions relating to the monthly radiology quality meetings, which were attended by the service manager and the lead radiographers for each modality. Many of the actions were still outstanding from July 2017. We were not assured that these meetings were effective.

Minutes of the breast-imaging unit were made available to us; we saw that all quality governance and risk issues affecting this unit were discussed and actions carried out. However, the roles of the attendees were not identified so it was unclear to us who attended the meetings.
Management of risk, issues and performance

The service was not managing and monitoring the service effectively to drive improvement or to mitigate risks to patients.

Leaders of the service did not ensure that they shared learning from incidents throughout the service. Similarly, leaders did not promote recording of ‘near misses’ which meant that learning opportunities were not seized.

Service leads did not gain assurance about the overall quality of the service. We did not see a comprehensive audit programme for the service that focussed on the legislation requirements of IR(ME)R. We saw that data was available from the CRIS for audit and service improvement purposes, but we did not see any documented audit activity with conclusions and outcomes. Again, this meant opportunity to improve the service may have been lost.

The service manager told us that a local risk register had been developed in 2017 from a departmental issues log; they said that the old issues log had transferred to the clinical business unit issues log. The trust provided the current risk register for the whole hospital; we did not see a department risk register; we not assured that there was a dynamic local risk register in place to manage and mitigate issues of concern.

We saw that environmental risk assessments had been developed in January 2018 for imaging rooms. These did not detail the specific hazards for the area or the potential risks to staff and patients.

The trust had introduced reviewing of images by non-radiology clinicians for in-patient and outpatient plain film images, but had not followed the guidelines issued by the Royal College of Radiology (RCR). They had not arranged the necessary training programme and had not assessed the competence of individual clinicians to review particular kinds of images. The issues surrounding the safety of this change had not been audited.

We were told that the radiologists were unhappy with the quality of the outsourced reports; however, this did not appear on any meeting notes that we saw. There was no evidence that the quality of these reports were benchmarked against the in-house quality of reporting. We did not see the shortage of radiologists on the hospital risk register or the impact that had on patient safety.

Leaders had recognised and responded to the risk of delayed reporting due to the shortage of radiologists. A development program was in place to upskill two further radiographers to undertake some film reporting; this will support the two already in post and relieve some of the workload of the stretched radiologist team.

Information management

The service did not consistently collect, analyse, manage and use information well to support all its activities.

We did not see evidence that a performance dashboard was in place to measure performance. At the time of our inspection, we were not assured that documents within the imaging department were well managed. The service was working towards ISAS accreditation and had begun changes to the electronic drive where team documents were stored. This was a well-intentioned plan to re–
organise working documents, audit forms and other procedural documents; but implementation was poorly managed, which meant staff struggled to find documents when they needed them.

We saw that patient information leaflets for patients relating to their imaging procedure were stored on the hospital web site. These were reviewed and updated by the modality lead radiographers.

**Engagement**

Some areas of the diagnostic imaging department encouraged patient feedback on the service they received. Surveys were not consistent throughout the department, but we did see that the majority of comments were positive and particularly complimentary of the staff. Feedback to staff was via e-mail, or through the recently introduced 10-minute team briefings.

We saw examples of some of the changes made further to patient feedback; such as introducing “scrubs tops and bottoms” rather than just open back gowns; curtains to separate those patients who have changed into gowns from those who have not and created a new fast check in area for ED, inpatients and those coming with patient transport.

The service manager told us that staff were encouraged to feedback good practice to their colleagues following attendance at regional or national meetings. Staff were offered opportunities to develop skills that enabled them to enhance the service provision to patients.

**Learning, continuous improvement and innovation**

The service manager had seconded a quality manager to the department in order to commence preparation work towards achieving ISAS accreditation.

The lead radiographer in the CT scanner offered open access for brain imaging, which meant that patients requiring this service did not have to travel to the mainland.

The team in the CT scanner were working towards improved access to patients who have had an allergic reaction to contrast media; these patients were not able to have more contrast media, so the whole referral pathway was under review.

The clinical lead was working with local GPs to improve the referral pathway for patients with suspected prostate cancer by allowing direct access to MRI scanning. The clinical lead suggested that this would reduce the pathway for these patients by ten days.

We saw examples of innovative practice. For example, role extension for non-medical staff was abundant in the imaging department. As well as reporting radiographers, one radiographer had trained in acute nursing care in order to support the care of the patient undergoing interventional radiology procedures. Similarly, one of the radiologists had developed a flagging system whereby all suspected cancers were identified quickly and referred to the next MDM.
Community health services for adults

Facts and data about this service

Community services for adults within the Isle of Wight were provided over three localities; West and Central Wight, North and East Wight and South Wight. The aim for these services was to support people to stay healthy, manage their long term conditions, avoid hospital admission, promote independence and support them following discharge from hospital.

The services provided included:

- District nursing
- Community nursing teams
- Community therapists
- Podiatry
- Diagnostic and rehabilitation clinics
- Clinical nurse specialists
- Phlebotomy
- Chronic pain
- Tissue viability
- Orthotics
- Podiatry
- Crisis response team
- Single point of access for rehabilitation
- Speech and language therapy

During this inspection we spoke with 89 members of staff, 31 patients, 21 carers and relatives and reviewed 17 patient electronic and paper records.

We visited numerous locations across the three Isle of Wight localities including the community nursing hubs, patient homes and community clinics.
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff, however not all staff in community adult services had completed them.

The trust set a target of 85% for completion of mandatory training and their overall training compliance was 72.4% against this target.

Following our last inspection in 2016, there had been a decline in the staff completion of mandatory training, in 2016 the compliance rate was 84%

A breakdown of compliance for the 30 mandatory courses between April 2017 and June 2017 for medical/dental and nursing staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Resuscitation</td>
<td>70.6%</td>
</tr>
<tr>
<td>Adult Resuscitation - Non-Clinical Staff</td>
<td>73.8%</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>87.0%</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>76.7%</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>74.9%</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>99.5%</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>93.2%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>88.5%</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>89.7%</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>79.8%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>62.1%</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>81.0%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>77.9%</td>
</tr>
<tr>
<td>Information Governance: A Beginners Guide</td>
<td>100.0%</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>79.3%</td>
</tr>
<tr>
<td>Load Handling</td>
<td>78.3%</td>
</tr>
<tr>
<td>Load Handling e-Learning</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>66.7%</td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>11.1%</td>
</tr>
<tr>
<td>Medicines Management - Maths &amp; Medicines Calculations</td>
<td>66.7%</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>8.9%</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>26.8%</td>
</tr>
<tr>
<td>People Handling</td>
<td>88.7%</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>69.6%</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>51.8%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>83.4%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>91.7%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>66.5%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>31.7%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td></td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>96.3%</td>
</tr>
</tbody>
</table>
The training was delivered by face to face in a classroom environment or by an online facility. Of the 20 non-compliant courses, most concerning were the extremely low compliance in medicines competency assessment at 11% and Mental Capacity Act at 8.9%. This could mean that nurses were administering medicines without being assessed as competent, and some nurses had no up to date knowledge of the Mental Capacity Act and its implications on their practice. The compliance of key staff who should be trained in safeguarding children level 3 was low at 31.7%, this may mean that signs of abuse may be missed, or appropriate actions not taken.

Some staff we spoke with, told us that getting time for training was problematic, with some stating they needed to complete it in their own time. Examples included mandatory and external training and professional updates.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, they were not always aware of when concerns had been raised within their team.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

As part of our inspection, we saw data evidence that safeguarding referrals had been made for the community teams. In the three months from November 2017 until January 2018 there had been 10 safeguarding referrals from various community services. In addition, we saw that community staff had also reported ten incidents relating to safeguarding between 1 January and 31 December 2017. Some of the staff we spoke with were not aware of any recent safeguarding referrals, although most stated that they were aware of the process and their responsibilities. This meant that the teams may not have been fully aware of potential risks to patients and were not always being updated when referrals were made.

There was a protocol for staff to follow if abuse was suspected; this included using the senior nurse on duty based at the integrated hub at weekends for advice and support.

The integrated hub flagged the patient’s record if they had a previous safeguarding alert. We saw how community teams worked together to provide the appropriate care of patients.

**Cleanliness, infection control and hygiene**

The service controlled most infection risks well. Staff kept themselves, equipment and the majority of clinic premises clean. However, they did not always use control measures to prevent the spread of infection.
Most of the community staff had received infection control training; the trust told us compliance against the trust target of 85% was 87% for blood borne virus training, 77.9% for infection prevention and control and 62.1% for hand hygiene training.

On inspection, we saw that community nurses observed ‘bare below the elbows’ to ensure effective handwashing. However, we observed clinic staff in one location to be non-compliant and wearing cardigans when undertaking clinical activities with a patient. Recent hand hygiene audits showed an average 77% staff compliance across all three localities.

We noted that staff used appropriate personal protective equipment (PPE) in the clinics and in the home environment. We observed good aseptic wound dressing techniques by the community nurses when in patients’ homes.

All clinic areas had sufficient hand washing facilities, and hand gels for staff and patients. Most clinic areas were visibly clean with disposable curtains changed appropriately every six months or when visibly dirty. However, there was some variation in the understanding of staff around whose responsibility the curtains were and the timeframes for changing them.

Following our previous inspection and our concerns being raised; an internal infection prevention and control (IPC) audit had taken place in all clinic locations. The audit had resulted in locality reports and action plans, most of which had been completed and detailed similar themes as we raised at our last inspection. Laidlaw clinic kitchen however, was found not fit for purpose as it had recently failed it’s IPC audit, and health and safety inspection. This was escalated to the community risk register in January 2018.

In some busy clinics, we saw there was no active cleaning between patients unless there was an indication of visible soiling or spillages. There were however daily cleaning checklists to provide assurance to the trust that daily clinical cleaning was now being undertaken.

**Environment and equipment**

The service had suitable premises and equipment and looked after the majority of them well. However, we were not assured that the community equipment was organised safely across all localities.

We visited the bases for community clinics in Ryde, Shanklin, Sandown and Cowes.

Since our previous inspection, the trust now had a planned annual preventative maintenance schedule to ensure that medical electronic equipment was regularly serviced and tested. We saw that in the community clinics, the majority of the equipment available was in date for servicing and safety testing which was an improvement from our last inspection.

Community nursing teams had recently had laptop computers issued, which enabled them to record patients’ records electronically. The senior team told us that the tablets were trialled by the staff before they were issued; the trust gave them out with protective covers and cleaning instructions. The community staff were also issued with individual ‘observation’ boxes which contained their equipment for patient monitoring, for example, stethoscope, pulse oximeter, and a blood pressure machine.

In all clinic areas there were resuscitation trolleys for emergency use, these contained both equipment and emergency medicines. The trolleys were not tamper evident, which meant there was a risk of equipment or medicines being removed and it not being obvious until an emergency. Clinic staff mitigated this risk by undertaking daily checks of the trolley. However, whilst we saw that most clinics checked the equipment and signed a booklet; they did not use a detailed itemised
checklist. The exception was one clinic area, where a non-clinical staff member was trained to check the trolley daily. Some areas also employed a draped clear plastic sheet, which meant that the sheet covered the accessible drawers. However, this may have caused delays in accessing life-saving equipment in an emergency.

The community patients could access equipment via two streams; the NHS integrated equipment store for larger items such as beds or bedside rails, pressure relieving mattresses or cushions. In addition, there was a Red Cross supplier for renting simple mobility aids such as toilet frames or walking sticks. There did not appear to be any delays in accessing equipment. There had been just one incident raised during 2017 due to a delay in accessing a pressure-relieving mattress over a weekend.

Community nursing staff told us that there were no bladder scanners for the community nurses to use to assess patients' bladders capacity prior to any interventions and prevent unnecessary re-catheterisation. We had raised this as a concern at the last inspection.

The crisis response team accessed urgent equipment from a small store located on the St Mary's site; the equipment was available to help support patients in the community to avoid an acute admission to hospital.

The local authority provided support to community patient from the independent living centre, which was based near to the St Marys site; occupational therapists were based there to provide advice and signpost patients to equipment and services to support them.

The trust had a housing and adaptation team which was a service funded by the local authority. This service triaged and organised accommodation adaptations or equipment requests to enable discharges or prevent admissions.

We found variation in the organisation of storage within the community nursing hubs. One hub was extremely disorganised and untidy with out of date sterile equipment still being stored, one item we saw was dated 2014. Other stock that was in date was stored with out of date clinical items, which meant there was a risk of them being used.

On our previous inspection in 2016 we raised concerns over the community equipment store and methods of storing clean and dirty equipment. On this inspection, we were told that the store was being managed independently and therefore we were denied access to inspect the premises. We noted that in a recent (December 2017) quality meeting the same issues were raised and not been resolved. These issues were not escalated to the community risk register.

**Assessing and responding to patient risk**

Staff completed risk assessments for each patient using a new electronic system. The staff had variability in their competence using the system and reassessments of patients' risks were not always taking place.

There was an effective method of receiving referrals into the community nursing team Monday to Friday 8 am until 4.30 pm. After 4.30 pm the senior nurse on duty was contacted and allocated the patients to the correct locality until 8.30pm. The out of hours cover was through the ambulance services that provided a paramedic or specialist practitioner.

Referrals came through an electronic system, which flagged any known home risks such as animals or difficult access, but was not able to flag any known safeguarding concerns. This meant community nurses could have undertaken home visits without knowing there were safeguarding concerns, which should have necessitated increased vigilance and observation and/or reporting.
There had been a new development in the community nursing teams; late in 2017, the trust introduced a new patient electronic record system, all new community patients were now on the system. We observed and staff told us that there was still variation in their understanding and its use across the localities. The new system incorporated most patient safety risk assessments and care plans; however, these were not all fully completed. The system was felt to be a potential improvement from our last inspection when patients’ risk assessments and records were found to be out of date or absent in many records. Most staff were still gaining experience in its use and we had variable feedback. Some nurses were concerned that reassessments of patient’s risks were not taking place in the new system.

Phase two of the records system roll out, was planned to incorporate continence care planning and further functionality relating to reporting trends. We saw that paper records were kept in patients homes for catheter care or self-management plans.

The community staff had also started to use the National Escalation Warning System (NEWS) for the prevention of deterioration of patients. This was a new paper recording sheet, which guided the nurse to actions or escalation depending on the patients’ observation score. These scores are the same as used in the acute trust so enables a clear understanding of the patient’s status if they needed eventual admission. Staff were aware of the link to identify SEPSIS by abnormal observations and we saw education posted in the community bases for both staff and patients. Community staff had personal ‘observation boxes’ of necessary equipment to ensure they could undertake patient observations when on visits.

The crisis response team provided a 7-day service between 8.30 am and 4.30 pm, with a four-hour response time. They provided for care or health needs and equipment for up to 72 hours to avert hospital admissions. The team consisted of nurse practitioners, associate nurse practitioners, occupational therapist, assistant occupational therapists and social worker. There was also a care coordinator, funded by a national charity to coordinate services for patients. The team were working closely with the new frailty team by trialling frailty scores. After 8pm, the community practitioners working from the hub monitored the patients, but there was a gap between 4.30pm and 8pm. The staff we spoke with were not aware of the changes in the community matron roles, the advanced clinical practitioner role and the impact on the patients.

At our last inspection, we raised concerns that fasting diabetic patients attending the community phlebotomy clinics were not being prioritised over other patients. This was so they could resume their normal diet as soon as possible as they may be taking insulin. We saw that this was still not happening despite the clinical risk to the patients.

The Isle of Wight health providers used various electronic patient record systems in use, unfortunately, they were not all accessible to all staff and they did not communicate with each other. For example, the acute trust used one system, which was different to the community, social services another, ambulances another. The lack of integrated records meant there was a risk that information could missed, particularly if a patient’s condition had worsened and they entered a crisis episode of ill-health.

At the previous inspection in 2016 the community matrons and the CNS teams utilised up to 20 telemedicine kits to monitor patients with various long term conditions remotely. CNS staff told us they were using about five with chronic obstructive pulmonary disease and heart failure patients. The CNSs had discovered that the patients became dependent upon them, which made it difficult to withdraw them.
There was one community matron who was based on site at St Marys who oversaw the telemedicine in use with 15 other patients. There was sufficient equipment for the support of up to 17 patients.

Staffing
The service had recruited more staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, there were still vacancies and some newly appointed staff without the necessary skills and experience for their roles. We were not assured that all rota gaps were adequately covered by temporary staff to keep patients safe.

Vacancies
Between October 2016 and September 2017, the trust reported an overall vacancy rate of 15% in community services for adults.

When we inspected, the community nursing team’s vacancies had further reduced to 8.1% across the three localities, which was a big improvement. In December 2016, the vacancies for community nursing were at 21%.

The total number of budgeted whole time equivalent (WTE) staff for the community adults’ team in September 2017 was 208.13 WTE, a reduction of 26 WTE from the previous year. The actual number of staff employed were 192.9 WTE which was a 16 WTE under establishment (or a gap of approximately 80 shifts per week) against the budget.

The reduction in WTE equated to a similar reduction in stated vacancies.

Turnover
Between October 2016 and September 2017, the trust reported an average turnover rate of 0.6% in community services for adults. The trust experienced 22.07 WTE staff leaving the community services for adults’ teams.

Teams stated that many senior staff had migrated to island GP practices, which had left a skills gap.

Sickness
Between October 2016 and September 2017, the trust reported an average sickness rate of 7.1% in community services for adults.

We could see from the previous twelve weeks off duty rotas, prior to the inspection we reviewed that some localities had a number of absent nurses due to sickness. The locality with the highest number of sickness shifts of 129, which correlated with the highest number of temporary nurses allocated. However, one locality lost 113 shifts but only had 24 shifts of temporary staff allocated. In total 268 shifts were lost through sickness during the twelve-week period, only partially covered by the 138 (51%) shifts of temporary staff. We were not assured that the risk of staff sickness was being appropriately managed to reduce the impact on patient care.

Nursing – Bank and Agency Qualified nurses
The data that the trust provided means that the bank and agency, and locum usage, cannot be calculated.

However, we reviewed the locality off duties for the previous twelve weeks prior to the inspection. We could see that the localities used 138 shifts for temporary nursing staff and 67 administration shifts during this time. The locality without a permanent administrator role used 59 shifts to cover the gap. One locality used far more temporary nursing staff (78 shifts) than the other two but the need had reduced as staff returned from absence and new staff joined the team.

Caseloads

From September 2016 until August 2017, the community nurses had on average caseload (visits per day) of 18 patients per nurse. The three localities had active caseloads in October 2017 of 295 for South Wight, 350 for North East and 411 for West and Central.

A visit from the Emergency Care Intensive Support Team (ECIST) last November signposted the teams to the new National Quality Board (2018) resource on community staffing, which the teams were due to start in March 2018.

Previously when we inspected there were locality based community matrons (CMs) in post, who held a caseload of 30 complex patients each. The posts were now divided between 4.8 WTE community matron posts and new advanced clinical practitioners (ACPs) with a different remit around admission avoidance. The CMs continued to manage a variable case on a day to day basis of complex or chronically ill patients and those they were case managing for continuing health care funding.

The community teams were using an excel spreadsheet for the allocation of patients to community nurses and there was a dependency scoring tool based on nursing time units, this was no longer in use as the new EPR provided this. This meant that patients were not lost or care doubled up as was happening previously, and was an improvement. Whilst it was still early in its adoption, staff told us that there had been no incidents relating to ‘missed’ patients since it was rolled out.

There was an escalation response plan in case of short staffing, excess patient referrals, or extreme weather. This plan held the details of staff actions to support the community patients based on prioritisation and risk.

The clinical nurse specialists (CNSs) that we spoke with supported people living with long term conditions in the community. They described a huge workload, which had increased since the changes in the community matron role. Their caseloads varied between 80 per WTE and up to 500. Some of them had access to electronic systems, some not, the lack of admin support for some made it difficult for them to engage with consultants or inpatient teams.

Quality of records

Community staff kept records of patients’ care and treatment on the new electronic system. There was variability in their completion as some staff struggled with the technology. Other community records, for example the rehabilitation team were paper based and very detailed. Electronic record systems in use on the Isle of Wight did not all talk to each other creating issues for the staff caring for the patient.

At the previous inspection in 2016 the community patient records were identified as a concern. We saw that since the inspection, senior nurses have undertaken documentation audits in the
localities to encourage improvements. The results were variable, with no sustained improvements seen.

In November 2017, the trust rolled out an electronic patient record (EPR) into the community teams. The trust gave each nurse two hours initial training on its use, and encouraged them to learn from other colleagues. Staff told us there were no identified super users yet, and consequently there was variation in the expertise and the confidence of staff using the system. Many staff told us that they felt under pressure and anxious as their level of IT skills had been over assumed. Staff felt support available was lacking.

Staff raised their concerns that team leaders needed to log both new patient referrals onto the system as they were received and all past patients by the end of March 2018. This was a huge pressure and meant they were not available to provide clinical support.

The inspection team watched the staff using the system and looked at the electronic records being created; there was variation seen in its use. However, the system had only been in use for a number of weeks and it was felt to be too soon to assess its effectiveness. The senior team told us that the system incorporates risk assessments, consent, care plans and access to protocols and NICE guidance. Most nurses indicated that they needed further training and their seniors acknowledged this. Staff we spoke with told us that new starters were embracing the system with more ease as they had used it before or were more computer literate. All staff however, told us they were ‘really pleased’ that the GPs could now access their new EPR as this would improve communication and patient care.

Some parts of the patient record were still on paper, for example the NEWS record and some specific care plans such as continence and catheter care. We reviewed the audit results of the catheter documentation; they were not all completed, but those that were showed 79% compliance. There were actions for improvement but no recent audits to check back to assess if improvements had been sustained, completing the audit cycle.

The CNSs told us that in general, they used a mixture of electronic and paper records; some paper records were scanned into the trust system. The CNSs could not all access the new community EPR but some could read and some could access the trust system.

The single point of access for referral, review and coordination service (SPARRCS) told us that they did not have an EPR. When SPARRCS received a patient referral for rehabilitation, they had to interrogate four different IT systems to ensure that they had a thorough history. The team then documented assessments and record of actions using word documents saved as PDFs. The team told us that their IT issues were escalated to their local risk register. Senior staff showed the inspectors the considerable paper record archives stored in locked cupboards within their department.

The staff we spoke with told us that when the rehabilitation team was supporting a patient in a nursing home, they were given a comprehensive set of records in a red folder for the home staff to use. When the team discharged the patient, the paper originals were archived in the record store in their department at St Marys.

Within the localities the teams were in the process of archiving their previous notes, we saw chaotic storage within some localities. We were therefore not assured, that patient records were protected and kept secure in these environments. In one locality team base, we found one set of patient records mixed with another. We saw from recent meeting minutes that there were 55 boxes of notes awaiting storage from one locality and that storage had been recently sourced.
Medicines

The service had improved its practice when prescribing, giving, recording and storing medicines since our last inspection. However, there were multiple reported errors relating to insulin administration and only 11% of staff were assessed as competent in medicine administration.

At the previous inspection in 2016, we raised concerns that there were no specific medicines policies related to the community. On this inspection, the trust had introduced a number of standard operating procedures (SOPs) in 2017. These included for example, ordering, prescribing, administration and the management of medication errors.

The trust had written the new SOPs clearly, they gave instruction to various practitioners such as community nurses and non-medical prescribers in their responsibilities within medicines and safety. Staff felt they were a good resource.

The community nursing teams did not routinely store medicines in their hubs; any patient’s own medicines were stored within their homes.

Many of the community nursing staff we spoke with raised concerns about the introduction of a new medicine administration record (MAR) for the community. Nurses described feeling worried about the process of ‘reconciling’ prescribed medicines onto the chart from various named sources and being counter signed by another nurse. We are assured that this process is permitted provided the original source is attached as per directions within the SOP.

The MAR however was designed for one medicine prescription per sheet, and to last for up to 3 weeks. Staff we spoke with described multiple pages to look through when the patient was having many medicines, which they felt was a potential risk of error. Although the trust SOP stated that completed or discontinued forms should be archived, there were not clear instructions as to where or when this should be done. For example, when the patient was discharged as part of the whole record or sheet by sheet when there may be a risk of loss from the main records.

We reviewed the reported medicine errors between 1 January 2017 and 31 December 2017 of 40 reported there were two errors, which had links to the new MAR chart. However, there were 28 incidents (70%) involving missed doses of insulin for various reasons. As the medicines competency assessments were at 11.1% completed, there may be a direct correlation between the two.

The new MAR form did expect both a signature and printed name and designation, which is considered best practice and an improvement from the last sheet.

The oxygen supplier trained the patients having oxygen therapy and then they were supported by the respiratory CNSs, the CNSs described how over the past year they had reassessed patients using oxygen. They had managed to save £30,000 from the oxygen budget as a result. As part of the patient’s support they were risk assessed to ensure that they would be safe at home having oxygen.

The three new advanced clinical practitioners (ACP) who replaced some of the community matrons had undergone non-medical prescriber training to support their role. Staff we spoke with were not aware the ACPs were already trained to prescribe.

Safety performance

Safety Thermometer
The service did not use safety-monitoring results well. They did not feed results back to staff for improvements to be made.

Although data was regularly collected by the team leaders for community services, the safety thermometer data was not visible anywhere. The senior team told us, that it was fed back within the regular quality report, although we could not see this in the last three reports. Staff told us the results were not shared with them, which meant that some junior staff questioned the time taken to submit, its relevance and purpose.

**Incident reporting, learning and improvement**

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. However, the proposal to stop community nurses incident reporting unwitnessed falls was not sufficiently risk assessed or planned with a replacement process.

**Serious Incidents (SIRI)**

From October 2016 to September 2017, trust staff in this core service reported one serious incident. This was the unexpected death of a patient.

However when on inspection we saw evidence that the service investigated five serious incidents (SIs) between 1 January and 31 December 2017, we read the investigation reports, they related to two patient deaths, actual harm from a fall, a serious pressure ulcer and a missed visit and catheter change which exposed poor systems and documentation. Each report appeared robust and included recommendations, actions, timescale and remedial actions taken. Examples included the redesign of the rehabilitation falls care plan, which were planned to be audited monthly. A new guide to their use was shared with the nursing homes, which housed the rehabilitation beds, and there was evidence of the reports being shared within teams to promote learning.

The process following a report of a SI was that it was followed up by an initial 72 hour report. This was discussed at the weekly senior nurse and governance meeting when the grading and investigation level was agreed.

**Incident Reporting**

Staff working in the community told us they were now confident to raise concerns using the electronic system of reporting. This was an improvement from the last inspection, when some staff said they had never raised an incident or a concern. Community adult services had reported 931 incidents from 1 January 2017 until 31 December 2017. The reported incidents divided by the three localities were, South Wight 335, West and Central Wight 314 and North East Wight 282. This showed that was a similar reporting culture for all the localities.

The highest themes of reported incidents were:

- Medicines related 40
- Patient slips trips or falls 155
- Pressure Ulcer or Moisture lesion (community acquired or inherited) 588
The community nursing staff were now able to report incidents via their new laptops, which meant that there was less risk of a delay in reporting and appropriate escalations could take place.

There was a new quality manager in the business unit who was planning to issue weekly flash reports outlining recent SIs, incidents and near misses for the teams to keep informed and to share learning.

We saw in a set of meeting minutes that community nurses had been told to ‘cease reporting unwitnessed falls’ by the head of nursing and quality for the AUCC business unit, as the data was not being used. By not reporting unwitnessed falls there would be a reduction of falls reported without any actions taking place. There were very few witnessed falls reported. It would assume that correct action post-fall was taken, for example, documenting the fall on the electronic documentation with an appropriate alert. Setting up a falls alert, assessment and care plan if indicated as well as recording a date for review. Although the electronic system had the ability to pull through appropriate actions if the fall was appropriately documented, we did not feel assured that currently nurses would have this ability. We did not see any consideration about managing the risk of frequent fallers in the meeting minutes.

Is the service effective?

Evidence-based care and treatment

The service provided the majority of care and treatment based on national guidance and evidence of its effectiveness.

Staff delivered care that took account of national guidance such as National Institute for Health and Care Excellence (NICE) guidelines. For example, the community heart failure team specialist nurses (CNS) adhered to best practice guidance relating to their specialism. The respiratory CNS also attended national conferences in order to be kept up dated and current.

The community staff had ready access to NICE, trust policies and procedures, working protocols, trust intranet and the intranet via their new laptops, which the trust issued late in 2017. The community hubs also displayed information on notice boards relating to the recognition of SEPSIS.

Some of the CNSs told us that due to their workload and lack of capacity they had to restrict their activities, some were unable to continue with home visits despite it being best practice.

Nutrition and hydration

Staff did not always assess patient’s nutritional status so they may not recognise when patients were at risk from malnutrition.

The community localities audited their assessments of their patient’s nutritional status using the malnourishment universal screening tool (MUST) quarterly. In 2017, the average assessment compliance was 74% meaning the service did not routinely screen all referred patients for risk of malnourishment.

Community patients could access the support of community dietitians, if required. The community nurses could refer them because of their MUST score or if they had other indicators such as a pressure ulcer. The patients’ wait was 36 days, against a target of 42 days.
Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those with chronic pain in developing coping skills and self-management.

We witnessed community nurses assessing patient pain when appropriate and saw safe management of the medicines in the patient’s home.

The chronic pain team was a multidisciplinary team that was based at St Marys but held clinics in a community location in Ryde. The team consisted of anaesthetics, physiotherapy, clinical psychology and a nurse specialist. The consultant initially triaged patients, as to whether the self-management programme would be of benefit to them and then invited them to attend the ten day, five-week programme. The programme included sessions on mindfulness, physiotherapy, and education on medicines and their actions, plus self-management techniques and attitudes to pain.

Patients attending the course wanted to feedback to us how ‘great the service was’, however, they pointed out there was a considerable wait of ‘up to six months’ to attend the programme.

Patient outcomes

Community services contributed to national audits to monitor the effectiveness of care and treatment and used the findings to improve them. Local audits however, were not consistently undertaken.

Audits – changes to working practices

Most services participated in the national audits for the services which they had responsibility. For example, the British Heart Foundation National Cardiac Rehabilitation, Chronic Obstructive Pulmonary Disease (COPD) national audit, the National Diabetes, and the Sentinel Stroke National Audit Programme.

The clinical nurse specialists (CNS) actively contributed to some national audits, for example, we were told that one Band 6 respiratory nurse’s role was collecting data for the national chronic obstructive pulmonary disease (COPD) audit. The heart failure CNSs told us there was no current community audit tool nationally.

The community teams audited their practice by localities; they undertook for example, audits in documentation, catheter care, uniform compliance. The data provided by the trust showed that the audits were not regularly done in each locality. They were not fully completed or remedial actions not always identified and followed up. The senior team told us that the new EPR system ‘phase two’ rollout incorporated data reporting function, which would produce audit results automatically.

The community teams audited the residential homes documentation in April 2017, we saw the action plan for improvements, but were not aware of any repeat audits to check for sustained improvements.

As part of the commissioning for quality and innovation (CQUIN) framework, the commissioners encourage services to continually improve how care was delivered. To improve wound assessment (CQUIN 10), the tissue viability team audited the community nursing teams wound assessments. An audit of 150 patient’s wound assessments took place in 2017. The audit found that there were no wound assessments that complied fully with the requirements of the ‘Leading Change Adding Value’ 2017. Because of the findings, the tissue viability team were producing best practice guidelines and pocket guides for the community nurses to support their educational sessions.
The chronic pain team measured patients outcomes based upon improvements to their patient’s quality of life, both short term and long term.

**Competent staff**

There were gaps in management and support arrangements for staff, such as appraisal and supervision. Appraisal rates had fallen to 54% and most front line community staff did not receive formal supervision. The service did not always make sure staff were competent and supported to do their roles. Many community nursing staff became stressed and anxious when talking about their roles.

**Clinical Supervision**

Community staff we spoke with told us that they usually had a handover meeting which they had been told was classed as supervision. They did not receive formal supervision. Others, such as the new clinical nurse practitioners had regular peer supervision, as part of their nurse prescribing. We saw minutes of these meetings, although we noted they had not been held recently. There was some evidence of informal supervision taking place, which staff told us they valued.

Many of the more senior community staff who spoke to us felt stressed and unsupported by the trust. The significant changes that the community staff were experiencing were making them feel anxious and some were clearly emotional. For these, the current supervision arrangements did not appear to be effective.

CNS’s told us that they were able to have supervision via various means, some with consultants, and some with other specialist nurses from the mainland. All acknowledged the importance of supervision as many were lone workers and needed to be able to share their experiences.

From October 2016 to September 2017 the average clinical supervision rate for some of the staff groups was 100%.

<table>
<thead>
<tr>
<th>Team</th>
<th>Clinical Supervision Target</th>
<th>Clinical supervision rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Rehab</td>
<td>N/A</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Appraisals**

Between April 2017 and September 2017, 54% of staff within the community services for adults core service had received an appraisal compared to the trust target of 100%.

A breakdown by staff group can be seen in the graph below.
The appraisal rates were slightly down on the previous years when in September 2016 59% of staff had received an appraisal. Staff told us how their development plans were linked to their appraisal.

New staff had both a trust and local induction. New starters in the community nursing team were supernumerary for six weeks according to the off duty roster, to allow them time to settle in and learn new policies and procedures. However, we saw some bank staff working in community clinics that had not had mandatory training.

Much of the staff training was in house, a combination of online and face to face, a review of the off duties showed where staff were allocated training. Some staff with specific learning requirements were supported to access training off the island. Community nursing staff spoke of having received lots of education from the tissue viability team, which had helped staff reduce the numbers of pressure ulcers. Community nursing staff also received training specific to their roles for example pressure bandaging for the prevention of vascular ulcers.

There was some specific training being provided by the University of Portsmouth to support the community nurses, we saw the programme of five sessions, which were being held in each of the three localities. The sessions included for example, appropriate assessments, professional accountability and safety, difficult conversations and care planning and evaluation.

Most CNSs also contributed to staff education by running annual staff updates, which were valued by the practice and community staff.

The crisis response team were looking at developing some practice-based competencies to support their staff’s professional development.

The new advanced clinical practitioners who had replaced some of the community matron roles were ‘masters level’ graduates with prescribing qualifications. In addition, they had skills in history taking, clinical assessment and diagnostic interpretation. There were pathways to potentially reduce emergency hospital admissions by managing deteriorating and complex patients with clinical management plans.
Multidisciplinary working and coordinated care pathways

Most community staff of different kinds worked together as a team to benefit patients.

We saw how there were some well-established examples of multidisciplinary care pathways. One example was the crisis response team, which provided emergency support for patients in the community to avoid hospital admission. Patients, following a referral through various emergency routes to the integrated hub, could receive a maximum of 72 hrs care between 8.30am and 4.30pm; the team had a four-hour response time to a referral. The team consisted of nurses, occupational therapy, a social worker funded by the local authority and a care navigator funded by a charity. Support for the patient could be either care or health need and equipment need. However, the team were unaware of the recent changes to the community matrons role and if changes would impact upon their team.

The amputee rehabilitation team was commissioned via NHS England specialist commissioning. The team held a weekly MDT meeting to discuss patients’ progress. Nurses, occupational therapists, physiotherapists, prosthetist, and a counsellor attended this. We observed this MDT meeting and were impressed with the holistic care being displayed, there were clear documented aims and objectives.

The community rehabilitation team had experienced recent changes; previous rehabilitation beds in St Marys were closed and were being recommissioned within nursing homes as part the service redesign. There were already 32 rehabilitation beds in various nursing homes, eight were reablement beds (local authority funded) and there was an additional ten being planned. The single point of access, referral, review and coordination service (SPARRCS) took all patient referrals from acute services. The team held a MDT weekly review of patient’s goal setting and handover meeting, with attendance from the therapists and advanced practitioner nurses. There used to be a consultant lead but they had recently moved to lead the frailty project, senior team members were not sure of the future medical cover but hoped to continue with the domiciliary visits.

The speech and language therapy (SALT) service was triaging referrals as to individual patient’s risks. Staff told us that those waiting longest would be those least likely to deteriorate whilst waiting. The changes to the community rehabilitation team meant that members of the SALT team would change to support the new frailty pathway.

We saw good links between podiatry and orthotics, with joint clinics being held regularly. A weekly visit from a mainland vascular consultant provided consultant support. There were close working links to tissue viability, diabetes and the amputee services.

There was an occupational therapy based housing and adaptations team, these were based at St Marys and liaised closely with the local authority and council to ensure that patient’s homes were appropriate for their ongoing needs. All patient discharges that required support to adapt of install equipment were referred through the council to the team. There was also a facility for self-referrals through the council website. The team were aware that the council had recently issued an invitation to tender, which included some changes to the service.

The integrated locality model was a coordinated approach for patients who needed more than two services in adult social care, voluntary sector, community service or health, to have a weekly MDT case review. The meeting discussed the patient’s referral and the MDT decided the appropriate action and who was responsible.

The CNSs spoke of differing team working, some of them had an effective MDT specialist team, for example respiratory and heart failure teams. Others spoke of being more isolated as their
medical support was off the island. Some were unable to access patient records, do home visits or attend joint clinics due to time and capacity restraints.

On our last inspection, we noted that there were no multidisciplinary team (MDT) meetings for the community nursing staff; despite these being a priority for development, they were still not fully established. In one locality, some GP practices reported they had not communicated with the locality lead for 18 months. However, we were informed following our inspection that there were MDT case review meetings set up during 2017. The attendance by community nursing staff was variable due to staff gaps.

Community nurses we spoke with told us that some handover meetings were no longer taking place daily, as it was felt there was less need following the introduction of the new electronic system.

Health promotion

The trust provided information for patients in various formats.

We saw that in the community clinics we visited, there was lots of patient information displayed. For example, we saw ‘Signs of Sepsis’, ‘Common Winter Ailment Treatments’, ‘Treat yourself’ pharmacy advice and ‘Heart Failure Symptoms’ displayed.

At others, we saw numerous patient information booklets provided by charities relating to specific health complaints. These were available in different languages if required.

The trust website provided information about the community services and their locations, it also signposted people to access services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff appeared to understand how and when to assess whether a patient had the capacity to make decisions about their care, despite only 8.9% of staff being trained. Staff did not all understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. The new electronic system incorporated consent into the initial assessment process.

Deprivation of Liberty Safeguards

The trust told us that 124 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority between October 2016 and September 2017. There were none that were for this core service.

We saw extremely low training compliance (8.9%) for the Mental Capacity Act 2005 (MCA), which meant that nurses might not be aware of the act and its implications on their practice and the safe care of patients.

The consent process was integral to the new electronic system, but it was not clear how this was carried out with a patient who had been assessed with no capacity. If completed this was an improvement from the last inspection when it was absent from most records. Staff we spoke with raised some issues relating to patients’ MCA and implied consent which indicated a gap in their understanding.

The occupational therapist had audited their verbal consent process as part of a notes audit and their compliance was stated as 74%. We saw that numerous paper documents asked for patient
Is the service caring?

Compassionate care
Staff cared for patients with compassion. Feedback from patients and care we observed confirmed that staff treated them well and with kindness.

On this inspection we accompanied community nurses out on visits to observe their practice and to gain feedback from patients. We also observed community clinics taking place. We spoke with 31 patients and 21 carers and relatives.

Overwhelmingly the patient feedback was positive with patients comments including, ‘excellent continuity of care’, ‘outstanding’ and ‘wonderful staff’

Nurses, therapists and other community staff engaged with patients positively and we witnessed compassionate care.

The patients fed back using ‘I want Great Care’, between January 2017 and January 2018 there were 2,514 reviews made. The majority, 75% of the respondents were patients and (47%) of the adults who responded were over 61 years old. The average score was 4.85 out of five, with 93.52% of patients likely to recommend the trust.

Those patients who were receiving infusions of disease modifying drugs in Laidlaw were still having them given in a public area. Although staff had audited the patients’ views, there was no other location option for them as a service except for individual patients.

Emotional support
Staff provided emotional support to patients to minimise their distress.

The psychology team supported the community patients; they were part of the chronic pain team and gave unfunded support to the community heart failure team. The chronic obstructive pulmonary disease team also accessed psychology support for their patient once a week.

The ‘I want Great Care’ feedback indicated a 4.83 score for staff listening.

Community staff could refer appropriate patients to the admiral nurses team who were available to support patients and carers living with dementia.

We witnessed emotional support being given to patients by many different staff in many different community environments. However, some staff we spoke with shared their concerns about the numbers of complex community patients who were previously case managed by the community matrons and who were without that previous level of support.

The heart failure CNSs, spoke of the dependence on telemedicine by some of their patients. Four or five patients used it, because they suffered increased anxiety without it. They told us that they had a good relationship with the hospice and could access it for respite and palliative care for their patients.

Understanding and involvement of patients and those close to them
Staff involved patients and those close to them in decisions about their care and treatment.
We witnessed the community staff educating the patient and their carers on their visits to their homes. For example, we observed the giving of information about the prevention of pressure ulcers and suitable seating.

We saw that the majority of assessment documents included the social situation and level of support that was in place for the patient and their carers.

The three community teams had undergone the ‘15 steps challenge’ to understand their patients perspective from four key aspects of their care. Care was reviewed by the patient on staff being well prepared, feeling safe and cared for, being involved and receiving good communication. We saw the reports for the latest reviews and patient feedback comments included, ‘district nurses are the ones that have made the last year more bearable’ and ‘the district nurses do a brilliant job’.

The chronic pain team tried to involve and educate carers to help patients deal with their pain management. Topics included relaxation, distraction, communication, posture and movement. Patients described being ‘treated holistically’ by the chronic pain team.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The trust planned and provided services in a way that met the needs of local people.

There were examples of responsive community services working together to meet people’s needs. They provided care close to, or within, the patient’s home environment and aimed to reduce hospital admissions and support early discharges. The community nursing services were arranged over three localities, but other services were either central or based around community clinic locations.

There were significant changes taking place in some community services. For example, the decommissioning of inpatient rehabilitation beds and recommissioning them in established nursing home rehabilitation beds across all three localities. The team told us that the moves had happened very quickly from the acute site which meant that work was still ongoing to release the therapy staff from the acute site into the community. There was an aim for 50 rehabilitation beds, of which eight were reablement (local authority funded) and seven non-weight bearing beds for slow stream trauma patients. The swift changes had meant that the service had many outstanding tasks still to complete which were flagged ‘red’ on their planning sheet.

The trust had recently introduced three locality based advanced clinical practitioners (ACPs). The aim for the ACPs was primarily admission avoidance. Recent data had shown which care homes the majority of community patients were being admitted from. The ACPs were working on educating the staff and monitoring the patients within the homes to prevent deterioration and admission. The remaining community matrons supported patients with complex or chronic conditions who were on the district nurses’ case load.

A new frailty service had been set up; this included reassigning the community rehabilitation beds, the use of a validated screening tool to assess the patient’s frailty. The tool was to be used in ED, by ambulance crews and by the therapy teams. A pilot in December 2017 had admitted 56% of 107 frail patients and anecdotally only three were still inpatients in January. The theory being that by being identified earlier, any problems were averted.

The community nursing team had recently started using an electronic system, for patient assessments and records. The system was said to replace the patient allocation and dependency
spreadsheet, which was seen in the inspection in 2016 to be not fit for purpose. However, staff we spoke with alerted us that the patient dependency scoring, which was used previously was removed but had not been replaced. There was no dependency scoring facility within the new system. Dependency scoring was used to ensure adequate time and staff were allocated to each patient to address their individual needs.

The community nursing teams had been using the results of the 15 steps challenge in each locality to identify more continuity for patients. One locality had started to use a virtual team for geographical locations to allow for continuity.

Service planning took account of nationally driven quality initiatives. One of the commissioning for quality and innovation (CQUIN) frameworks was to improve personalised care and support planning. CQUIN 11 was directed at supporting people with long term conditions, chronic pain, chronic obstructive pulmonary disease, diabetes, heart failure, blindness or severe visual impairment and deafness or severe hearing impairment. There were 307 patients within the community caseload with one or more of the conditions. The new electronic system had incorporated the five agreed points, stopping smoking, maintaining a healthy weight and diet, increasing activity, promoting wellbeing and reducing alcohol use. The community nurses were expected to complete the five indicators in addition to their normal assessment and care planning.

Some patients were transferred off the island to receive treatment, for example, patients suffering with a heart attack were treated at another local mainland NHS. This was not popular with patients, as they had limited access to visitors and felt they had poor support on their return.

Meeting the needs of people in vulnerable circumstances

The community services took account and of the needs of most vulnerable people. However, the impact of the removal of community matron posts on long term patients had not been adequately risk assessed.

Numerous community staff we spoke with were concerned about the complex patients previously case managed by the community matrons, but who they felt were no longer closely monitored. We were assured following our inspection that these patients remained on the district nurses’ case load within the ‘step up, step down’ model. The staff had not been informed or were unaware of this.

Band 6 community nurses, some of whom told us they had not been fully trained, were now undertaking the continuing health care (CHC) paperwork also undertaken by other band 6 and 7 community nurses. They worked with the government led support company but still took considerable amounts of time to complete.

Fast track continuing health care patients, although funding could be agreed promptly, sometimes had to access care through the hospice ‘carers’ due to the shortages of carers on the island.

Staff were able to easily access interpreters for patients without English as their first language, we saw signs directing staff and patients on how to access them.

Community patients and their families living with dementia were able to access the support of admiral specialist nurses on the island. These had been in post for the past two years and were accessed via a referral. Community patients could also access Macmillan cancer support nurses; these were available in the community, in St Marys and in the hospice supporting end of life or palliative patients and their families.
The crisis response team worked hard to ensure patients were safe at home; staff told us that if care was not available within a quick time frame they would act as a ‘bridging service’ to prevent admission to hospital.

The housing and adaptations team funded by the local authority, provided support to patients’ safety at home by working with providers to provide equipment and adaptations to their homes. They would also access funding grants on behalf of individuals in need.

Some CNS told us they were struggling to cope with the increasing numbers of patients on their caseloads. This meant that some home visits and joint clinics were no longer taking place and some patients may not access their support.

**Access to the right care at the right time**

Most people could access the service when they needed it. Waiting times from referral to treatment and arrangements to treat and discharge patients were in line with good practice.

GPs raised an ongoing issue relating to urgent phlebotomy or blood taking to CQC inspectors. They told us that urgent bloods needed to be requested by 12 midday to the community nurses, but GPs highlighted that their home visits did not start until 1pm, which meant that same day bloods were not available. The locality lead nurses felt this was not an issue, as urgent bloods could be accommodated at any time by the phlebotomist in each locality and the number of community nursing staff with blood taking skills.

The walk in phlebotomy service at Ryde still did not prioritise diabetic patients having fasting blood tests. We raised this previously in 2016 and remains a safety concern, as it could be a clinical risk to the patients. We were still not aware that this had been risk assessed; diabetic patients attending St Marys were fast-tracked or prioritised.

Patients who were transferred for care on the mainland spoke of difficulties accessing therapy or social support, referrals had to come from their island GP and not another provider which presented delays.

Patient referrals for the community nursing service went through the integrated hub and allocated to each locality; the locality team leaders prioritised and entered them onto the new electronic system.

The rehabilitation service had teams that covered the nursing homes, which included nurse practitioners, assigned physiotherapists and their assistants, occupational therapists and their assistants. Medical cover was provided by the registered GP for the home.

Chronic pain patients accessed a five-week programme, which was based in Ryde, patients’ spoke of waiting six months to get on it. But it was ‘excellent once they started it’.

**Accessibility**

The largest ethnic minority group within the trust catchment area is White Asian with 0.53% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
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<tbody>
<tr>
<td>First largest</td>
<td>White Asian</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian Other</td>
</tr>
<tr>
<td>Third largest</td>
<td>White/Black Caribbean</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Indian</td>
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Referrals
The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The trust met the referral to assessment target in 13 of the 14 targets listed. The area that did not meet the target was Speech and Language Adults which had a target of 84 days and an actual of 121 days.

The trust did not have an assessment to treatment target. Performance ranged from 7 days in Prosthetics to 121 days in Speech and Language Adults.

The CNSs targets for referral to assessment of patients were 126 days; they all achieved this and were between 13 and 42 days. Physiotherapy had a target of 42 days and achieved 21 days. These meant that most patients were waiting 6 weeks for assessment, but many were waiting much less.

Learning from complaints and concerns
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and were planning to have a more robust system to share with all staff.

Community staff we spoke with told us that there were few formal complaints that they were aware of; there were occasional issues that were escalated, and dealt with by team leaders. This complied with trust policy.

Many of the complaints noted on our last inspection were related to lack of continuity of staff. Community nurses now were allocated to the same group of patients, which was popular with staff, and patients.

The community quality, patient safety and risk meeting discussed complaints as part of the agenda. However, we saw from the minutes that this was about numbers and timescales rather than changes as a result or learning. We saw that there was a new trust wide ‘lessons learned’ project being planned to start soon, there was no other information available.

Patients were sent a letter informing them of the change to an electronic record system. This was to keep patients informed and hopefully avert complaints relating to nurses spending time on computers.

Is the service well-led?

Leadership
Whilst local clinical managers were supportive to staff, not all senior leaders had the right skills and abilities to run a service providing high-quality sustainable care.

A clinical director, a head of operations and a head of nursing and quality for community and one for the remaining services led the Ambulance, Urgent Care and Community (AUCC) clinical business unit. Four operational managers supported the services of the AUCC, which included therapeutic services, specialist services and community nursing.

Locality lead nurses managed the community nursing teams and the other community services were divided between two of the operational managers.
We heard from staff that there was variation in their view of their managers; the majority of the junior staff we spoke with considered their direct line managers or community team leaders to be supportive and accessible. We heard less favourable views of their more senior business unit managers and locality lead nurses, although the new executive team appointments were generally viewed as positive.

Many of the community staff expressed serious concerns over the management techniques and language used by the senior nursing leadership within the business unit. Many staff became tearful and upset when they described their personal experiences with them.

Some of the staff working in clinics felt disconnected with the senior managers and described never seeing them in their location. Although other staff spoke of the ‘meet Maggie’ opportunity to meet with the Chief Executive Officer (CEO), others had not engaged with it and felt isolated. Other staff felt the CEO was viewed as proactive, open and approachable and staff felt more positive with her leading the organisation.

The trust managed the Clinical Nurse Specialists (CNSs) through the acute business units relating to their specialism, to provide specialty support for them. In reality, the acute teams were often far removed from the CNSs location and did not always understand or engage in the community issues. This meant that some CNSs felt undervalued and unsupported by the organisation.

**Vision and strategy**

Whilst the trust had a vision, the AUCC business unit did not have a vision, or clear strategy and plans, for what it wanted to achieve for community services. Some transformation changes were being planned but staff were unaware of what was happening.

The trust had a vision and guiding principle to ‘provide quality care for everyone, every time’. The trust told us that these were defined into value statements, and had been widely communicated for a number of years.

The AUCC unit did not have a clear vision and strategy for the community nursing services, the senior team told us one of the locality lead nurses was working on it. There had been considerable recent change within the AUCC business unit without a strategy to work within or engage people with. The senior community nurses no longer referred to the previous community strategy, which was for all locality teams to have mirrored community teams.

Staff spoke of not knowing what was happening outside of their department and the implications of any changes on their own service. When asked about recent changes to services, which we had been made aware of – they did not know. Staff we spoke with told us that GPs were not aware of the changes to the community matrons and were concerned about the care of the patients previously monitored by them.

There was a draft technology enabled care strategy, however this was dated May 2017 and still in a draft document when we inspected. Staff did not refer to it in conversations, and existing telecare patient numbers appeared to have changed since our last inspection. We were not aware if it had been adopted by the trust.

We were told about, and saw, the programme charter for transforming community services project, which was adopted in December 2017. However, despite this project being progressed as the Community Service Redesign (CSR) we were not assured that all staff affected were aware and engaged with its aims and objectives. Many of the teams, which for example included rehabilitation, the crisis response team and the community nursing teams, could not fully describe
the redesign and its aims. They appeared to not be fully informed and therefore some staff were unaware of its impact on their own service. We were told that the locality lead nurses were not linked into the project although the head of community nursing was.

**Culture**

There was no understanding of the importance of culture in ensuring high quality, sustainable care. Senior business unit nurse managers did not promote a positive culture that supported and valued staff.

All community staff we spoke with told us of work related stress and anxiety. Some of the teams were exhibiting signs of stress and anxiety when we visited, many of the community nurses talked about how recent changes were being managed. Some staff were obviously upset and tearful about the new electronic system, quoting how people had been told they would have adequate support but in reality that had been insufficient. Many staff felt that their level of IT skills had been over estimated. Staff we spoke with told us that audits were now planned to ‘name and shame’, the staff not completing patient assessments properly.

There were obvious communication issues between some of the staff and the locality lead nurses with staff, one stated ‘it was difficult to get the district nurses voices heard’ ‘the relationships and culture make it difficult to escalate issues… do not feel safe escalating’, ‘managers crush us’. Other teams spoke of locality lead nurses not answering concerns or emails which lead to staff ‘feeling undervalued and not worth listening to’. Some staff described a lack of cohesion in the locality lead nurses' management approach and level of support given by them. Staff told us they were frightened to talk to the locality lead nurses for ‘fear of retribution’.

The senior community nursing leadership was described as distant and ‘punitive’. There was no presence at team meetings and emails were often sent with ‘unrealistic’ deadlines. Staff we spoke with told us that workforce planning and development plans affecting the localities did not involve the team leaders, one example given was the new electronic system. The care plans were developed without the community team leaders input, are said to be lengthy and do not have evidence of the reassessment of patient’s needs. Despite concerns being raised, and ideas put forward staff have been told ‘it cannot be changed and must be used as it is’.

Some staff shared their concerns that the AUCC management team did not understand or ‘value’ the community matron roles within the community. Many had left to join GPs but no exit interviews or queries were made about why they had all left.

The chronic pain team talked of rumours about their service being outsourced to the mainland, which were unsettling for staff and patients. Their senior managers had not discounted these rumours.

**Governance**

There were insufficient governance arrangements in place for oversight of safety and quality of services. The records of the meetings were disorganised, informal and poorly filed.

The trust was planning a new governance framework, but in the meantime the AUCC business unit was having monthly quality, patients’ safety and risk meetings. These were attended by service leads and were formally minuted. We reviewed the minutes and attendance record of the past three meetings, all head of services and leads were invited to attend. The agenda covered reported incidents, risks, ‘I want great care’ responses, contracts and other department updates.
We noted that two sets of minutes marked ‘final’ had the same date although they were clearly different meetings.

The management and leadership meeting minutes agenda indicated that governance should feed into the meeting, however the draft minutes supplied by the trust showed that four of five meetings had no reference to it.

The trust held a twice weekly incident and serious incident (SI) review panel to attempt to comply with the 48 hour target to declare a SI set by NHS England. One meeting proposed that the 48hr meeting should be stretched to 72hrs. A weekly community senior nurse action group ‘SNAG’ fed into this meeting and discussed and graded any recent reported incidents and to agree on the level of investigation required. This meeting was also used for mortality reviews of patient care.

The trust had just appointed a new quality manager to the AUCC business unit. Their role included producing weekly ‘flash reports’ to all staff that included updates on complaints, serious incidents, reported incidents and near misses but this had not been fully implemented at the time of our inspection.

**Management of risk, issues and performance**

The business unit did not have an effective system for identifying risks, the risk register contained just three risks, none of which detailed the risks of recent service changes. The impact of service changes on the quality and sustainability of care were not understood.

The business unit had held a monthly management and leadership meeting chaired by the AUCC head of operations. We reviewed the past five-month’s minutes. They were all marked as draft, with no final versions and no record of who attended the meetings. The invited attendees were operational or finance managers plus the consultant and head of nursing and quality for the business unit. The agenda covered for example, finance, contracts, training and governance.

A new weekly local operational meeting had just been set up for the locality lead nurses and the community team leaders; we did not seen the terms of reference or any outputs from these meetings as they had only just started.

The community risk register had been rationalised and reduced in size since our last inspection in 2016, there was a single register for all localities with just three risks detailed. These were related to a lack of community capacity, failing standards in the district nursing service and the Laidlaw kitchen failing to meet infection control regulations. There were no risks for example, associated with the changes to the community matron role, the implementation of the electronic documentation system or the upload of past patients to the system.

The community service redesign project, which incorporated three other programmes (integrated localities, frailty and community rehabilitation), identified the scope of the project and the approach and activities. We did not see a quality impact assessment on the proposed redesign.

We saw that the quality, patient safety and risk meeting was used to discuss risks and other issues. One topic that was documented was the need for district nurses to stop reporting unwitnessed patient falls as the ‘data was not used’. Although there was no commissioned falls service, the proposed not reporting of unwitnessed falls incidents, may not ensure those patients at high risk of falls were treated appropriately. The new electronic system was not being used robustly to follow through on required actions from a patient fall. The system was reported in the meeting as ‘everyone is very positive’, this did not reflect what the community staff actually fed back to us on our inspection.
The community teams worked under the trusts lone worker policy, this required the staff to utilise a 'buddy system' for notifying a colleague of when they were on and off duty. Staff spoke with us that often staff forgot to phone in or the phone signal was poor and colleagues had to spend time ensuring they were safely at home. Some teams used a white board to ensure that all staff were accounted for at the end of the day. Staff spoke with us that they risk assessed patients before undertaking visits and if there was an identified risk would do the visits in pairs. Staff had just been issued with pocket 'code cards' to help their colleagues respond to any potential risks.

Staff working at community clinics did not use a system to ensure that if there was an emergency such as a fire; numbers of staff working on the premises could be identified to the emergency services.

**Information management**

The community services senior team did not collect, analyse, manage and use performance and quality information sufficiently, to support its activities.

Community staff told us that they did not always have access to senior meeting minutes or notes. For example, they did not see the 'safety thermometer data' results, which the senior managers received.

The community teams affected by the new service redesign project were not aware and had not been involved in the development of the new plans.

Senior leaders told us they had started to develop a community dashboard but it was still in a draft format.

The new electronic system had rolled out a method of recording patients records, however staff were concerned that the system did not provide adequate reassessment information and was not able to be adapted for short-term patients. Despite the system being used for all patients, the community staff were still trying to get to grips with how best to use it, for example to schedule visits. There was no dependency or workload tool built in to the system. We requested details about the tool being used with the new system but no information was received.

**Engagement**

The community services senior team did not engage well with patients, staff, public and local organisations to plan changes and service improvements.

The community services redesign charter did not outline plans for engagement with service users or staff. This could have been because it had just been agreed and implementation only started in December 2017. However, the detailed actions to achieve the redesign did not outline future engagement which suggested this element of managing the changes had been overlooked.

The trust produced a weekly 10 minute team brief for staff, a variety of topics shared with staff. These included, for example, information on the improvement journey known as 'getting to good', the appointment of new trust staff and information on ongoing trust improvements. There was a section for local business unit news.

The 2017 staff survey had been completed in November 2017; the response rate for acute, ambulance and community Isle of Wight services was 42%, which was above the national average of 39%.
The trust told us it was aiming to develop an Employment Engagement Strategy to ‘win hearts and minds and create a great place to work’. We saw no reference to this in any of the business unit meeting minutes. Staff we spoke with were not aware of this initiative.

**Learning, continuous improvement and innovation**

The community services business unit appeared committed to improving services by innovations, however frontline staff were not encouraged to contribute to service improvements and planned changes were poorly communicated. There had been insufficient actions or improvement since the previous inspection.

The head of nursing and quality for the AUCC business unit undertook a review of the community nursing service in October 2017. This was titled a ‘Deep Dive’ and was updated and shared with us on inspection in January 2018. The review was divided into concept analysis: for example, education, the new electronic system, the use of 15 steps, and opportunities for redesign. The paper described the potential opportunity for redevelopment some of the former community matron roles into advanced clinical practitioners (ACPs) using a pilot to prove the concept. However, the pilot was not taking place until February and March 2018 although ACPs had already been recruited. The community staff did know this was a pilot; they spoke of changes to their structure and the support of long term patients that had already taken place.

The new service redesign of community services offered scope for innovation and improvement; however, the project managers had not engaged community staff in identifying improvements or outlined the potential changes at the time of our inspection.

The AUCC senior team told us that they had just issued staff with pocket ‘code cards’ for lone working, for them to use to alert colleagues of potential difficulties.

Staff we spoke with were not aware of any trust wide innovations that they could describe to us at the time of the inspection.

Three of the ‘MUST’ and two of the ‘SHOULD’ actions had not been addressed since the previous inspection, which meant that some regulations were still not met.
Community health services for children, young people and families

Facts and data about this service

The Isle of Wight NHS Trust offers a range of services for children, young people and families, including health visiting, school nurses, podiatry, orthotics and prosthetics and speech and language therapy. These services are offered at a number of different community locations across the island as well as at St Mary’s Hospital.

(Source: Community RPIR – Context CHS tab)

Children and young people form 20% of the island’s 140,000 population. Child health profiles show the number of children under 16 in low income families is above the England average. In 2014 21.4% of children under 16 lived in a low income family compared to the national average of 20.1%. The rate of family homelessness was better than the England average, 1.1 per 1000 compared to an England average of 1.9 per 1000 families. This meant there were less families experiencing homelessness compared to the England average. The Isle of Wight had a higher number of children in care compared to both the regional and England average. In 2017, 90 per 10,000 children were in care compared to an England average of 62 per 10,000 children and regional average of 51 per 10,000 children. The rate of teenage mothers was slightly higher than the England average at 1% compared to 0.9% nationally and 0.7% regionally.

The Isle of Wight NHS Trust provides a range of community based services to children, young people and their families on the island. The 0-19 service provides a combined health visiting and school nursing service for children and young people across the age range. Children’s community therapy teams provide occupational therapy, speech and language therapy and physiotherapy to children and young people.

Health visitors held clinics in a variety of locations across the island including children’s centres, GP surgeries and community centres. The trust did not own or manage these locations. The school service carried out screening, immunisations and health promotion in both primary and secondary schools across the island. The 0-19 service was managed jointly and had a new service lead in post at the time of our inspection.

The 0-19 service also provides school nursing provision for two schools caring for children and young people with severe and complex needs such as learning difficulties, physical disabilities, medical conditions and autistic spectrum disorder.

The sexual and reproductive health service provide a variety of clinics based at St Mary’s hospital these include a dedicated under 25’s drop in clinic, family planning service and a psychosexual counselling service.

The children’s community therapy teams were co-located in a building on the St Mary’s Hospital site. The teams provided a range of clinics in the building in addition to community clinic and home and school visits. Each therapy service had a service lead, however, the occupational therapy service lead post was vacant at the time of our inspection.

The looked after children team provided oversight of care and support for children and young people in the care of the local authority including arranging health assessments and care planning. The team cared for children and young people until they reached their 25th birthday to ensure a smooth transition to adult services.

During this inspection, we inspected:

- The 0-19 service (health visiting and school nursing)
Our inspection was announced at short notice (staff knew we were coming) to ensure that everyone we needed to talk to was available. During our inspection, we spoke with 30 members of staff including school nurses, health visitors, sexual health nursing staff, student nurses and therapies staff. We also reviewed 22 sets of patient medical records including paper records, electronic records and parent held records. We spoke with 20 children, young people and parents and observed nine consultations. We observed interactions between parents and staff, considered the environment and reviewed a range of documents both before and after the inspection.

### Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

#### Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff completed this and there was particularly low compliance with some key modules.

The trust set a target of 85% for completion of mandatory training. As of June 2016 their overall training compliance for all staff working in community services for children, young people and families was 84% against this target.

Nursing staff in community services for children, young people and families achieved 79% compliance overall against the target of 85%.

A breakdown of compliance for mandatory courses as of June 2017 for nursing staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>47</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>47</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>47</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>47</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>47</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>47</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>47</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Medicines Scenarios</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>47</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>46</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>47</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>46</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>47</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>47</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Pass (%)</td>
<td>Target (%)</td>
<td>Compliance</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>----------</td>
<td>------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Load Handling</td>
<td>47%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>85%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>34%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>People Handling</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicines Management - Competency Assessment</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicines Management - Maths &amp; Medicines Calculations</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>79%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
</tbody>
</table>

Data provided by the trust showed the breakdown of mandatory training compliance by service:

- Genitourinary medicine medical staff – 84%
- Integrated sexual health staff – 95%
- Occupational therapy and wheelchairs – 86%
- Physiotherapy – 77%
- Paediatric speech and language therapy – 77%

The data provided by the trust prior to our inspection showed that staff who worked in community services for children, young people and their families were required to complete 22 modules for their mandatory training. Overall, the service did not meet the trust target of 85% for 14 of the modules which included adult resuscitation, hand hygiene and health and safety. This posed a risk that some staff would not be up to date with essential knowledge and skills.

The trust provided online and face to face mandatory training which included the range of topics listed above. Clinical service leads held responsibility for ensuring staff completed mandatory training and this was discussed during appraisals. Staff also monitored their own training compliance via an electronic database. We observed staff accessed this easily through the trust intranet. Managers had oversight of this system but told us they had to access each individual’s record separately and could not access a team training report.

The staff we spoke with reported they were up to date with their mandatory training and found this easy to access. Staff who worked outside trusts office bases for example in specialist schools had access to the trust mandatory training system.

Staff reported that Prevent training was new and not all staff were aware they had to complete it. This was reflected in the data presented above where the compliance for prevent training was 34%. Prevent training educated staff on the risk of vulnerable people being exploited and drawn into terrorism.

Staff we spoke with were aware of the trust sepsis policy and told us they could access training sessions via the online training system. All the staff we spoke with told us they had completed this training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, there were multiple records systems in place which posed a risk for safeguarding children and young people. Not all staff completed safeguarding children and adults training appropriate to their role.
Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include physical, emotional, financial, sexual, neglect and institutional.

Each authority has their guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Data provided by the trust showed that from January 2017 to December 2017 health visitors made 64 safeguarding children referrals, school nurses made nine referrals and sexual health services made two referrals. The occupational therapy team made eight referrals. This meant that all departments actively made referrals to the local authority for children and young people they felt were at risk of harm. Staff referred directly to the multi-agency safeguarding hub (MASH).

A breakdown of compliance for safeguarding courses as of June 2017 for nursing staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>47</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>45</td>
<td>95.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>44</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>35</td>
<td>71.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff in the school nursing team told us they received level 3 safeguarding children training which reflects the data presented above. Staff in the school nursing service could give examples of when they had made referrals to MASH.

Staff who worked with children and young people in the integrated sexual health service, and physiotherapy team received safeguarding level 3 training and had achieved 100% compliance. Staff working with children and young people in occupational therapy, wheelchair services and paediatric speech and language therapy received safeguarding children level 2 training. The occupational therapy and wheelchair services department achieved 92% compliance with this training. However, the paediatric speech and language team achieved 82% compliance which was slightly below the trust target of 85%. The Safeguarding Children: Roles and competencies for Health Care Staff. Intercollegiate Document (2014) defines required levels of safeguarding training for a variety of staff groups The document states:

- Level 2: Minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers.
- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
Following our 2016 inspection, we raised concerns with the trust that key groups of staff did not complete safeguarding children level 3 training. Whilst there has been some improvement in the compliance rate of this training, key groups of staff working with children and young people do not complete safeguarding children training at an appropriate level for their role.

There was low compliance with safeguarding adults level 2 training across all services. The compliance rate for each service at the time of our inspection is listed below.

- Integrated sexual health – 20% (2 out of 10 staff)
- Occupational therapy and wheelchair service – 17% (2 out of 12 staff)
- Physiotherapy department – 14% (2 out of 14 staff)
- Paediatric speech and language therapy service – 0% (0 out of 11 staff)

This posed a risk that staff would not be able to recognise situations where vulnerable adults were at risk of harm or abuse. Staff told us the low compliance rate was due to difficulty sourcing the training.

Staff in the school nursing service told us that they had completed training in Female Genital Mutilation (FGM) as an online training module provided by the local safeguarding children board. Staff told us that after completion of this training they received a certificate but there was no electronic record kept by the trust of who attended. This meant the trust were not aware of which staff had attended the training. The staff we spoke with were aware of the warning signs of FGM and how to report it.

Health visitors received three monthly safeguarding supervision as recommended by the National Health visiting service specification 2014/2015.

There were multiple record systems across the service which did not support safeguarding children and young people. The LAC team had to review information held on four different systems to review the health and care needs of children and young people on their caseload. Staff told us this was very time consuming. This meant that staff did not have easy access to all the information held about children and young people who had an identified risk of harm or vulnerability. Staff in the sexual health service and paediatric therapies had paper records and had to email the safeguarding team if they wanted to record anything on the child or young person’s electronic record. This meant that specialist nurses within the safeguarding team had to add this information to the child’s electronic record. Whilst two members of staff in sexual health had read only access to the electronic records systems, paediatric therapies did not have any access to the system and therefore had to contact the safeguarding team to find out information.

There was a safeguarding children team who oversaw the safeguarding children work in all services. The team was led by a named nurse and named doctor for safeguarding children and young people. The team also consisted of a specialist band 7 nurse for looked after children supported by a band 6 nurse and a full time administrator. The team planned to recruit two additional safeguarding nurses and one looked after children band 6 nurse. Staff within community children’s services spoke highly of the team and told us they could always access them for help, advice or support.

There was a good relationship between the safeguarding children team and sexual health department. The sexual health department chaired a safeguarding children and young people meeting on a quarterly basis and this was attended by the safeguarding team. Staff discussed young people at particular risk of harm. We observed staff presented a case for discussion. The safeguarding team gave advice on how to escalate the concern and offered to support the
member of staff through the process. The sexual health service also employed two nurses with a particular interest in working with vulnerable young people.

Paediatric therapy staff did not always feel involved in safeguarding cases which concerned children and young people they had seen in clinic. Some staff told us they were not always asked for information in safeguarding cases. A group of staff gave an example of a child who presented with fabricated illness and therapy staff were not asked for information about the child, despite holding information valuable to the case. Other therapy staff felt their professional opinion was sought in safeguarding cases.

The health visiting service undertook an assessment of maternal risk factors at antenatal visits. We observed staff discussed risk factors such as domestic violence, mental health concerns and drug and alcohol use. We also observed health visitors clearly recorded other children and adults who were living in the house. This meant staff considered safeguarding as part of their antenatal visit.

The sexual health service had developed a Sexual Exploitation Risk Assessment Framework (SERAF) for all young people under the age of 18 years old. The SERAF assessed the young person’s risk factors for child sexual exploitation (CSE). Staff told us, if the young person scored highly on the SERAF they discussed the case at a Multi-Agency Risk Assessment Conference (MARAC). However, we reviewed five medical records of young people, two of these did not have a SERAF completed. This posed a risk that staff were not consistently using the framework to identify risk factors of CSE.

The sexual health service had a chaperone policy where all children and young people were offered a chaperone. Staff recorded this in the child or young person’s notes. We reviewed five sets of notes where children or young people should have been offered a chaperone. Staff had offered patients a chaperone in all five cases and this was recorded in their notes.

**Cleanliness, infection control and hygiene**

The service did not always manage infection risk. Staff did not always adhere to hand hygiene procedures or clean equipment after use.

Most of the locations we visited were visibly clean and tidy. In the sexual health clinic, we observed clinic rooms were visibly clean. Staff had access to hand gel and cleaning wipes in each room. We observed there was disposable curtains used in each room. These were changed routinely on a six-monthly basis or earlier if they were contaminated with bodily fluids. The service had spare curtains to use immediately if required. The service submitted an environmental infection control audit in November 2017 which showed the service achieved 100% compliance. However, in the paediatric therapies building we observed some clinic rooms were not visibly clean and some equipment was visibly dusty. In some therapy clinics we observed staff did not use disposable towels to cover examination couches or change these after every patient.

Staff adherence to infection control procedures such as being bare below the elbow, long hair tied up and appropriate use of personal protective equipment was inconsistent across the service. We observed staff in both therapy and health visitor clinics did not adhere to the trust’s policy of being bare below the elbow. In one health visitor clinic, there was no handwashing sink available in the room of the clinic. Staff had to use the hand wash basin in the toilets. Whilst there was a hand gel dispenser available we did not see staff using this routinely.

Services did not undertake hand hygiene audits and therefore could not be assured that staff were complying with hand hygiene policies and procedures. Infection prevention and control training was provided as part of staff’s mandatory training. The overall compliance with this training for the
whole service was 85% which met the trust target. The trust also provided hand hygiene training for staff. However, the overall compliance for the service was 72%, which did not meet the trust target of 82%. There were no clear plans from service leads to address the low compliance of hand hygiene training.

Environment and equipment

The service had suitable premises and equipment, which they looked after well.

Health visitor clinics were held in various locations which were not owned by the trust, for example children’s centres. However, staff ensured there was were adequate facilities for children and families such as age appropriate toys, parking and disabled access. However, in some health visitor clinics we observed that there were no door protectors on doors in health visitor clinics. This posed a risk that young children could get their fingers trapped in the door.

Therapy services for children had recently moved into a separate building. Staff valued the space in this new building and felt it was a more appropriate space for children, young people and their families.

Staff told us they had enough equipment to meet the needs of children and young people. We reviewed equipment servicing in sexual health, paediatric therapies and the health visitor service. All equipment apart from one set of scales had been serviced within the last year. We raised our concern to the 0-19 lead about the one set of scales which had not been calibrated. The lead arranged for a replacement set of scales to be sourced for the clinic immediately and these were available in clinic the next day.

We observed that staff in the sexual health clinic had not carried out daily checks to ensure the resuscitation trolley was complete and in good working order. In December 2017, there were eight occasions on weekdays where staff had not checked the resuscitation trolley. We raised this with senior staff who told us that the department had recently made a decision to check the resuscitation trolley on a daily basis. We observed records for January 2018 to show this had been completed.

Waste management including arrangements for the disposal of contaminated and hazardous waste was in line with national standards and trust policy. All bins we inspected across the service were filled correctly, and were labelled with a date of opening and signed as per trust policy.

Staff were provided with mobile phones and laptops. Staff were able to access desktop computers at their offices. However, some staff reported connectivity issues in and outside of the office. Staff told us there was enough office space to work comfortably.

The school nursing service told us they carried out an audit of connectivity in schools. The results of this audit showed staff could not access the electronic records system in 35 schools. The audit also showed staff were unable to access the electronic system in county hall where a number of child protection meetings took place. There was no action plan submitted by the service to demonstrate how the connectivity issues were planned to be resolved.

Assessing and responding to patient risk

Health risks to children, young people and their families were assessed, monitored and managed appropriately.

The Healthy Child Programme (HCP) and National School Measurement Programme (NCMP) include assessment stages and tools to identify and respond to children, young people and
families (CYPF) between 0 and 19 years of age who may be at risk of harm, disorder or ill health. The HCP meant that risks in relation to parental or child welfare or child development could be identified at routine checks carried out by, health visitors, nursery nurses, school nurses and the LAC team.

The 0-19 service had implemented and embedded the HCP and NCMP and used these as the key opportunities for assessing and monitoring the welfare of children, young people and families and responding to identified risks. There was more targeted support such as the universal plus programme available for those who required a brief period of extra support and the universal partnership plus for families who required intensive support involving other professionals.

The proforma for children and young people under the age of 18 in the sexual health service assessed sexual health risks such as sexual history and the risk of blood borne viruses. The assessment also assessed risk behaviours such as smoking, alcohol and drug use.

Health visitors assessed risks and gave advice on risks such as Sudden Infant Death Syndrome (SIDS) at antenatal visits. For example, we observed staff asked about smokers in the house and explained that this increased the risk of SIDS.

The health visitors and school nurses we spoke with had a good understanding of the signs and symptoms of sepsis and how to respond if they encountered an unwell child. The trust provided sepsis training as an online learning module but not all staff were aware of this. Health visitors told us they discussed the signs of sepsis with parents at the antenatal or new birth visit.

Staffing

Slow recruitment processes led to long term unfilled vacancies which meant some services did not always have enough staff to meet the needs of children and families.

Total numbers – Planned vs Actual

- The trust did not provide a breakdown of planned vs actual staffing by staff group, however the table below details planned vs actual staffing for all staff working within community services for children, young people and families, showing figures for the last financial year (March 2017) and year to date as of September 2017.

<table>
<thead>
<tr>
<th></th>
<th>Last financial year (as of March 2017)</th>
<th>Year to date (as of September 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned staff WTE</td>
<td>66.82</td>
<td>74.47</td>
</tr>
<tr>
<td>Actual staff WTE</td>
<td>60.82</td>
<td>66.73</td>
</tr>
<tr>
<td>Actual staff – Whole number/ headcount</td>
<td>78.00</td>
<td>85.00</td>
</tr>
</tbody>
</table>

The sexual health service employed one consultant and two associate specialists on a part-time basis. The nursing team in sexual health consisted of one clinical service manager, a nurse consultant, a band 7 clinical lead and four band 6 nurses.

Staff in the health visiting service told us the weighting of caseloads had been adjusted and was reviewed on a monthly basis. Staff felt this worked well in practice and helped balance caseloads for each member of staff. One member of staff gave an example that one health visitor had a caseload of over 300 children last year. The team reviewed the caseload and re-allocated it to ensure all members of the team had a fair workload.

In our 2016 report, we found the looked after children specialist nurse had over 250 children and young people on their caseload which was over double the national average. On this inspection,
we found the looked after children nurse had recently been promoted to a band 7 post and a new band 6 post had been filled. Staff told us there was a plan to create another band 6 post to support the team. This meant that there were more staff able to share the caseload and ensure high quality care for each child.

Vacancies

From October 2016 to September 2017, the trust reported an overall vacancy rate of 6.0% in community services for children, young people and families. Nursing and midwifery registered staff was the only staff group recorded for this core service.

Health visitors told us they had one band seven post vacant and one band 6 post which would become vacant soon. The 0-19 lead told us they planned to review the service to determine how these posts would be utilised to ensure the service met the needs of children, young people and their families.

Staff across the services raised concerns that vacancies were not being filled as quickly as needed. We spoke to one member of staff who planned to resign as they were aware that a post was becoming available in the near future but had not had assurance that the post would be filled. Therefore, they had concerns that they would be short staffed and have a larger caseload as a result. There was a band 8 post available in occupational therapy which staff told us had been vacant since August 2017 and not advertised until December 2017. Staff felt this was having a significant impact on waiting times for children and young people to access the service and representation at Clinical Business Unit meetings. However, the trust told us the post was not re-advertised due to role redesign which involved the team leads of the service.

Turnover

From October 2016 to September 2017, the trust reported an overall turnover rate of 3.4% in community services for children, young people and families. Nursing and midwifery registered staff was the only staff group recorded for this core service.

Sickness

From October 2016 to September 2017, the trust reported an overall sickness rate of 3.5% in community services for children, young people and families. Nursing and midwifery registered staff was the only staff group recorded for this core service.

Nursing – Bank and Agency Qualified nurses

From October 2016 to September 2017, the trust reported an overall bank usage of 46 shifts for qualified nursing staff in community services for children, young people and families, no usage of agency staff was reported. All 46 shifts were for the health visiting and school nurse service.

The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

Nursing - Bank and Agency Healthcare Assistants

From October 2016 to September 2017, the trust reported an overall bank usage of 61 shifts for nursing assistants in community services for children, young people and families, no usage of agency staff was reported. All 61 shifts were for the community paediatric service.
The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

**Suspensions and supervisions**

From October 2016 to September 2017, the trust reported no suspensions or supervisions for staff working in community services for children, young people and families.

**Quality of records**

There were multiple records systems in place which did not always allow staff to access full and up to date information about children, young people and their families. The electronic patient record system was not reliable or fit for purpose, and paper records had not been scanned onto the system. These issues created significant risks for children and young people using the service.

The trust used different systems for patient records which staff consistently told us were not compatible and staff felt they were not fit for purpose.

Staff in the sexual health department recorded patient care and treatment on paper records. Two members of staff had access to read electronic patient records but did not have access to add any information. Staff told us that since our last inspection in 2016, all young people’s electronic records were reviewed by a member of staff who had access to the record following their clinic appointment. However, the nursing staff were not able to add information to the system and therefore had to email this to the safeguarding nurse who would add the information on their behalf. Staff told us this was frustrating as they could not add even basic information. For example, a child on a child protection plan was seen in clinic and engaging with the service. The nurse had no concerns but was not able to record this on the system. Therefore, staff had to email the safeguarding nurse in addition to completing their paper record to get the information logged on the system.

All therapy services used paper based records. The clinical service leads told us that staff accessed clinician’s notes and x-rays via an electronic image recording system.

Staff in the 0-19 service raised several serious concerns about information technology systems within the service. Staff told us that they frequently lost internet connectivity in the office. Staff gave examples of when they had completed incident reports or clinical records and had lost their work due to the internet connection. Staff told us that they were unable to access the electronic system in schools. This meant that if a teacher had a concern about a child, they would be unable to look up the notes for that child or young person.

One member of staff gave an example of when they made a follow up appointment for twins to attend a follow up screening appointment. Although staff had booked both children to be recalled, the system only recalled one child. Staff told us the electronic system they used was a results system and therefore they could not enter children before they had seen them. For example if a new child moved to the island, staff would not be able to add them to be seen until they had already seen them in school. Staff estimated that around five children a term were missed by the system and this meant to an average of 45 children per school per year who could be missed for appointments.

School nursing staff told us that on one day, all notes entered onto the electronic system disappeared from the system. Another member of staff told us that if they did not write the notes of the children as they appeared on the system then the notes would automatically be entered in for the child or young person who was first on the list. Staff demonstrated this on the live system.
As a result, staff kept their own paper records to ensure children’s appointments were not missed. One member of staff told us, ‘we have more paper using this paperless system than when we had paper records.’ Each staff member stored paper records in a different way. For example, one member of staff told us they kept them in their drawer, one member of staff kept them in a folder and another member of staff kept them in a filing cabinet. There was no oversight of the information or location of these paper records. This posed a risk that if a member of staff was off sick, they would not have access to all the information held about a child or young person.

Staff in the health visiting service told us that the system did not allow them to enter expectant mothers into the system and therefore, antenatal notes were held separately in paper records. This posed a risk that professionals did not have all the information related to a child and family on one system.

We reviewed 22 sets of records in total. These records showed evidence that staff addressed the needs of children and young people. All records were focussed on the child or young person and included a plan of action.

Health visitors recorded in the parent held child health record (PHCHR) or ‘red book’. Parents were encouraged by staff to bring their PHCHR to every clinic appointment. We reviewed 11 children’s PHCHR and all were complet

The school nursing team submitted data for four audits which had been undertaken during 2017. The audits reviewed 10 records and looked at eight areas of documentation such as are all entries signed, can you identify what is happening for this child and are the notes jargon free. Out of the four audits submitted, one did not have a date and was not totalled to show how many records were compliant. The three other audits had been completed in February 2017, summer 2017 and December 2017. The compliance rates were 79%, 71% and 86% respectively. However, the trust did not submit any action plan with the audit to show how the results had been used to improve documentation within the service.

We found 16 boxes of paper records in a room downstairs in the school nursing base office. There were also 19 boxes in the child health office, which is in the same building and seven other boxes, which had been scanned and were awaiting destruction. The 0-19 service lead told us these records were from over five years ago when the team used paper records instead of an electronic system. The service lead told us they were short of administrative staff which is why the records had not been scanned into the system or destroyed. Staff also told us they held the mothers notes, which could not be scanned onto the system. The 0-19 lead told us they had just recruited additional staff to help scan the notes onto the system. Although the notes were stored securely in a room with keypad entry, this posed a risk that information may be missing from a child or young person’s health record.

**Medicines**

The service did not always manage medicines correctly. Staff did not ensure temperature sensitive medicines and vaccines were stored safely and that the medicines were administered as prescribed.

Medicines in the sexual health service were stored in a pharmacy room in locked cupboards. Oxygen was in date and stored appropriately in an upright position. Medicines such as vaccines were stored in a medicines fridge in the pharmacy room. We reviewed the daily medicines temperature recording log. In November 2017, there were 12 occasions where the fridge temperature had not be checked and recorded. In December 2017, there were six occasions
where the fridge temperature had not been recorded. This meant that staff could not be assured medicines such as vaccines had been stored at the correct temperature consistently. We raised this with a senior member of staff who told us they would ensure fridge temperatures were monitored and recorded daily.

Vaccines for the school nursing service were kept in a fridge in the school nurse base office. We reviewed the daily fridge temperature monitoring log which showed the fridge temperature was not always recorded on daily basis. We observed that fridge temperatures had not been recorded on two occasions in July and August 2017, on one occasion in November 2017 and on three occasions in both December 2017 and January 2018. Staff in the school nursing office told us there was no clear responsibility for checking the fridge temperature. They also told us they were aware there were issues with the fridge and storage of vaccines and they thought there was a plan of action but this was not written down. This meant that staff could not be assured vaccines were always stored at the correct temperature.

In our 2016 report, we identified concerns with the storage of medicines at one school for children with physical and learning disabilities. On this inspection, we found all medicines were stored in locked cupboards within the classrooms and teaching staff administered children’s regular medication. School staff received yearly training from the school nurse in medicine administration.

One school we visited required some medicine to be kept in the fridge. There was an appropriate medicine fridge which was checked on a daily basis Monday to Friday. During school holidays the fridge was emptied and switched off. This was clearly recorded on the fridge temperature recording log. Controlled drugs were also stored appropriately and checked in and out by two members of staff.

At one special school, we found oxygen cylinders stored laid down on a work surface. For safety, national guidance recommends oxygen cylinders should be stored in an upright position. We raised this to the nurse on duty who told us they would source appropriate storage for oxygen cylinders.

At one special school, the school nurse sought permission from the parents to administer medicine. The parents recorded the medicine their child needed with information about the dose required and how frequently to give the medicine. However, this was not checked against a consultant or GP letter. Therefore, staff were administering medicines to children and young people without a prescription from a medical or non-medical prescriber. This posed a risk that children and young people may not receive the correct therapeutic dose of medicine.

There were eight patient group directions (PGD’s) in place in the sexual health department. A PGD is a written instruction for the supply and / or administration of a named licenced medicine for a clearly defined condition without the need for a prescription or an instruction from a prescriber. The health professional working within the PGD is responsible for assessing that the patient fits the criteria set out in the PGD. When staff administered medicine under a PGD, they placed a pre-printed label in the patient’s notes which documented the batch number and ensured the patient met the criteria for that particular medicine. We observed these in patient’s medical records filled out correctly.

**Safety performance**

Services for children, young people and families did not care for any acutely unwell children and therefore there was no safety performance data available for this core service.
Incident reporting, learning and improvement

There were some significant safety concerns across the service, and some risks had become normalised. There was inconsistency across the service in incident reporting and management. Whilst staff did recognise incidents they did not always report them and were not confident that action would be taken.

The trust used an electronic incident reporting system. Data submitted by the service showed that the children, young people’s and families services reported 77 incidents from January 2017 to December 2017. Of these 77 incidents, two were classed as moderate impact and the 75 as minor impact. The paediatric occupational therapy service reported 38 of these incidents, health visitors reported 24 incidents, the school nursing service reported 14 of the incidents and one incident was reported by sexual health. We reviewed all the incidents reported and key themes were information technology systems, wheelchair and equipment access for occupational therapy and communication between maternity services and health visitors.

There was inconsistency in incident reporting in the school nursing service. Some junior staff in the school nursing service told us that they reported incidents to a senior member of the team to report. One member of staff told us they had not reported an incident for 18 years and other members of staff told us they did not always report information technology incidents as they happened so frequently.

Staff in the sexual health service knew how to report incidents and gave examples of when they had done so. Staff told us they received feedback which informed them of the outcome of the incident. However, the data submitted by the trust showed only one incident had been reported between January 2017 and December 2017. This may pose a risk that incidents were not always reported within the service. Staff told us incidents were discussed at the team meetings.

Staff across the service told us they received feedback about incidents and we saw evidence of this when we reviewed incidents. However, staff told us if they had reported an incident with the electronic reporting system, they received a response just stating the issue was already known about. Some staff were able to give examples of incidents they had reported and learning from these incidents. Staff told us that incidents were shared at local team meetings. One senior member of staff told us they had to keep resubmitting incidents reports as no feedback was being provided. Staff were unable to give examples of learning from incidents.

Some community staff told us that they felt the incident reporting system was aimed at acute hospital services and therefore was time consuming for community staff to fill in as they had to repeat information. Staff told us the system was not user friendly and took approximately 45 minutes to fill in.

Serious Incidents - STEIS

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community services for children, young people and families, which met the reporting criteria, set by NHS England from January 2017 to November 2017.

Serious Incidents (SIRI) – Trust data

From October 2016 to September 2017, trust staff in community services for children, young people and families reported no serious incidents.
The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Although we found all staff knew about their duty to be open and honest with patients, no staff knew of any examples where DoC had been implemented. Staff told us that the trust had issued all staff with pocket cards reminding them of their duties under the DoC regulation. Staff also told us training was available as an online training module.

**Is the service effective?**

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

**Evidence-based care and treatment**

The service followed national care and treatment programmes and pathways. However, some clinical policies and procedures had not been ratified and did not include up to date clinical guidelines.

We reviewed care pathways used by the health visiting service and found that these did not show evidence of quality assurance or include a date. This meant the inspection team were unable to tell if the policy was recent. However, some policies were clearly out of date and did not reflect national best practice guidelines.

The health visiting and school nursing services followed the Department of Health’s national initiative called The Healthy Child Programme (HCP). The programme required the early intervention of health visitor contacts with babies and children. It offered regular contact with every family and included a programme of screening tests, developmental reviews and information, guidance and support for parents. We saw that health visitors gave information to parents in line with the Healthy Child Programme.

The health visiting teams used the Ages and Stages Questionnaires (ASQ-3), as part of the Healthy Child Programme specification as set out by NHS England in 2015. Parents completed the questionnaires which were reviewed by health visitors. Health visitors were able to identify follow up actions for any concerns identified.

The service delivered the National Child Measurement Programme (NCMP). The programme measured the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10-11 years) to assess overweight and obesity levels. This is a government initiative, supported by NHS England. There were clear written pathways for underweight or overweight children. The pathways outlined that, children who were recorded as underweight or very overweight would be referred by the band 4 practitioner to a school nurse. The school would check the weight and then if correct send a letter to the parents and follow up. However, we found school nursing staff did not always contact parents when children were found to be overweight when measured. Band 4 nursing staff told us that if a child was overweight but looked ‘ok’ they would not always act on the information. However, staff told us they would always call the parents of ‘very overweight’ children. This assessment was made by band 4 staff who did not hold a nursing or public health qualification. This meant that there was no robust and consistent method of identifying and raising concerns for children who were identified as overweight. There was no oversight from a registered health professional of the decisions being made.
The occupational therapy team used the Canadian Occupational Performance Measure (COPM), which was adapted for use with children, young people and their parents. The purpose of the COPM was to help individual goals to meet the patient’s needs.

There was no clear protocol or guidance within the health visiting service or the electronic record system on how a new birth visit should be carried out. For example, we reviewed two new birth visit records, one showed full documentation about the observations made at the new birth visit. The second record only recorded minimal information.

**Nutrition and hydration**

Staff, in health visiting and school nursing, educated families and carers to a high standard regarding nutritional health.

We observed 11 health visitor clinics or interactions and observed health visitors gave clear, evidence based information to expectant mothers about breastfeeding and feeding regimes in each appointment.

We observed school nursing staff gave advice and education on healthy eating and drinking to school aged children. For example, advice on snacking and promotion of the change4life sugar swap initiative.

Data from the national child measurement programme reflected in child health profiles 2016/2017 showed that the Isle of Wight had an above average level of overweight and obese children. The level of overweight reception aged children on the Isle of Wight was 22% compared to an England average of 13%. For year six children the England average for overweight children was 14.3% compared to an average of 35.6% on the Isle of Wight.

**Pain relief**

Staff used age appropriate pain tools to recognise and assess pain in children and young people.

Staff in both special schools we inspected used age appropriate pain tools to assess pain. Staff in a school for children aged up to 11 used a behavioural pain tool. Staff assessed five key behaviours to assess the severity of the child’s pain. In the school for older children with physical and learning disabilities there were a range of pain tools which included a behavioural tool, a visual aid, an adapted visual aid, and a numerical scale. The school also had a chart where children and young people could point to the part of their body which was hurting or use Makaton to communicate their pain.

**Patient outcomes**

The service had limited processes in place to monitor the effectiveness of the service through audit, other than through submission of national data. The service performed well in the healthy child programme, but vaccination rates were below the national average, including for children in care.

**Audits – changes to working practices**

The trust have recorded no clinical audits in relation to community services for children, young people and families which they have participated in as part of their Clinical Audit Programme.

The sexual health service carried out two audits in 2017. The first was the British HIV Association (BHIVA) psychological well-being, support, and use of alcohol and recreational drugs. This
showed the service was in the top 25% for three of the five outcomes measured and in the third quartile for the remaining two outcomes. The second audit was the British Association for Sexual Health and HIV (BASHH) national clinical audit for management of syphilis. There was no action plan for either of the two audits, which meant we were unable to measure any changes in working practices because of the audit.

There were no audits in place across the 0-19 service or therapies service. The 0-19 lead told us they planned to implement a clinical audit programme to gain data and help improve patient outcomes. However, as the service lead was new in post this had not been implemented.

Vaccinations rates for the service were sometimes lower than the national average. Data from Public Health England showed the service achieved the vaccination rates below:

- Diphtheria, tetanus, acellular pertussis (DTaP-IPV-HIB) for babies at one year old was worse than the England average at 83.6% compared to an England average of 93.4%.
- The measles, mumps and rubella (MMR) vaccine at two years of age was slightly less than the national average, 88.1% of children had been immunised on the island against a national average of 91.6%.
- Hib and meningitis C vaccine for two year old children was worse than the England average, 85.1% compared to 91.5%.
- DTaP-IPV-HIB at for children at two years of age was slightly less than the national average of 95.1%.
- Hib and meningitis C vaccine for five year old children was similar to the national average 92.6% compared to a national average of 92.9%.
- The number of children who had received one dose of the MMR vaccine by age five was similar to the England average. The vaccination rate for the Isle of Wight was 95.8 compared to an England average of 95.8%.
- The number of children who had received two doses of the MMR vaccine by age five was also similar to the England average. The vaccination rate for the Isle of Wight was 86% compared to an England average of 87.6%.
- The service did not submit the vaccination rate for the Human Papillomavirus (HPV).
- Data published by Public Health England showed that in 2016 the vaccination rate for looked after children was 79.3% compared to an England average of 87.2%. During this inspection staff told us the vaccination rate for children in care was 83%. This meant children in the care of the local authority did not always receive vaccinations.

The health visiting service performed better than the England average for the completion of screening visits in line with the healthy child programme. From October 2017 to December 2017, the service saw 95% of babies for a six to eight week check compared to a national average of 83.5%. The health visiting team completed 91% of babies’ 12-month reviews by the age of 12 months and 90% of two to two and half-year-old reviews in the same time period. This was higher than the England average of 82.5% and 77.4% respectively. This information enabled the service to monitor contacts with mothers and babies and assess babies’ growth and development.

Data submitted to Public Health England from April 2016 to March 2017 showed breastfeeding initiation was below the England average, 66.4% of mothers were breastfeeding 48 hours after delivery compared to an England average of 79.1%. However, breastfeeding prevalence for mothers of babies aged six to eight weeks old was better than the England average. Data showed that 47.2% of mothers were still breastfeeding at six to eight weeks after birth compared to an England average of 44.4%.
Staff ensured a smooth transition between services for Children and young people in the care of the local authority. The Looked After Children (LAC) nurse supported children and young people through their transition to adult services. Looked after children remained on the specialist nurse’s caseload until they reached their 25th birthday.

Looked after children had appropriate health assessments and health care plans to meet their needs. We reviewed four health care assessments which showed staff clearly assessing and planning the needs of the child or young person. In our 2016 report, we found that not all health assessments considered the emotional and behavioural wellbeing of the child or young person. During this inspection, we found that all the notes we reviewed included these assessments. Staff told us that children and young people aged 11-17 years were sent a strength and difficulty questionnaire which helped assessed their emotional and behavioural well-being.

**Competent staff**

A high percentage of staff had completed a yearly appraisal, although this was still below the trust target. Scholl nursing services did not have evidence of competency assessments for staff.

**Appraisals for permanent non-medical staff**

- As of June 2017, 82% of permanent non-medical staff within the community services for children, young people and families’ core service had received an appraisal compared to the trust target of 100%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>21</td>
<td>17</td>
<td>81%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>9</td>
<td>8</td>
<td>89%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>55</td>
<td>45</td>
<td>82%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>70</td>
<td>85</td>
<td>82%</td>
</tr>
</tbody>
</table>

The data above showed that 82% of staff working within children, young people’s and family services had an appraisal. This did not meet the trust target of 100%.

Nurses in special schools told us that they had a yearly appraisal with their manager. In one school, the nurse had a joint appraisal with the head teacher and service lead. The nurse felt this was positive as they both their line manager and head teacher had a valuable contribution to make.

Staff in the school nursing service told us the appraisal system had improved and had become more focused. One member of staff shared their appraisal document with us which showed evidence they had discussed key topics such as health and wellbeing challenges, performance and improvements.

At our last inspection in 2016, three members of the school nursing team had completed the Specialist Community Public Health Nursing (SCPHN) postgraduate degree. At this inspection, we
found that six members of staff had completed the course and two other members of the school nursing team were completing the course at the time of our inspection. Staff that had completed the course felt this enabled them to bring new ideas and evidence based practice into the team. Some members of staff felt it was difficult to keep up to date with changes in clinical practice and new clinical guidelines due to the lack of geographical location of the trust.

Staff in the 0-19 service told us they received clinical supervision every three months, this included the nurses who worked in special schools. Band 7 staff supervised band 6 nursing staff who in turn supervised band 3 and 4 staff. One member of staff shared their supervision record which identified concerns from the previous session, performance management, service improvements, training and upskilling and any concerns with performance management. We saw records which showed that staff had been supported to discuss a variety of subjects for example aggressive patients and confidentiality breaches in a structured way.

The school nursing and health visiting service held practice development meetings where they discussed current issues, improvements new ways of working. We reviewed minutes of these meetings which showed staff had discussed service developments in locality teams, developments in technology to aid practice, for example new electronic applications and information on specific medical conditions. The meetings also included an outside speaker from another agency.

The paediatric occupational therapy and speech and language therapy team had separate programmes of continuous professional development (CPD). This included training sessions on autistic spectrum disorders, posture management, specific medical conditions and teaching parents to play.

The speech and language therapy team held a journal club once every half term where each team selected an article and submitted this for others to read. Each team were asked to critically evaluate one of the articles during their team meetings and read the other two. Teams were then asked to bring a good practice example or case study to the meeting based on the topic to share with other staff.

There were no competencies for band 4 or 5 nurses in the school nursing service. The 0-19 lead had only been in post for seven weeks. They told us they planned to introduce a training and competency programme. This meant that service leads did not have any assurance that band 4 and 5 nursing staff were competent to carry out their duties caring for vulnerable children and families.

**Multidisciplinary working and coordinated care pathways**

Staff of different kinds worked together as a team to benefit patients.

There was an emphasis on multidisciplinary team working across all services. Staff in all children services referred children, young people and their families to a variety of external services such as children’s centres, early help, children’s charities and counselling services.

Staff in the sexual health service were notified by pharmacies if patients under the age of 25 obtained emergency contraception. This meant staff were aware if vulnerable young people were obtaining contraception outside the service.

We attended an integrated sexual health safeguarding meeting where there was representation from the school nursing team.
The school nursing service had access to the young adults’ transition service run by a local hospice. The service supported young people from 14 to 25 years with terminal or life limiting illnesses to move from children’s to adult services.

The school nursing service had access to the child and adolescent mental health service (CAMHS). Staff told us would telephone CAHMS for advice if needed. CAMHS staff also ran workshops on a range of different topics such as self-harm, anxiety and resilience. This meant that staff gained knowledge and skills to help children and young people if they did not meet the threshold for the service.

In schools catering for children and young people with physical and learning disabilities, we found joint clinics were held to reduce the need for children to attend multiple appointments. In one school, clinics were held for children with epilepsy, asthma, allergy clinic and diabetes. This meant that the school nurse was involved in these clinics and a joint care plan was developed. In another school there was access to dietician, podiatry and audiology appointments. The school was planned to start a wheelchair clinic for children and young people. Teaching staff in special schools spoke highly of the nursing staff and told us they had good working relationships with them.

Physiotherapy teams worked with school staff and support workers to carry out physiotherapy sessions. This meant that children and young people did not need to miss school to attend appointments and school support workers learnt physiotherapy techniques. Staff told us this was helpful so they were able to carry on physiotherapy techniques throughout the school day.

Staff told us and we observed good joint working between services and the safeguarding children team. Staff in all services told us they accessed the team for advice and support and we observed members of the safeguarding team attended service led meetings.

Health promotion

The service effectively promoted and empowered service users to manage their own health, care and wellbeing to maximise their independence.

Sexual health staff worked with a number of schools to ensure young people had access to sexual health education, this included special schools and faith schools. The service provided sexual health training for schools and other health professionals. These sessions covered a variety of topics such as safeguarding, sexually transmitted diseases, condoms and where to access support. The service delivered these sessions to teaching staff before they presented to young people in the school to ensure staff were able to answer questions if they arose after the sessions. Staff left a locked question box in the school for one week after they had delivered the session so children and young people could leave questions. One week later staff ran a follow up session based on the questions submitted. Staff told us these sessions were well received by students and one sixth form had set up their own peer sexual health teaching group.

Staff in the sexual health department had access to a virtual doll which they used to help educate young people on the demands of having a baby. If a member of staff thought a young person would benefit from the virtual doll, they discussed this with the team to ensure it was the most appropriate option. We heard an example where this had been used successfully for a vulnerable young person who wanted to have a baby.

The health visiting team ran antenatal parent craft sessions for expectant parents even though this was not part of the commissioning arrangement. These sessions included information on a variety of topics for example, baby brain development and responsive feeding. Parents told us they valued these sessions to them prepare for having a baby.
We observed health visitors discussed vaccinations with expectant mothers. For example, one mother had not had the whooping cough vaccine. We observed staff discussed the benefits of the vaccine which included current research that had taken place.

Band 4 staff in the school nursing service delivered health promotion teaching sessions to children and young people at school. The sessions covered topics such as healthy eating, e-safety, handwashing and dental care. We observed a health promotion session for year 6 children. This was well presented and had good engagement from the children and teaching staff. The session gave children information on nutritional labels, portion size, sugar consumption and exercise.

We observed health promotion leaflets were available in all the clinics we visited. This meant patients had access to information to help them manage their own health and care needs.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff were aware of their responsibilities to seek consent using Fraser guidelines and the principle of Gillick competence.

**Deprivation of Liberty Safeguards**

The trust reported that no Deprivation of Liberty safeguard (DoLS) applications were made to the local authority from October 2016 to September 2017 that were pertinent to community services for children, young people and families.

Staff demonstrated a good knowledge of Fraser guidance. Fraser guidance is used by professionals to determine if young people under the age of 16 can receive contraceptive advice or treatment without parental knowledge or consent.

At our 2016 inspection, we found that staff in sexual health did not always document they had assessed a young person’s ability to consent to receiving treatment without a parent present in line with Fraser guidance. On this inspection, the sexual health service had implemented a form for young people under the age of 18 which prompted staff to record their competency assessment. We reviewed the medical records of five patients under the age of 16. Staff had documented they had assessed competency for four of these patients. However, for one 14 year old patient the staff member had not documented a competency assessment. The service had not carried out an audit to assess compliance against this new form.

Gillick competence refers to a term used in medical law to decide whether a young person (under the age of 16) can consent to his or her own medical treatment without the need for parental permission or knowledge.

We observed staff in the sexual health clinic gained informed consent from young people for procedures such as coil fitting. Staff explained the benefits and risks of the procedures to enable them to make an informed choice.

School nurses had a clear process for managing parental consent for the audiology and vision screening and national child measurement programme. Staff sent parents information about the programme, a questionnaire and consent form. If parents did not return the consent form they were sent another letter which informed them that the school nurse would see the child unless they opted out.

School nurses who saw children and young people at school without their parents were aware of consent and confidentiality. Staff told us that they made it clear to children and young people that

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1 Universal RPIR – DoLS tab
they had a choice whether to speak to them. Staff told us they explained to children and young people if they were concerned about the information they disclosed, staff would have to pass on the information.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness.

We observed staff engaged with children, young people and their families across the service. We saw compassionate and caring interactions and staff were skilled in communicating with children and families.

All the feedback we received from children, young people and their families throughout the inspection was extremely positive. We spoke with 11 parents who attended health visitor clinic appointments. They told us the staff were kind and compassionate and staff took the time to really listen to them. Parents described the service as supportive, positive and available.

Data submitted by the sexual health service during our inspection showed 99.54% of patients who completed the ‘I want great care’ trust patient satisfaction survey in sexual health would recommend the service. Young people who used the service spoke highly of the staff and commented, ‘I was really nervous but they made me feel comfortable’, ‘staff are really nice, friendly and kind, ‘they don’t judge me’ and ‘staff are really cool’. We requested data for patient satisfaction surveys in other services but these were not submitted by the trust.

We observed a school nurse was called to see a child who was unwell in a special school, the nurse spoke calmly to the child, other children in the class and teaching staff to reassure them. The nurse stayed with the child until their parents arrived.

We heard about examples of when the looked after children nurse (LAC) had supported children and young people at specific times. For example, the LAC nurse gave an example of when they were asked by a young person to support them when they had dental surgery at the hospital. The LAC nurse provided this support and there was a positive outcome for the young person.

Emotional support

Staff provided emotional support to patients to minimise their distress.

We observed staff across the service interacted with children, young people and families in an open and non-judgemental way. We saw examples in the sexual health clinic where staff discussed sensitive subjects such as abuse, drug and alcohol use and sexual history with children and young people. The children and young people told us afterwards that they felt they could be open and honest with the staff as they did not judge them.

School nurses and health visitors were aware of the emotional needs of children. Staff in the 0-19 service referred children aged 3-19 years of age to a local counselling service run by a charity.

The school nursing team used a wellbeing scale to help children and young people communicate how they were feeling. Although staff mainly used this with LAC, it could be used for any child or young person. The wellbeing scale covered a range of different situations such as how the child or young person felt at school, at home or this week. Children and young people were also encouraged to fill out an ‘about me’ which asked the child to identify things they were good at and made them laugh, things that made them angry and sad and words that they and their friends
used to describe them. We observed school nurses used these to understand how children and young people were feeling.

We observed health visitors discussed post-natal depression with expectant mothers at their ante natal visit. The health visiting service offered baby massage sessions to parents who were identified as being in need for example, mothers with postnatal depression or families identified as vulnerable or subject to a child protection plan. These sessions were provided on a one to one basis.

One of the nurses in a special school had a qualification in cognitive behavioural therapy. Although they did not offer formal sessions to children, the nurse told us they used it in their day to day work to support children. The nurse gave an example of a young person who had suffered severe bullying in a mainstream school and had developed anxiety as a result. The nurse told us they worked with the young person, using CBT techniques to help the child develop coping strategies. As a result the young person now managed their anxiety well.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

Staff across all services clearly placed the child, young person and their family at the centre of their work. We spoke with 20 children, young people and parents across the service who all praised the care they received. We also observed nine clinic appointments across sexual health, health visiting and children’s therapies where we observed staff involved children and their families in decisions about their care and treatment.

We observed health visitors discussed a variety of information with expectant mothers. This included explaining the benefits and risks of breastfeeding, vaccinations and general health advice. We observed staff used evidence to support their discussions and gave parents information on where they could find further information if needed. One parent told us they accessed the health visiting service on a number of occasions when they had concerns about their child. The mother told us the health visitor provided practical, helpful advice and was very approachable and supportive.

We observed one of clinic appointments for young people in the sexual health service. We observed staff explained procedures and treatments to patients. Staff used demonstrations and both written and verbal explanations.

**Is the service responsive?**

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

**Planning and delivering services which meet people’s needs**

The trust planned and provided services in a way that met the needs of local people

Parents, children and young people had access to clinics which were held in accessible locations. These included children’s centres and drop in clinics which staff and people who used the service told us met their needs. Parents at health visitor clinics told us that appointments were easily available and clinics were accessible. Parents were particularly satisfied with clinics which ran all day as they found these the most accessible.

All sexual health clinics provided by the service were held at the main hospital. Young people told us it was easy to get to by bus after school or college. The sexual health service told us they had changed their service to meet the needs of patients. For example, they had previously held a clinic
on Friday and Saturday evenings but found these clinics were not well attended. As a result, the service moved the clinic to a weekday evening.

The sexual health service used text reminders to inform patients of their appointment. The service told us this had reduced the rate of patients not attending their appointment. Young people told us this was helpful to remind them of their appointment.

The 0-19 service lead told us they were developing a community profile for each locality. This would identify the needs of the local population for example, areas with high deprivation may need more intervention from school nurses and health visitors. The lead had only recently started in post and therefore had not completed this at the time of our inspection.

The school nursing service provided a drop in session at a children’s centre on alternate weeks which was run by a band 4 member of staff. The drop in sessions were placed in this area as increased vulnerability had been identified and there was an increase in children presenting as overweight or obese in the national child measurement programme. However, there was no child or parent feedback sought about these drop in sessions.

Services were aligned to national programmes such as the healthy child programme and national child measurement programme with set key performance indicators to monitor progress. The health visiting service planned for five universal visits this included an antenatal visit, new birth visit and further visits when the baby was six weeks old, nine to 12 months old and 27 months old. However, health visitors scheduled more visits if required to meet the child and family’s needs.

GP’s carried out a surveillance programme in some localities alongside health visitor checks for babies aged six to eight weeks old. The majority of health visitors across the service were co-located with GP’s and were able to provide this service. Health visitors saw this as good time management and told us that it reduced the number of requests for home visits. Parents told us they particularly valued this service.

The school nursing service did not have any form of electronic messaging for children and young people to access. This meant that children and young people who wanted to speak to a school nurse had to access the service through an adult. This posed a risk that children and young people may not access the service.

There was no psychologist designated for looked after children. Looked after children also did not have a priority pathway to the child and adolescent mental health service. This may mean that some of the most vulnerable children and young people are not able to access mental health services in a timely way.

Meeting the needs of people in vulnerable circumstances

Staff demonstrated a good understanding of the needs of the local population where they worked.

The sexual health service worked with education staff in schools for children and young people with physical and learning disabilities to provide sexual health education. Staff worked with teachers to ensure the content was appropriate and pupils would be able to understand the sessions. For example, in one school, a sexual health nurse delivered an education session while a teacher signed to allow young people with hearing loss to understand the content.

Nurses in schools for children and young people with physical and learning disabilities adapted teaching sessions to meet the needs of children and young people with communication problems or sensory loss. This included delivering sessions using Makaton, textures, picture symbols and props. For example, when teaching personal hygiene the nurse used bottles of shower gel and shampoo so children could see, touch or smell the products.
Children and young people not in education, employment or training (NEET), home educated children or children missing from education have been identified as being particularly vulnerable. At the end of March 2017, there were 294 children who were home educated and 77 children missing from education on the Isle of Wight. The school nursing service assigned a senior school nurse who worked with this group of children and young people. The school nurse also worked with the pupil referral unit and provided support for children and young people at risk of being excluded. Staff made home visits to undertake an initial needs assessment for children who were excluded or at risk of being excluded and made arrangements for children to have vaccines outside of school. Staff told us there were plans to extend this role, for example to become more visible in colleges and the island learning centre.

Staff in the school nursing service told us the team did not keep leaflets in other languages for children or families who English was not their first language. However, staff told us that they could order leaflets if needed and had access to an interpreter.

The speech and language therapy team dedicated one clinic a month to children and young people who had additional learning needs. This meant children and young people assessed a clinic which was completely focused on meeting their needs.

**Access to the right care at the right time**

Children and young people could access most services when they needed it. However, there were significant delays in accessing outpatient appointments in occupational therapy particularly for children with autistic spectrum disorders.

**Accessibility**

- According to the trust’s RPIR submission, the largest ethnic minority group within the trust catchment area is White Asian with 0.53% of the population. The four largest ethnic minority groups are as follows:

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White Asian</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian Other</td>
</tr>
<tr>
<td>Third largest</td>
<td>White/Black Caribbean</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Indian</td>
</tr>
</tbody>
</table>

**Referrals**

- The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.
- The trust met the referral to assessment target in all but one of the targets listed

<table>
<thead>
<tr>
<th>Name of in-patient ward or unit</th>
<th>Days from referral to initial assessment</th>
<th>Days from assessment to treatment</th>
<th>Comments, clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National Target</td>
<td>Actual (mean)</td>
<td>National Target</td>
</tr>
</tbody>
</table>

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The data above showed that waiting times for treatment were in line with national targets in all services apart from occupational therapy.

Information we received on site from the paediatric occupational therapy team showed there were significant delays in occupational therapy appointments for children and young people. There were particular delays for children with autistic spectrum disorders. We reviewed waiting times for December 2017 which showed one child with an autistic spectrum disorder had been waiting 45 days for an appointment against a trust target of 3 days. There were 16 children and young people classed as needing an urgent appointment on the waiting list. The average wait for this was 45 days with the longest wait being 85 days against a trust target of 7-10 working days. For routine appointments, the trust target was 10-12 weeks. We found there were 24 children and young people on the waiting list. The average wait was 220 days (44 weeks) and the longest wait was 430 days (86 weeks). In addition to this there were 71 children with autistic spectrum disorders waiting for routine appointments, the average wait for these children was 305 days (61 weeks) and the longest wait was 480 days (96 weeks). Staff told us this was due to staffing shortages and a vacant band 7 post. Staff in the SALT team told us this impacted on SALT input as the sensory needs of children with autistic spectrum disorders were not being addressed. Staff told us they had recently gained the contract for providing occupational therapy for children with autistic spectrum disorders.

The sexual health service held a dedicated drop in clinic for young people under the age of 25 once a week. The service also offered a psychosexual counselling clinic. Patients accessed the clinic by referral against a set criteria from a health professional. The clinic was open to all age groups which included young people. The service informed us there was no waiting list for this clinic.

Patients made appointments over the telephone for the sexual health clinic. There was no online booking facility for the clinic. Staff told us that if a patient requested an appointment for screening for sexually transmitted infections did not have symptoms they were directed to an online testing service. This allowed the patient to apply for a test online and complete it at home. Test results were available 24 hours after the completed test had been received. The sexual health service had a triage system in place. A nurse telephoned patients who had requested an urgent
appointment. This meant the service ensured patients who required urgent appointments were prioritised.

Staff in the sexual health department were trained and had access to microscopy equipment which allowed staff to analyse swabs immediately, diagnose infections and dispense appropriate treatment.

There were no clear systems or processes to contact a duty health visitor. The health visiting team did not have a duty line. This meant that the service could not guarantee a member of staff was available to answer a telephone call if a parent telephoned the office. However, staff told us there was nearly always a member of staff in the office who took a message and documented in a message book for the appropriate health visitor. We reviewed the message book and found that although staff documented the date of the message they did not document the time, who the message had been taken by or who had actioned it. Staff told us they ticked the message when it was actioned. We observed that out of 33 messages taken over seven days, five of these did not show they had been actioned. This posed a risk that staff did not follow up messages. However, health visitors told us this process was working well and parents told us that they could always speak to a health visitor when they phoned.

The LAC team used text messaging to communicate with children and young people. All messages were recorded on the electronic records system. Children and young people were aware this was a service only available during office hours and not for use in a crisis.

Children and young people waited an average of eight weeks for their Initial health assessments (IHAs). National guidelines recommend IHAs are carried out within 20 days of notifications. The trust told us this was due to the difficulty obtaining documentation from the local authority the child or young person was transferring from.

At our last inspection we found that 30% of children and young people were not being brought to their initial health assessments. At this inspection, we found that from January 2017 to January 2018 only four children or young people were not brought to their appointment. Staff told us that they had reduced this rate by working more closely with social workers and offering a text or email reminder service for carers.

**Learning from complaints and concerns**

Although the service treated concerns and complaints seriously, children, young people and their families were not always given information on how to make a complaint. There was no child friendly complaints process within the service.

**Complaints**

Community services for children, young people and families received one complaint from September 2016 to August 2017 relating to the values and behaviours of a school nurse.

The children’s physiotherapy team had one complaint in September 2017 from a parent about confidentiality and sharing information. The team meeting minutes showed the team had discussed and reflected on the complaint and learning was shared within the team. However, the learning from this complaint was not shared across all teams.

The school nursing service information leaflet ‘about your school nurse’ included information about how to comment on the care children, young people or families had received. This meant that if parents wanted to contact the service to make a complaint they would be able to do so. However,
this information was aimed at parents and not children. There was no information within any of the
children or young people’s services aimed at children or young people to inform them about how
to comment or make a complaint about their care.

We did not see any information for patients and their families to inform them on how to make a
complaint in the therapies and sexual health service. The patients we spoke with in the sexual
health service did not know how to make a complaint.

The school nursing service ran a health education programme for children in school. Staff told us
that they attempted to get feedback using questionnaires for the teachers. However, there was no
system in place to gather children’s views on the sessions. There was also no clear evidence
about how the service used the information from questionnaires to improve the sessions.

Compliments

- The trust did not record any compliments during the last 12 months that related directly to
  community services for children, young people and families.

Is the service well-led?

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

Leadership

Whilst local leaders had the right skills and abilities, they were not always supported by senior
leaders to run a service providing high-quality sustainable care. There was a lack of confidence in
the clinical business unit leaders experience and interest in services for children, young people
and their families

Community services for children, young people and families were part of the ambulance, urgent
care and community clinical business unit (CBU). The CBU consisted of a head of community,
operations manager and head of nursing. There were service leads in place for the 0-19 service,
speech and language therapy, paediatric physiotherapy and sexual health. The paediatric
occupational health team did not have a service lead at the time of our inspection and a band 7
was leading the service. The 0-19 service and sexual health reported to the head of community
and the therapies service leads reported to the operational manager. The head of community
reported to the director of nursing within the executive team.

Some community services felt they did not always have the support of some senior leaders within
the clinical business unit. Staff commented they had arranged meetings with senior leaders to
discuss important concerns within their services but these had been cancelled. Service leads told
us that they did not always feel that the CBU understood or gave enough priority to some key
concerns within the children’s community services. For example, staff felt more priority had been
given to urgent care and adult services and therefore essential improvements had not taken place.
The service leads told us that there had been a plan to separate community services from the
CBU but this had not yet happened and they were not kept informed of the progress of this
change.

The sexual health service were undergoing significant changes to their service. The service
planned to have their budget reduced by almost 50% and therefore were looking at new ways of
providing the service. Staff told us that they did not always feel supported by the CBU through this significant change. However, the trust told us that support for the redesign of the service had been provided on an ongoing basis by the operations manager of the CBU. This included discussions with the service manager on a one to one basis and also negotiations with public health.

At service leadership level, staff told us that leaders were supportive and encouraged staff engagement. Staff in the sexual health department talked positively about the local leadership of the sexual health service. Staff felt the clinical service manager was approachable and visible in the service. The 0-19 service lead had been in post for seven weeks at the time of our inspection. Staff in the school nursing service told us they found them supportive and approachable.

Staff in sexual health and the 0-19 service felt connected to the trust leadership and had been given opportunities to meet the executive team. Health visitors and school nurses told us that the chief executive of the trust had visited the service when they were new in post. Staff told us they valued this opportunity. Staff also told us that they had raised concerns about the information technology systems and felt these had been listened to. However, staff told us they had not received any further feedback about the concerns raised.

There was no evidence of succession planning within the service. In occupational therapy a service lead post had become vacant in April 2017 and was not advertised until December 2017. In health visiting a band 7 post was available, however the service lead told us they were reviewing the team requirements before recruiting for the post.

**Vision and strategy**

Services for children, young people and their families did not have a vision for what it wanted to achieve and workable plans to turn it into action.

The trust had an overarching strategy which was described as working beyond boundaries to be the preferred choice for sustainable integrated care. The five strategic priorities were excellent patient care, work with others to improve our services, a positive experience for patients, service users and staff and cost effective sustainable services.

However, there was no strategy in place for the children and young people’s community services. This has been highlighted in both our 2014 and 2016 report. Whilst the new 0-19 service lead told us they planned to develop the service to become more public health focussed, there was no clear plan in place to achieve this.

The trust had a vision to provide quality care to everyone, every time which was displayed on the trust website. However, staff did not have a clear understanding of this vision or what it meant for them in their everyday work.

Health and social care organisations on the Isle of Wight jointly published a strategy ‘My Life a Full Life’ which included a whole system integration with a particular focus on health and social care, lifestyle risk factor management, sexual health, substance misuse and children’s public health. Whilst there was evidence of local initiatives in some services, staff did not appear aware that this may have been part of a wider strategy.

**Culture**

Most managers across the trust promoted a positive culture that supported and valued staff which created a sense of common purpose based on shared values.

Most staff across the service felt proud to work within the children and young people’s service and spoke positively about the impact the service had on the health of their patients. Most of the staff we spoke with felt it was a good service to work in and there were opportunities for development.
There was a culture of mutual respect amongst staff in the sexual health department. Staff described working in a happy team, which developed new ideas and new ways of working. The clinical service manager told us the team were positive and passionate about their work.

Some staff in the school nursing department described the culture as ‘hierarchical’ and some junior staff told us they did not feel supported by more senior staff. However other staff felt well supported within the team.

Staff in the special schools did not have links with the school nursing team on a regular basis. This meant that they felt more part of a team with school staff than other trust staff.

There were positive working relationships and cohesive team work across the service. There was a clear culture of multidisciplinary learning and development to improve patient care.

Staff described a ‘no blame’ culture and all the staff we spoke with told us they would feel comfortable to raise concerns within their role.

Staff worked collaboratively and supported each other in their roles. For example, health visiting staff gave an example of when one member of staff had an increased caseload and the other team members helped share the work to ensure that individual was not overwhelmed.

Staff were aware of their responsibility to be open and honest under the Duty of Candour regulation. Staff told us the trust encouraged staff in their responsibilities and provided pocket card reminders and online training.

All the community teams we spoke with had a lone working system in place. Some teams utilised a buddy system which staff told us was effective to support staff safety.

**Governance**

There were not sufficient governance arrangements in place for oversight of safety and quality the children, young people and family service.

We requested information from the service about the CBU governance structure. However, the service did not submit this information. Service leads attended quality meetings with senior leaders in the CBU on a monthly basis to discuss key quality and governance issues. The standard agenda included summary of incidents reported, clinical audit, patient feedback results and top highlights or concerns to escalate to the directorate board.

We found the governance of individuals services was inconsistent. Staff in the sexual health service told us that the clinical service lead attended clinical business unit meetings and then cascaded information to the team in a ‘10-minute brief’. The 10-minute brief was a summary of key information discussed at the meeting.

However, we reviewed the minutes of these meetings for October 2017 and January 2018 which showed that out of all the services within children and young people’s community service only sexual health was discussed. The 0-19 service lead post was vacant and there was no representation from another member of staff despite staff raising serious concerns over the electronic records systems and connectivity. There was no record of any discussions of issues or concerns which may have impacted the children’s community therapy team for example, waiting list for children’s occupational therapy. This meant that concerns and issues were not being discussed at a senior level for some services and therefore there was no trust oversight of these concerns.
Management of risk, issues and performance

The service did not have an effective system for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected. Significant safety risks had not been adequately addressed.

There was inconsistency in the way risk was managed within each service. The service lead for sexual health told us they had a service level risk register and had escalated risks to the CBU risk register. We reviewed the CBU risk register and observed this included the risk of the reduction in the sexual health service.

The 0-19 service did not have any risks included on the service level risk register despite key risks to patients being identified within the service. The lead for the service told us they were working to rectify this. The trust submitted the CBU risk register following our inspection which included the risks associated with the electronic patient records system. However, the action plan to rectify this was to discuss reporting with service leads and implement training for staff. This did not address the issue of missing children, duplication of records or lack of oversight of paper records.

The service had not sufficiently the significant safety issues identified during our 2016 inspection. There were multiple different patient records systems in place. In sexual health and therapies staff used paper records, the 0-19 service used an electronic system, the inpatient children’s ward and emergency department used another electronic system and the child and adolescent mental health service also used a different system. We raised this as a concern in our 2016 report and whilst some teams had been given access to read the other electronic systems they could still not add information to the system. Therefore, teams without access to the electronic system were required to email information about vulnerable young people to the safeguarding team to add to the electronic system. This meant staff duplicated work for themselves and the safeguarding team spent time adding information to the electronic system. The looked after children team had to access four different records systems to gain information for child protection conferences. Some teams felt they were not asked for information before child protection conferences which posed a risk that not all essential information was available for consideration. Despite several risk factors, the multiple records systems was not included on the CBU risk register. This meant there was not oversight of this at a senior level and the trust executive team may not have been aware of a severe risk to the organisation.

There was no systematic programme of clinical and internal audit across the service which meant that senior staff could not be assured of the quality or safety of the service. Where audits had been carried out, there was no evidence that service leads had used the results of these to implement improvements or changes to the service. This had been highlighted as a concern at our 2014 and 2016 inspection but no action had been taken to address this.

In the August 2017 service quality report submitted to the CBU by the 0-19 service detailed hand hygiene, medicine management and documentation audits had been carried out by staff. However, we requested this information following our inspection and the trust were unable to provide this.

Services had also not repeated audits which caused concern during our last inspection, this meant although teams had put in processes to address the concern, they could be assured that these had been effective.
Information management

There were insufficient processes for accessing, sharing and using performance and quality information across services. There were significant failings in the information technology systems used by the service.

The information technology systems used by staff in the service were not reliable or fit for purpose. Staff reported a range of concerns with the information technology systems including connectivity issues, being unable to access patient’s records in a timely manner and the system wiping appointments for children and young people. This had a significant impact on the management of information as staff had individual paper records with no clear oversight of the data being stored or how it was being stored. We found 25 boxes of old patient medical records stored in the school nursing office waiting to be scanned onto the electronic notes system. The failings with the information technology system posed a significant risk to patients and the security of their confidential data.

There was evidence that the sexual health and 0-19 service had submitted a service quality report to the CBU in August 2017. These included services compliance with training, incident investigations, risk and staff management. However, there was no evidence that a therapies service quality report had been submitted and it was not clear how often the service quality reports were completed. The 0-19 service quality report for August 2017 identified that information technology and the electronic records system were a reoccurring theme in incident reports and a risk to the service. However, this had not been placed on the risk register and there was no evidence that the CBU used this information to address the risks.

We requested data from the service both before and after our inspection. Some of the information was presented as raw data which meant we were not able to draw conclusions from the data. For example, we asked the service to submit the results of their patient satisfaction surveys. This information was submitted for sexual health but presented as a spreadsheet with raw data. Therefore, the trust did not use information effectively to implement improvement in services.

Engagement

The service did not effectively engage children, young people and their families to plan and manage appropriate services.

Services did not always use feedback from children, young people and families to improve or develop their services. In sexual health staff gained feedback from young people in schools by placing a questionnaire on the back of a question slip given to all young people who attended the session. However, this meant that young people who did not need to ask a question would not necessarily fill in the questionnaire. We also did not see evidence that this information was being used to develop the service.

All services also used the ‘I want great care’ trust feedback questionnaire. However, the sexual health service told us the response rate was approximately 30%. We requested the results of the survey, however this was presented as raw data and therefore we were unable to draw conclusions from this.

Out of 11 parents with spoke with at the health visitor clinics, none of them had been asked to fill in a patient feedback questionnaire. Out of the four patients we spoke with in the sexual health clinic, none of them had been asked to fill in a patient feedback survey. The service contacted us after the inspection and told us that they had not asked these patients to fill in a questionnaire as they were speaking to the inspection team.
We did not see any evidence displayed in any area about changes that had been made as a result of patient feedback. Although some areas did display results, this did not include information about any improvements or changes made.

There were no service development groups with representation from children, young people or their families. This meant that the people using the service did not have the opportunity to help design or improve the service.

We requested the staff survey results from the children’s community services following our inspection but the trust were unable to provide this information.

**Learning, continuous improvement and innovation**

There were no robust systems or processes in place to improve services by learning, continuous improvement and innovation. There had been insufficient actions or improvement following the previous inspection.

We found the improvement systems within the service were undeveloped. While some services recognised improvements or innovation, staff told us this was not always supported by the clinical business unit leads, and therefore was not consistent across the service. There had been insufficient action to address the concerns and requirements identified at the previous inspection.

The lead for the 0-19 service had outlined many areas to make improvements. However, they had only been in post for seven weeks at the time of our inspection and therefore these changes had not yet been implemented so we were unable to assess the impact or progress of these. The service lead told us that she had outlined objectives for the service with the leads for the clinical business unit.

The 0-19 lead told us they planned to complete the 15 assessment model to look at clinics and adopt standards which could apply to all clinics. We requested this information from the trust but this was not available as it was still in the review process at the time of our inspection.

During our 2016 inspection the health visiting and sexual health service told us they were working together to build a business case for health visitors to prescribe the contraceptive pill to mothers of babies under one year old. Service leads told us they had identified that there was a high unwanted pregnancy rate among mothers who had babies under one. However, during this inspection the business case had not progressed. Staff told us they were waiting for a meeting with senior leaders which had not yet taken place. We requested a copy of the business case from the service but they were unable to provide this.

We asked the service to provide information on any accreditations or awards received for the service. However, the trust was unable to provide this information.
## Mental health services

### Acute wards for adults of working age and psychiatric intensive care units

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Ward name</th>
<th>Number of beds</th>
<th>Patient group</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary's Hospital</td>
<td>Osbourne</td>
<td>16</td>
<td>Mixed</td>
</tr>
<tr>
<td>St Mary's Hospital</td>
<td>Seagrove</td>
<td>6</td>
<td>Mixed</td>
</tr>
<tr>
<td>St Mary’s Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is the service safe?

Safe and clean care environments

Safety of the ward layout

Both wards carried out daily checks of the environment to ensure the wards were safe and that they reported necessary repairs to the estates department. Both wards were well-laid out, spacious and airy. The wards had good lines of sight with exception of two conservatory areas on Seagrove ward, at either end of the ward. Staff had a good view of the male corridor of ward.

The ward managed its ligature risks well. When we inspected in April 2017 we found that both wards had multiple ligature risks. A ligature point is an environmental feature or structure that is load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. There had not been a full comprehensive assessment of ligature risks on either ward since 2012, with some areas not being assessed at all.

On this inspection, we found that there was a comprehensive ligature point risk assessment completed. The assessment showed how staff should manage the risk and if the trust could replace them with a lower risk version. The ward managers and deputies attended regular ligature risk meetings with the other wards in the trust. This gave an opportunity to share learning and ensure a consistent approach to ligature management across the trust. The building was undergoing a refurbishment programme to remove and reduce ligature risks, this included installing anti-ligature doors, paper towel and hand soap dispensers in the en-suite facilities. The trust was replacing ward doors with anti-barricade doors and anti-ligature doors. The trust had replaced door handles that were not in the main ward area, with anti-ligature versions, piping was boxed in and other features that gave a ligature point had been removed.

Following our earlier visit, the trust had restricted access to the ward kitchen on Osbourne ward because of high-risk ligature points. On this inspection, we found that the trust had refurbished the kitchen and removed the high-risk ligature points. Patients could access the kitchen without staff support. For example, pipe work was boxed in, wall mounted kitchen units had been removed and floor units had anti-ligature handles.

The garden on Seagrove ward was free from hazards and open to patients. On Osbourne ward, the garden was redesigned with a fence preventing access to the out of view areas. The garden is currently inaccessible to patients due to the high ligature risks still present. The trust has plans in place to remove high-risk ligature points inside the fenced area. The changes would allow patients to have access to the courtyard. The ward manager told us that the changes would be complete by the end of March 2018.

Staff on both wards followed the trust’s observation policies and procedures to manage risk from potential ligature points. The trust had plans in place to reduce ligature risks that were still present on the ward. For example, the lounges still had ligature points and the ward manager explained that all patients were risk assessed before they used this space.

Wards had systems for ensuring environmental checks were completed. Both wards had a security nurse in charge of checking personal and safety alarms, environment checks and leading the fire safety oversight to ensure the exit routes were free of obstructions. The security nurse checklists were complete.
At the last inspection (April 2017) we found that the staff’s personal alarm system would at times not sound when activated or lead staff to the wrong areas potentially placing patients and staff at increased risk of harm. At this inspection, the trust had replaced all the old alarms and staff told us they were much more effective.

Both wards were mixed sex and had separate areas for male and female patients including bedroom areas and lounges. We had concerns during or visit in April 2017 about interconnecting en-suite bathrooms, but wards had reduced the number of beds to address this. All the plans for renovation of en-suite bathrooms and rooms are expected to be completed by March 2018.

Over the 12 month period from 1 October 2016 and 30 September 2017 there were zero mixed sex accommodation breaches within this core service. Both wards were mixed sex and had separate areas for male and female patients including bedroom areas and lounges. We had concerns during or visit in April 2017 about interconnecting en-suite bathrooms, but wards had reduced the number of beds to address this. All the plans for renovation of en-suite bathrooms and rooms are expected to be completed by March 2018.

**Maintenance, cleanliness and infection control**

Both the wards were clean, tidy and well-maintained.

The wards were bright with evidence of patient participation in decorating the ward, and having an input in the art pieces displayed throughout.

The staff followed hand washing and infection control procedures. The signage with hand washing instructions was clearly placed around the wards. Mattresses were checked every week.

Patient-Led Assessments of the Care Environment assessment is a system for assessing the quality of the patient environment. The only location, St Mary’s hospital, scored about the same as expected as other similar trusts for three of the four aspects overall. The location scored worse than other similar trusts for disability scoring 70.7% compared to 81.5% nationally.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Cleanliness</th>
<th>Condition appearance and maintenance</th>
<th>Dementia friendly</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST MARY’S HOSPITAL</td>
<td>97.9%</td>
<td>93.6%</td>
<td>78.6%</td>
<td>70.7%</td>
</tr>
<tr>
<td>Trust overall</td>
<td>97.9%</td>
<td>93.6%</td>
<td>78.6%</td>
<td>70.7%</td>
</tr>
<tr>
<td>England average (Acute/specialist)</td>
<td>98.4%</td>
<td>93.8%</td>
<td>75.5%</td>
<td>81.5%</td>
</tr>
</tbody>
</table>

**Seclusion room**

During our last visit in April 2017 patients needed to leave the seclusion room to use the toilet or shower and therefore staff would need to end seclusion. If it was unsafe to do so staff gave them a disposable utensil to use. The situation was the same on this visit, and the room was still used for seclusion. However, the ward manager told us that the trust had agreed building work to correct this. Staff could observe patients in seclusion and there was a two-way communication system.
Clinic room and equipment

Both the wards had clean and tidy clinic rooms. Staff kept records of fridge temperatures for the safe storage of medicines. Equipment such as weighing scales and blood pressure machines were regularly calibrated and the equipment was checked on a regular basis. Emergency equipment and medicines were stored on the wards in the clinic rooms, and staff knew how to use these. However, checks on the resuscitation bag on Seagrove Ward were disorganised. Staff were using two different lists to audit the contents of the bag, and neither list was accurate. We raised this to the ward manager, and a new list was commenced during the inspection. Staff made aware of the new procedures for the list.

In the clinic room on Osbourne Ward we found an opened bottle of Methadone which had expired although it had not been administered to any patients since its expiry. We raised the issue with staff, and they disposed of the medicine.

Safe staffing

Nursing staff

The trust set staffing levels on each ward.

On Osbourne Ward, 85% of the staff we spoke to said that there were not enough staff to meet patients’ needs. These staff said that at times, activities and some patient leave had to be deferred until a later time or day, or cancelled. Staff also reported that they were finding it difficult to provide structured activities because the acuity levels on the ward may affect the number of staff available to carry these out. Staff said they do not get a lot of time to make entries in the care records and therefore it was difficult to achieve the high quality of care records needed.

Definition

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of substantive staff</td>
<td></td>
</tr>
<tr>
<td>Total number of substantive staff leavers</td>
<td></td>
</tr>
<tr>
<td>Average WTE* leavers over 12 months (%)</td>
<td></td>
</tr>
<tr>
<td>Vacancies and sickness</td>
<td></td>
</tr>
<tr>
<td>Total vacancies overall (excluding seconded staff)</td>
<td></td>
</tr>
<tr>
<td>Total vacancies overall (%)</td>
<td></td>
</tr>
<tr>
<td>Total permanent staff sickness overall (%)</td>
<td></td>
</tr>
<tr>
<td>Establishment and vacancy (nurses and care assistants)</td>
<td></td>
</tr>
<tr>
<td>Establishment levels qualified nurses (WTE*)</td>
<td></td>
</tr>
<tr>
<td>Establishment levels nursing assistants (WTE*)</td>
<td></td>
</tr>
<tr>
<td>Number of vacancies, qualified nurses (WTE*)</td>
<td></td>
</tr>
<tr>
<td>Number of WTE vacancies nursing assistants</td>
<td></td>
</tr>
</tbody>
</table>
Qualified nurse vacancy rate | October 2016 – September 2017 | 8.2%
---|---|---
Nursing assistant vacancy rate | NA | NA

**Bank and agency Use**

| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | October 2016 – September 2017 | 21
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | October 2016 – September 2017 | 40
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | October 2016 – September 2017 | 63
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | NA | NA
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | NA | NA
| Shifts NOT filled by bank staff where there is sickness, absence or vacancies (Nursing Assistants) | NA | NA
| Shifts NOT filled by agency staff where there is sickness, absence or vacancies (Nursing Assistants) | NA | NA

*WholeTime Equivalent*

The trust’s staff fill rates for registered nurses and care staff was not available through the trust website.

This service reported an overall vacancy rate of 8.2% for registered nurses from October 2016 to September 2017. The highest number of vacancies within registered nurses was seen in the last six months of this 12 month period. September 2017 saw the highest number of vacancies within this year with 4 (23%).

Additional clinical services staffing group had a lower overall vacancy rate compared to registered nurses with 3.5% from October 2016 to September 2017.

This service has reported a vacancy rate for all staff of 6.3% from October 2016 to September 2017. This is lower than the reported trust wide vacancy rate of 9.9% from October 2016 to September 2017.

Data broken down by team/ward was not sent in from the trust.

From October 2016 to September 2017, bank staff filled 21 shifts to cover sickness, absence or vacancy for qualified nurses. In the same period, agency staff covered 40 of shifts for qualified nurses. The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked. There were 63 shifts were unable to be filled by either bank or agency staff.

This data is in relation to the Osbourne ward.

This core service had 1.6 (6%) staff leavers from October 2016 to September 2017. This is lower than the reported turnover rate trust wide of 9%.

Data broken down by team/ward was not sent in from the trust.
The sickness rate for this core service was 5% from October 2016 to September 2017. This was higher than the reported trust wide sickness rate of 4.3%. The most recent month’s data (September 2017) showed a sickness rate of 6.4%.

Registered nursing staff had a sickness rate of 5.5% across this time period. The highest levels of sickness were seen in the first six months of this year. January 2017 and February 2017. August saw the highest levels of sickness with 10.2% and 11.6% sickness rates reported respectively.

Data broken down by team/ward was not sent in by the trust.

The compliance for mandatory training courses within the core service as from April 2017 to October 2017 is 77%. Of the training courses listed, 11 failed to achieve the trust target of 85% and nine failed to score above CQC’s compliance benchmark of 75%. The trust set a target of 85% for completion of mandatory training.

Immediate life support (4%) and Mental Capacity Act (6%) had the lowest mandatory training compliance within the core service with the later also being the lowest trustwide.

Key:

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service</th>
<th>Trust wide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>96%</td>
<td>73%</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>96%</td>
<td>94%</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>89%</td>
<td>92%</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>89%</td>
<td>88%</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>81%</td>
<td>88%</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>77%</td>
<td>84%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>74%</td>
<td>69%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>70%</td>
<td>85%</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>65%</td>
<td>79%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>65%</td>
<td>83%</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>63%</td>
<td>54%</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>59%</td>
<td>70%</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>59%</td>
<td>77%</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Core service total %</td>
<td>77%</td>
<td>78%</td>
</tr>
</tbody>
</table>
Assessing and managing risk to patients and staff

Assessment and management of patient risk

Risk assessments were completed for all patients on admission to the hospital. Staff used nationally recognised risk assessments and tools such as the ‘historical, clinical and risk management scales’ and the ‘structured assessment of protective factors for violence risk’. This is a set of comprehensive guidelines for assessing risk of violence. Risk assessments were updated following incidents. Staff reviewed risk assessments every week and discussed specific patients’ risks.

A risk management plan was put into place for each patient within four hours of their admission. This was followed by a clinical assessment and care plan within 72 hours.

Staff told us, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased in response to increased risks. Risks were identified and plans to mitigate the risk were in place. In addition, the wards took part in the daily board meeting where risk issues and progress for each patient were discussed.

At the last inspection (April 2017), we found that the wards showed a lack of adherence to the National Institute of Health and Care Excellence guidance when administering medicines required to bring about the rapid sedation of patients. National Institute of Health and Care Excellence and the Code of Practice (CoP) both indicate that patients should be subject to regular physical health monitoring post rapid tranquilisation (RT) administration.

At this inspection, the wards had made improvements to their policies and procedures around the use and monitoring of rapid tranquilisation. Staff told us they now use a rapid tranquilisation competency tool which clarifies the medicine uses and dosages. Staff were also doing physical health observations for most patients administered with RT, although we found that there were some gaps. The wards carry out monthly audits of the physical observation records, and were rolling out training to improve further.

Seagrove ward completed a successful pilot of physical health screening. Following positive feedback from staff, the registered nurse and patients, the ward recruited a dual qualified nurse with training in mental and physical health. Patients received a full physical health screening on admission and routinely afterwards.

The wards had access to an electrocardiogram machine. An electrocardiogram is a test that measures the electrical activity of the heart to show whether it is working normally. Patients on neuroleptic medicine had at least two weekly.

There were good policies and procedures for the use of observation and searching patients. Staff told us that patient searches were done in a supportive and dignified way, ensuring that it was conducted in a private area of the ward and by the appropriate gender of staff. Staff made patients aware of any banned or restricted items in the admission agreement.

On Osbourne Ward, patients had fixed smoking times every hour. This was to ensure that patients were supervised while smoking, as the smoking area in the garden still had high ligature risks. The ward manager told us that this blanket restriction would be revisited and reviewed once the garden works had been completed.

Both wards had patients that were detained under the Mental Health Act, who negotiated leave with clinical staff.
Use of restrictive interventions

Staff told us that restraint was only used after de-escalation had failed and we found no evidence whilst talking to patients or reviewing care records to demonstrate otherwise.

This core service had 33 incidents of restraint and 12 incidents of seclusion between 1 October 2016 and 30 September 2017.

Of the 33 restraints, 12 (36%) resulted in rapid tranquilisation of the patient.

The trust reported that there had been one incident of patients restrained resulting in or held in a prone restraint.

There were no instances of long term segregation reported.

<table>
<thead>
<tr>
<th>Seclusions</th>
<th>Restraints</th>
<th>Patients restrained</th>
<th>Of restraints, incidents of prone restraint</th>
<th>Rapid tranquilisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>33</td>
<td>Not provided</td>
<td>1</td>
<td>12 (36%)</td>
</tr>
</tbody>
</table>

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust was unable to assign safeguarding referrals to services for the period between 1 October 2016 and 30 September 2017.

At the last inspection, we had concerns that not all safeguarding events that should be reported were being reported. At this inspection, staff we spoke told us that they knew how to raise a safeguarding issue or concern. Staff told us they had regular discussions about safeguarding, and what to report, and that information was much more available and accessible than at the last inspection in April 2017. Staff said they completed an electronic incident form and informed the nurse in charge or the ward manager if they felt there was a safeguarding concern. The nurses’ office held up to date flowcharts and referrals information. Staff knew who their safeguarding lead was and the internal process for safeguarding referrals was clear and evidenced in paper and electronic format.

The safeguarding assessments we looked at were comprehensive and complete, with clear evidence of patient involvement and care plans being updated.

The wards carry out regular audits on safeguarding care plans to ensure compliance with the minimum standards.

Staff told us how they keep patients safe from harassment and discrimination by observing behaviours on the wards and between patients and visitors.
The safeguarding training compliance on both wards was very low, and staff told us that this is because there is no training availability at present.

Isle of Wight NHS trust has submitted details of zero external serious case reviews commenced or published in the last 12 months that relate to this core service.

**Staff access to essential information**

Staff used a mixture of paper records and an electronic care record system to make notes on patients’ treatment and progress. The electronic system was available to all relevant staff when they needed it. Information was available between different teams across the trust.

Ward managers had access to the trust risk register and anyone could add items to it if they felt it presented a risk to the safe performance of the ward. Ward staff and managers received training the use of the risk register since the last inspection, and staff had been taught how to use the risk register effectively.

**Medicines management**

There were appropriate arrangements across both wards for the management of medicines. Staff gave patients information about their medicines. There were no errors or omissions in the recording of medicines dispensed. Sharps boxes were available. If patients had allergies, these were listed on the front of the prescription chart. Medicines were available and in date. There were good processes and procedures in place on the ward for medicines reconciliation. This is where the ward staff contacted general practitioners on admission, to confirm what medicines and dosages the patient was taking so that these medicines could continue while the patient was on the ward.

The prescribing of medicine was done online. The staff we spoke to said that there is sometimes an issue with accessing the prescription records if someone else is looking at it at the same time.

The wards have a back-up computer in place.

A pharmacist visited each of the wards and carried out routine audits to ensure that staff were managing medicines safely. Patients at risk of side effects from taking high dose antipsychotic medicines were monitored. Medicines to be given when required, were prescribed for patients appropriately and staff regularly reviewed and discontinued them if they were no longer needed. Medicines to be given to patients detained under the Mental Health Act were documented accurately. Forms were always signed by the consultant overseeing the patient’s treatment, by the patient, if they had capacity to do so or by a second opinion appointed doctor.

**Track record on safety**

Seagrove Ward had reported one serious incident over the last year, and Osbourne Ward had none. The serious incident on Seagrove Ward was dealt with in an efficient and safe manner. The ward staff held a professional meeting with all parties involved (including the patient concerned and family members), and set a new terms of reference for serious incidents to be followed and recorded.

Children were not allowed on the wards. Staff on the wards encourage family members and visitors to arrange planned visits, so that arrangements can be made if children visit.
Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. Between 1 October 2016 and 30 September 2017 there were no serious incidents reported by this core service.

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

Staff knew how to recognise and report incidents on the providers’ electronic recording system. Incidents and lessons learnt from incidents were shared at the wards’ daily handover meetings and multidisciplinary team meetings. Staff gave us examples of incidents reported and lessons learnt from safeguarding incidents, the use of rapid tranquillisation, assault and verbal abuse.

Staff had access to debriefing and support following incidents; this was in the form of regular or ad hoc reflections, or a debriefing session led by the ward matron.

Staff understood the Duty of Candour and told us they were open and transparent with patients and their families, if something went wrong. Managers gave examples of where they had engaged families and carers in reviews when things went wrong.

Staff were aware of the policies and procedures around reporting patient crimes, and followed ward procedures.

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there has been one ‘prevention of future death’ report sent to Isle of Wight NHS Trust which the trust had responded to.

**Is the service effective?**

**Assessment of needs and planning of care**

Care planning had improved on both wards, however they were still not recovery orientated. At the last inspection, patients’ care plans on both wards were incomplete and on occasion missing. Care plans were not patient centred, personalised, holistic or goal orientated. Some information relating to physical health assessments was missing.

At this inspection, we noticed a significant improvement in care plans. We reviewed 14 care records and all patients had detailed and timely assessments of their previous history and physical healthcare needs. Care plans were holistic, and showed staff had a good understanding of the patients’ care needs. Staff regularly updated care records and linked them to risk assessments.

However, care records were not always recovery orientated and lacked goal setting and monitoring of patients’ progress.

**Best practice in treatment and care**

Staff in the majority followed National Institute for Health and Care Excellence guidance when prescribing medicines, care planning, and physical health care delivery.

The occupational therapist provided social based educational groups, and additional activities including arts and crafts, music, cookery and trips to the local community.
Staff engaged in clinical and management audits. These included reviewing physical healthcare ligature risks, enhanced observations and medicine management. Staff reviewed care plans and risk assessments to ensure quality and completion.

Staff representatives from each ward, senior clinicians and managers attended regular business meetings to review clinical effectiveness and looked at, for example, models of care, quality of care records, physical health promotion, consent, audit and research.

**Skilled staff to deliver care**

The staff across the wards came from various professional backgrounds, including medical, nursing, social work and occupational therapy. Staff were experienced and qualified to undertake their roles. All staff, including bank and agency staff, received an induction to the service.

Staff told us they had access to regular supervision, and evidence for this was seen. Staff had access to reflective group sessions which helped to keep them motivated and aware of new developments.

The trust offered preceptorship training to newly qualified nurses.

Staff had access to appropriate training and professional development. Staff members had access to the talks and seminars at the hospital. The ward manager on Osbourne ward was involved in the ‘safer collaborative’ teaching initiative, and in clinical risk training and care planning training as a trainer.

At the previous inspection, we had concerns access to medical staff out-of-hours. At this inspection, we saw that there is junior doctor cover in place throughout the day and night and they could be easily reached in the case of an emergency.

There was no psychology input on either ward. The support workers, nursing staff and occupational therapists engaged the patients in different activities, such as arts and crafts, quizzes, coffee mornings, walks and outings. However, patients did not have access to specialist psychological therapies and groups. Staff had no access to expert advice on behaviour support plans and therapies for patients. Ward staff had completed basic cognitive behaviour therapy.

The wards had been unable to recruit a specialist doctor, and this put pressure on the medical team.

The wards had not completed all the appraisals for all the staff on the wards. However, the ward managers told us that some of the staff members are new and will be having an appraisal at their year’s term.

The trust’s target rate for appraisal compliance was 100%. From October 2016 to September 2017, the overall appraisal rates for non-medical staff within this core service was 70%.

The rate of appraisal compliance for non-medical staff reported during this inspection was worse than the 82% reported at the last inspection. The trust’s target rate for appraisal compliance is 100%. There was no medical appraisal information provided for this core service.
<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>Appraisals YTD</th>
<th>% Appraisal rate last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osbourne ward</td>
<td>25</td>
<td>18</td>
<td>70%</td>
<td>82%</td>
</tr>
<tr>
<td>Core service total</td>
<td>25</td>
<td>18</td>
<td>70%</td>
<td>82%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2,730</td>
<td>1,433</td>
<td>70%</td>
<td>85%</td>
</tr>
</tbody>
</table>

**Multi-disciplinary and inter-agency team work**

The multi-disciplinary team had regular team meetings and effective handovers. Staff worked well with other teams, including the home treatment team and crisis team. They also had good links with other agencies, and trusts on the mainland. They had regular contact with other services, and maintained good links for transfers and bed management.

The ward rounds had improved since our last inspection. These are held twice weekly and included community teams and pharmacists.

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

We looked at care records of patients who were detained under the Mental Health Act. The Mental Health Act documentation was present and available in the records.

Copies of up-to-date section 17 leave forms were kept on the ward. This is the section of the Mental Health Act which allows the Responsible Clinician to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave the hospital site. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave. These were regularly reviewed and updated.

The service reported a Mental Health Act training compliance of 65% compared to a trust average of 79% as at 9 October 2017.

**Good practice in applying the Mental Capacity Act**

The trust had a Mental Capacity Act and Deprivation of Liberty Safeguard (DoLS) policy. Staff knew where to get advice regarding Mental Capacity Act, including Deprivation of Liberty Standards within the hospital. Specialist independent mental capacity advocacy was available to all patients.

The service reported a Mental Capacity Act training compliance of 6% compared to a trust average of 19% as at 9 October 2017. The ward manager told us that this has since improved, and we asked the trust for an update on the data. However, the data has not been provided.

Isle of Wight NHS trust reported one Deprivation of Liberty Safeguard (DoLS) application was made to the Local Authority between 1 October 2016 and 3 September 2017 relating to the core service. The application was also approved.
<table>
<thead>
<tr>
<th>Number of DoLS applications made by month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>Applications made</td>
</tr>
<tr>
<td>Applications approved</td>
</tr>
</tbody>
</table>

**Is the service caring?**

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

Patient-Led Assessments of the Care Environment assessment is a system for assessing the quality of the patient environment. The 2017 PLACE score for privacy, dignity and wellbeing score for Westlands was 77.6% - worse than similar organisations.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Core service(s) provided</th>
<th>Privacy, dignity and wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust overall</td>
<td></td>
<td>77.6%</td>
</tr>
<tr>
<td>England average (Acute/specialist)</td>
<td></td>
<td>82.4%</td>
</tr>
</tbody>
</table>

Patients were complimentary about staff. Patients told us they got the help they needed. Patients told us they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us staff were pleasant and were interested in their wellbeing.

Patients told us staff were consistently respectful towards them. Patients said the staff tried to meet their needs, that they worked hard and had patients' best interests and welfare as their priority. During our inspection, we saw positive interactions between staff and patients. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.

Staff showed patience and gave encouragement when supporting patients. When patients became distressed and agitated, staff intervened gently and kindly and helped to calm patients. The atmosphere throughout the wards was calm and relaxed.

Staff knew about their patients including their likes, dislikes and preferences. Staff understood the individual needs of their patients, including their personal, cultural, social and religious needs.

Staff said they could raise any concerns about disrespectful, discriminatory or inappropriate attitudes or behaviour towards patients without fear of the consequences.

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

**Involvement of patients**

Patients were being involved in their care. At the last inspection, staff did not sufficiently involve patients in their care. At this inspection, the trust had developed a new template for their electronic system to improve patient engagement. The ward staff spoke extensively with patients on
improvements they would like to see on the ward. This led to a more person-centred approach, with more individualised care plans and engagement meetings. There was also an embedded process of patients receiving a copy of their care plans. Where patients had declined a copy of their care plan, this was also clearly noted on the care notes.

Patients were encouraged to give feedback in the community feedback box on the ward. All comments are read, and put upon the 'you said, we did' board. Staff gave examples of where patient feedback had led to change in the service provided.

Patients were involved in recruitment processes, as part of the interview panel.

During our inspection, we joined a multidisciplinary care review meeting where staff discussed the views and wishes of patients.

Information was available on both wards about local advocacy services. The advocate provides a seven day service and attended out of hours where necessary.

**Involvement of families and carers**

Patients told us that, where they wanted them to, their families were included in their care planning. Information leaflets and regular newsletters were made available to relatives and friends and regular information and educational sessions were available at the hospital. Staff had embedded the ‘triangle of care’ initiative that attempts to improve carer engagement in inpatient units by ensuring staff worked with families and friends.

There were posters around the wards of carers’ groups and other local support groups for the benefit of carers. The ward manager on Osbourne ward started a carers’ group but there was no uptake. Staff encouraged carers to attend.

There was also a carers’ lounge in the main hospital building which was open to carers from across the hospital, and did not require a referral.

**Is the service responsive?**

**Access and discharge**

**Bed management**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Average bed occupancy range (1 October 2016 and 31 September 2017) (current inspection)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osbourne</td>
<td>65% - 97% (87% average)</td>
</tr>
</tbody>
</table>

The trust provided information for average length of stay for the period 1 October 2016 and 30 September 2017. The average was 18 days and the range between 6 - 28 days.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Average length of stay range (1 Oct 16–30 Sept 17) (current inspection)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osbourne</td>
<td>6 - 28</td>
</tr>
<tr>
<td>Trust total</td>
<td>6-1002</td>
</tr>
</tbody>
</table>
This service reported no out area placements between 1 October 2016 and 30 September 2017.

This service reported 23 readmissions within 28 days between 1 October 2016 and 30 September 2017, of which 19 were admitted back to the same ward.

<table>
<thead>
<tr>
<th>Number of readmissions (to any ward) within 28 days</th>
<th>Number of readmissions (to the same ward) within 28 days</th>
<th>% readmissions to the same ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>19</td>
<td>83%</td>
</tr>
</tbody>
</table>

Beds were always available when patients returned from leave.

Staff told us patients were not moved between wards during an admission episode unless it was for a clinical reason, for example requiring more or less intensive nursing care.

On Seagrove ward, there were two incidents of informal patients being admitted to the ward out of hours. This was due to a lack of beds elsewhere. In order to manage this, patients had a care plan in place that incorporated what items are restricted and for the patients to agree and adhere with while on the ward. Records showed these patients and found that the ward was compliant with guidelines on informal patients, and that their rights were being protected.

**Discharge and transfers of care**

Between 1 October 2016 and 30 September 2017, 17.6% of discharges were delayed trustwide. This data was not provided at core service or ward level.

All patients were transferred to the home treatment team upon discharge from the ward. The home treatment team supported patients in their home environment, and helped them to rehabilitate back into their daily routines.

While the care plans did not show a marked focus on recovery orientation, the discharge planning was an intensive and carefully considered approach.

A bed management and referrals meeting was held weekly. The meeting was attended by key clinical and managerial staff. Bed occupancy was scrutinised as well as transitions into, through and move on from the service. The bed management meeting monitored and tracked appropriate bed usage and identified any pressures in the system. Key clinical discussions took place at the meeting to enable the entire senior management and clinical team to be aware of updated information. The bed management meeting also monitored all actual and potential inpatient delayed discharges.
Facilities that promote comfort, dignity and privacy

Patient-Led Assessments of the Care Environment assessment is a system for assessing the quality of the patient environment. The 2017 PLACE score for ward food at St Mary’s was worse in comparison to similar trusts with 77.3% compared to the England average of 89.5%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Core service(s) provided</th>
<th>Ward food</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST MARY’S HOSPITAL</td>
<td>Mixed</td>
<td>77.3%</td>
</tr>
<tr>
<td>Trust overall</td>
<td></td>
<td>77.3%</td>
</tr>
<tr>
<td>England average (Acute/specialist)</td>
<td></td>
<td>89.5%</td>
</tr>
</tbody>
</table>

Both the wards had a full range of rooms and equipment available. There were spaces for consultations, therapeutic activities and treatment. Every patient had their own bedroom, and these were being renovated as en-suite rooms. Patients could store their possessions securely in their bedrooms. All patients had access to their bedrooms and communal areas of the ward at any time.

Quiet rooms were available where patients could meet visitors. Patients had access to multi-faith rooms and spiritual support.

Both wards had access to private pay phone facilities.

On Osbourne ward, staff and patients expressed their frustration at not having a garden, because it provided a calming and therapeutic space for patients. However, staff reported that they were managing to keep stress levels at a minimum. Staff arranged outings as an alternative, and tried to keep patients engaged in indoor activities for stimulation.

The patients we spoke to said that the quality of food was good.

At the last inspection, we raised concerns about the lack of a private entrance for Seagrove Ward. The ward could only be accessed through Osbourne ward. This raised issues of privacy, dignity and risk to patients on both wards. At this inspection, ward managers informed us that a business case had been made for a private entrance to Seagrove Ward.

Patients’ engagement with the wider community

Staff displayed daily and weekly activities on both wards. Patients had access to support from occupational therapists during the week, and support staff members ran activities and outdoor trips on weekends.
Meeting the needs of all people who use the service

The provider was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients. For example, patients did not always have access to their section 17 leave and activities according to their care plans. Of the patients we interviewed, 40% said deferred or cancelled leave was an issue for them. However, we did not see any records which recorded cancelled leave.

Staff respected patients' diversity and human rights. All staff had received training on equality and diversity. The trust provided a training course for patients on spirituality, beliefs and values. The ward staff made attempts were made to meet people’s individual needs including cultural, language and religious needs.

Interpreters were available to staff and were used to help assess patients’ needs and explain their rights, care and treatment. Leaflets explaining patients’ rights under the Mental Health Act were available in different languages.

Patients had access to support from a dietician, and staff could refer patients to the general hospital if needed.

Adjustments were made for patients with disabilities that required adjustments. The ward managers could have extra staff cover for those patients one to one support. The premises were accessible for patients with disabilities.

We saw up to date and relevant information on the wards detailing information, which included, information on mental health problems and available treatment options. In addition, staff made information about local services available including, benefits advice, information on legal and illegal drugs, help-lines, legal advice, advocacy services and how to raise a concern or make a complaint.

There was evidence to show that staff actively supported patients with finding suitable accommodation, or in helping to access financial support.

Listening to and learning from concerns and complaints

Staff met regularly to discuss learning from complaints. This informed a programme of improvements and training, for example, improving communication between staff and carers in relation to care planning.

Copies of the complaints procedure were on display on the information boards on the wards and in the ward welcome packs. Patients knew how to make a complaint. Information was also available on how patients could contact the Care Quality Commission should the patients wish to do so.

Staff knew how to handle complaints. Staff told us they tried to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns. Informal complaints were logged and tracked as well as formal complaints.

Staff were responsive to suggestions and concerns raised by patients, and were able to give examples of learning from these.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.
### What is your internal target for responding to complaints?

<table>
<thead>
<tr>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>100%</td>
</tr>
</tbody>
</table>

The policy is 20 days, although we do negotiate response timeframes with complainants.

### What is your target for completing a complaint

<table>
<thead>
<tr>
<th>If you have a slightly longer target for complex complaints please indicate what that is here</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 or 60 Days if SI leading investigation</td>
</tr>
</tbody>
</table>

### Number of complaints resolved without formal process in the last 12 months?

<table>
<thead>
<tr>
<th>Total</th>
<th>Date range</th>
</tr>
</thead>
<tbody>
<tr>
<td>888</td>
<td>01/10/16 - 30/09/17</td>
</tr>
</tbody>
</table>

### Is the service well led?

**Leadership**

Ward managers and lead nurses had the skills, knowledge and experience to perform their roles to a good standard. Managers knew their staff and patients well and were able to confidently describe their services.

Staff also felt that they work well together as a team, and could approach one another when they required extra support.

The senior management team had regular contact with staff and patients. The senior management and clinical teams were visible to staff and staff said senior management regularly visited the services. All staff and patients knew who the senior management team were and felt confident to approach them if they had any concerns. Staff knew who the trust’s executive team were and said they visited the wards.

Staff spoke highly of the Mental Health executive lead of the trust, and staff felt that their role had provided invaluable support to mental health wards and services, and in helping others understand the services better.

However, ward managers felt there was a lack of opportunity for training and development which was tailored towards managers and team leaders.
Vision and strategy

Staff did not feel they fully understood the vision and strategic objectives of the trust. However, staff felt they embedded good and positive values within their own teams and were able to have a positive impact on patients.

Staff members felt that the trust was moving in the right direction, and that there was a clearer vision and strategy in place since the last inspection in April 2017. The ward managers attended regular review and business meetings with other ward managers and senior leads. Staff we spoke to said that the ward managers feed important updates back to the staff through handovers, and staff meetings and face-to-face supervision.

Culture

Staff on the ward said the last year has been difficult with a lot of changes taking place in the organisation. Staff members felt that there had been a ‘knee-jerk’ reaction to changes to be made, and that some of the changes were implemented without much consultation from staff members. However, this was before the new senior leadership came into place, and staff members felt more positive about the new leadership team. They felt proud of the work they did, and the immediate leadership on the wards.

Staff felt respected, supported and valued in their work. They felt supported by their team, ward managers and the matron.

All staff we spoke with felt confident to raise any concerns and they knew how to do this, including the availability of the whistle-blowing process should they want to use this.

Teams worked well together for the well-being of patients, we saw this happening in clinical care reviews and discharge planning meetings.

Staff appraisals included discussions on personal and professional development needs and action plans to achieve this development. All staff commented on how their professional development needs had been supported.

During the reporting period there were two cases where staff was placed under supervision. One member of staff has had their supervision concluded whilst the other is still under restricted practice arrangements until 2018. Of the two cases, both were graded as ‘Specialty Doctors’.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

<table>
<thead>
<tr>
<th></th>
<th>Restricted practice</th>
<th>Suspended</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Governance

The ward was involved in clinical quality audits and had access to human resource management data and data on incidents and complaints. The information was summarised and presented monthly in a report for staff and discussed in team meetings. Ward managers, senior managers and senior clinicians attended monthly meetings where they looked at patient safety, patient
experience and staff management. This meant that the management teams were able to receive assurances and apply clear controls to make sure the services ran effectively.

There were sufficient suitably trained staff available on every shift in each ward to deliver safe care to patients. However training compliance fell below the trust target.

Staff on Osbourne ward said an increase in staffing numbers had been agreed in the latter part of 2017, but then retracted soon after. Staff and ward managers felt that in this case they were not getting a consistent message from the senior management team and that their concerns about staffing are not always taken seriously.

Staff felt positive about the recruitment of the mental health executive lead. They felt that there had been a dynamic change in the culture of mental health in the trust, and they felt more supported and valued. Staff felt more empowered to talk about the issues that mental health services face.

Staff were confident that they learnt from incidents, complaints and patient suggestions and feedback.

Staff felt that the trust direction and leadership had improved for the better, but that it still needed to make mental health feel part of the culture and vision of the trust.

The trust have not provided a board assurance framework for this inspection.

**Management of risk, issues and performance**

Staff showed us the ward operational risk registers. Staff told us they could submit items of risk for inclusion on the risk register. The risk register had inclusions from all the wards and support services, which showed that risks were escalated appropriately from all areas of the service.

**Information management**

Staff had access to information and technology to support them in their work. Staff said that now the electronic care records system was embedded, information was more accessible. Staff felt the lack of computers hindered them being able to complete assessments and care records in a timely manner.

Information governance systems ensured confidentiality of patient records across both wards.

Ward managers had access to information to support them in their role, for example clinical quality audits, human resource management data and data on incidents and complaints. Managers used information across the wards to monitor provision and identify areas for improvement.

Staff had processes in place to ensure they made notifications to external bodies as required, for example to the Care Quality Commission and local authority.

**Engagement**

Staff, patients and carers had access to timely and relevant information about the trust. For example, through the trust’s website, newsletter and open day sessions.

Patients and carers had opportunities to give feedback, through regular surveys, satisfaction questionnaires, comment cards and via meetings arranged by managers.
Learning, continuous improvement and innovation

Staff on Seagrove ward had employed a dual qualified nurse to ensure that the physical health of patients is monitored in a responsive way.

Staff showed that they were open to feedback from patients and family members, and we saw evidence of improvements being made to the service as a result, for example, the quality of the food and accessibility of the female lounge.

Seagrove ward is a member of the National Association of Psychiatric Intensive Care Units (NAPICU), who had recently visited in order to verify NAPICU compliance. The outcome of this had not been known at the time of the inspection.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme</th>
<th>Service accredited</th>
<th>Comments and date of accreditation / review</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMS - WA (Working Age Units)</td>
<td>Not provided</td>
<td>Not provided</td>
</tr>
<tr>
<td>AIMS - PICU (Psychiatric Intensive Care Units)</td>
<td>PICU</td>
<td>Not provided</td>
</tr>
</tbody>
</table>
### Facts and data about this service

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Ward name</th>
<th>Number of beds</th>
<th>Patient group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Rose Avenue, Wootton</td>
<td>Woodlands</td>
<td>11</td>
<td>Mixed</td>
</tr>
</tbody>
</table>
Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff did not have a good view of the whole environment because of its lay out. The ward was not open plan and set out over two floors with bedrooms on both. Staff mitigated this by completing regular observations of patients based on their risk level. We checked five days of observations and found that they were all completed.

The trust had improved the environment since our last inspection in November 2016. We found many ligature risks that could easily be removed, had now been removed. For example, hooks for fire extinguishers and curtains. The trust had replaced door closures that were potential ligature points with lower risk ones in isolated areas, such as upstairs. There was a comprehensive ligature assessment which included how staff should mitigate risks. We did not find any risks in the building that staff had not included in the ligature risk assessment. There remained several ligature risks in the bedrooms such as taps and medication safes. Staff managed the risk in the bedrooms with observation levels based on a risk assessment of the patients. The ward manager attended a monthly ligature risk meeting that addressed ligature risks, shared learning and encouraged a consistent approach to ligature risk management. Staff locked rooms that had many high-risk ligatures such as the gym and patients needed to be accompanied when they accessed them.

The trust had taken actions in order to mitigate ligature risks.

Woodlands was a mixed sex ward, it had good separation between male and female sleeping areas and separate bathrooms and toilets. However, because of its age and layout it did not offer a female only lounge. This was a breach of the national guidance on eliminating mixed sex accommodation.

Over the 12-month period from 1 October 2016 and 30 September 2017 there were zero mixed sex accommodation breaches within this core service.

Staff had access to a personal alarm system within the building. This allowed them to call for help in the advent of an emergency.

Maintenance, cleanliness and infection control

The wards carried out regular environmental checks. When we inspected the ward in November 2016 we found that the ward was well maintained but there were no regular checks of the environment, to ensure issues were picked up quickly. On this visit, we found that staff completed environments checks, to ensure any needed maintenance was reported. For example, broken door handles or locks.

The ward was clean, tidy and in a good state of repair. There were cleaners who visited the ward regularly. We found no issues in relation to the cleaning of the building and neither staff nor patients raised any concerns with us.

Staff followed infection control procedure such as handwashing. There were posters up in the ward and clinic room areas to encourage staff and patients to follow infection control procedures.

Clinic room and equipment

The clinic room was clean and tidy. All medical devices had stickers on them showing when staff had last cleaned them, they had been portable appliance tested and calibrated correctly. Staff kept
the defibrillator in the main office and records showed staff checked the defibrillator and resuscitation equipment regularly.

**Safe staffing**

**Nursing staff**

The ward had appropriate levels of staffing to meet the needs of the patients. There were two qualified nurses and one support worker on each shift throughout the day and night. This had increased by one member of qualified staff since the last inspection. In addition to this the manager worked Monday to Friday 9am to 5pm and an occupational therapist worked at the service three days a week offering group and one to one sessions. The changes to the staffing had followed a trust wide consultation the manager had attend following our inspection in November 2016.

The ward manager could increase the number of staff on the ward if needed. The manager had to report any increases in staff to a senior management panel, who reviewed the reasons why the ward needed an increase in staff. The manager told us that the panel would not prevent the ward from increasing staff.

There was always an experienced member of staff present on the ward.

There were enough staff to give patients one to one time. Staff told us that they occasionally cancelled escorted leave due to staff shortages, but they would rearrange for the same day or as soon as possible. At the time of our visit staff had assessed all patients as being able to have unescorted leave.

Nursing assistant data was not supplied by the trust.

**Definition**

Substantive – how many staff in post currently.

Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of substantive staff</td>
</tr>
<tr>
<td>Total number of substantive staff leavers</td>
</tr>
<tr>
<td>Average WTE* leavers over 12 months (%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vacancies and sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total vacancies overall (excluding seconded staff)</td>
</tr>
<tr>
<td>Total vacancies overall (%)</td>
</tr>
<tr>
<td>Total permanent staff sickness overall (%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establishment and vacancy (nurses and care assistants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment levels qualified nurses (WTE*)</td>
</tr>
</tbody>
</table>
This core service reported an overall vacancy rate of 7.2% for registered nurses from October 2016 to September 2017.

The highest number of vacancies within registered nurses was seen in January 2017 and February 2017, both with 1.46 total vacancies (17%).

Additional clinical services staff within this core service had a higher overall vacancy rate from October 2016 to September 2017 compared with registered nursing staff, with 13.3%.

This core service has reported a vacancy rate for all staff of 9.7% from October 2016 to September 2017. This is similar to the reported trust wide vacancy rate of 9.9% from October 2016 to September 2017.

The ward had two agency staff on long term placements and senior managers had agreed they could employ a third staff member this way, this was to cover current unqualified vacancies. All agency staff received an induction to the ward. The induction covered general information about the ward and patients.

Data broken down by team/ward was not sent in from the trust.

From October 2016 to September 2017, bank staff filled 75 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 301 of shifts for qualified nurses.
The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

The trust reported that the Woodlands Ward saw some of highest usage of bank and agency staff throughout this 12-month period across the whole trust. The trust attributed this to vacancies. The trust plans to address this by having a focused recruitment developed by the recruitment strategy as part of the IIF. The trust state that they will also hold regular meetings with

There were 36 unfilled shifts by either bank or agency staff.

<table>
<thead>
<tr>
<th>Team</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts NOT filled by bank or agency staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woodlands</td>
<td>71</td>
<td>301</td>
<td>36</td>
</tr>
<tr>
<td>General Medicines Management Team</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Core service total</td>
<td>75</td>
<td>301</td>
<td>36</td>
</tr>
<tr>
<td>Trust Total</td>
<td>38,932</td>
<td>12,792</td>
<td>6,767</td>
</tr>
</tbody>
</table>

**Turnover**

This core service had 1.4 (10.8%) staff leavers from October 2016 to September 2017. This is higher that the reported turnover rate trust wide of 8.6%. Data broken down by team/ward was not sent in from the trust.

**Sickness**

The sickness rate for this core service was 7.7% between from October 2016 to September 2017. This was higher than the reported trust wide sickness rate of 4.3%. The most recent month’s data (September 2017) showed a sickness rate of 9.3%.

Registered nursing staff had a sickness rate of 5.3% across this time period. The highest levels of sickness were seen in the beginning of this period. October 2016 saw the highest levels of sickness with a16.8% sickness rate reported.

Data broken down by team/ward was not sent in from the trust.

The trust’s staff fill rates for registered nurses and care staff was not available through the trust website.

The trust did not train staff to use physical interventions to control patients’ violence and aggression. The trust had trained staff to use break away techniques as self-defence. They also had an alarm system that would alert an operator at a remote location of an issue who would contact the police.
**Mandatory training**

The service was not compliant with the trust target for mandatory training. Staff told us that mandatory training was available and that they completed it, but they were out of date in a number of areas.

The trust set a target of 85% for completion of mandatory training.

The compliance for mandatory training courses within the core service from April 2017 to October 2017 was 82%, which did not meet the trust’s target of 85%. Of the training courses listed, nine failed to achieve the trust target of 85% and seven failed to score above CQC’s compliance benchmark of 75%.

**Adult Resuscitation - Non-Clinical Staff (0% - only 1 eligible staff) and Mental Capacity Act (10%)** had the lowest mandatory training compliance within the core service with the latter also being the lowest trust wide.

**Key:**

<table>
<thead>
<tr>
<th>Below CQC 75%</th>
<th>Between 75% &amp; trust target (85%)</th>
<th>Trust target and above</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service</th>
<th>Trust Target</th>
<th>Trust wide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>100%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>100%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>100%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>100%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>100%</td>
<td>85%</td>
<td>83%</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>100%</td>
<td>85%</td>
<td>98%</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>100%</td>
<td>85%</td>
<td>92%</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>100%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>84%</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>94%</td>
<td>85%</td>
<td>93%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>94%</td>
<td>85%</td>
<td>96%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>93%</td>
<td>85%</td>
<td>69%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>82%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
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<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>81%</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>Load Handling</td>
<td>75%</td>
<td>85%</td>
<td>76%</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>63%</td>
<td>85%</td>
<td>77%</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>60%</td>
<td>85%</td>
<td>79%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>53%</td>
<td>85%</td>
<td>73%</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>47%</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>38%</td>
<td>85%</td>
<td>54%</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>10%</td>
<td>85%</td>
<td>19%</td>
</tr>
<tr>
<td>Adult Resuscitation - Non-Clinical Staff</td>
<td>0%</td>
<td>85%</td>
<td>74%</td>
</tr>
<tr>
<td>Core service total %</td>
<td>82%</td>
<td>-</td>
<td>81%</td>
</tr>
</tbody>
</table>
Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed five patient records and found that they all had up to date risk assessments. The ward used a comprehensive and detailed risk assessment template from the electronic care record system. The risk assessments were competed on admission and reviewed regularly after that.

Management of patient risk

On this inspection, we found that there were care plans to manage all the identified patient risks. Previously, in November 2016 we found that known risks did not always have a risk management plan to address them. Now, staff documented in the progress notes what action they had taken to help patients manage risks. For example, if risks related to substance misuse, staff documented what education the patient had and how they responded to this.

Staff reviewed and updated risk assessments every two weeks.

Staff completed a risk assessment, checking that the patients was well enough to access the community, every time patients left the unit and recorded them in the electronic record. However, when we reviewed them it appeared staff had not recorded the risk assessment in the care record until the end of the shift with the rest of the progress notes relating to that shift.

There was an observation policy in place and staff completed observation records.

There were policies and procedures for searching patients. There were no random or routine searches of patients or their property because of the nature of the service as patients were moving towards discharge into the community.

The building was smoke free but patients could smoke in a designated area in the garden. Staff told patients about the rules around smoking before admission and there were signs up to remind patients where they could and could not smoke. The ward manager told us that patients had occasionally smoked in their bedrooms and this was against the rules. Staff reminded patients of the rules and why they were in place. There were no plans for the ward to go smoke free at the time of our inspection.

Staff did not lock the front door so patients could leave at will. No one could enter the ward from the outside without ringing the doorbell, for safety purposes.

Use of restrictive interventions

- This core service reported no restrictive interventions between 1 October 2016 and 30 September 2017.

Safeguarding

Staff knew what needed reporting as safeguarding and how to make an alert. The manager had displayed the process and relevant contact information on a notice board.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse.
Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust was unable to assign safeguarding referrals to core services for the period between 1 October 2016 and 30 September 2017. Isle of Wight NHS trust submitted details of zero external case reviews commenced or published in the last 12 months that relate to this core service.

Staff had made three safeguarding referrals in the past year. The referrals related to verbal abuse between patients, and substance abuse issues.

A responsible adult accompanied children when they visited the ward.

**Staff access to essential information**

The service used an electronic record and paper record system, staff recorded most information on the electronic system and staff had been putting all care plans on to the electronic system over the past few months as the ward changed to using electronic records.

All staff had access to records when they needed them. There were enough computers to allow staff to access the electronic notes each shift.

Staff we spoke to did not report any issues with co-ordinating between the paper and electronic records and we did not find any.

**Medicines management**

There were policies and procedures in place around ordering and storing medication.

Staff securely stored medicines in the clinic room and recorded that they remained within their recommended temperature ranges.

The estates team had not fixed the controlled drugs safe to a wall. When we raised this with staff they acted to arrange for the safe to be fix to a wall. At the time of the inspection, the ward was not holding controlled drugs.

**Track record on safety**

During our inspection, we did not identify any incidents that should have been reported to the Strategic Information Executive System that staff had not.

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 October 2016 and 30 September 2017 there were no serious incidents reported by this core service.

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

All staff we spoke with knew what they needed to report as an incident. All staff had access to the electronic incident reporting system.

The manager could access a record of all reported incidents relating to the ward. We checked three incidents that we found in the records and they were all reported.

The manager told us that the service would always explain to patients and families if something had gone wrong with their care but that they had not needed to.
Staff received feedback from incidents they reported on the electronic reporting system when the manager reviewed them. Ward staff shared learning from incidents in handovers and team meetings. The ward manager told us that they received information about learning elsewhere in the trust at the business unit meeting that they shared with the ward staff. The manager was unable to explain any learning from incidents.

Staff and patients received debrief following incidents. This was usually part of handovers or supervisions as there had not been any serious incidents that needed a formal debrief.

The manager reported that recent improvements to the service had come as part of the action plan following our earlier inspection.

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been one ‘prevention of future death’ report sent to Isle of Wight NHS Trust which the trust have responded too.

### Is the service effective?

#### Assessment of needs and planning of care

Staff used recognised tools, such as the Camberwell Assessment of Need, to identify the patients’ mental health needs. We reviewed four sets of patient notes including the electronic and paper versions. Staff completed a full assessment of patients’ mental and physical health needs on admission. Staff used this information to formulate plans to meet the patient’s rehabilitation needs.

Care plans were personalised and there was a care plan for each identified need. When we visited in November 2016 we found that care plans were not personalised and staff had used the same care plan for more than one patient. At this inspection, staff had identified goals together with patients. However, there was a lack of clear planning for discharge in place for patients. Staff did not identify patients’ strengths in their care plans.

All care plans were up to date and staff reviewed them regularly. The ward had recently introduced a monthly care review meeting where the patient and their care team met to review and update care plans. The meeting included the patient, nurse, psychiatrist and advocate. However, although staff told us they provided clients with one to one daily living skills support, we did not see any care plans addressing these issues. For example, such as budgeting and cooking care plans.

#### Best practice in treatment and care

The ward offered a wide range of interventions including medical and occupational. The occupational therapist offered groups on daily living skills including meal planning, cooking and road safety. An employment advisor visited the ward monthly to help find job opportunities for patients. Staff saw their roles as empowering patients to gain the skills needed to live safely in the community. However, staff told us there needed to be more emphasis on patients gaining the skills needed in the community.

As part of the re-enablement process, staff encouraged patients to self-administer their medicines. All bedrooms had medication safes in them so that patients could manage their own medication.
However staff told us they lacked the policies and guidance to allow people to keep their medicines in the room safes and self-administer.

The manager told us the ward consultant psychiatrist had given education sessions for staff on National Institute of Health and Care Excellence guidance for psychosis and depression. The ward had a folder of up to date National Institute of Health and Care Excellence guidance relevant to the service available for staff to read.

Staff assessed and monitored patients’ physical health needs to ensure they were met. All patients had registered with a local GP. Staff continued to regularly monitor physical health needs and there were care plans in place to manage physical health concerns. A sexual health nurse visited the ward once a month to give advice and complete well men and women checks.

Ward staff used the Rethink physical health assessment tool for general monitoring of physical health. They used the Waterlow assessment for patients at risk of pressure ulcers and the Malnutrition Universal Screening Tool (MUST).

Staff encouraged patients to have healthy life styles. There were care plans relating to substance misuse, healthy eating and advice was available to help patients stop smoking.

The ward did not measure its effectiveness. Staff did not use a recognised outcome rating tool such as the health of the natation outcome scale for adults of a working age, to find areas for improvement.

At the time of our visit the manager told us they did a monthly audit on care notes to check them against the trust standards and to see if staff completed and reviewed care plans. Staff had displayed the results of the audit on a notice board in the office. The trust audited the ward on the use of the Mental Health Act, medication and infection control but the trust did not provide information specifically to this core service and there was no specific action plan relating to this.

The trust did not provide us with any audit data relating to this core service.

There have been no local or clinical audits completed specifically for the core service in the last 12 months.

Skilled staff to deliver care

The service still did not have a full range of mental health professionals. There was still no psychology input on the ward and if staff referred a patient to the community team psychologist, it would take over a year before work began. The allocation of occupational therapy was still three days a week and psychiatrist was two sessions a week. Staff told us that they could access advice outside of these hours.

Staff attended the trust’s induction course and they could access mandatory training but they did not receive specialist training in mental health rehabilitation. Staff told us that some specialist training was available but this related to physical health such as doing electrocardiograms and taking blood. Staff found it difficult to access anything other than mandatory training.

There was a local induction to the ward that explained the ward’s routine and explained local policies and procedures.

Staff were not receiving regular supervision. The manager told us that the trusts policy was that all staff received supervision monthly. However, we reviewed the ward supervision record and saw that no staff had received supervision every month in the past 12 months. Some staff had received
no supervision during the last year. Staff reported a mixed response to supervision, some felt supported and that they received enough supervision while others felt unsupported.

There were monthly team meetings that informed staff about changes to the service and gave them the opportunity to express their opinions.

The ward had not met the trust’s target for staff annual appraisals. The manager told us they were booking appraisals. This meant that staff had not had performance targets set for the year and the manager would not be able to identify the training needs of the staff team. When we visited in November 2016 all staff had received an annually appraisal.

The trust’s target rate for appraisal compliance is 100%. From September 2016 to October 2017, the overall appraisal rates for non-medical staff within this core service was 38%.

The rate of appraisal compliance for non-medical staff reported during this inspection was similar to the 40% reported the previous year.

<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woodlands</td>
<td>16</td>
<td>6</td>
<td>38%</td>
</tr>
<tr>
<td>Core service total</td>
<td>16</td>
<td>6</td>
<td>38%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2,847</td>
<td>1,349</td>
<td>47.4%</td>
</tr>
</tbody>
</table>

The trust’s target rate for appraisal compliance is 100%. There was no medical appraisal information provided for this core service.

There were no clinical supervisions specific to this core service.

No staff were being performance managed. The manager knew how to get information and support if they need to performance manage staff.

**Multi-disciplinary and inter-agency team work**

There was a multi-disciplinary team meeting every week. The nursing and medical team attended the meeting. Ward staff always invited the patients care co-ordinator but they were not always able to attend. The team discussed each patient every two to three weeks. Patients records we reviewed showed good joint working between the medical and nursing teams.

There was an effective handover between each shift. We reviewed the records of the handovers and saw that staff received a comprehensive review of each patient at the start of their shift. The record gave information about patients’ current mental health state, changes to their legal status, care plans and risk assessments. Staff used a standard template to ensure consistency during shift handovers.

The team reported good working relationships with other teams and agencies. They could get input from patients’ care co-ordinators when they needed it.
Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff we spoke to had a good understanding of the Mental Health Act and understood the restriction on patients detained under sections of the Mental Health Act. Staff knew how to get advice and support about the Mental Health Act and the Mental Health Act code of practice from a Mental Health Act administrator based at St Mary’s Hospital.

The core service reported a Mental Health Act training compliance of 60% compared to a trust average of 79% as at 9 October 2017.

The provider had policies and procedures relating to the Mental Health Act and staff could access these via the trust intranet. There was an independent mental health act advocate available and contact information was available for patients and staff knew how to refer patients. The manager told us that they visited once a week and attended care review meetings if the patient requests them to.

Staff explained patients their rights under s132 of the Mental Health Act regularly and recorded they had done so in the patient electronic record. Patients had applied for Mental Health Act tribunals and Mental Health Act managers meetings which indicated patients were aware of their rights to appeal.

Staff could access paper work associated with patients’ detention electronically. Staff could also access section 17 leave paper work on the electronic patient record. At our previous inspection in November 2016 we were concerned that patients were not able to access their section 17 leave. At this current inspection, the service had increased staffing to ensure that leave could occur.

The Mental Health Act administrator conducted audits of the use of the Mental Health Act but ward staff were not aware of the results.

Good practice in applying the Mental Capacity Act

Staff were aware of the principles of the Mental Capacity Act.

The core service reported a Mental Capacity Act training compliance of 10% compared to a trust average of 19% as at 9 October 2017.

Isle of Wight NHS trust reported no Deprivation of Liberty Safeguard (DoLS) applications to the Local Authority between 1 October 2016 and 3 September 2017 relating to the core service.

Staff had access to a policy and told us that they could get advice on the Mental Capacity Act from the Mental Health Act administrator.

At the time of our inspection, no patients were subject to deprivation of liberties safeguards (DoLS). Staff did not understand their role in the assessment of capacity under the Mental Capacity Act. Ward staff saw assessing capacity as the consultant’s role. Staff ticked a box in the electronic record to show that they had assessed a patient’s capacity but we could not find any evidence in the record to document how they had done this or they had made that decision. We did see one detailed capacity assessment but there was no care plan to help staff manage this issue with the patient.
Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with respect. All interactions between patients and staff in both group and one to one situations we saw were respectful and caring. Staff responded to patients’ needs without undue delay. Staff and patients had positive relationships. However, we did express concerns at our last inspection in November 2016 that boundaries were lax. For example, patients entered the office, when confidential information was being used, to speak with staff and get water and we saw that patients still freely access the office during this inspection.

Patients were support in their care. For example, Staff explained patients’ conditions and treatment, referred patients to external services such as advocacy, housing and the re-enablement team.

Patients said staff treated them in a friendly, helpful and caring manner. Staff understood the patients’ needs including their different social and cultural needs including those with protected characteristics such people from the Lesbian, Gay, Bisexual and Transgender community. Not all staff we spoke to said they felt confident in raising concerns about other staff attitudes towards patients with the ward manager. However, staff knew how to raise concerns the trusts internal systems outside of the ward in a confidential manner and would do so if needed.

Staff mostly stored confidential information securely. Staff kept patient records in locked cupboards and on an electronics system to protect confidentiality. However, staff allowed patients had access to the staff office even when they were using confidential information. There was information about patients recorded on boards in the office including names which could compromise confidentiality.

The involvement of people in the care they receive

Involvement of patients

Staff would showed newly admitted patients around the ward and gave them information relating to the ward, house rules and a recovery folder that explained treatments.

Patients and staff told us that they were involved in planning care. Staff sat with patients and discussed their care plans and what the patient would like recorded in them. Staff had written care plans in a mix of first and third person to reflect what the patient had contributed to the care plan. There was a care planning meeting, attended by the patient and their multidisciplinary team, to discuss current treatment and review care plans and staff recorded the meeting in the electronic care records.

Staff had not routinely encouraged patients to input into service development. Patients could give feedback about the service via a “we want good care survey”. However, the manager told us they did not use the survey often, and that the staff need to be better at this. The manager was not aware of any changes made to the service relating to this questionnaire. Patients had given questions to the interview panel to ask interviewees.

Patients could access advocacy, we saw leaflets on the ward and staff could refer when needed.
Involvement of families and carers

Staff and patients discussed the level of involvement patients wanted their family and carers to have and staff respected this. Patients had invited their families to care programme approach meetings.

Is the service responsive?

Access and discharge

Staff completed initial assessments before admission to show the patient’s suitability for the service. At the time of our visit there were eight patients admitted to Woodlands.

Bed management

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Average bed occupancy range (1 October 2016 and 30 September 2017) (current inspection)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woodlands</td>
<td>63% - 93% (81% average)</td>
</tr>
</tbody>
</table>

The average length of stay at Woodlands was within the CQC published guidelines for this core service.

The trust provided information for average length of stay for only five of the 12 months in the period from the period 1 October 2016 to 30 September 2017.

The average for over the 12 months was 248 days with the longest wait in the most recent month (September 2017) – 1002 days.

This core service reported three out area placements between 1 October 2016 and 30 September 2017.

This core service reported no readmissions within 28 days between 1 October 2016 and 30 September 2017.

The manager told us that there was always a bed available for patients who needed admission and there was no waiting list. The ward never admitted patients into beds of patients on leave, which meant they could return from leave at any time. Staff only asked patients to move bedrooms for clinical reasons.

Staff told us that when they had needed to move patients back to an acute or intensive care unit, they were able to do so. Patients could be moved to local wards so they could remain in contact with family and friends.

Discharge and transfers of care

Patients and staff planned discharges and they happened at an agreed time. The ward manager told us that there was one patient who was ready for discharge. At the time of our inspection there was no plan for discharge in place. The ward did not view this as a delayed discharge as there was no community placement available and they would not be discharged until one was available. The trust did not provide delayed discharge information at a service level to confirm if the trust viewed this as a delayed discharge.
Between 1 October 2016 and 30 September 2017, 17.6% of discharges were delayed trust wide. This data was not provided at core service or ward level.

The trust has identified no services as measured on ‘referral to initial assessment’ and ‘assessment to treatment’ within this core service.

Staff supported patients to access other services such as primary care services.

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

Woodlands offered privacy for patients. Each patient had a private bedroom and en-suite bathroom. Patients could personalise their rooms with posters, use their own bed linen, and have personal belongings such as stereos and televisions.

There were many rooms and facilities within the ward including a lounge, clinic room, conservatory, gym, dining area and kitchen. Staff also used the dining area to offer group and one to one activities. At our inspection in November 2016 we said there was not enough space for staff to provide one to one sessions for patients on the ward. On this visit, we found staff had converted an unused bedroom into an office for one to one sessions. Patients used the conservatory as a quiet area. The manager told us that they did not have a visitor’s room but allowed patients to use their bedrooms and staff encouraged patients to access leave with their visitors.

The ward phone was not in a private area. However, patients could use their mobile phones and staff encouraged patients to use them in their bedrooms for privacy.

The ward had a large garden that patients could access without restriction. Staff encouraged patients to go out into the community daily.

Although staff told us that patients could access food and drink 24 hours a day, we received a comment card from a patient saying they could not access food from the kitchen after the evening meal had been served.

**Patients’ engagement with the wider community**

Staff helped patients to find educational and employment needs, and then planned with them to meet these needs. There was an employment worker who visited the service to help patients with employment opportunities. Staff supported patients to visit family and friends and encouraged them to visited the ward regularly. We saw evidence of this in the care records and a comment card.

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

The service was accessible to patients with disabilities that needed adaptations and there was an adapted bedroom and bathroom. The service adjusted practice to meet patients’ needs. Staff gave us examples of how they had used accessible signs to help a patient.

There were information leaflets available for patients. Staff could access information in different languages and an interpreter when needed. Leaflets were available about complaints, rights, advocacy, local groups, medication and the Mental Health Act.

The service did not have any spiritual support available on site. Staff encouraged patients to visit local places of worship and would support them to if required.
Listening to and learning from concerns and complaints

The manager had a local log for complaints. During our inspection in November 2016 the ward did not record complaints locally. The manager showed us the local log but there had not been any complaints.

The service had an appropriate complaints process in place. There were leaflets telling patients how to make a complaint that staff gave patients on admission. There were posters on display on the ward telling patients of how they could complain. Staff told us how they would manage complaints and feedback to patients following a complaint. The manager told us that they received feedback relating to concerns and would share this with staff via meetings and supervision. Staff were unable to give examples of learning from concerns or complaints elsewhere in the trust.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
</tr>
<tr>
<td>The policy is 20 days, although we do negotiate response timeframes with complainants</td>
<td></td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td></td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>45 or 60 Days if SI leading investigation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>Date range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>888</td>
</tr>
</tbody>
</table>

The trust could not provide complaint data at core service level.

It was not clear from the data provided by the trust as to how many, if any, compliments were received by the core service.

Is the service well led?

Leadership

Leadership has been effective in some areas of the core service. The ward manager had been working in their role for several years and they have made improvements to the service since the last inspection. However, supervision and appraisal rates have stayed below the trust target and
not staff felt they could approach the manager with issues, but they knew how to address issues using the trusts complaints process if necessary.

**Vision and strategy**

Staff knew what the trust values were and how they reflected the work they did. However, there were no targets or performance measures used by the service to show how they were delivering the values.

There was no discharge pathway for patients and the trust did not follow generally accepted practice in monitoring whether patients discharge was delayed.

The manager told us that the service was changing and that they and the ward staff had been part of the group tasked with the redesign. The manager told us that the staff team had been able to express their opinions via team meetings which then informed the group that was looking at different options for the service development.

**Culture**

Staff felt proud to work in the service. Although we received mixed reports from staff with most saying they felt valued.

All staff told us that it had been difficult in the past year with uncertainty about the wards future and the changes the trust was making to ward. There had been plans to move the ward to a different building and to change the service to a social care accommodation with qualified nursing as a in reach team.

Not all staff were happy to raise concerns locally but knew how to use the whistle-blowing policy. The manager felt supported and able to raise concerns with senior managers.

During the reporting period there were no cases where staff have been either suspended or placed under supervision.

Staff reported working well together, with some concerns around communication outside of the handover. We were not aware of any incidence when leaders had needed to address issues between staff.

Sickness was higher at this core service than for the trust. The manager felt this was due to non-work related long term sickness. Staff were aware of the support available to them from through the occupational health service.

**Governance**

The quality of governance on the unit was mixed. There were audits in place around ligature assessment and care records and the manager showed us detailed action plans relating to these. However, the manager was not aware of any other audits taking place on the unit. There were no further quality improvement plans in place relating to patient care. Leaders told us that there were no performance indicators used in the unit to measure the team’s performance. The capacity of patients was mainly seen in relation to treatment and staff members did not understand their role in assessing capacity.

The trust have not provided a board assurance framework for this inspection.
Management of risk, issues and performance

The ward manager kept a local risk register that included safeguarding referrals they had made. The manager told us they discussed the risk register at the business unit management meeting and agreed to escalate risks to the trust board if needed.

- The trust have not provided a risk register for this inspection.

Information management

The core service had recently transferred most of its paper records on to the electronic care record. Staff reported that this had been a long process and that they had needed to learn how to do this as they did it. Staff reported that they were beginning to see the benefits of having information on the electronic care record.

The manager had access to information relating to incidents, safeguarding referrals, sickness and complaints. There were no improvement plans relating to these.

Engagement

The service collected feedback from patients through the friends and family test and via the trust “I want great care” feedback site on the internet. No feedback had been received at the time of our inspection.

Learning, continuous improvement and innovation

At the time of our visit the ward team were not involved in any research and the core service was not working toward any quality accreditation schemes.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to a team the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service that have an accreditation together with the relevant dates of accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme</th>
<th>Service accredited</th>
<th>Comments and date of accreditation / review</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMS - Rehab</td>
<td>Woodlands Unit</td>
<td>Not provided</td>
</tr>
</tbody>
</table>
## Facts and data about this service

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Ward name</th>
<th>Number of beds</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary’s Hospital</td>
<td>Afton</td>
<td>10</td>
<td>Mixed</td>
</tr>
<tr>
<td>St Mary’s Hospital</td>
<td>Shackleton</td>
<td>4</td>
<td>Mixed</td>
</tr>
</tbody>
</table>
Is the service safe?

Safe and clean care environments

Safety of the ward layout

During our inspection in 2016, we had serious concern about the suitability and safety of the ward environments. We said that the provider must assess and address in full the risks associated with the physical ward environments. Until the necessary changes were made to make the environments as safe as possible, appropriate measures had to be implemented to mitigate effectively the risks to people using the service.

During this inspection, we saw records that both wards were completing daily checks of the environment to ensure it was safe and that staff had reported any maintenance issues. We did not find any immediate maintenance concerns.

During our inspection in 2016, we found that Shackleton ward was designed in such a way that staff could not observe all parts of the ward. As the trust had no building work planned to change this, the situation was the same.

When we visited Afton ward we saw that it was undergoing a complete refurbishment. It had a nurses’ station in the centre of the ward, which prevented good lines of sight for observation of patients. The refurbishment plans included removing the current nurse’s station and rebuilding it in a way that would allow good observations of the ward areas. The building’s redesign will remove and reduce ligature risks, these included anti-ligature doors on the ensuite facilities and anti-ligature grab rails for the toilets, basins and showers. A ligature point is an environmental feature or structure that is load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. The trust had also installed anti-ligature paper towel and hand soap dispensers. The trust was replacing all the doors with anti-barricade doors that were anti-ligature. There was one assisted bathroom which due to the equipment in the room had ligature points, which staff kept, locked and a second bathroom, which was low risk and therefore left open. This demonstrated staff assessing and mitigating environmental risk appropriately.

At our last inspection in 2016, we raised concerns with the trust about the privacy of patients on Afton ward, as there was a communal area at the end of one corridor opposite a car park allowing people to see into the unit. Staff told us that sometimes members of the public had seen distressed patients. During this visit the ward manager told us they had considered several options including putting a fence outside, but this would have prevented patients having a view of the outside. An anti-ligature curtain was now in place to offer privacy when needed. Staff had considered different options but because patients liked to look out the windows it was decided that curtains were the preferred option. We considered this to be a sufficient way of offering privacy to patients in their bedrooms.

At our last inspection in 2016, we discovered privacy concerns with the inter-connecting bathrooms. There had been an occasion where a patient had opened the inter-connecting door and entered another patient’s bathroom. This particular incident also breached same-sex guidance. On this inspection, both wards had either removed the inter-connecting ensuite bathrooms or no longer put patients in both rooms that connected. This was managed by reducing the number of patients they could admit and the remodelling work.

During our visit to Afton Ward in 2016, we had concerns about the safety of the garden. The trust had not maintained it and there was a large slope presenting many slip and trip hazards. The trust had redesigned the garden and put in measures to reduce the risks, which included a floor
covering made from a resin that would give a softer base if a patient fell on it. The garden improvements were not complete and patients had not been able to access the garden for a year. However, patients were regularly using their ground leave and section 17 leave.

The ward manager told us that the refurbishment of the ward and garden should be complete by the end of March 2018.

**Same sex accommodation breaches**

Over the 12 month period from 1 October 2016 to 30 September 2017 there were three mixed sex accommodation breaches within this service – all were on Afton Ward.

All breaches were due to bed pressures.

The use of the female lounge on Shackleton ward was not in line with the Mental Health Act Code of Practice. There was no sign to tell patients that the lounge was for females only. Staff told us that men sometimes used the female lounge but if staff thought the men were a risk to the females then the staff would stay with them in the lounge or lead the men away. This meant that female patients were not always protected from male patients when in they were in the female lounge.

At the time of our inspection on Afton ward the trust were complying with same sex accommodation protocol. Consideration had been given to this when planning the ward refurbishment.

**Ligature risks**

There were ligature risks on both wards within this service, none of which were classed as ‘high risk’

For both wards (Afton and Shackleton), the risk assessments were completed on 16 December 2016 and were described as follows: "The building has many ligatures and those that scored 81 using the Manchester tool have been removed."

On Shackleton ward, we found that the trust had addressed the issues of ligature points. The ward had a comprehensive ligature risk assessment, during the inspection we did not find any ligature points not named on the ligature risk assessment. The trust had replaced ward fixture and fittings with lower risk ones. For example, the estates team had secured the wardrobes to the walls to prevent their use as a ligature point. Staff showed us that they could open the new window much further than the earlier ones, but posed no risk to patients falling from them due to the design, giving extra ventilation. The ward windows and the nurse call bells were replaced with an anti-ligature version. However, we noted that the nurse call bells in the lounge areas had not been replaced, despite the wards ligature assessment saying they had been. We asked the trust to correct this.

The ward was mitigating existing ligature points by observing patients and by locking areas that still had high-risk ligature points in them. There were cupboards in the bedrooms that had electrical and medical device connection points in them; during our inspection in 2016, staff had not locked them. During this visit, we found that they were all locked.

Staff kept the bathrooms and bedrooms on Shackleton ward were locked when not in use, patients had to request access to them. This was because bedrooms still had ligature risks in them. We were told that the trust planned to move the ward to a purpose-built environment. The trust was not going to change the ward environment to address blind spots and other ligature risks until they had decided on the location of the ward, once this was agreed, the trust would decide whether to move the ward or make further improvements to the current location.
Maintenance, cleanliness and infection control

The ward environments at both Afton and Shackleton were clean and well maintained. We reviewed cleaning schedules and they were thorough and up to date. However, the environment in Shackleton ward was not homely and was clinical. There was mismatched furniture and the ward felt sterile. There was very little personalisation of bedrooms. There were no signs above washbasins to remind staff and patients to wash their hands. Hand gel was available on the outside of the entrance doors.

On Afton ward, building work was being completed following recommendations from our last inspection. Staff ensured that patients were kept safe with appropriate signage and activities continued in the most appropriate area. There was signage above washbasins reminding staff and patients to wash their hands.

In the 2017 Patient-led assessments of the care environment (PLACE) St Mary's scored similar to other trusts for cleanliness and condition, appearance and maintenance. The location scored worse than other similar trusts for Dementia friendly (66.6% compared to 75.5% nationally) and Disability (72.7% compared to 81.5% nationally).

<table>
<thead>
<tr>
<th>Site name</th>
<th>Core service(s) provided</th>
<th>Cleanliness</th>
<th>Condition appearance and maintenance</th>
<th>Dementia friendly</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary's Hospital</td>
<td>Older people wards</td>
<td>99.1%</td>
<td>95.6%</td>
<td>66.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td></td>
<td>Multiple</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust overall</td>
<td></td>
<td>99.1%</td>
<td>95.6%</td>
<td>66.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>England average</td>
<td></td>
<td>98.4%</td>
<td>93.8%</td>
<td>75.5%</td>
<td>81.5%</td>
</tr>
<tr>
<td>(Mental health and learning disabilities)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Safe staffing

Nursing staff

Nursing assistant data not submitted by the trust.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
<th>30 September 2017</th>
<th>52.097</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of substantive staff</td>
<td>October 2016 – September 2017</td>
<td>0</td>
</tr>
<tr>
<td>Average WTE* leavers over 12 months (%)</td>
<td>October 2016 – September 2017</td>
<td>0%</td>
</tr>
<tr>
<td>Vacancies and sickness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total vacancies overall (excluding seconded staff)</td>
<td>30 September 2017</td>
<td>1.35</td>
</tr>
<tr>
<td>Total vacancies overall (%)</td>
<td>October 2016 – September 2017</td>
<td>9.2%</td>
</tr>
<tr>
<td>Total permanent staff sickness overall (%)</td>
<td>October 2016 – September 2017</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establishment and vacancy (nurses and care assistants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment levels qualified nurses (WTE*)</td>
</tr>
<tr>
<td>Establishment levels nursing assistants (WTE*)</td>
</tr>
<tr>
<td>Number of vacancies, qualified nurses (WTE*)</td>
</tr>
<tr>
<td>Number of vacancies nursing assistants (WTE*)</td>
</tr>
<tr>
<td>Qualified nurse vacancy rate</td>
</tr>
<tr>
<td>Nursing assistant vacancy rate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bank and agency Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)</td>
</tr>
<tr>
<td>Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)</td>
</tr>
<tr>
<td>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)</td>
</tr>
<tr>
<td>Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)</td>
</tr>
<tr>
<td>Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)</td>
</tr>
<tr>
<td>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)</td>
</tr>
</tbody>
</table>

*Whole-time Equivalent

**Staff Fill Rates (Remove before publication)**

This service reported an overall vacancy rate of 12.7% for registered nurses from October 2016 to September 2017.

The highest number of vacancies within registered nurses was seen in the first six months of this 12 month period. From October 2016 to March 2017 there were 3.63 vacancies each month. This number reduced over the latter six months to 1.56 total vacancies for registered nurses in the latest month (September 2017).

There were two other staffing groups within this service which had a lower overall vacancy rate from October 2016 to September 2017 compared with registered nursing staff.

This service has reported a vacancy rate for all staff of 9.2% from October 2016 to September 2017. This is similar to the reported trust wide vacancy rate of 9.9% from October 2016 to September 2017.

Data broken down by team/ward was not sent in from the trust.
From October 2016 to September 2017, bank staff filled 308 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 298 of shifts for qualified nurses.

The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

There were 54 shifts unable to be filled by either bank or agency staff.

Shackleton ward did not have enough staff to keep patients safe. Shackleton ward establishment was four staff on each shift in the daytime; this was broken down into either two nurses and two support workers or one nurse and three support workers. However, staff told us there were often only three staff on shift in the daytime and this included one staff member on a one-to-one observing a patient. Night shifts were covered adequately. Due to low staffing levels, activities provided by ward staff were often cancelled. The patients on the ward were not having access to fresh air and only one of the four patients under a Mental Health Act section had section 17 leave authorised although they were not using it. Staff were not able to provide us with records evidencing when patients last had access to fresh air but they told us they thought it had been weeks.

The ward manager on Shackleton was on long-term sick leave and the two band six registered nurses were acting up as ward managers. There were two vacancies for support workers, one band five registered nurse and one ward clerk. These vacancies were yet to go out to advertise although there were plans to advertise. The ward was receiving some administration support from another department. There were also two support workers on maternity leave and a registered nurse and a support worker that had been temporarily transferred to other wards. Shifts often had shortages that could not be filled, although staff did try to cover with regular and bank staff. There was no use of agency staff.

Afton ward was operating at establishment level, Afton ward had one part-time band two vacancy as they were supporting a member of staff to complete their nurse training through secondment, following a safer staffing review, Afton ward also had a part time band five vacancy. All vacant hours were being backfilled through regular bank staff. We observed staff facilitating group and individual activities and the atmosphere was calm and pleasant despite the ongoing building works.

The electro-convulsive therapy team provided therapy to patients across the trust, the majority of which were from the two wards. However, nursing staff and support workers had no dedicated time in the clinic. Afton ward had to lend staff members to support the lead electro-convulsive therapy nurse so that the clinic could run. Staff that were allocated to support the clinic were not backfilled on the wards; this meant that some wards had to run under their establishment levels for the duration of the clinics two days per week. A business case was submitted to the trust three years ago to recruit additional staff for the clinic. However, this had not been approved.

Below is the number of bank/agency staff split by team:

<table>
<thead>
<tr>
<th>Team</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts NOT filled by bank or agency staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afton Ward</td>
<td>96</td>
<td>200</td>
<td>15</td>
</tr>
<tr>
<td>Shackleton</td>
<td>212</td>
<td>98</td>
<td>39</td>
</tr>
<tr>
<td>Core service total</td>
<td>308</td>
<td>298</td>
<td>54</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Trust Total</td>
<td>38,932</td>
<td>12,792</td>
<td>6,767</td>
</tr>
</tbody>
</table>

### Turnover

This service had 0 (0%) staff leavers from October 2016 to September 2017. This is lower than the reported turnover rate trust wide of 9%.

Data broken down by team/ward was not sent in from the trust.

### Sickness

The sickness rate for this service was 4.6% from October 2016 to September 2017. This was similar to the reported trust wide sickness rate of 4.3%. The most recent month’s data (September 2017) showed a sickness rate of 3.4%.

Registered nursing staff had a sickness rate of 4.8% across this time period. The highest levels of sickness were seen in January 2017 with a sickness rate of 12.6% recorded.

Afton ward had an overall sickness rate of 2.3% from October 2016 to September 2017. Shackleton ward had a higher overall sickness rate in this same time period with 7.3%.

Staff sickness levels were high on Shackleton ward. This was putting pressure on the team who often had to ask other wards to support them. We saw a recent example where there were only two staff on shift including the staff member observing the patient on a one-to-one. Staff from other wards eventually came to support the team following a call to the on call manager. Staff we spoke with told us that sickness was an ongoing problem on Shackleton ward; this was reflected in ward records.

Sickness levels on Afton ward were low and there were no staff on long-term sick leave.

### Medical Staff

There was sufficient medical cover across both wards. There were two substantive consultants and one locum consultant across both wards. Staff told us there were no difficulties in accessing a psychiatrist or junior doctor should they need one.

### Mandatory training

#### Training data summary

The trust set a target mandatory training completion rate of 85%.

The compliance for mandatory training courses from April 2017 to October 2017 was 87%. Of the training courses listed, eight failed to achieve the trust target and of those, four failed to score above 75%.

The training course with the lowest compliance rate across both wards was Immediate life support with 11 out of 41 (27%) of members of staff having completed this. However, Afton ward had a compliance rate of 90% of members of staff completing this. This data included registered nurses as well as health care support workers. Immediate life support is only mandatory for registered nurses within this trust.
The management on Shackleton ward were in ‘acting up’ roles. They were unable to show us the training matrix because they had not been given access to the system. This meant that there was no overview at a leadership level of training statistics within the team and no oversight of areas for improvement and development.

Afton ward had a training matrix in place. 97 per cent of staff were compliant with mandatory training.

Assessing and managing risk to patients and staff

Assessment of patient risk
Staff on both wards completed risk assessments for all patients on admission and then on a weekly basis by the primary nurse. Staff updated risk assessments and care plans following on a weekly basis and following incidents.
Management of patient risk

Staff on Afton ward had prioritised falls prevention. There was a falls lead within the clinical team. The falls lead attended the trust patient safety meeting on a monthly basis where falls prevention and learning was discussed. The lead then fed back information from the meeting to the team on Afton ward. There were posters in patients’ bedrooms reminding patients to use their walking aids and advising them of how to keep safe when moving around the ward. Staff could refer to occupational therapy and physiotherapy if a patient required an assessment of their mobility or mobility equipment.

Patients on Afton ward were having their weight and nutrition monitored on a monthly basis. We reviewed records and found that the malnutrition universal screening tool was being updated and showed that patients on the ward were not losing weight. We also saw evidence of an email from the trust clinical nutrition nurse specialist congratulating the staff on Afton ward on achieving the best results across the trust in the last quarter in this area.

On Shackleton ward we saw there were low level beds and crash mats in place to reduce injuries if a patient was to fall out of bed. Staff could also access the trust occupational therapists and physiotherapists should a patient require a mobility assessment.

Shackleton ward had a number of blanket restrictions and interventions in place. Patients’ bedrooms were locked at all times, if a patient wanted to access their bedroom they would have to ask a member of staff to open it for them. Patients’ had no access to washing facilities within their bedrooms. The washing facilities that were located in patients' bedrooms were locked and for staff use only. This did not promote patients’ independence and was a further restrictive intervention. Patients’ were unable to help themselves to drinks and snacks and had to ask staff if they wanted something to eat or drink. Blanket restrictions were not based upon individual risk assessments of patients.

Use of restrictive interventions

There was no restrictive intervention programme in operation on either ward. The National Institute for Health and Care Excellence recommends wards develop a restrictive intervention programme to reduce violence and aggression and encourage a positive and therapeutic environment.

This service had 62 incidents of restraint between 1 October 2016 and 30 September 2017.

Of the restraints, 17 (27%) restraints resulted in rapid tranquilisation of the patient.

There were no incidents where prone restraint, seclusion or mechanical restraint was used.

Over the 12 months, there was no obvious trend over time.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Seclusions</th>
<th>Restraints</th>
<th>Patients restrained</th>
<th>Of restraints, incidents of prone restraint</th>
<th>Rapid tranquillisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afton</td>
<td>0</td>
<td>30</td>
<td>Not provided</td>
<td>0</td>
<td>7 (23%)</td>
</tr>
<tr>
<td>Shackleton</td>
<td>0</td>
<td>32</td>
<td>Not provided</td>
<td>0</td>
<td>10 (31%)</td>
</tr>
<tr>
<td>Wards for older people total</td>
<td>0</td>
<td>62</td>
<td>Not provided</td>
<td>0</td>
<td>17 (27%)</td>
</tr>
</tbody>
</table>

Restraint

Over the 12 months, there has been no clear trend in relation to restraints.
Incidents resulting in rapid tranquilisation for this services seem to have been fluctuating, with the highest numbers in October 2016 (5). The core service went from having five incidents where rapid tranquilisation is used then for the next two months have zero incidents. The data provided by the trust above did not match the evidence that we found on Afton ward. This illustrates an issue with the leadership and governance recording systems.

Staff on Shackleton ward told us that they had not restrained a patient on the ward for approximately eight months. However, staff regularly used ‘Physical Interventions’ when carrying out personal care. These interventions included ‘gentle safe holds’. We reviewed records which showed staff interventions when supporting patients with personal care. Patients often attempted to bite, kick, scratch and head butt staff during personal care, this is when the gentle safe holds were used. Staff told us that these incidents were documented in daily records but they were not documented on the trust incident recording system because there were too many and it would take too much time. This meant that the ward staff were not escalating risk issues to senior management and this was not in line with trust policy.

Staff on Afton ward told us there had been no incidents of restraint within the last 12 months with the exception of the week preceding our inspection. Staff on Afton ward told us there had been no incidents of restraint within the last 12 months with the exception of the week preceding our inspection when staff had used restraint on three occasions. On one occasion rapid tranquilisation (sedating medicine to reduce aggression and violence) had been given to a patient detained under section 5 of the Mental Health Act. This section provides a holding power to allow professionals time to organise further assessment of the patient. Treatment, which includes rapid tranquilisation, should not be given under this section of the Act. Staff on the ward and the senior mental health managers we spoke with showed little understanding of why we were concerned about this practice.

Staff did not document the necessary post rapid tranquilisation physical health checks in line with National Institute for Health and Care Excellence guidelines. This meant that patients that had been sedated and were at increased risk of respiratory depression and were not being monitored. In addition to this, the trust policy did not advise staff that post rapid tranquilisation physical health checks were necessary.

Seclusion

Over the 12 months, there were zero incidents of seclusion reported to us by the trust.

Segregation

There have been no instances of long-term segregation over the 12-month reporting period. During our visit in 2016, we had significant concerns about the room that was used for seclusion on Shackleton ward as it was unfit for use. When we revisited the ward on 18 and 19 January 2017, we found that the trust had decommissioned the room and staff told us patients were no longer secluded on the ward. However, staff said that they would close the doors in the corridor of the ward to keep a disturbed patient in one area. This prevented the patient from leaving and stopped other patients from accessing their bedrooms. Seclusion refers to the supervised confinement and isolation of a patient who is being prevented from leaving. If a patient is confined in any way that meets this definition, they have been secluded.

Staff could not tell us on how many occasions this had happened and told us that the records of these incidents were archived. Staff also told us that if a patient was admitted and was physically threatening towards staff in the future then they might consider locking patients in the corridor again. We asked the trust to provide data around incidences of this nature. The data we received did not match the information staff gave us. Staff told us there had been up to 20 occasions of this
type eight months prior to our inspection, the data provided by the trust only showed five occasions of seclusion which were three to four months prior to this inspection.

**Safeguarding**

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

There had been one safeguarding referral since the timeframe of the data request on Shackleton ward. This incident was referred appropriately to the local authority and the trust safeguarding team.

Staff were aware of how to identify abuse and how to raise concerns. Staff told us they would raise concerns with their manager. The ward and acting ward managers were aware of the safeguarding alert process and told us they would raise concerns if they had any. There were leaflets and posters available for staff, which detailed what actions needed to be taken if they suspected someone was at risk of abuse.

**Serious case reviews**

There are no serious case reviews relating to this service.

**Staff access to essential information**

The wards used electronic records for patients’ notes and all staff had access to these when they needed to. Staff had access to electronic information about patients from Afton or Shackleton ward that had transferred to the general medical wards for treatment. This meant that staff could keep track on the patients’ progress and check any assessments or results for that patient.

**Medicines management**

During our previous inspection, we raised concerns that the controlled drugs on Shackleton ward were being stored in a locked but unsecured tin box. This did not comply with the legislation relating to controlled drugs management. During this inspection, we found that the controlled drugs box still had not been fixed inside the medication cupboard. This meant that drugs, which were identified within the Misuse of Drugs Act, were more likely to be misused if stored in this way. This was addressed immediately by the trust when we raised it.

On Afton ward, we reviewed one record where a patient had been given medication covertly. There was no mental capacity assessment or best interest plan in place. The prescriber had not documented a plan for how the medication should be given or disguised. However, staff told us they consulted a relative although there was no detail of this discussion in the patient’s notes. We asked the trust to look into this incident, but the response we got did not match current guidelines.

**Track record on safety**

**Serious incidents requiring investigation**

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.
Between 1 October 2016 and 31 September 2017 there were no STEIS incidents reported by this service.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported no never events during this reporting period.

There was one serious incident. A patient on Afton ward had sustained a fracture whilst on the ward. The ward manager completed a 72 hour report, which was escalated to a serious incident investigation. The outcome of this investigation was due to be fed back to the staff team through a staff meeting.

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

Staff did not report all incidents of violence and aggression using the trust electronic reporting system on Shackleton ward. Staff told us they do not report every incident because they would not have time to do so. The trust incident management policy defines violence, abuse or harassment as a reportable incident. A violent incident can be any incident involving verbal abuse, unsociable behaviour, racial or sexual harassment or physical assault whether or not it results in injury.

Failure to report incidents of violence and aggression meant that the trust do not have a true overview of the level of risk on the ward.

Staff on Afton ward told us there were rarely incidents on the ward but when there were, there would be formal or informal staff debriefs. Staff reported incidents using the electronic reporting system following incidents on the ward.

**Is the service effective?**

**Assessment of needs and planning of care**

Staff completed pre-admission and then post-admission risk assessments on both wards. The consultants completed a pre-admission risk assessment and care plan prior to admission. Risk assessments and care plans were written on admission. Records showed that care plans and risk assessments were reviewed and updated weekly. However, records did not sufficiently include the views of the patient or the carers.

We reviewed eight care plans across both wards. Care plans were detailed, holistic and provided assessments of the patients' previous history and physical health needs. There was evidence of a full physical health examination upon admission and ongoing physical health assessments.

On Shackleton ward, we found that all patients were automatically placed on food and fluid charts regardless of whether there was an identified risk. Night staff totalled the fluid charts but there were no set fluid targets. Staff gave us inconsistent responses about what a good fluid target would be for patients. Staff did not know why food and fluids were being monitored and without targets for fluid charts, they could not ensure that patients were receiving a sufficient amount of fluids.

**Best practice in treatment and care**

Staff on both wards had heard of the National Institute for Health and Care Excellence guidance but they were not able to give us examples of how they applied it.
Staff on both wards told us that there had been improvements in accessing occupational therapy and physiotherapy. Referrals were completed on the trust electronic system and contact was made from the appropriate team within 24-48 hours. This was evident on Afton ward in the care observed and in the records. This was an improvement since our last inspection in 2016. However, there was little evidence of this on Shackleton ward.

**National and local audits**

There were no audits specific to this service.

**Skilled staff to deliver care**

There were no clinical psychologists working in the wards. Therefore, patients were not receiving the psychological input required to improve their quality of life.

New staff received a corporate and local induction. Staff on both wards worked supernumerary shifts at the beginning of their employment to learn the role. On Shackleton ward, this was one to two weeks, on Afton ward this was two weeks.

The local induction on Shackleton ward was a one page checklist and orientation to the ward rather than an induction, which showed them how to perform their role. The new staff member and the line manager signed this off.

Management had designed the local induction on Afton ward in house and included an introduction to the ward, shift patterns, uniform, activities and expectations. The induction pack also included a learning section, which linked to the main types of symptoms, and behaviours that patients on Afton ward may experience and a database of some of the common medications used and their side effects.

Staff on Shackleton ward were not effectively supervised. Clinical and managerial supervisions were frequently cancelled due to staffing shortages. The supervision records we reviewed were brief and of poor quality.

Staff on Afton ward received supervision regularly. There was a matrix in place, which showed that staff received supervision. Staff told us they felt supervised and supported by management. However, we were unable to review any supervision records on Afton ward because staff were given the record and management did not retain a copy.

**Appraisals for permanent non-medical staff**

The trust’s target rate for appraisal compliance is 100%. From October 2016 to September 2017, the overall appraisal rates for non-medical staff within this service was 6%. However, the records reviewed on Afton ward showed that since the reporting period, there had been an increase in completion of appraisals.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afton Ward</td>
<td>29</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Shackleton</td>
<td>27</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td>Core service total</td>
<td>56</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2,730</td>
<td>1,433</td>
<td>53%</td>
</tr>
</tbody>
</table>
Management on Shackleton ward had fallen behind with staff appraisals. This was mainly due to staffing shortages and temporary management arrangements.

Seventy-five per cent of staff on Afton ward had received an annual appraisal. We saw evidence that there was a schedule of staff appraisals for the remaining staff with appraisers identified.

**Appraisals for permanent medical staff**

The trust’s target rate for appraisal compliance is 100%. There was no medical appraisal information provided for this service.

**Clinical supervision**

Management on Shackleton had fallen behind with staff supervisions due to staffing shortages. There were diarised supervision lists but nine out of nine of these appointments were cancelled. We reviewed records for 2017 and found that the quality of supervisions were poor and they were brief in content.

Staff on Afton ward received regular supervision from their supervisor. The ward had a structure for who was providing supervision to which members of the team.

**Multi-disciplinary and interagency team work**

Staff held regular and effective multidisciplinary meetings. There was evidence of good team working across different wards. This was an improvement from our last inspection in 2016.

The ward teams had effective working relationships with other teams both internally and externally to the trust. Staff told us they had good relationships with the local authority and the GPs.

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

Staff received training in the Mental Health Act. In addition, they could request advice about the Mental Health Act from the mental health act office. Staff scrutinised section papers on admission or when there were changes to the patients’ legal status. A duty Approved Mental Health Professional was available seven days a week 24 hours a day for advice or guidance.

Patients received their rights under the Mental Health Act in line with legislation. Staff told us that if the patient did not understand the information, they were reminded of their rights in a way that allowed them to understand. All patients detained under the Mental Health Act had the correct documentation present in their records.

Four out of five patients on Shackleton ward were detained under the Mental Health Act. Of those four patients, only one patient had authorised section 17 leave. The one patient with section 17 leave had not used it for weeks because there was no one available to take them out and staff told us the weather conditions were poor. However, patients on Afton ward were regularly using their section 17 leave.

The Mental Health Act Code of Practice was available in the Mental Health Act office and on the trust intranet.

There were leaflets available on the ward with contact details for the Independent Mental Health Advocacy service (IMHA).
There was no notice on either ward to inform informal patients that they could leave the ward freely. Staff told us that if an informal patient requested to leave either ward then they would be assessed by the nurse in charge who would consider applying a section 5(4) nurses holding power to detain them in hospital. Whilst it is important to assess that someone is well enough to leave the ward without coming to harm, we were not assured that voluntary patients knew they were allowed to leave the ward.

There were no audits being undertaken in relation to the Mental Health Act. Medication was used to sedate a patient on Afton ward under restraint whilst detained under a section of the Mental Health Act where there were no treatment powers.

**Mental Health Act training figures**

As of 9 October 2017, 91% of the workforce in this service had received training in the Mental Health Act. This was higher than the trust’s average 82% completion rate, and met the trusts’ 85% target.

### Good practice in applying the Mental Capacity Act

We did not have confidence that staff were applying the Mental Capacity Act. Staff could not show us an example of when a mental capacity assessment had been completed. Staff could not show us a tool or pro-forma that they would use to record capacity and five out of six staff across the two wards could not talk us through either the principles of the Mental Capacity Act or how they would complete an assessment. Staff told us that the Consultant Psychiatrist would complete mental capacity assessments but they could not show us an example of this on the electronic record system.

Shackleton ward had an informal patient who potentially lacked capacity. The patient was not detained under the Mental Health Act or schedule A1 of the Mental Capacity Act (Deprivation of Liberty Safeguards). Therefore, if they could not give informed consent, the patient was deprived of liberty without legal authority and was not benefitting from the safeguards of either the Mental Health Act or the Mental Capacity Act. Staff could not tell us if a Mental Capacity Assessment had been completed and did not understand the necessity to complete one. We raised this with the trust at the time of our inspection.

Staff on Afton ward had given medication to a patient covertly without a mental capacity assessment or a best interest care plan. This was not in line with the Mental Capacity Act.

There were no arrangements to monitor the application of the Mental Capacity Act.

**Mental Capacity Act training figures**

As of 9 October 2017, 62% of the workforce in this service had received training in the Mental Capacity Act, compared to the trust average of 19%. This did not meet the trust's target of 85%.

### Deprivation of liberty safeguards

The trust told us that four Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 October 2016 and 31 September 2017. The numbers matched those that were received by CQC.

<table>
<thead>
<tr>
<th>Number of DoLS applications made by month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-16</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Is the service caring?

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

Staff treated patients with kindness and compassion. We observed staff speaking with patients with respect in a gentle and calm tone. Staff responded thoughtfully and compassionately when supporting patients with their meals and basic care needs.

Patients felt cared for and felt they were treated with dignity and respect. Patients gave positive feedback about the care they received from staff through completing comment cards and one-to-one feedback with our inspection team.

Patients we spoke with on both wards were positive about the staff providing their care. Patients told us they got the help they needed. Patients told us staff were polite, friendly, and willing to help, took a genuine interest in their well-being.

Patients told us staff were consistently respectful towards them. Patients said that staff tried to meet their needs, they worked hard and had patients’ best interests and welfare as a priority. Staff responded promptly to any requests made for assistance or support.

Patients’ confidential information and records were not stored securely on either ward. We observed staff completing paperwork in a file, which included personal information about patients, which was left in communal areas. Staff told us the file was usually kept in a cupboard in a communal area but the cupboard was unlocked. On one occasion, the file was left in the lounge and on another occasion, it was left on a table in the communal area.

On Afton ward there was a large white board in the nurses’ station. This contained confidential information about patients. It was visible from outside of the nursing station. In addition, there were patients’ files within the nurse’s station that were not locked away and the nurses’ station was accessible to patients and visitors. Staff told us that records would be kept securely after the planned refurbish. However, staff were not mitigating patients’ confidentiality at the time of our inspection.

**PLACE - data in relation to privacy, dignity and wellbeing**

The 2017 PLACE score for privacy, dignity and wellbeing at St Mary’s Hospital scored worse than similar organisations.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Core service(s) provided</th>
<th>Privacy, dignity and wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary’s Hospital</td>
<td>MH OP wards</td>
<td>77.6%</td>
</tr>
<tr>
<td></td>
<td>Multiple</td>
<td></td>
</tr>
<tr>
<td>Trust overall</td>
<td></td>
<td>77.6%</td>
</tr>
<tr>
<td>England average (MH and LD)</td>
<td></td>
<td>82.4%</td>
</tr>
</tbody>
</table>
The involvement of people in the care they receive

Involvement of patients

Staff used the admissions process to inform and orient patients to the ward.

On Shackleton ward there was some evidence of patient involvement within the care records. There was no evidence that patients or their carers received a copy of their care plans. Staff told us this was an area they were developing.

On Afton ward staff showed us the process of involving patients in their care plans. Staff printed off care plans and showed them to patients before they were uploaded to the electronic system. Patients were then given a photocopy of their signed care plan which they placed into their bedroom.

Staff knew how to access advocacy services for patients. There were leaflets available in the communal area on Afton ward for patients and carers. On Shackleton ward there were leaflets available in the airlock.

Staff did not enable patients to make advance decisions (to refuse treatment, sometimes called a living will) where appropriate.

Involvement of families and carers

An audit of the Care Programme Approach on Shackleton ward showed that involvement of the patient, their carers' and family was present in all cases. However, the auditor rated the level of involvement as 'less than good'.

On Afton ward, staff had developed a board on the wall, which encouraged feedback from patients, carers and relatives about their care planning. Patient's carers and relatives were invited to all multidisciplinary meetings with the patient's consent.

There was a carers' lounge within the hospital. Carers were able to be referred for a carers' assessment through a hospital social worker.

Is the service responsive?

Service Planning

Access and discharge

There were not always beds available for patients on the most appropriate wards. For example, patients with dementia were admitted to Afton ward because there were not enough beds available on Shackleton ward.

Bed management

Bed occupancy

The trust provided information regarding average bed occupancies for two wards in this service between 1 September 2016 and 31 August 2017.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

| Ward name | Average bed occupancy range (1 Sep 16 - 31 Aug 17) |
The trust provided information for average length of stay for the period 1 September 2016 and 31 August 2017. We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Average length of stay range (1 Sept 16 - 31 Aug 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afton</td>
<td>85% (range 74% - 97%)</td>
</tr>
<tr>
<td>Shackleton</td>
<td>97% (range 91% - 100%)</td>
</tr>
</tbody>
</table>

Patients that were transferred to the general medical wards did not always have a bed to return to on Shackleton ward. This meant that patients were frequently transferred to Afton ward where there were more beds. This was not always appropriate because Afton ward served a different patient group.

Management on Afton ward told us that if a patient was transferred to an acute ward or went home for section 17 leave, their bed would always be kept open for them.

**Out of Area Placements**

This service reported no out area placements between 1 October 2016 and 30 September 2017

This service reported no readmissions within 28 days between 1 October 2016 and 30 September 2017

**Discharge and transfers of care**

Between 1 October 2016 and 30 September 2017, 17.6% of discharges were delayed trust wide. This data was not provided at core service or ward level.

Management on Shackleton ward often struggled to accommodate the amount of patients that required the service. During our inspection, there were three patients due to be transferred back to Shackleton ward but there was only one bed available. Management on Shackleton ward had to attend a multidisciplinary meeting to ensure that the needs of the patient admitted to Shackleton ward were safely met. There was also an impact on Afton ward who would also need to accommodate patients that did not always meet their admission criteria. We observed that two patients with a diagnosis of dementia had been admitted to Afton ward during our visit, as there were no other available beds on more appropriate wards.

Staff told us that discharges could sometimes be delayed. This was usually due to lack of residential placements or funding issues. The Home Treatment Team was working with the staff at Afton ward to support patients out into the community to build confidence and get them home sooner. Staff told us that when there were delayed discharges, they sent a notification to the local authority. If patients were transferred or discharged, this was always at an appropriate time of day.

**Referral to assessment and treatment times**

The trust has identified no services as measured on ‘referral to initial assessment’ and...
Facilities that promote comfort, dignity and privacy

PLACE Assessments

The 2017 PLACE score for ward food at St Mary’s scored worse when compared to other similar trusts.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Core service(s) provided</th>
<th>Ward food</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary’s Hospital</td>
<td>Multiple</td>
<td>77.3%</td>
</tr>
<tr>
<td>Trust overall</td>
<td></td>
<td>77.3%</td>
</tr>
<tr>
<td>England average (mental health and learning disabilities)</td>
<td></td>
<td>89.7%</td>
</tr>
</tbody>
</table>

The environment on Shackleton ward was not dementia friendly. For example, patients were not cared for in the least restrictive way, and the décor did not lend itself to a dementia friendly environment.

In bedrooms, there was a mesh present on half of the window to provide a privacy screen so only half the window provided privacy.

Bedrooms on both wards had limited personalisation. Staff told us that patients were welcome to bring in their things to personalise their rooms and were not sure why they had not done this.

On Shackleton ward, there were limited meaningful activities. Occupational therapy staff visited the ward on a Tuesday, Wednesday and a Thursday afternoon. This was an improvement from our last inspection in 2016. Ward based activities were often cancelled due to ‘staffing constraints’. When activities were facilitated by the ward, records showed these only involved colouring. On the two occasions, we visited the ward there were no activities offered by ward staff and patients were either watching television in the lounge or walking around the corridors.

There were regular activities on Afton ward and additional activities provided by Occupational Therapy. These included walking, games, colouring, newspaper group, keep fit, quizzes, bingo, relaxation, crafts and mindfulness.

Patients on Shackleton ward had not used the garden for a number of weeks. Staff told us this was due to staff shortages and poor weather conditions.

Patients on Afton ward were using escorted leave and section 17 leave to access fresh air frequently.

Patients’ engagement with the wider community

Staff supported patients to maintain contact with families and carers and they were welcome to visit the wards.

Patients on Shackleton did not engage with the wider community. Patients had not left the ward for a number of weeks due to staffing shortages although staff told us this was also because it was cold and the weather conditions were poor.
Patients on Afton ward were able to access the community if authorised by their consultant. We reviewed section 17 leave forms, which evidenced that patients were regularly using their section 17 leave in the community.

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

Patients on Afton ward had access to a range of leaflets to support their recovery. For example, there were leaflets about domestic abuse, alcohol, panic, bereavement, depression, anxiety and stress.

Management told us that leaflets could be made available to patients with disability or sensory loss or in other languages. Although, we only saw the standard format of leaflets on the ward.

On Afton ward, there were two bedrooms with wheelchair access; one for male use and one for female use.

There was a rolling menu programme for mealtimes. Patients could choose from different options including hot and cold food, vegetarian, vegan and kosher meals. The kitchen would fortify food if they were advised of a dietary need. On Afton ward, we saw allergen information available for every menu option.

Staff told us that the chaplain would visit the ward if a patient requested to see them.

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

**Complaints process overview**

- The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>What is your internal target for responding to</em> complaints?</em>*</td>
<td>3</td>
</tr>
<tr>
<td>The policy is 20 days, although we do negotiate response timeframes with complainants</td>
<td></td>
</tr>
</tbody>
</table>

| **What is your target for completing a complaint** | |
| | |

| **If you have a slightly longer target for complex complaints please indicate what that is here** | 45 or 60 Days if SI leading investigation | not recorded |

| **Number of complaints resolved without formal process in the last 12 months?** | 888 | 01/10/16 - 30/09/17 |
Formal complaints

The trust could not provide complaint data for this service. Staff on both wards told us they would support a patient to make a complaint and were aware of the complaints process. However, on Shackleton ward, there were no posters or leaflets for patients as it was felt they might be damaged or be taken down by the patients. Staff told us that there was no team feedback or learning following complaints.

On Afton ward, there were leaflets available for patients and their relatives advising them how to complain and introducing the advocacy service and the Patients’ Advice and Liaison service.

Compliments

It was not clear from the data provided by the trust as to how many, if any, compliments were received by the service.

There were a number of compliments from patients and their relatives on Afton ward. These were sent to the ward in letters and cards, in addition, there were six CQC comment cards that all had positive feedback about staff and the service that patients received on Afton ward.

Is the service well led?

Leadership

Staff told us that the executive team were more visible on the wards. Executives had attended a staff meeting and staff felt more listened to and had more confidence in the senior leadership.

There was a lack of leadership on the Shackleton ward. The ward manager was on long term sick leave and so the two band six nurses had stepped up to be acting ward managers. Whilst they felt supported, there had not been suitable training to equip them to carry out the roles.

Staff on Shackleton felt the lack of staffing had an impact on the way the team was led. As the ward was frequently short staffed, shifts felt disorganised and staff had little time for one-to-ones with patients. There had been a number of unresolved staffing issues on the ward, which were ongoing.

Staff on Afton ward felt positive about the leadership on the ward. Staff felt they could raise concerns with managers and would be listened to. They felt involved in the running of the ward.

A member of staff on Afton ward had been seconded to do their nurse training through the Open University.

Vision and strategy

Staff were unaware of the vision and values of the trust. However, staff felt more involved in developments within the service. Staff felt they were kept up-to-date with improvements that were being made within the hospital and plans for the future.

Staff on Shackleton ward were unsure about whether the business case to move the ward to more suitable premises had been approved. Staff were unaware of time frames for any proposed ward moves. This left staff feeling frustrated and in limbo.

Culture

On Shackleton ward there had been a number of staffing problems, staff had been transferred to other departments within the hospital. We saw evidence in supervision notes and staff meeting minutes that there was a culture of conflict and gossiping, which was an ongoing issue.
Staff reported low morale on Shackleton ward. Staff commented this was partly due to being short staffed but also due to feeling that the trust had overlooked the service and it did not get the attention staff thought it should.

On Afton ward, the staff team appeared to be cohesive and supportive of one another. Staff reported a happy team that respected each other. There were no concerns raised about staff conduct or performance. Staff felt supported and valued within the team.

Staff on Afton ward felt confident they could raise concerns and would be listened to. Staff knew how to access the whistleblowing policy.

One member of the staffing team on Afton ward had received an award from the trust at the staff awards for ‘going the extra mile’.

**Suspension and supervised practice**

During the reporting period there were no cases where staff have been either suspended or placed under supervision.

**Governance**

There was a lack of governance and oversight on Shackleton ward. Supervisions and appraisals had fallen behind and were frequently cancelled. Staff meetings were taking place. However, we found meeting minutes written out on scrap paper with holes in that were several weeks old; the minutes were still not typed up. The content of the staff meetings had a negative theme of staff complaints and dissatisfaction. Audits appeared to be happening but the outcomes of these did not appear to be fed back to the staff team to encourage positive changes in practice. Ward leadership could not identify staffing skill mix needs or how the ward was performing in key performance areas.

The team on Afton ward operated effective systems to ensure they assessed and monitored the service. Staff on Afton ward were auditing their practices. We were given examples of how outcomes of falls audits had led to the introduction of a new falls care plan.

There was evidence of action plans for the improvement of the service on Afton ward. This demonstrated that the service was looking to continually develop the services it provides to patients.

Staff were supervised and appraised on Afton ward. There was a schedule for supervisions and appraisals. Staff meetings were regular and productive.

The trust have not provided a board assurance framework for this inspection.

The trust have not provided a risk register for this inspection.

**Management of risk, issues and performance**

Management on both wards had the ability to report risks to the trust risk register. Staff were able to describe how risks could be entered onto the risk register.

We saw examples of contingency plans for the wards. Management knew how to access these and had been involved in their development.

There was no programme in place to reduce restrictive practice on either ward as recommended by the National Institute for Health and Care Excellence.
There was a positive response in relation to most of the more serious environmental risks on the wards. Afton was having a complete refurbishment of the ward environment. Shackleton ward was still in a state of a limbo and whilst some of the risk issues had been dealt with such as, managing ligature risks and blind spots. There had been no consideration to positive risk taking and dementia friendly environments.

**Information management**

Staff on both wards had access to computers to allow them to create and update records. There had been a recent upgrade to the electronic system, staff were in the process of being trained to use the updated version. Staff told us that the updated electronic version was an improvement from the previous system.

Patients’ records were not stored in a confidential way on either ward. On Shackleton ward records were left in communal areas unattended. In Afton ward patients’ records were kept in an unlocked trolley in the nurses’ station.

On Shackleton ward, team management did not have access to the information required to support them with their management role. For example, we were told that the acting managers had not been given access to information about staff training.

On Afton ward, the team leader had access to information about ward performance which was discussed with staff at team meetings.

**Engagement**

Staff had access to up-to-date information about the work of the trust. For example, through the trust intranet and internal newsletters.

**Learning, continuous improvement and innovation**

Staff were not involved in any research opportunities or national quality improvement programmes.

Staff were not involved in any national audits or accreditation schemes.

**Accreditation of services**

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates.

<table>
<thead>
<tr>
<th>Accreditation scheme</th>
<th>Service accredited</th>
<th>Comments and date of accreditation / review</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMS - OP (Wards for older people)</td>
<td>Afton</td>
<td>Not provided</td>
</tr>
</tbody>
</table>
Community mental health services for people with a learning disability or autism

### Facts and data about this service

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team name</th>
<th>Number of clinics</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthur Webster Clinic Shanklin</td>
<td>Arthur Webster Clinic Learning Disabilities</td>
<td>-</td>
<td>mixed</td>
</tr>
</tbody>
</table>
Is the service safe?

Safe and clean environment
The service shared premises with other community health services. All areas were clean with good furnishings. Cleaning records were up to date.

Interview rooms had alarms fitted, although one was inaccessible to staff behind an examination couch. Staff had mitigated this by use of a personal alarm.

Safe staffing
The service currently had one vacant post that was being covered by an agency nurse. This was reported following the submission of data. The team manager was currently an interim post as the manager was backfilling another specialist post within the team. There was evidence of planning for future staffing issues. For example, the acting team manager discussed plans to cover two posts due to upcoming maternity leave.

Staff reported low, manageable caseloads. Nurses reported an average of 12 cases each. The team manager told us that caseloads were discussed in individual supervision. However there was no evidence of regular caseload management occurring, for example one record reviewed had no activity from April 2017 until a discharge letter was completed in December 2017, however it was still showing as an active case on the clinicians caseload.

Staff reported easy access to the psychiatrist when they need support or reviews. However, there were disagreements within the service surrounding the best use of the psychiatrists’ capacity that had not been resolved. For example, staff discussed the need for more outpatient clinics however the psychiatrist did not agree.

Staff reported that service users could see the psychiatrist quickly. We spoke to five carers and one service user, they confirmed that this was the case.

Definition
Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

<p>| Substantive staff figures                                      | 30 September 2017 | 20.6 |
|                                                               | October 2016 – September 2017 | 2 |
| Total number of substantive staff                             | October 2016 – September 2017 | 9.9% |
| Average WTE* leavers over 12 months (%)                       | October 2016 – September 2017 | 0.4 |
| Total vacancies overall (excluding seconded staff)            | October 2016 – September 2017 | 4% |
| Total vacancies overall (%)                                   | October 2016 – September 2017 | 4.9% |
| Total permanent staff sickness overall (%)                    | October 2016 – September 2017 | 0.4 |
| Total permanent staff sickness overall (%)                    |</p>
<table>
<thead>
<tr>
<th>Establishment and vacancy (nurses and care assistants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment levels qualified nurses (WTE*)</td>
</tr>
<tr>
<td>Establishment levels nursing assistants (WTE*)</td>
</tr>
<tr>
<td>Number of vacancies, qualified nurses (WTE*)</td>
</tr>
<tr>
<td>Number of vacancies nursing assistants (WTE*)</td>
</tr>
<tr>
<td>Qualified nurse vacancy rate</td>
</tr>
<tr>
<td>Nursing assistant vacancy rate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bank and agency Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)</td>
</tr>
<tr>
<td>Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)</td>
</tr>
<tr>
<td>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)</td>
</tr>
<tr>
<td>Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)</td>
</tr>
<tr>
<td>Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)</td>
</tr>
<tr>
<td>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)</td>
</tr>
</tbody>
</table>

*WholeTime Equivalent

**Staff Fill Rates**

This core service reported an overall vacancy rate of 7.1% for registered nurses from October 2016 to September 2017.

April 2017 and May 2017 saw the highest vacancies in registered nursing and midwifery staff, with 2 vacancies in both months. These vacancies have now been filled and since July 2017, there have been no vacancies.

This core service has reported a vacancy rate for all staff of 4% from October 2016 to September 2017.

This has been influenced by the additional clinical services staffing group which had a vacancy rate of -1.1% from October 2016 to September 2017, demonstrating a surplus number of staff in this staffing group.

This core service had 2 (9.9%) staff leavers from October 2016 to September 2017. Both of these staff leaver were from the Nursing and midwifery staffing group. One left in February 2017 and one left in March 2017. This was similar to the core service average of 8.6% for this time period.

The sickness rate for this core service was 4.9% from October 2016 to September 2017. The most recent month’s data (September 2017) showed a sickness rate of 6%.

The sickness rate recorded for nursing and midwifery staff was 6% from October 2016 to September 2017.
This was higher than the trust’s overall sickness rate of 4.3% for this twelve month period.

The trust set a target of 85% for completion of mandatory training.

The compliance for mandatory training courses from April 2017 to October 2017 was 82%. This did not meet the trust's target of 85%. Of the training courses listed seven failed to achieve the trust target and of those, five failed to score above 75%.

Training courses with the lowest completion rates were people handling, with zero out of one eligible member of staff having completed this, and prevent training levels 1&2 with six out of 22 eligible members of staff having completed this (27%).

Key:

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service</th>
<th>Trust target %</th>
<th>Trust wide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance: A Beginners Guide</td>
<td>100%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>100%</td>
<td>85%</td>
<td>96%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>100%</td>
<td>85%</td>
<td>69%</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>100%</td>
<td>85%</td>
<td>98%</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>100%</td>
<td>85%</td>
<td>77%</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>95%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>95%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>95%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>95%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>94%</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>92%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>90%</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>89%</td>
<td>85%</td>
<td>83%</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>88%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>86%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Fire Safety Part 1 – Theory</td>
<td>86%</td>
<td>85%</td>
<td>92%</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>85%</td>
<td>85%</td>
<td>93%</td>
</tr>
<tr>
<td>Load Handling</td>
<td>78%</td>
<td>85%</td>
<td>76%</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>77%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>72%</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>67%</td>
<td>85%</td>
<td>73%</td>
</tr>
<tr>
<td>Adult Resuscitation - Non-Clinical Staff</td>
<td>50%</td>
<td>85%</td>
<td>74%</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>27%</td>
<td>85%</td>
<td>54%</td>
</tr>
<tr>
<td>People Handling</td>
<td>0%</td>
<td>85%</td>
<td>74%</td>
</tr>
<tr>
<td>Core Service Total %</td>
<td>82%</td>
<td>85%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Staff had not received sufficient mandatory training to support them to deliver their role safely. We saw evidence that the team were 86% compliant at the time of the inspection. However there were areas of mandatory training which were below 75%. Care planning and hand hygiene was 71%, fire safety 70%, mental health 58%, disability awareness was 50%, health and safety 50%, risk management training 50% and safeguarding adults’ level 2 was 33%.
Assessing and managing risk to patients and staff

Assessment of patient risk

Staff within the service no longer used a recognised risk assessment tool. At our last inspection, staff had been using a standardised core assessment and all records had risk assessments as part of that core assessment. The improvement program the trust was undertaking had led to the core assessment on the electronic record system being revised. However, when it was implemented it was found by staff not fit for purpose for people with a learning disability. Due to this staff were told not to use the core assessment by senior managers in an email sent in January 2018. This meant that new service users were not having standardised assessments and risk assessments completed. A clear picture of a service users risks was not immediately apparent despite evidence of risk being considered in the 12 electronic records we looked at. Staff commented on risk in their clinical notes and letters.

Staff discussed risk in multi-disciplinary team (MDT) meetings and responded promptly to the service users need. For example we saw evidence of urgent appointment being arranged following concerns raised at the MDT.

Management of patient risk

Staff responded quickly when services contacted them with concerns about any deterioration in service users’ presentation. We spoke with six carers and two service users who confirmed this to be the case. We also spoke with staff at two supported living placements who reported the same. However, two carers and one service user reported difficulties in getting through to talk to someone in the office as there was only one dedicated telephone number to contact the team.

There was evidence that the waiting list was monitored and patients were assessed and prioritised according to risk. Staff kept a spreadsheet that showed when service users were referred and how long they had been waiting. This included a summary of risk and what had been done so far.

Staff no longer had personal alarms for use in the community as staff in the service had not used them and they had been removed on cost grounds. The service had developed a buddy system that all staff said was effective. Where there were known concerns, staff worked in pairs to manage the risks. There appeared to be a good safety protocol in place that staff followed. Staff followed the trust lone working policy and kept their diaries up to date to reflect where they were.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted.
to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust only submitted information on safeguarding referrals at a trust wide level so this data cannot be reported per core service.

Only 33% of staff were trained in safeguarding adults’ level 2, this training was renewed every three years. Staff told us that the training was not available until September 2018. Staff were able to demonstrate a good understanding of safeguarding and give examples of partnership working with the local authority to address concerns. Records reflected this.

**Staff access to essential information**

The electronic records system was where information about service users’ care was stored. Information was not easily accessible and was often stored in different areas of the electronic notes. The trust was working to address some of the issues in the electronic records and there was a working group specifically looking at the needs of the learning disability service which some members of the service attended.

**Medicines management**

Medicine was not stored at the clinic as patients had this in their own homes or supported living placement.

There were regular reviews for service users prescribed medicine. These included recording behavioural observations as well as physical observations. For example, in the treatment of a service user with attention deficit hyperactivity disorder where a support worker completed observations in the service users home before the medicine review in line with guidance from the national institute for health and care excellence (NICE).

**Track record on safety**

There were no serious incidents reported in the last 12 months.

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

Incidents were reported on an electronic system. The team manager reported that staff were good at reporting incidents. Staff we spoke with were aware of how to report incidents. We saw evidence of incidents which had been reported and how they were managed. Staff were aware of the duty of candor and there was evidence of staff being open with patients and carers in the electronic notes we looked at.

Lessons learnt from incidents were discussed in the multi-disciplinary team (MDT) meeting.
Is the service effective?

Assessment of needs and planning of care

Staff completed comprehensive assessments of each service user. Since the trust had stopped staff using the core assessment, assessments were not always easy to find in the clinical records. Staff were recording the assessments in different areas of the system. Clinical information about the service user was difficult to find.

Assessments considered physical health needs.

Care plans were not always easy to find on the electronic recording system. They were recorded in clinic letters or individualised plans that were then uploaded. However, they were personalised, holistic and considered the service user's needs. Staff reviewed and updated them when necessary.

Best practice in treatment and care

Staff demonstrated a clear focus on service users physical health needs and considered its impact in their interventions in all records reviewed. On an observed review, the nurse knew which GP the service user was under when considering the possible impact of constipation on behaviour.

Service users did not always receive annual health checks and health action plans from their GP. Managers in the service were working to address this with local practices and the care commissioning group (CCG). We saw evidence that out of 912 patients only 120 (13%) of service users had an annual health check. The team manager also explained that not all services users would have registered with their GP as having a learning disability. The team manager was liaising with the CCG about this and there were efforts made by the service to ensure that the GP was monitoring service users' physical health needs.

The service had a dedicated nurse working with service users to prepare them for physical health interventions. This also involved supporting carers with the process and liaising with acute health services. One supported living manager said that this was a major benefit to service users in helping them get medical care. Care plans and interventions for this were detailed, comprehensive and considered capacity and consent.

Staff delivered a range of evidenced based care and treatment interventions that were suitable for people with a learning disability. These were in line with National Institute for Health and Care Excellence (NICE) guidance. For example, care plans for behaviours that challenge were comprehensive and based on positive behaviour support. The care plan quoted the relevant NICE guidance (NG11). Care plans for service users with epilepsy included detailed risk assessments and interventions that referenced the 2012 NICE guidance and other research such as a medical journal article on sudden unexpected death in epilepsy.

Skilled staff to deliver care

The team were fully staffed and had all professions required for the service. Staff were experienced and qualified for their roles. Staff reported that the speech and language therapist was not based in with the rest of the team which meant it was more difficult to access.
Staff were offered supervision. However, in the six staff supervision records reviewed, none were having regular supervision. The supervision frequency varied and was not in line with trust policy. The quality of supervision record varied, for example, some were recorded on a standardised electronic template and others were hand written without following any agenda. We looked at six staff personal files that showed that supervision was not completed monthly. This was not in line with the trust supervision policy that stated that supervision should be completed monthly.

The trust’s target rate for appraisal compliance is 100%. From October 2016 to September 2017, the overall appraisal rates for non-medical staff within this core service was 67%.

At the time of the inspection all staff had received an annual appraisal. Staff appraisals included conversations about career development and how it could be supported. The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 90% reported in the previous year.

Staff felt that they had good access to training and development and that the trust supported the logistics to access courses and conferences.

<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD/Autism/ADHD</td>
<td>24</td>
<td>16</td>
<td>67%</td>
</tr>
<tr>
<td>Core service total</td>
<td>24</td>
<td>16</td>
<td>67%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2,730</td>
<td>1,433</td>
<td>53%</td>
</tr>
</tbody>
</table>

The trust’s target rate for appraisal compliance is 100%. There was no medical appraisal information provided for this core service.

**Multidisciplinary and interagency team work**

The team had weekly multi-disciplinary team meetings. There was evidence that these meetings were productive and followed an agenda. Staff were able to raise concerns, discuss risk and ensure that patients were receiving the correct care and treatment.

Records showed very good joint working and liaison with general practitioners and other health professionals. For example, staff used assessments and records from the community health service to help in the delivery of a continence intervention.

Staff had good working links with other partner organisations to support service users care. There were positive relationships between staff and the managers of local supported living provision. Staff in supported living environments said that staff in the community learning disability team treated them as equal partners and respected their knowledge of the service users and their skills.

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

MHA specific training was not completed by staff as the trust had not made this part of the teams mandatory training. However staff we spoke to appeared to have a good knowledge of the Mental Health Act. The trust intranet site had access to policies and procedures relating to the Act. Staff
were able to navigate the trust intranet site and all staff reported that they could find the information when required.

There were no current services users on a community treatment order. Staff were able to explain how they had managed this previously in line with the code of practice.

As of 7 October 2017, no members of staff were listed as being required to complete or having completed Mental Health Act training.

**Good practice in applying the Mental Capacity Act**

Mandatory training covered the Mental Capacity Act (MCA), 91% staff had completed the training.

Staff we spoke to appeared to have a good knowledge of both the Mental Capacity Act. The trust intranet site had access to policies and procedures relating to the Act. Staff were able to navigate the trust intranet site and all staff reported that they could find the information when required.

The majority of service users had significant learning disabilities and did not have verbal communication skills. Staff considered this carefully in their interactions with service users and their carers.

Consent for interventions were considered on a decision specific basis. For example, the service arranged a capacity assessment for a service user with complex health needs who was refusing food and drink. A referral to an independent mental capacity advocate (IMCA) was completed to ensure the service user had an independent voice in the decision making process.

**Is the service caring?**

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

Staff spoke about service users and carers with dignity and respect. This was also evident in how they addressed them in assessments and correspondence.

In interactions with service users, staff gave patients time to respond and used their preferred communication methods. When faced with aggression from a service user who did not have verbal communication skills, staff correctly interpreted this as them not wanting to communicate at that time, and gave them the space they required whilst remaining calm and polite.

We spoke with two service users, one reported that they thought the service was excellent and the other said it was very good. The service users said that staff treated them with dignity and respect and understood their care needs. They also reported that the service was responsive to their individual needs.

We spoke with six carers, they all reported that they thought staff treated the service user professionally and support and was good overall. All of the carers we spoke with reported that staff appeared to understand the needs of the service users and that staff adapted their approach to communicate.

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

**Involvement of patients**

One service user said that they had needed their medication reviewing following a change in their circumstances, staff dealt with this quickly and efficiently.

Staff communicated with service users in a manner that they could understand. For example, for service users with literacy issues staff used simple wording or pictures to explain the care plan including the use of social stories.
Involvement of families and carers

Staff involved families and carers to understand service users likes, dislikes and specific needs where appropriate. For example, if the service user had significant communication difficulties. Carers said that they felt staff involved in them in care planning and that they felt supported and involved. All of the carers we spoke with reported that they were able to contact the service users care coordinator. All carers reported feeling involved in the care of the service user.

Carers reported that they received copies of letters that were sent to the GP about the service users’ care.

Is the service responsive?

Access and waiting times

The service had a clear referral process that the team followed. Patients were seen within the trusts own referral criteria.

Service users were assessed quickly when referred to the service. However, there was a waiting list to receive treatment. At the time of the inspection, three service users had waited longer than the national target of 18 weeks for treatment. The three service users waiting for treatment were discussed weekly at the multi-disciplinary team (MDT) meeting and risk was assessed. We saw evidence of how the waiting list was managed and there was a clear understanding of the needs and risks of the services users. At the time of the inspection there were 22 service users waiting for treatment, 19 were waiting to see a psychologist.

External partners in social care said that the service was very responsive and staff were always available to give telephone advice if the young persons allocated worker was unavailable. If a supported living environment requested a visit then this was facilitated quickly. However, one service user reported that they found it difficult to get through to the office to speak to staff as there was only one telephone number to contact staff.

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The core service had no referral to assessment targets or assessment to treatment targets for teams in this core service.

The attention deficit hyperactivity disorder (ADHD) and Autism service was run and reported on separately to the LD service.

<table>
<thead>
<tr>
<th>Name of team</th>
<th>Service Type</th>
<th>Days from referral to initial assessment</th>
<th>Days from assessment to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>National target</td>
<td>Actual (mean)</td>
</tr>
<tr>
<td>LD - PARIS Recorded</td>
<td>-</td>
<td>-</td>
<td>37</td>
</tr>
<tr>
<td>ADHD - PARIS Recorded</td>
<td>-</td>
<td>-</td>
<td>138</td>
</tr>
<tr>
<td>AUTISM - PARIS Recorded</td>
<td>-</td>
<td>-</td>
<td>195</td>
</tr>
</tbody>
</table>

The facilities promote comfort, dignity and privacy

The service had access to a range of rooms for interviews. However, they were rarely used as most service users were seen in their own homes. The interview rooms were sound proofed.
Meeting the needs of all people who use the service

The trust had made reasonable adjustments to the building. At our last inspection, we raised concern about the main door being difficult to open for wheelchair users. Although the door was still in place, a clearly marked bell had been installed at an appropriate height to enable wheelchair users to call for assistance in entering the building.

The building had large easy read pictorial signs for the reception and toilets.

Information about local services was readily available in the waiting room. Community staff had access to a range of accessible information that they would provide to service users and carers as appropriate.

The service provided information to service users in accessible format when required. For example, in the use of social stories to prepare them for hospital admissions.

Listening to and learning from concerns and complaints

The trust did not provide any data on concerns and complaints. The service manager said that there no current complaints about the service. Service users and carers we spoke with knew how raise concerns and how to complain.

There were no formal complaints reported for the service over the last 12 months.

There were no compliments reported for the service for the last 12 months.

Is the service well led?

Leadership

The interim team manager had minimal management experience although had good knowledge of the team and service and was clinically experienced.

Vision and strategy

Staff were aware of and shared the trusts visions and values. The trust values and vision was available on the trust intranet which staff were aware of.

Staff expressed concerns that they had not been involved with the transformation plan and future relationship with the local authority services. Staff reported feeling out of the loop and did not know what was happening.

The service was not taking positive action to support the national Transforming Care programmes aim of reducing hospital admissions for people with learning disability or autism. The service was not effectively monitoring the progress of service users who had been placed out of area. Staff and managers were unable to confirm the numbers of service users in hospital when asked and had to review records to identify all cases. The lack of caseload management meant that there had been limited or no contact with some hospitals where service users were placed. One record had no care programme approach (CPA) documents since 2016 and the last entry had been in July 2017 when the service user had contacted the service to request to speak to the care coordinator and this had not been followed up. Another stated in November 2017 that a home visit to a potential new social living provider should occur in December 2017 to help facilitate a return to the island, but there were no further entries to say if this occurred. Staff had not attended any CPA meetings for another service user since 2016. Only one of the four records sampled showed ongoing engagement and monitoring to help facilitate a return to the local area.

The interim team manager was had limited management experience and had not been offered development opportunity by the trust. There were no leaderships course available for staff to develop skill within the trust.
**Culture**
Staff felt supported by leadership within the team. However, were a little unsettled about future management arrangements. The current team manager post was an interim post as the substantive team manager was seconded into a specialist role within the team. At the time of the inspection, staff did not know how long these arrangements would be in place.

Staff felt able to raise concerns without the fear of retribution. Staff reported feeling confident to raise concerns through senior manager and knew how to raise concerns. Staff were aware of the whistle blowing process and how to use it. Staff were able to show me the process on the trust intranet.

Managers supported staff with health needs. For example, a sit-stand desk had been provided for a team member.

Staff were nervous about the upcoming joint transformation program with the local authority and did not feel fully informed or engaged with the process by leadership within the team or by the trust.

Staff still felt distant from the trust but did feel that communication from senior leaders had improved from both the chief executive and leadership within the mental health business unit. Staff reported senior managers being more visible and visiting the service over the past year.

Conflicts between staff were not managed quickly by senior managers. There were tensions within the leadership of the service. There was not clear understanding or appreciation of each other’s different roles and responsibilities.

During the reporting period there were no cases where staff have been either suspended or placed under supervision.

**Governance**
There was not a robust oversight of governance for the service. The acting manager did not have the experience and the trust did not offer the opportunities to develop.

The trust have not provided a board assurance framework for this inspection.

**Management of risk, issues and performance**
The service did not have any concerns which were on the risk register. Staff were aware of and had access to the trust risk register.

**Information management**
Information about service users’ care was not easily accessible and was often stored in different areas of the electronic notes. The trust was working to address some of the issues in the electronic records and there was a working group specifically looking at the needs of the learning disability service which some members of the service attended. The improvement program the trust was undertaking had led to the core assessment on the electronic record system being revised, however when it was implemented it was found by staff not fit for purpose for people with a learning disability. This meant that new service users were not having standardised assessments and risk assessments completed. Staff commented on risk in their clinical notes and letters, however a clear picture of a service users risks was not immediately apparent.

**Engagement**
Staff had access to the trust intranet and were able to keep up to date with developments, news and changes.
Staff have raised concerns that they do not feel involved in the transformation plan.
Service users and carers we spoke to were not currently involved in decisions about the service and were not involved in the transformation plan.

**Learning, continuous improvement and innovation**

The trust was participating in the Learning Disability Mortality Review Programme which was ongoing at the time of the inspection.

The trust have not been awarded any accreditations for this service.
# Community-based mental health services for adults of working age

## Facts and data about this service

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team name</th>
<th>Number of clinics per month</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chantry House, Pyle Street, Newport</td>
<td>Chantry House Community Mental Health Services</td>
<td>120</td>
<td>mixed</td>
</tr>
<tr>
<td>St Mary's Hospital</td>
<td>Memory Service</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>St Mary's Hospital</td>
<td>Single Point of Access Team</td>
<td>43</td>
<td>mixed</td>
</tr>
<tr>
<td>St Mary’s Hospital</td>
<td>Early Intervention in Psychosis (EIP)</td>
<td>-</td>
<td>mixed</td>
</tr>
<tr>
<td>The Gables, Newport, PO30 2ER</td>
<td>IAPT Plus</td>
<td>166</td>
<td>mixed</td>
</tr>
</tbody>
</table>
Is the service safe?

Safe and clean environment
Staff provided care to people accessing the community mental health service from a central base in Newport called Chantry House. There were satellite services in Ryde and Shanklin. Staff also travelled to visit patients in their own homes. The previous inspection in November 2016 found that staff did not have access to personal safety alarms in trust buildings. This had been resolved with personal safety alarms in therapy rooms. There was a specific room allocated for staff to use if there was an identified risk of violence towards staff from patients.

The clinic room at Chantry House was dark and in need of updating. However, staff felt it was big enough for the administration of depots and physical healthcare. There was equipment to carry out physical observations and cabinets to store medicines. Sharps bins were available and there was a clinical waste bag.

The lack of fridge and clinic room temperature recording was raised at the previous inspection. Staff recorded fridge temperatures daily to ensure that the medication fridge was operating at the correct level to keep medications safe. However, staff did not record the clinic room temperature; so staff were unable to ensure the correct storage medicines that do not require refrigeration.

Safety of the ward layout
The environment of Chantry House was tired and in need of updating, however it appeared clean. Ligature points within the building had been assessed and there ligature cutters were available to staff. Senior leaders within the organisation had identified issues with the environment of Chantry House. As a result, the Mental Health and Learning Disability Strategy had stated that the building was not fit for purpose and that there should be significant improvements to the environment.

Managers were seeking an alternative building.

Prior to the inspection staff members raised that they felt the storage of paper notes in the roof of the building was a fire risk.

Ligature risks had been identified at one location within this core service. The trust had undertaken recent (4 October 2017) ligature risk assessments at this location.

This location did not present a high level of ligature risk due to “This is an old building not on the main site. Access control mitigates a lot of risk and this area is next for discussion at the ligature group meeting.”

Safe staffing
Staffing within the community mental health service was placed on the risk register due to high vacancies affecting patient treatment. At the time of the inspection, there were five whole time equivalent vacancies for band six mental health nurses and 2.6 whole time equivalent vacancies for support workers. Since the beginning of December 2017 there had been, four permanent staff and three agency staff leave the service with one more agency staff member leaving at the end of the week of inspection. Staff said that the issue with continuity of agency staff and permanent staff vacancies had been the worst ever with 157 patients needing to be reallocated over the previous two months.

The trust recruited agency staff into roles to mitigate the risk of staffing levels. There were nine agency staff in place including an agency band 7 interim team leader. Both team leaders covering the whole of the Isle of Wight were interim posts and agency staff back filled them. However they were due to leave their posts shortly after the inspection. Team leaders felt that it was increasingly difficult to attract both permanent and agency staff into the vacancies and often they were sent
inappropriate agency staff. They also felt it was increasingly difficult to get the trust to agree to recruit extra agency staff.

The high turnover of substantive and agency staff meant that there was a continuity of care risk due to regular reallocation of patients to new staff. At the time of the inspection, the service needed an extra four agency staff to cover vacancies. This was due to 102 current caseload patients needing to be reallocated at the end of the week, six that had been assessed as needing a service and requiring allocation, 22 patients that were open to other teams and there were a further four referrals that had not been looked at. This meant that there were 134 that needed allocation with no guarantee of staff. The longest wait was since the 7th December 2017. The standard operating procedure stated that under extreme circumstances a waiting list would be commenced following approval from the clinical director, the head of operations and highlighted to the operations manager. Despite the issue of the pending allocations being escalated by staff via meetings, emails and incident forms, when we raised this with the operations manager, they reported to inspectors that they were not aware of any waiting lists. It was not clear what the plan was to address this.

At the previous inspection in November 2016, staff held high caseloads of up to 54 patients. Team leaders did not effectively monitor caseloads, staff did not received regular caseload supervision and adjustments were not made according to patient acuity. On this inspection, it was clear the service had taken positive steps in managing staff caseloads. Full time members of staff had a maximum caseload of around 35 patients with the guide for staff being seven patients per day working. Staff worked with their supervisor to discharge patients when appropriate in order to free up caseloads when they reached 35 patients. Team leaders said that encouraging the staff to discharge patients from the caseload was difficult to embed as previously they had held onto patients for a long time when they could have been discharged. This was confirmed when we heard that staff were reluctant to discharge patients in case they relapsed.

Senior managers had updated the community mental health service standard operating procedure following issues identified with caseload size at the previous inspection. We reviewed the standard operating procedure and spoke with staff who told us that when their caseloads went above the upper limit of 40 patients for a full time member of staff an incident report was generated. This allowed team capacity issues to be escalated within the business unit. The business continuity plan would be triggered if the team caseload had reached capacity.

The service had brought in a tool in order to measure patient acuity on the caseload. This identified the demand of each patient on a staff member’s time. Staff had not used this measure consistently within supervision, for example, at the time of the inspection only two staff had used the acuity tool that month and the team leader said that over the previous few months there was little uptake of the acuity tool. This meant that there was no management oversight of the acuity of caseloads. Higher acuity of patients would indicate the need for a lower caseload for the staff member.

The duty worker provided support to patients in the event of annual leave and sickness. For high-risk patients the duty worker was proactive in contacting them to offer support.

Three psychiatrists covered the community mental health service. Staff felt that the psychiatrists were responsive to changes in patient need and risk and they were able to access them for support. Out of hours, the crisis team provided cover.

**Definition**

Substantive – how many staff in post currently.

Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.
**Substantive staff figures**

<table>
<thead>
<tr>
<th></th>
<th>30 September 2017</th>
<th>68.35</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of substantive staff</strong></td>
<td>October 2016 – September 2017</td>
<td>6.73</td>
</tr>
<tr>
<td><em><em>Average WTE</em> leavers over 12 months (%)</em>*</td>
<td>October 2016 – September 2017</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

**Vacancies and sickness**

<table>
<thead>
<tr>
<th></th>
<th>30 September 2017</th>
<th>10.13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total vacancies overall (excluding seconded staff)</strong></td>
<td>October 2016 – September 2017</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>Total permanent staff sickness overall (%)</strong></td>
<td>October 2016 – September 2017</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

**Establishment and vacancy (nurses and care assistants)**

<table>
<thead>
<tr>
<th></th>
<th>30 September 2017</th>
<th>21.31</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>Establishment levels qualified nurses (WTE</em>)</em>*</td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><em><em>Establishment levels nursing assistants (WTE</em>)</em>*</td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><em><em>Number of vacancies, qualified nurses (WTE</em>)</em>*</td>
<td>30 September 2017</td>
<td>4.4</td>
</tr>
<tr>
<td><em><em>Number of vacancies nursing assistants (WTE</em>)</em>*</td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Qualified nurse vacancy rate</strong></td>
<td>October 2016 – September 2017</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Nursing assistant vacancy rate</strong></td>
<td></td>
<td>NA</td>
</tr>
</tbody>
</table>

**Bank and agency Use**

<table>
<thead>
<tr>
<th></th>
<th>October 2016 – September 2017</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)</strong></td>
<td></td>
<td>478</td>
</tr>
<tr>
<td><strong>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)</strong></td>
<td>October 2016 – September 2017</td>
<td>5</td>
</tr>
<tr>
<td><strong>Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)</strong></td>
<td>October 2016 – September 2017</td>
<td>Not submitted</td>
</tr>
<tr>
<td><strong>Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)</strong></td>
<td>October 2016 – September 2017</td>
<td>Not submitted</td>
</tr>
<tr>
<td><strong>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)</strong></td>
<td>October 2016 – September 2017</td>
<td>Not submitted</td>
</tr>
</tbody>
</table>

*WholeTime Equivalent

**Staff Fill Rates**

This core service reported an overall vacancy rate of 14% for registered nurses from October 2016 to September 2017.

The highest number of vacancies within registered nurses were seen in the last six months of this 12 month period. April 2017 and May 2017 saw the highest number of vacancies with 7.11 (32%) and 6.11 (28%) respectively.
There were two other staffing groups within this core service which had a higher overall vacancy rate from October 2016 to September 2017 compared with registered nursing staff. Medical and dental staff had a vacancy rate of 32.2% and administrative and clerical staff had a vacancy rate of 23.5%.

This core service had reported a vacancy rate for all staff of 14% from October 2016 to September 2017. This is higher than the reported trust wide vacancy rate of 9.9% for the same period.

From October 2016 to September 2017, bank staff filled 40 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 478 of shifts for qualified nurses.

The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked.

There were five shifts not filled by either bank or agency staff.

Below is the number of bank/agency staff split by team:

<table>
<thead>
<tr>
<th>Team</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts NOT filled by bank or agency staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHS WS</td>
<td>3</td>
<td>296</td>
<td>4</td>
</tr>
<tr>
<td>LD/Autism/AD HD</td>
<td>37</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Adult Mental Health Medics</td>
<td>85*</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>MHLD Management Team</td>
<td>264*</td>
<td>182</td>
<td>7</td>
</tr>
<tr>
<td>Psychiatry Adult</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Core service total</td>
<td>389</td>
<td>478</td>
<td>16</td>
</tr>
<tr>
<td>Trust Total</td>
<td>38,932</td>
<td>12,792</td>
<td>6,767</td>
</tr>
</tbody>
</table>

*not registered nursing staff

This core service had 6.73 (10.8%) staff leavers from October 2016 to September 2017. This is higher than the reported turnover rate trust wide of 8.6%.

Data broken down by team/ward was not sent in from the trust.

The sickness rate for this core service was 6.0% from October 2016 to September 2017. This was higher than the reported trust wide sickness rate of 4.3%. The most recent month’s data (September 2017) showed a sickness rate of 10.9%.

Registered nursing staff had a sickness rate of 15.1% across this time period. The highest levels of sickness were seen in the latter part of this year. August 2017 and September 2017 saw the highest levels of sickness with 29.3% and 28.2% sickness rates respectively.

There was also a high rate of sickness recorded for allied health professionals with 9.7%.

Below is the breakdown of sickness rate by team:

<table>
<thead>
<tr>
<th>Team/Ward</th>
<th>Sickness rate October 2016 to September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Medics</td>
<td>1.4%</td>
</tr>
<tr>
<td>CMHS WS</td>
<td>7.7%</td>
</tr>
<tr>
<td>MHLD Management Team</td>
<td>7.0%</td>
</tr>
<tr>
<td>OT Psychiatry Adult</td>
<td>8.8%</td>
</tr>
</tbody>
</table>
Staff reported that they received regular mandatory training essential to their role.

The trust set a target mandatory training completion rate of 85%.

The compliance for mandatory training courses from April 2017 to October 2017 was 84%. This fell just short of the trust's training target of 85%. Of the training courses listed 14 failed to achieve the trust target and of those, seven failed to score above 75%.

The training courses with the lowest completion rates were people handling, zero out of two (0%) members of staff completion this, mental health act, zero out of one members of staff completed this (0%) and mental capacity act, four out of 23 members of staff completed this (17%).

**Key:**

- **Below CQC 75%**
- **Between 75% & trust target**
- **Trust target and above**

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service</th>
<th>Trust target %</th>
<th>Trust wide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>98%</td>
<td>85%</td>
<td>97%</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>97%</td>
<td>85%</td>
<td>98%</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>95%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>93%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>91%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>91%</td>
<td>85%</td>
<td>93%</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>88%</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>88%</td>
<td>85%</td>
<td>89%</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>87%</td>
<td>85%</td>
<td>92%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>86%</td>
<td>85%</td>
<td>72%</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>85%</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>84%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>81%</td>
<td>85%</td>
<td>86%</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>81%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>79%</td>
<td>85%</td>
<td>86%</td>
</tr>
<tr>
<td>Information Governance: A Beginners Guide</td>
<td>75%</td>
<td>85%</td>
<td>95%</td>
</tr>
<tr>
<td>Adult Resuscitation - Non-Clinical Staff</td>
<td>73%</td>
<td>85%</td>
<td>74%</td>
</tr>
<tr>
<td>Load Handling</td>
<td>73%</td>
<td>85%</td>
<td>77%</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>72%</td>
<td>85%</td>
<td>78%</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>67%</td>
<td>85%</td>
<td>55%</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>67%</td>
<td>85%</td>
<td>89%</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>60%</td>
<td>85%</td>
<td>71%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>60%</td>
<td>85%</td>
<td>76%</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>17%</td>
<td>85%</td>
<td>19%</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>0%</td>
<td>85%</td>
<td>82%</td>
</tr>
<tr>
<td>People Handling</td>
<td>0%</td>
<td>85%</td>
<td>75%</td>
</tr>
<tr>
<td>Core Service Total %</td>
<td>82%</td>
<td>-</td>
<td>82%</td>
</tr>
</tbody>
</table>

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

**Assessment of patient risk**

Staff undertook risk assessments of patients access the team, however there was variation in the quality and they were not always comprehensive. Progress notes did not demonstrate that risk
was considered at every appointment. We reviewed 37 sets of care records, two records did not have risk assessments and others often lacked narrative or detail particularly in the letters for patients who were not on the Care Programme Approach (CPA). Progress notes were difficult to follow, there were instances where patients displaying risks and required support had not been followed up, and there was no clear communication documented. For example, staff did not follow up a patient who did not understand which medicines to take and there was an instance where patients had been left with no contact from the service for up to nine months. The 89 patients accessing the depot clinic were not care coordinated so had no routine assessment of risk or oversight of their care.

Staff did not regularly use crisis plans to mitigate risks for services users in the event of experiencing a mental health crisis. This meant that patients were not necessarily clear on steps to take to aid them in the event of a crisis. Information reviewed prior to the inspection found that there was a completion rate of 92% of risk assessments. This meant that they were compliant according to their own minimum target for risk assessment completion, however there was no clear information around the quality of the assessments.

**Management of patient risk**

There was inadequate oversight of patient risk while on internal waiting lists. There were a number of internal waiting lists in operation. These held patients waiting for group work, psychological therapies and for psychological screening assessment. There were 377 patients on internal waiting lists waiting for treatment. Staff reported that when patients not on CPA were placed on a waiting list for a group or psychological therapy then they would no longer be care coordinated and would be open to duty, which would be their point of contact for support.

The poor administration of the waiting lists, in addition to poor communication with patients, had resulted in waiting list information being unclear or out of date. For example, patients on multiple lists, patients noted as discharged from groups, or attending groups in the care records but remaining on the waiting lists in the main electronic record system. It was not possible for the trust to be assured that all patients were consistently being managed appropriately. For example, waiting lists were not vetted to understand who may not have had any other service in place, if patients were booked for appointments in a timely manner. The psychological therapy team had employed an agency staff member to begin to undertake this role for their waiting lists. This was not in place at all in the community mental health service.

The current systems used to manage waiting lists/clinics have inadequate controls and audit trails, and the information recorded in patient records was limited. Staff confirmed that poor management of additions to the waiting lists resulted in patients potentially being added to the waiting list before they were ready for treatment. There was a risk of being added for treatments that later proved inappropriate/ineffective and a risk that patients who present less immediate risk continually getting moved down the list to make way for new, higher risk patients.

Because of the limited evidence in patient records, it was difficult, and in many cases impossible, to identify what discussions staff had with patients about offers of treatment and rationale for referral into one or more groups with waiting lists. Staff confirmed that patients may be referred to several groups depending on a `what came up first` basis rather than the most appropriate decision for the care of the individual. We noted several patients had been discharged, as they had not attended one session of a group. It was not clear that patients were given adequate information about the risk of being removed from the waiting list if they did not attend an appointment without giving notice. Or, if decisions had taken into account patient’s individual circumstances, such as: access to transport, mobility, deterioration of condition while waiting, additional support needs or frequent changes in community staff.
The service held an effective daily meeting to review the highest risk patients on the caseload and to ensure that patients received their injectable medicines. This ensured that staff provided support to those most at risk. As treatment progressed, staff rerated patient’s risks from red to amber to green before being taken off the risk board and managed individually. The meeting enabled joint visits to be arranged and for risk information to be shared within the team.

**Safeguarding**

Training was provided in order to safeguard children and vulnerable adults from abuse. There was good knowledge of safeguarding procedures and processes amongst the staff.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust only submitted information on safeguarding referrals at a trustwide level so this data cannot be reported per core service.

There were no serious case reviews relating to this core service.

**Staff access to essential information**

The electronic records system continued to be a problem for staff due to its complexity. The previous inspection in November 2016 found that the system was not fit for purpose. On this inspection staff continued to raise concerns about the system, despite it being updated to be easier to use. A new core assessment section was added in order for staff to record essential care planning and risk information in one place, and be more user friendly. However, it meant that staff took over three hours to document one core assessment, which meant that they often worked longer hours to record information. Staff had raised this issue with management. Consultants used paper records that were not always transferred onto the electronic system. This posed a risk that essential patient care information was not shared within the nursing team.

Staff were not always contactable when working alone, this posed a risk to those working remotely or at satellite clinics. We found that nurses working alone in nurse led clinics were not contactable by staff and had to use their own mobile phones to contact their colleagues or patients.

**Medicines management**

There were serious safety concerns over the management of medicines in the Chantry House clinic room. There was no oversight of the management of medicines. There were out of date syringes and there was an out of date injectable medicine found in the clinic room cupboard, within the box there were three out of date ampoules and an in date syringe needle. We sought assurance from staff within the service that this medicine was not given to patients; the staff were not able to provide this assurance so this was escalated to the operations manager. Staff reported that it was normal for practitioners to store medicines in bags in order to have a stock of it on them. When staff left to go to a new job, they then returned the injectable medicine to the clinic room cupboard. On review of the depot administration cards it became clear that there was a risk that the medicine could have been administered over the previous few days to a number of patients. It was reported by staff that the clinic room was checked around two weeks prior to the inspection, there was however no record of this. Staff told us that they checked the expiry date prior to administration.
Depot medicine cards were not suitable and missed essential information and there was poor organisation of the medicine cards. There was no recording of expiry dates or batch numbers of medicines on the depot cards, which would have mitigated the risk of administration of out of date medicines. The cards were missing patient identifiable information, essential clinical details and allergy information. Team leaders had brought this up with pharmacy who told them to look for a depot medicine card that they felt was appropriate but had not followed this through at the time of the inspection. There were patient depot cards and 'to take out' medicine cards that were out of date in the folders, some of these dated back to 2013. It was not clear if these prescriptions had been stopped. Depot clinic medicine cards were mixed in with community prescriptions. Following the inspection, the trust reported that they had initiated an investigation into the management of medicines.

**Track record on safety**

Serious incidents were recognised and escalated accordingly.

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 October 2016 and 31 September 2017 there were no STEIS incidents reported by this core service.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

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

Staff reported incidents using an electronic incident reporting system. At the previous inspection staff knew how to report incidents and learning from incidents was cascaded to staff through the team meetings. On this inspection, there remained a positive approach to reporting and learning from incidents. Team leaders were able to demonstrate learning, for example, the daily review of patients receiving injectable medicines was commenced due to three patients missing their injections.

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no ‘prevention of future death’ reports sent that relate to this core service.

**Is the service effective?**

**Assessment of needs and planning of care**

Staff reported that they completed a comprehensive mental health assessment for each patient however on looking through the electronic notes on the electronic system it was evident these assessment were difficult to find and not stored consistently. The single point of access team confirmed where the assessments should be found, they were not always fully complete and did not contain in depth information essential to patient care.

Clinical decisions for treatment made following assessment were not always based on the needs of the patient. For example, there were three decisions to not provide treatment made by a practitioner that needed to be over ruled by a senior member of staff in order to gather more information and refer to treatment.
Care plans we reviewed did not meet the criteria set out in the standard operating procedure, they lacked information that managed assessed risk, crisis or services required to meet need. The previous inspection in November 2016 found concerns about the completion of care plans that were not person centred or holistic in their nature with poor evidence of patient involvement in care planning. On this inspection there continued to be poor documentation of person centred, holistic care plans. There were inadequate levels of information that did not direct a practitioner on patient care. For example, care plans were often one line that was a statement of fact rather than a descriptive plan of care. Concerns were raised with the trust over serious gaps in care for a patient with no physical health care plan or plan for managing suicidal thoughts, despite there being a very real risk to the patient’s life. The lack of robust care planning had been placed on the service risk register with actions such as creating an audit tool. Team leaders demonstrated a local audit of the care notes to ensure care plan completion and quality, with the outcome addressed through supervision. However, there was little evidence of this having an impact during the inspection with a consistent lack of appropriate care planning.

There was a deficit in support for patients who did not require care under the Care Programme Approach (CPA). Staff care coordinated services users who required met the Care Programme Approach framework criteria. Core assessments were completed and information was shared with the GP. However, staff told us that those patients that did not require Care Programme Approach were therefore not care coordinated and were referred onto external services or put on the waiting list for group work.

**Best practice in treatment and care**

Medical staff followed National Institute for Health and Care Excellence (NICE) when prescribing medication. Staff gave examples of prescribing medication that met with NICE guidance.

The service was not set up to provide effective and prompt interventions based on NICE guidance. For example, the standard operating procedure, effective from April 2016 prior to the previous inspection identified clear treatment pathways to be developed identifying evidence based treatments. Patients accessing the service needed to be clustered to groups depending on the outcome of the assessment; this would then trigger a treatment pathway. The standard operating procedure had again been reviewed in 2017 and there had been no progress on developing an evidence-based service. Staff working within the community team said that there had been no progress on the development of these pathways due to the lack of staff within the service to develop them.

At the previous inspection there was no psychologist working within the community mental health service, this had not changed. The service provided group work, this had its own waiting list and there were extensive waits to access the groups. We heard from staff that while these were based on NICE guidance there was a lack of supervision and direction for them. The service provided three groups; emotional coping skills, self-esteem and anxiety. There were 183 patients on the group waiting list. There were an extra four waiting for the discontinued depression group. The development of clinical pathways was placed on the risk register with an action plan to address the issue. The trust CQC self-assessment seminar to the board in November 2017 identified that NICE guidance was an improving picture for the service but needed further work. However, staff felt there were several gaps within the service that posed a risk due to the lack of evidence-based treatments. For example, there were 304 patients that were placed in cluster
eight, which indicates a diagnosis of personality disorder. This was the highest percentage of patients accessing the service. Staff felt that this diagnosis was more common and that the NICE approved treatment dialectical behaviour therapy (DBT) was not provided by the trust; Instead patients were required to wait for the emotional coping skills groups with no option of individual evidence-based therapy.

We found serious safety concerns for patients accessing support for an eating disorder. The service did not provide specialist eating disorder support. No eating disorder service had been commissioned so community staff were required to support those with an eating disorder. Staff we spoke with felt that they contained risks for patients with an eating disorder rather than provide treatment. Treatment was shared with the GP in order to monitor physical health but the lack of training for community staff meant there was little support from the service in treating the patient group. We heard examples of specialist mainland placements being required when they were no longer able to contain the risk, however, data showed that there had been no placements made in the previous year up to November 2017. There was no defined care pathway for eating disorders. Immediate risks with a patient at a critically low weight were raised with the trust in order to seek assurance that these risks had been managed.

The service had a set up a physical health clinic in order to assess patient’s health when prescribed antipsychotic medicines. This ensured that patients had an annual physical review of their health. Staff gave lifestyle advice as well as monitoring vital physical health signs. The GP received results of tests performed in the clinic. Due to the uptake of this clinic it had been extended to anyone accessing the community service.

The service had not embedded individual service-user rating scales and outcome measures as part of standard practice. Staff told us that they often used anxiety rating scales or tests for monitoring depression. Health of the nation outcomes scales (HONOS) were used to assess severity and then staff clustered patients according to intervention. However, due to the lack of pathways and interventions for patients, staff were not able to provide treatment with a clear start and finish with an effective outcome based on the use of the clustering.

The team leader conducted two on-site audits and then fed the results back to the quality team. Data showed that there was varying adherence to expected auditing of care notes, with a range of 21% to 162% completion rate each month. However, we found that there was little information on the quality of the notes and outcome of the auditing. The team leader felt that there was little communication from the quality team. The team leader commenced discharge auditing but stopped due to it not being effective.

The trust has detailed 15 Mental Health audits as part of their clinical audit programme. The time period was not provided.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Core service</th>
<th>Audit type</th>
<th>Date completed</th>
<th>Key actions following the audit</th>
</tr>
</thead>
</table>
| Early Intervention in Psychosis audit   | Mental Health | Mental Health | Clinical   | Jul-17         | Success: 4/8 standards met  
Concern: Clear documentation required for PARIS entry.  
Actions:  
• Clear documentation of baseline readings (Weight, BP)  
• Community health clinics  
• PARIS retraining classes |
Section 17 leave *(annual)*

These remain unaltered from the previous audit as none have yet been implemented.

1) There are no obvious problems with the current form used to record leave authorisation. Guidance for Responsible Clinicians is printed on the reverse of the form. Revisions are overseen by the MHASC and are made in line with changes to Mental Health Legislation, Code of Practice guidance and local policy. The form was last revised in 2012 to reflect the latest change to the Trust’s name.

2) Revision of the Inpatient Care Review template to allow a more prominent and explicit record of discussions around leave, including considerations of risk and benefit to patients, might be helpful in facilitating more consistent record keeping.

3) A facility within the Electronic Patient Record (EPR) to record stand alone risk assessments would assist staff in recording relevant risk issues when patients are due to go out on leave. It would also be easier to review and record changes in risk status generally.

4) Further development of the Mental Health Act functionality within the EPR would be extremely helpful in a repeat audit of Section 17 and indeed any audit of the use of the Mental Health Act. In particular, the ability to access historical data and the use of a structured record of leave granted - and actually taken - would greatly facilitate future audit and perhaps encourage more systematic record keeping. A fully developed electronic record might also make the current Section 17 paper record redundant.

5) The care record may be revised to include a section on the patient’s physical description. This should be prominently located on the ‘front page’ of the care record.

6) A policy on photographing patients was drafted in 2008/9 but was never implemented. There may be a case for revisiting this as it continues to be a recommendation in the Code of Practice.
<table>
<thead>
<tr>
<th>Programme</th>
<th>Speciality</th>
<th>Clinical</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidential Enquiry into Patient Outcome and Death (NCEPOD):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical and mental health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of mental health patients in acute hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme: Suicide by children and young people in England (CYP)</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme: Suicide, Homicide &amp; Sudden Unexplained Death</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme: The management and risk of patients with personality disorder</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>prior to suicide and homicide</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of side effects of depot and LA antipsychotic medication</td>
<td>Mental Health/P Pharmacy</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of depot/LA antipsychotics for relapse prevention</td>
<td>Mental Health/P Pharmacy</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing for</td>
<td>Mental Health/P Pharmacy</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
</tbody>
</table>
Skilled staff to deliver care

A variety of professionals made up the team. Nursing staff, support workers, social workers, occupational therapists and medical staff supported patients accessing the service. Team leaders and administrative staff provided induction; however, when reviewing paperwork it was clear that this was not always conducted effectively. For example, there were several incomplete agency staff inductions in folders. Training was included as part of the induction but staff felt that it often took a long time to be trained in using the electronic records system.

Agency staff did not always receive an effective handover, team leaders stated that often caseloads needed reallocating without a safe handover. This was due to the high turnover of agency that left with short notice.

Staff received caseload management supervision in order to review their caseloads and to identify risks and treatment progress. This process had increased to 100% of staff receiving caseload management from June to September 2017. Staff were encouraged to identify patients to discharge during caseload management. There was a decline in caseload management supervision from October 2017.

There was no specialist training available to staff and this made staff consider whether they were motivated to stay within the trust. This was due to staff feeling that there was little incentive to stay in the role or potential for future progression.

The trust’s target rate for appraisal compliance is 100%. From October 2016 to September 2017, the overall appraisal rates for non-medical staff within this core service was 41%.

The teams failing to achieve the trust’s appraisal target were CHMS WS with an appraisal rate of 58%, MHLD management team with an appraisal rate of 8% and OT psychiatry adult team with a rate of 0%.
<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHS WS</td>
<td>36</td>
<td>21</td>
<td>58%</td>
</tr>
<tr>
<td>MHLD Management Team</td>
<td>13</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>OT Psychiatry Adult</td>
<td>5</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Core service total</td>
<td>61</td>
<td>27</td>
<td>41%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2,730</td>
<td>1,433</td>
<td>53%</td>
</tr>
</tbody>
</table>

The trust’s target rate for appraisal compliance is 100%. From October 2016 to September 2017, the overall appraisal rate for medical staff within this core service was 71%.

<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent medical staff requiring an appraisal</th>
<th>Total number of permanent medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Medics</td>
<td>7</td>
<td>5</td>
<td>71%</td>
</tr>
<tr>
<td>Core service total</td>
<td>7</td>
<td>5</td>
<td>71%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>135</td>
<td>90</td>
<td>67%</td>
</tr>
</tbody>
</table>

**Multidisciplinary and interagency team work**

Staff expressed they had good links with services such as social services or the local drug and alcohol services. However, we found examples where they did not work together due to a differing of opinion, for example if social services were not able to provide a care package. Staff reported that the relationship with CAMHS was poor. They reported that they were unable to get information about patients referred and that staff were reluctant to work with each other.

Staff held regular multidisciplinary team meetings. Daily meetings allowed staff to identify those most at risk on the caseload and shared the risk within the team, as well as ensuring services users receiving depot medicine received their injection. Staff expressed that the rooms at Chantry House were not big enough for all staff to attend the weekly multidisciplinary team meeting, for example, the therapy team were not able to attend due to the size of the room. Team leaders shared essential trust information and learning from incidents in business meetings.

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

Staff were confident in their knowledge of the Mental Health Act and were aware of how to seek support and advice. Staff were confident in their understanding of their responsibilities under the Act.
As of 9 October 2017, 0% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for one member of staff and renewed every three years. The training compliance reported during this inspection was lower than the 100% reported in the previous year (1 April 2016 – 31 March 2017).

Good practice in applying the Mental Capacity Act

Staff worked within the guidance of the Mental Capacity Act. We found examples of presumed capacity and good examples of capacity assessments when required. Staff were competent in their knowledge and were able to provide examples of patients whose capacity has been a concern. For example, for a patient requiring depot medication there were clear capacity assessments.

As of 9 October 2017, 19% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for inpatient and all community staff in this core service and renewed every three years.

The training compliance reported during this inspection was lower than the 23% reported the previous year.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff were caring, they treated patients with dignity and respect. At the previous inspection in November 2016, we reported that staff had an understanding of patient need, were committed and conscientious in the delivery of the care and were patient centred. On this inspection staff continued to support services users in this way.

Patients were positive about their care they received from staff at Chantry House. We spoke with five patients; all had a positive experience and felt supported by the staff. They felt that their care was discussed with them prior to any changes, for example to medication. Care coordinators or a duty worker were easily contactable. Overall, patients felt that they got regular support; however, we heard examples of delays in receiving care such as group work due to the waiting lists.

The involvement of people in the care they receive

Involvement of patients

Staff ensured patients were involved in the care planning process. Staff spoke about how they planned care with patients and shared copies of the care plan with them. The five patients we spoke with stated that they were aware of their plan of care and that they were offered copies of their care plan. However, the electronic records did not always demonstrate that care plans were shared and did not always show patient involvement or provide a holistic, person-centred care
plan. There were well-written comprehensive letters to patients and their GP’s that documented a plan of care as well as an assessment.

The service recruited ex-patients as volunteers to aide with the group activities. In-house training was provided regarding managing risk and working in groups.

Service users fed back via a ‘you said, we did’ board in the waiting room at Chantry House. Staff provided a suggestions box. However, there was no formal feedback sought from staff about the effectiveness of the service.

**Involvement of families and carers**

There was limited documented evidence of carer involvement in patient care records but patients confirmed that family and carers were involved when necessary. However, staff provided carers assessments when needed and then assisted in accessing the appropriate support.

The trust provided a service users and carer’s forum, this was in order to communicate changes within the mental health service and seek input. This forum gave carers and patients an opportunity to feedback on the service.

**Is the service responsive?**

**Access and waiting times**

The service was open to patients aged 18 and above, with no upper age limit. The service offered assessment and treatment for people aged 65 and over who did not require treatment for an organic disorder such as dementia. The service offered an early intervention in psychosis service for patients that met the criteria. The single point of access team assessed and triaged referrals through to the community mental health service. Team leaders at Chantry House allocated referrals to staff when single point of access considered patients met the criteria for the service.

There were set referral to treatments times; however, team leaders were not aware of their compliance to these targets. The service received on average 14 referrals per week. Staff were required to see urgent referrals within 48 hours and routine referrals within one week. Team leaders allocated the referrals to care staff but were not able to evidence whether the patients were followed up within this period. The onus was on the practitioner to see the patients in this time. The table below demonstrates the average waiting time for those accessing the service through single point of access; however, the team leaders were not cited on data that showed the responsiveness of the community service. As a result, there was no assurance those at highest risk had received care in a timely manner. For example, data dated 7th January 2018 provided by the trust showed 49 patients needing to be allocated with 27 waiting over 31 days, there was no indication of the urgency of the referrals.

There had been a push by the trust to manage caseloads in order to identify patients that could be effectively discharged, however there were a high number of re-referrals taking place that showed that treatment had not been effectively completed. There were 729 referrals received in the previous year up until January 2018. Of these, 151 referrals were patients that had been re-
referred to the service within nine months of discharge. Out of the 151 re-referrals, 46% of them had come in within three months of discharge.

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The core service met the referral to assessment target for the one team with a national target listed.

The core service met the assessment to treatment target for the one team with a national target listed.

<table>
<thead>
<tr>
<th>Name of team</th>
<th>Service Type</th>
<th>Days from referral to initial assessment</th>
<th>Days from assessment to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>National target</td>
<td>Actual (mean)</td>
</tr>
<tr>
<td>Adult MH Services (SPA)</td>
<td>-</td>
<td>-</td>
<td>22</td>
</tr>
<tr>
<td>IAPT</td>
<td>-</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td>EIP</td>
<td>-</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Memory Services</td>
<td>-</td>
<td>-</td>
<td>56</td>
</tr>
</tbody>
</table>

There were extensive waits for evidence-based interventions such as psychological therapies. At the time of the inspection, 190 patients were waiting for psychotherapy, psychological therapy or psychological screening for assessment. Staff said that the wait could be up to two years on the waiting list and that group work would be quicker. Information provided by the trust showed that the longest wait for psychological therapies was 74 weeks with an average wait of 30 weeks. The longest wait for screening to be accepted for therapy was 51 weeks with an average wait of eight weeks. The longest wait for psychological groups was 49 weeks with an average wait of 33 weeks. However, the majority of patients had waited over 52 weeks for these services.

Nurse led clinics aimed at patient’s that were mentally stable were created to assist in management of the caseload but no clear recovery definition. Following the previous inspection the service had set up nurse led clinics in response to the 164 patients that were on the caseload but did not have a core assessment or risk assessment. After reviewing the patient’s the service began to develop a standard operating procedure for the clinics but this had not been completed at the time of the inspection. Despite this, it held a caseload of 232 patients. The operations manager felt that it was not a clearly defined service. Staff were not sure of the scope of the clinic and the criteria had not been set out. There was no physical monitoring or change of medications being conducted but this was expected to be added to the clinic in the future. Staff running the clinics had not submitted any performance measures in order to use data to measure their effectiveness. Information provided by the trust prior to the inspection said that the clinics were using outcome measures and rating scales but there was no evidence that this was happening.

The service was not always providing treatment that met the criteria for the service. Staff felt that they were being forced to accept patients that would have been more appropriate for the Improved Access to Psychological Therapies Service (IAPT). This was due to people not meeting the criteria for IAPT when they expressed any suicidal thoughts. Staff said they therefore often supported patient’s that were lonely or needed minimal anxiety support.
The trust had employed an allocated duty worker to effectively respond to patients phoning for support. This had changed since the previous inspection in November 2016 where staff were required to cover duty as part of their workload. This had placed a strain on their ability to manage their caseloads. The duty worker responded well to patients phoning. There was a concern, however, that this function could be overloaded due to needing to cover staff sickness and holidays.

Staff were not always effectively responding to patients that did not attend their appointments. While they were aware of how to respond to a DNA, we found evidence in the notes where staff had not proactively followed up patients who did not attend appointments. For example there was no cold calling as staff preferred to send opt-in letters. Staff had discharged patients without effective follow-up to establish why they had not attended their appointment. This meant that they were not always assured on patient safety.

Staff were flexible in their appointment times and only cancelled these when absolutely necessary. Staff were supportive of each other and used the duty function to help cover appointments when needed.

Lost to Follow Up

The trust did not provide data for this area.

The facilities promote comfort, dignity and privacy

The premises had remained unchanged from the previous inspection. There were rooms for therapies and clinic rooms to provide physical health care. Rooms were sound proofed and private and there were waiting areas.

Patients’ engagement with the wider community

Staff felt that there was a lack of extra voluntary sector services for patients to access. As a result staff felt that they were taking people on the caseload when they could be engaged in groups or services in the community.

Meeting the needs of all people who use the service

There was disabled access to the sites where the community mental health service operated. Staff were able to explain how they would access an interpreter. There was information about the Isle of Wight LGBT Network.

Listening to and learning from concerns and complaints

There remained issues regarding the recording of informal complaints within the service. At the previous inspection in November 2016, there was no log of informal complaints within the service. This meant trends in were not identified and learning from informal complaints did not happen. This had not changed on this inspection. Patients knew how to complain and staff felt that they would try to resolve complaints locally before they escalated. The trust held a central log of formal
complaints and communicated these with the team leaders. Staff directed patients towards the patient advice and liaison service for formal complaints.

Team leaders were able to give examples of formal complaints about the service. For example a lack of follow up by a care coordinator for a patient discharged from hospital. Team leaders were able to give an example of the use of the duty of candour in situations where a mistake had been made by the service.

The trust could not provide complaint data at core service level.

It was not clear from the data provided by the trust as to how many, if any, compliments were received by the core service.

Is the service well led?

Leadership

The community mental health services did not have stable or clear leadership and there was a lack of support for the interim team. There were a number of positions filled by interim staff; these included senior management positions and the two team leaders, neither of whom were willing to continue with the role. The early intervention in psychosis team leader was also an interim. Staff felt the redesign of the service towards care pathways was not possible with the staffing issues and interim posts.

Vision and strategy

Oversight of the mental health services had improved greatly since the previous inspection in November 2016. Staff felt that mental health was now being given attention by the senior leadership team within the trust with the appointment of a director for mental health. Staff could see changes had been made within the executive board that influenced the service and felt that changes would be made within the service.

Culture

Team leaders were under pressure and felt at breaking point. There was high staff turnover that had affected their ability to run the service effectively; as time was spent, recruiting staff and working with a large number of patients that needed reallocating. An interim operations manager brought in to support the team had little impact. Staff felt that it was not a supportive culture despite trying their best to support each other. There was a feeling that staff did not feel supported or valued by the trust. For example, there had been staff communication upwards about stress and staff burn out but they had not heard anything back.

Morale was consistently low; the workforce was disenchanted. Staff reported that they felt that they had little guidance and that they kept professional in order to keep people safe rather than providing them with effective evidence-based treatment. Staff were frustrated with the waiting times for psychotherapy and the lack of psychology. They felt that there was a lack of career progression and specialist training so there was little incentive to stay. Staff were unsure why people were leaving as they were never told, a number of staff were looking for jobs as they felt badly treated by the trust.
Despite these issues, staff felt able to raise concerns without fear of victimisation and gave examples of when they had been listened to when escalating concerns, for example, through the changing of a job specification. The local business meetings had a good practice section to celebrate successes such as money saved from sending back unused medicines.

**Governance**

Quality concerns were identified during the inspection that showed a gap in governance, for example, in the clinic room, care plan and risk assessment quality, and in staffing. The previous inspection identified issues with patient outcome measures that inhibited ability to identify team performance issues. This had not changed on this inspection. Data was not being used effectively to improve the service and the lack of effective care pathways affected the re-referral rates into the service. Whilst there was data on completion of records, there was little assurance around the quality of these records.

There was no centralised waiting list oversight by local or senior management. There was no clear guidance or consistency on managing waiting lists or clinic lists. This had resulted in the current use of multiple internal waiting and clinic lists, highlighting that the community mental health service continues to have insufficient provision of services to meet demand. The service did not use data relating to offers made to patients for treatment, attendance/non-attendance, re-referral following discharge, outcomes, or performance indicators to understand the use of the waiting lists.

Staff received training relevant to their role. There was an improvement in supervision levels and staff told us that they received regular caseload management. Since the previous inspection, measures had been put in place to manage the service caseload. Staff caseloads had been capped and there was a clear escalation plan added to the standard operating procedure. Staff confirmed that when caseloads increased they were listened to and were not allocated any further patients. Audits had been commenced on the caseload, however, there continued to be a lack of oversight of the risks of the caseload and the acuity of staff caseloads. Staff were not effectively using the acuity tool to help assess their caseloads despite being reminded in business meetings. Measures such as the nurse led clinic put in place to manage the caseload had not been clearly defined.

**Management of risk, issues and performance**

There were a number of areas of concern highlighted and placed on the risk register and there had been progress made in addressing certain issues. Items on the trust risk register included inadequate staffing, insufficient psychological therapy and the lack of robust risk assessment and the electronic care record system.

**Information management**

Staff did not have laptops or tablets provided by the trust in order for them to complete notes or care plans with patients remotely. Some staff were not provided with mobile phones for remote working. Staff felt that they would be able to write more effective care plans and risk assessments if the trust provided the equipment for them to work remotely.

**Engagement**
Staff felt that they were able to feedback to the senior management of the service since the previous inspection. The trust had held a number of events for staff to communicate their concerns and discuss plans for service development.

**Learning, continuous improvement and innovation**

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
## Mental health crisis services and health-based places of safety

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team name</th>
<th>Number of clinics</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary’s Hospital</td>
<td>CRHT</td>
<td>-</td>
<td>Mixed</td>
</tr>
<tr>
<td>St Mary’s Hospital</td>
<td>A&amp;E/Self ham</td>
<td>-</td>
<td>Mixed</td>
</tr>
<tr>
<td></td>
<td>Liaison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Mary’s Hospital</td>
<td>Serenity</td>
<td>-</td>
<td>Mixed</td>
</tr>
</tbody>
</table>
Is the service safe?

Safe and clean environment

The home treatment team and single point of access team were based in Sevenacres on the St Marys hospital site. The offices were spacious and well equipped.

Interview rooms inside Sevenacres were not fitted with wall alarms; however staff could access personal safety alarms from the main reception when meeting patients in interview rooms. These alarms were connected to the main hospital alarm system. The hospital and the crisis teams had an established protocol for using the personal safety alarms.

Some of the staff working in the single point of access team informed us they often felt unsafe speaking with patients in the interview rooms and that the rooms were not laid out adequately. Some of the furniture blocked the exit route from the room.

The clinic room in the home treatment team was clean and well organised. The room was equipped with medical equipment to carry out physical health observations. Medicines were stored appropriately in locked cupboards.

Safe staffing

Staffing levels in the single point of access were not safe. The single point of access had the highest number of vacancies with four qualified nurse vacancies at the time of inspection. The vacancies for qualified staff meant there was only one qualified member of staff on duty with a support work during out of hours periods. This meant support workers often had to answer and triage calls on their own if the qualified nurse was out of the office conducting an assessment.

Three administrative staff informed us that qualified staff were not always available to take crisis calls from patients. This meant they were often left to speak and engage with patients experiencing a crisis. The administrative staff had not received any training or support to work with patients in a crisis.

Staff had raised their concerns about staff levels in the team meeting prior to the inspection. Two incidents forms we reviewed and the minutes from a team meeting, recorded staffing levels being below the minimum requirements on three occasions. One particular incident reported there had been only one member of staff on a shift in the home treatment team, to work with a caseload of 17 patients. Another incident reported there was only one member of staff to receive phone calls and carry out assessments in the SPA. This incident also recorded there has been no on - call doctor cover from 1700hrs to 2100hrs.

The trust did not have a plan of how to address the vacancy rates for qualified nurses in the single point of access team.

The single point of access team used a high level of agency staff to fill qualified nurse shifts. The service had four shift patterns over the 24 hour period. A number of shifts were routinely not filled by either bank or agency staff so the team would operate without the required number of staff. We reviewed the single point of access staffing rotas for October 2017 and found there were four occasions where the staffing levels were below minimum requirements. Team meeting minutes from October 2017 showed that team mangers had raised concerns with the senior management
team about staffing. During October 2017 the service did not fill 158 hours of qualified nurse cover. Agency staff had been used to fill 100hrs of this shortfall. It was not clear from the data submitted by the trust how the remaining 58 hours were covered.

The home treatment team and single point of access team shared one locum consultant psychiatrist. This was not sufficient medical cover for a crisis service including a home treatment team and single point of access service. The home treatment team had no junior medical staff, so medical staff working with the single point of access team often saw these patients. The waiting time for medic appointments within the crisis services was approximately six weeks at the time of inspection. This is not safe and is too long to wait for an appointment in a single point of access service.

The A&E liaison service did not have allocated medical cover. The consultant psychiatrist covering the single point of access and home treatment teams also covered the psychiatric liaison service. This was not a safe level of medical cover and meant there was significant potential for delays in obtaining a medical review of patients seen in the A&E department.

**Definition**
Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
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<tbody>
<tr>
<td>Total number of substantive staff</td>
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<tr>
<td>Total number of substantive staff leavers</td>
</tr>
<tr>
<td>Average WTE* leavers over 12 months (%)</td>
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<table>
<thead>
<tr>
<th>Vacancies and sickness</th>
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<tbody>
<tr>
<td>Total vacancies overall (excluding seconded staff)</td>
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<tr>
<td>Total vacancies overall (%)</td>
</tr>
<tr>
<td>Total permanent staff sickness overall (%)</td>
</tr>
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<table>
<thead>
<tr>
<th>Establishment and vacancy (nurses and care assistants)</th>
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</thead>
<tbody>
<tr>
<td>Establishment levels qualified nurses (WTE*)</td>
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<tr>
<td>Establishment levels nursing assistants (WTE*)</td>
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<tr>
<td>Number of vacancies, qualified nurses (WTE*)</td>
</tr>
<tr>
<td>Number of vacancies nursing assistants (WTE*)</td>
</tr>
<tr>
<td>Qualified nurse vacancy rate</td>
</tr>
<tr>
<td>Nursing assistant vacancy rate</td>
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<table>
<thead>
<tr>
<th>Bank and agency Use</th>
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</thead>
<tbody>
<tr>
<td>Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)</td>
</tr>
</tbody>
</table>
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | October 2016 – September 2017 | 478
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | October 2016 – September 2017 | 104
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | October 2016 – September 2017 | NA
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | October 2016 – September 2017 | NA
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | October 2016 – September 2017 | NA

*WholeTime Equivalent Staff Fill Rates*

The trust’s staff fill rates for registered nurses and care staff was not available through the trust website.

This core service reported an overall vacancy rate of 9.9% for registered nurses from October 2016 to September 2017. The highest vacancy levels were found from June 2017 to August 2017 with 6.32 (22%) total vacancies each month. This level dropped to 4.99 (18%) in September 2017. There was also a high vacancy rate for additional clinical services members of staff with a vacancy rate of 7.3% from October 2016 to September 2017.

This core service has reported an overall vacancy rate of 5.8% from October 2016 to September 2017. This is lower than the reported trust wide vacancy rate of 9.9% for the same period.

From October 2016 to September 2017, bank staff filled 58 shifts to cover sickness, absence or vacancy for qualified nurses. February 2017 and March 2017 saw the highest number of shifts covered by bank staff, 11 and 12 respectively.

In the same period, agency staff covered 478 shifts for qualified nurses. Notably, the latter part of this year period saw the highest number of agency staff used with 0 agency staff used from October 2016 to January 2017. June 2017 to September 2017 had the highest number of agency staff used, 96, 98, 98, and 93 respectively.

The data supplied by the trust does not allow us to calculate the bank and agency usage rates as proportions of overall shifts worked. There were 104 shifts that were unable to be filled by either bank or agency staff.

The trust reported that the crisis resolution & home treatment team saw some of highest usage of bank and agency staff throughout this 12 month period across the whole trust. The trust attributed this to vacancies. The trust plans to address this by having a focused recruitment developed by the recruitment strategy as part of the IIF.

There retention of staff was good and there were few staff leavers. This core service had 1.2 (3.6%) staff leavers from October 2016 to September 2017. This is lower than the reported turnover rate trust wide of 8.6%. This figure was largely influenced by one member of staff leaving from the additional clinical services staffing group in December 2016.

Data broken down by team/ward was not sent in from the trust.

The sickness rate for this core service was 5.1% from October 2016 to September 2017. This was higher than the reported trust wide sickness rate of 4.3%. The most recent month’s data September 2017 showed a sickness rate of 4.9%.
Registered nursing staff had a sickness rate of 4% across this time period. The highest levels of sick-ness were seen in January 2017 with a sickness rate of 7.9%. In September 2017, their sickness rate was lower with 2.1%.

From October 2016 to September 2017, the crisis resolution and home treatment team had a lower overall sickness rate of 4.4%.

Staff had not received sufficient mandatory training to support them to deliver their role. Training completion rates for the crisis services and health based places of safety were low for safeguarding and the Mental Capacity Act. The trust target for completion of mandatory training was 85%. Only 21% of staff working in the home treatment team had completed risk assessment training.

The compliance for mandatory training courses from April 2017 to October 2017 was 82%. Of the training courses listed eleven failed to achieve the trust target and of those, seven failed to score above 75%.

The training courses with the lowest completion rates were the Mental Health Act with (0%) member of staff having completed this, and the Mental Capacity Act with one out of seven (14%) members of staff having completed this.

Key:

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service</th>
<th>Trust target %</th>
<th>Trust wide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Resuscitation - Non-Clinical Staff</td>
<td>100%</td>
<td>85%</td>
<td>74%</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>100%</td>
<td>85%</td>
<td>98%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>100%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>97%</td>
<td>85%</td>
<td>96%</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>97%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>97%</td>
<td>85%</td>
<td>92%</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>94%</td>
<td>85%</td>
<td>93%</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>92%</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>89%</td>
<td>85%</td>
<td>85%</td>
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<tr>
<td>Conflict Resolution Refresher</td>
<td>89%</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>89%</td>
<td>85%</td>
<td>69%</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>86%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>86%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>81%</td>
<td>85%</td>
<td>83%</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>80%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>80%</td>
<td>85%</td>
<td>73%</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>80%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Load Handling</td>
<td>68%</td>
<td>85%</td>
<td>76%</td>
</tr>
</tbody>
</table>
### Assessing and managing risk to patients and staff

#### Assessment of patient risk

Risk assessments were incomplete and inconsistent across the crisis services. We reviewed risk assessments in seven patient records in the home treatment team; six of the seven care records did not have a risk assessment. The majority of these care records documented significant risk event such as self-harm or suicidal thinking either prior to or during the treatment period. We reviewed 10 risk assessments in the psychiatric liaison service. There was inconsistency in how these risk assessments were completed. Most of the risk assessments were brief and lacked detail.

Of the 10 care records reviewed in the psychiatric liaison service only 2 had a completed core assessment. The trust had recently introduced guidance for staff, which stated staff only needed to complete the core assessment for patients referred onto another service provided by the trust. This meant patients who were seen and assessed in the A&E liaison team not referred onto another trust service did not have a record of the electronic care programme approach documentation of the core mental health assessment.

The home treatment team used a risk assessment grading system to categorise patient risk. Patients were categorised as red, amber or green depending on the level of identified risk. The risk rating determined the frequency of patient contact and support. Patients categorised as red, were seen once a day, amber every two days and green every three days. Staff reviewed patient risk ratings during the daily home treatment team handover meeting.

The single point of access team used a threshold assessment grid rating system to screen and provide an initial assessment of a patient’s mental health problems, risks and safety.

#### Management of patient risk

The management of potential risk to staff working in the community settings alone was not safe. The trust had a lone working policy but there was no lone working protocol for the home treatment team. All of the staff we spoke with told us they had to use their personal mobile phones when visiting patients in the community. The clinical team leaders had raised the need for work mobile phones for staff but the trust had not addressed this.

Two members of staff raised concerns about poor mobile phone coverage across the island and felt this increased risks. Staff did not like using their personal phones for work purposes.

The home treatment team reviewed patient risks, presentation and care plans daily in the handover meeting.
Staff responded promptly to deterioration in patient health. We saw staff discussing patients on the home treatment team caseload that were a priority visit due to changes in circumstances and a deterioration in mental health.

**Safeguarding**
The completion rates for staff training on safeguarding in both the home treatment and single point of access teams were low. Safeguarding adults level 1 had a completion rate of 61% and safeguarding adults level 2 had a completion rate of 17% for this core service.

Staff understanding of safeguarding procedures was inconsistent across the core service. However, during the inspection the home treatment team identified a safeguarding concern and were able to make an urgent referral.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust only submitted information on safeguarding referrals at a trust wide level so this data cannot be reported per core service.

**Staff access to essential information**
Staff in the home treatment team used a combination of electronic and paper records to document and store information about patient care. We observed a handover meeting in the home treatment team which was very time consuming and involved the shift co coordinator reading from printed pieces of paper. Staff also printed off paper copies of care plans and patient details and stored these in home treatment team office alongside the electronic care records system. Home treatment team staff told us the electronic care records system was confusing and they were not confident in using it.

**Medicines management**
Staff in the home treatment team stored medicines appropriately in locked cupboards. These were well organised and well maintained. Any controlled drugs were also stored appropriately according to guidance within locked cupboards. Staff followed appropriate guidance administering controlled medications.

Staff in the home treatment team transported medicine in locked bags when visiting patients in the community.

The home treatment team had patient group directives. Staff could administer certain medications without a prescription under the patient group directive. This enabled staff to provide prompt access to medicine in a crisis and prevent treatment delays.

A pharmacist visited the home treatment team weekly to audit and review medication.

Patients prescribed Clozapine or Lithium were referred to clinics run by the community mental health teams.
We reviewed eight prescription charts; they were complete with patient detail, allergies and sensitivities recorded. Staff followed national guidelines for prescribing medicines.

**Track record on safety**
At the time of inspection, the single point of access team was investigating two serious incidents. Both of these related to an incident of harm to a service user, this harm occurred between referral and first contact with the service.

**Reporting incidents and learning from when things go wrong**
Learning from incidents was not shared across the core service. We reviewed 5 sets of team meeting minutes from across the core service. Only one of these meetings included information about lessons learnt from a recent incident. Staff we spoke to in the psychiatric liaison service were not aware of any learning from incidents which have occurred across the trust.

Staff knew how to report incidents using the electronic incident reporting system. However, staff we spoke to were not aware of any learning from incidents which had occurred.

**Is the service effective?**

**Assessment of needs and planning of care**
Staff completed initial assessments when patients were referred to the home treatment team. We observed two handovers in the home treatment team where staff discussed referrals and assessment in detail.

We reviewed 18 care plans across the home treatment team and A&E liaison service. The majority of care plans we reviewed were not person centred or holistic, they were brief and lacked patient involvement. Of the eight care plans reviewed in the home treatment team, only four contain language reflective of patient involvement and included views and preferences of the patient.

**Best practice in treatment and care**
Home treatment team staff used patient group directives to provide medicine to patients in crisis. These meant patients could access certain medicines to help with the control and management of symptoms in a crisis situation. Staff followed national institute for health care and excellence guidelines when prescribing medication.

The crisis services were not able to offer psychological therapy to patients. There was no full time employed clinical psychologist to lead the delivery of psychological therapies. Three qualified nurses were trained in dialectical behavioural therapy. This meant staff could offer support and interventions for patients engaging in self harm.

The clinical team leader for the home treatment team had built links with the improving access to psychological therapies service to provide psychological therapy training to staff.

The physical health and wellbeing lead for the home treatment team facilitated wellbeing groups which patients could attend. They also conducted a physical health review of each patient referred to the team and liaised with GPs and other service to gather more background information if required.
The trust have detailed 15 Mental Health audits as part of their clinical audit programme. The tie period was not provided by the trust.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Core service</th>
<th>Audit type</th>
<th>Date completed</th>
<th>Key actions following the audit</th>
</tr>
</thead>
</table>
| Early Intervention in Psychosis audit | Mental Health | Mental Health | Clinical    | Jul-17         | Success: 4/8 standards met  
Concern: Clear documentation required for PARIS entry.  
Actions:  
• Clear documentation of baseline readings (Weight, BP)  
• Community health clinics  
• PARIS retraining classes                                                                 |
| Section 17 leave *(annual)*     | Mental Health | Mental Health | Clinical    | Sep-17         | These remain unaltered from the previous audit as none have yet been implemented.  
1) There are no obvious problems with the current form used to record leave authorisation. Guidance for Responsible Clinicians is printed on the reverse of the form. Revisions are overseen by the MHASC and are made in line with changes to Mental Health Legislation, Code of Practice guidance and local policy. The form was last revised in 2012 to reflect the latest change to the Trust’s name.  
2) Revision of the Inpatient Care Review template to allow a more prominent and explicit record of discussions around leave, including considerations of risk and benefit to patients, might be helpful in facilitating more consistent record keeping.  
3) A facility within the Electronic Patient Record (EPR) to record stand alone risk assessments would assist staff in recording relevant risk issues when patients are due to go out on leave. It would also be easier to review and record changes in risk status generally.  
4) Further development of the Mental Health Act functionality within the EPR would be extremely helpful in a repeat audit of Section 17 and indeed any audit of the use of the Mental Health Act. In particular, the ability to access historical data and the use of a structured record of leave granted - and actually taken - would greatly facilitate future audit and perhaps encourage more systematic record keeping. A fully developed electronic record might also make the current Section 17
paper record redundant.

5) The care record may be revised to include a section on the patient’s physical description. This should be prominently located on the ‘front page’ of the care record.

6) A policy on photographing patients was drafted in 2008/9 but was never implemented. There may be a case for revisiting this as it continues to be a recommendation in the Code of Practice.

<table>
<thead>
<tr>
<th>Learning Disability Mortality Review Programme (LeDeR)</th>
<th>Mental Health</th>
<th>Mental Health</th>
<th>Clinical</th>
<th>ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Physical and mental health care of mental health patients in acute hospitals</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme: Suicide by children and young people in England (CYP)</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme: Suicide, Homicide &amp; Sudden Unexplained Death</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme: The management and risk of patients with personality disorder prior to suicide and homicide</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
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<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK): Assessment of side effects of depot and LA</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
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</tbody>
</table>
**Prescribing Observatory for Mental Health (POMH-UK): Use of depot/LA antipsychotics for relapse prevention**

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<th>Mental Health/P</th>
<th>Mental Health/Pharmacy</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Clinical ongoing</td>
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</table>

**Prescribing Observatory for Mental Health (POMH-UK): Prescribing for bipolar disorder (use of sodium valproate)**

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<th>Mental Health/Pharmacy</th>
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**Section 136 Audit - Bi-Annual***

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**Communication with gp*CQUIN**

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<tbody>
<tr>
<td></td>
<td></td>
<td>Clinical ongoing</td>
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</table>

**Mortality and unexpected death - Annual 2016 >**

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<thead>
<tr>
<th></th>
<th>Mental Health</th>
<th>Mental Health</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Clinical ongoing</td>
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</table>

**An Audit of Nurses Documentation of the Mental State Examination (MSE Documentation Audit)**

<table>
<thead>
<tr>
<th></th>
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<th>Mental Health</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Clinical ongoing</td>
</tr>
</tbody>
</table>

**Cardiometabolic assessment*x3**

<table>
<thead>
<tr>
<th></th>
<th>Mental Health</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Clinical cancelled</td>
</tr>
</tbody>
</table>

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**Skilled staff to deliver care**

The home treatment team comprised of qualified nurses, support workers, a social worker and a locum consultant psychiatrist. There was no occupational therapy staff, psychologist or staff grade doctors working in the service. There was a lead for physical health and well being and lead for older peoples care within the them treatment team. The nurse lead for older peoples care worked closely with the older person service consultant psychiatrist regarding assessment and reviews of patients.

The single point of access service was staffed with qualified nurses and support workers. The medical cover was provided by the locum consultant psychiatrist who also covered the home treatment team.

The A&E liaison service provided advice on perinatal mental health assessment and screening to inpatient ward within the adult general hospital. The service was also staffed with a dementia nurse specialist and a drug and alcohol specialist nurse. This meant specialist assessments could be provided for patients presenting with dementia or drug and alcohol misuse.

The trust’s target rate for appraisal compliance was 100%. From October 2016 to September 2017, the overall appraisal rates for non-medical staff within this core service was 14%.
The teams failing to achieve the trust’s appraisal target were the crisis resolution & home treatment team with an appraisal rate of 0%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 68% reported the previous year.

<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admiral Nurses</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Crisis Resolution &amp; Home Treatment</td>
<td>32</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Core service total</td>
<td>37</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2,730</td>
<td>1,433</td>
<td>53%</td>
</tr>
</tbody>
</table>

The supervision and appraisal completion rates for this service were low. Staff told us they did not received regular clinical supervision. The clinical team leaders were not able to produce or demonstrate a record of clinical supervision.

During the inspection we requested information on completion rates for clinical supervision. However, the service was not able to produce this information. Staff told us they had not received clinical supervision.

Administrative staff triaged referrals and crisis calls across the service. They did not receive training or support to communicate with patients in crisis. The administrative staff were situated in a room outside of the single point of access teams main office with no clinical staff nearby. There was no nursing support or guidance to assess referrals.

**Multidisciplinary and interagency team work**

The crisis services held weekly team meetings. We reviewed the meeting minutes for five team meetings. These showed staff were able to raise concerns, particularly about staffing levels. The team meeting minutes also showed staff were informed of changes and developments.

Interagency working within the trust was difficult at times. Staff explained that staffing issues in the community mental health teams resulted in delayed discharges from the home treatment team. At the time of inspection, five patients were awaiting allocation within the community mental health teams and remained on the home treatment team caseload.

A delayed discharge meeting had been implemented to review the number of patients awaiting admission and discharge from acute inpatient wards, and referral to the community mental health teams.

The Serenity project had fostered good communication and working between the police, the trust and the accident and emergency department. The serenity project leads employed by the police, had recently started a high intensity meeting group between the police, the trust, the ambulance service, and the accident and emergency department. Meeting minutes of this were not available as it had recently been started, though demonstrated the service working towards the principles of the crisis care concordat. The aims of this group is to develop care response plans to support police when working with patients who present frequently to police and health services and reduce admission to acute inpatient wards under section 136 of the Mental Health Act.
Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 9 October 2017, 0% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for additional clinical services and nursing and midwifery registered, staff and renewed every three years.

During the period 2012 – 2017 the Serenity project had reduced the number of episodes of the use of Section 136 of the Mental Health Act and had a positive impact on diverting the use of this detention, seeking an alternative to avoid a hospital admission. During the 2012 there were 186 episodes of the use of Section 136 of the Mental Health Act. This had decreased steadily each year and during the period April 2017 to December 2017 there were 27 episodes of the use of Section 136.

We reviewed the purpose built Section 136 assessment suite which was located at Seagrove Ward. Staff we spoke to informed us that the section 136 room was not routinely used and as an alternative, staff used a room in between the Section 136 assessment room and Seagrove Ward which was adjacent to the seclusion room on the ward. This enabled safer observation of patients detained under Section 136 of the Mental Health Act. This trust had plans to refurbish the purpose built Section 136 assessment suite. The environment used to detain and assess a patient under Section 136 of the Mental Health Act was not welcoming and did not always maintain the privacy of patients. The room used to assess patients detained under Section 136 did not have any natural light and was not comfortable. There was no bed in the room, only a large leatherette sofa. If patients needed to sleep the staff completed a risk assessment and moved patient to a bed on the ward. Staff could safely observe patients in the room as there was a large glass window at the front of the assessment area. However this also meant other patients could see a patient being assessed in the Section 136 assessment room and this compromised privacy and dignity. The room did not display the rights of patients detained under Section 136 of the Mental Health Act. However, we reviewed three care records which demonstrated patients were having their rights explained regularly during the period assessment.

We reviewed the detention to assessment times for patients detained under Section 136 of the Mental Health Act. The average detention to assessment time was 10.46 hrs. The longest period of time from detention to assessment was 27 hours and 55 minutes and the shortest was 45 minutes. This was not meeting the recommended time of 3 hours identified in the Mental Health Act code of practice and the trust policy.

The section 136 policy provided by the trust was out of date. The policy related to the previous Code of Practice which was replaced on April 1st 2015. The current policy was not approved until June 2015 after the new Code had been introduced. The guidance on the use of section 136 was amended in December 2017, reducing the previous 72 hours detention period to 24 hours. The policy has not been updated to reflect these changes.

Good practice in applying the Mental Capacity Act

As of 9 October 2017, 14% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services additional clinical services and nursing and midwifery registered staff and renewed every three years.

The training compliance reported during this inspection was higher than the 11% reported in the previous year (1 April 2015 – 31 March 2016).

The care records reviewed in the home treatment team showed that mental capacity was assessed appropriately and recorded clearly in notes,
Is the service caring?

Kindness, privacy, dignity, respect, compassion and support
We observed staff working in the home treatment team treating patients with respect and dignity. Staff discussed patient health and social care needs with sensitivity and compassion, demonstrating an understanding of the presentation and history of patients using the service.

We spoke with four patients who told us that staff were respectful, kind and supportive.

One patient we spoke with commended the service and the staff. The feedback as they had received a service beyond their expectations. They had been supported by staff to attend GP appointments, with shopping and regaining confidence for living independently and supported to get food vouchers to help with financial challenges.

We observed staff working the home treatment discussing the need to refer a patient to the reablement service to provide intensive support and access further resources following the crisis period and deterioration in health and wellbeing.

The involvement of people in the care they receive

Involvement of patients

We reviewed 15 care records and care plans within the home treatment team. Only four of the care plans reviewed contained language which reflected patient involvement and included the views and preference of the patient. Overall, the home treatment team was not demonstrating patient involvement in care planning and care plans.

We spoke with two patients who told us they had not received a copy of their care plan and were not aware what their care plan entailed.

Staff supported patients to access advocacy services and support groups.

Involvement of families and carers

During a handover meeting in the home treatment team, we observed staff discussing the needs of families and carers. These discussions sensitively considered interventions and needs of families and carers. Staff also explored options to increase the number of visit to provide support and advice for families who were supporting relatives during a crisis period.

Is the service responsive?

Access and waiting times
Telephone to access the home treatment and single point of access teams was unsafe. The home treatment team and single point of access team shared only one telephone line which for incoming calls. This caused significant problems when patients or referrers called the service and the line was already in use. The clinical team leaders, nursing staff and administration staff all raised this as a concern and challenge during the inspection.

Administrative staff operated this telephone line and transferred calls to nursing staff once they had taken key patient details. At times calls were diverted to the home treatment team office if the crisis line was engaged. There was no guarantee that a member of staff would be available to
answer the call in the home treatment team. Plans to install an answer machine had not been completed. The clinical team leader told us that callers not being able to get through to the single point of access happen regularly, and this is reported as an incident. We requested the incident reports for these incidents, only one incident of this happening was recorded.

There were clear referral and inclusion criteria. Patients were not excluded based on diagnosis. The single point of access team referred calls to qualified member of staff in the team. However if there were no qualified nursing staff available, administrative staff often received and triaged crisis calls. They did not have appropriate support or training to respond to patients or carers in crisis or to triage crisis referrals. Administrative staff said this causes them a great deal of stress. Due to low staffing levels support worker often completed threshold assessment grid (TAG) screening for referrals, however, they had not received and training or support to carry out this role.

The trust did not provide data on ‘referral to initial assessment’ and ‘assessment to treatment’ for this core service. We requested this data during the inspection, the trust were not able to provide this data.

The home treatment team had a referral to assessment target of 24 hours and most patients were seen in the same day. Staff working in the team screened and triaged each referral on an individual basis and made initial contact with patient within a four hour period from receiving the referral.

The home treatment team was working towards avoiding hospital admission where appropriate through providing support in community settings. The crisis services had recently reintroduced two 72 hour assessment beds on the acute inpatient admission ward. The aim of this part of the service was to engage promptly with patients admitted informally or under Section 2 of the Mental Health Act to the acute inpatient ward, and explore care planning, risk assessment to facilitate early discharge. This discharge may involve referrals for support from the home treatment team. Staff allocated to work in this role worked on the acute inpatient ward daily, reviewing patients referred to this service with the ward multi-disciplinary team consultant psychiatrist.

This service had recently been reintroduced two months prior to the inspection and had not routinely collected data to show the referral to assessment times. Of this service. However an audit completed in October 2017 showed from 42 patients admitted to the 72 hour assessment beds, 11 (27%) went on to be admitted to an treatment bed and 30 (73%) were discharged to home treatment team or other community service including the GP.

Administrative staff kept a record of referral and assessment dates for each patient. On review of this record, patient referral and assessment dates had not been recorded for the month of December 2017. Administrative staff were not sure how to extract this data from the electronic patient record system. There was duplicate recording of assessments in electronic care records.

The A&E psychiatric liaison service had set target of assessing patients within a four-hour period of referral. We reviewed 10 care records and this target was being met in this team.

The single point of access service categorised referrals into urgent and non-urgent referrals. Staff assessed urgent referrals within 24 hours and non-urgent referrals within 7 days. The team did not always meet this target; a recent serious incident occurred where an urgent referral was not assessed within 24 hours and subsequently the patient took an overdose.

Staff working in the home treatment team were flexible to the needs and preferences of patients and their carers/families. Appointments were made according to patients’ wishes and where possible staff saw patients in alternative settings to help promote engagement.

The home treatment team had a nominated shift coordinator. This role helped to organise and prioritise home visits.

The single point of access team actively followed up patients who did not respond to initial phone contact with three further phone calls. Staff were proactive in attempting to follow up patients who were hard to engage, and made attempts to contact patients.
The facilities promote comfort, dignity and privacy
Staff working the home treatment team and single point of access sometimes met with patients at the hospital. Staff could meet and speak with patients in rooms which were comfortable and private, maintaining patient dignity. These rooms were located in the sevenacres building and were adequately soundproofed.

Patients’ engagement with the wider community
Staff supported patient to maintain and build relationships with families and support networks in the wider community. During a home treatment team handover we observed staff reviewing and discussing the support and care needs of the carers and families of patients they were visiting. This included referral suggestions to external agencies and interventions so increase the level of support.

Meeting the needs of all people who use the service
The home treatment team had a bank of resources which could be accessed to provide information and psychoeducation for patients. Staff provided patients with information on medicines, access to advocacy groups and support with employment and housing.

Staff were able to access an interpreting service if required.

Listening to and learning from concerns and complaints
There was no data at core service level about listening to and learning from concerns and complaints. The data submitted by the trust was not broken down at core service level.

Staff knew how to handle complaints appropriately, and gave examples of how they would provide information to patients or carers if they wished to make a complaint.

Is the service well led?

Leadership
The mental health crisis service and health based places of safety had not had a stable operational manager for the past 12 months. Two interim operation managers had worked for a period of 3 months at a time within the past 12 months. The Interim clinical team leaders were not adequately managed or supported for the 12 months prior to the inspection.

Staff told us the clinical team leaders were visible and accessible.

The clinical team leaders were committed to delivering services which met the needs of patients.

Vision and strategy
Staff were aware of proposals for the redesign of mental health services though they were not able to describe or give details of what these changes entailed.

Culture
The staff we spoke to reported a positive work culture. Many of the staff working in the home treatment team had worked in the service for a number of years. Staff told us it was a supportive and friendly team to work in. The administrative staff working in the single point of access team reported low morale and stress, particularly when they had to triage crisis calls.

The crisis services held monthly team meetings. We reviewed the meeting minutes for five team meetings. These showed staff were able to raise concerns, particularly about staffing levels.
Governance
The trust have not provided a board assurance framework for this inspection.

The trust have not provided a risk register for this inspection.

Referral times were not being monitored. The governance processes in the crisis service and health based places of safety were not embedded or effective. The crisis services were not accurately or routinely capturing the assessment to treatment times for patients referred to the service. This meant the clinical team leaders were not monitoring the quality and safety of the service being provided.

Management of risk, issues and performance

Staff working in the home treatment team were able to escalate concerns about risk, particularly the impact of the low staffing levels within the single point of access and home treatment team. However this was only shown in minutes of team meetings where managers had informed staff they had escalated concerns about staffing levels. Overall, processes to manage risk and issues of performance were not robust. The single point of access and home treatment team were not capturing and monitoring key performance indicators such as referral to assessment times, in a format which could be reviewed easily risks in the service.

Information management
Staff did not have access to information technology and equipment to carry out their role in both the home treatment and single point of access teams. Staff were not proved with suitable work mobile phones or a personal lone working security system to safely complete their roles.

The majority of staff told us they found the electronic records system difficult to use and operate.

Engagement
Staff had access to the trust intranet and were able to keep up to date with developments, news and changes.

Learning, continuous improvement and innovation
Staff were not engaged in any quality improvement initiatives within this service.

The serenity project had received recognition for the positive impact the team had made at reducing the use of Section 136 of the MHA.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No details were provided on relevant services within this core service that have been awarded an accreditation.
## Specialist community mental health services for children and young people

### Facts and data about this service

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team name</th>
<th>Number of clinics</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pyle Street, Newport</td>
<td>CAMHS</td>
<td>23</td>
<td>mixed</td>
</tr>
</tbody>
</table>
Safe and clean environment

The service did not ensure that the premises were safe for children and young people. They had access domestic knives in the unlocked kitchen. The manager had completed an environmental risk assessment but had not included this issue. The assessment was completed in a reactive manner rather than a proactive one. For example, the manager had addressed issues raised at the previous inspection in 2016 that young people had uninterrupted access to the ground floor offices, by installing keypad locks. However, this was only completed after an incident involving the police in 2017 where a young person had managed to enter the offices. If young people become agitated and left the interview rooms, as had happened in 2016 then they could easily access dangerous objects in the kitchen.

The service had premises that were well maintained. Interview rooms were fitted with alarms, so staff could alert others if they needed assistance. Therapy rooms were clean and appeared well maintained. We reviewed the most recent cleaning records and they were up to date, complete, and filled in correctly.

The service controlled infection risk well. Staff adhered to infection control principles including hand-washing. There was signage on the premises instructing how to wash hands correctly.

Safety of the ward layout

There were ligature risks on the one location within this core service. The trust had undertaken recent (24 July 2017) ligature risk assessments at this location.

This location did not present a high level of ligature risk due to “Young People are risk assessed and their care plan amended according to their risk and are escorted from the reception to any of the clinic rooms. All are escorted up and down the staircases and when using the bathroom facilities either a parent/carer or clinician will escort them to mitigate the risks.”

Safe staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children and young people safe and provide the right care and treatment. The current staff complement included mental health nurses, nurse practitioners, in-reach/outreach mental health nurses, family therapists, primary mental health practitioners, a child psychotherapist and consultant psychiatrists.

The service ensured staff had manageable caseloads to provide safe care and treatment. The average cases loads were between 30 to 45 children and young people for each staff member with the average being 40. The manager regularly reviewed caseloads to ensure equity across the team. The staff team had monthly clinical supervision where they looked at caseloads. Decisions were taken based on clinician’s specialities and the acuity of their current caseloads.

The service did not fully plan for emergencies. Whilst the manager ensured that there were clear cover arrangements for sickness, leave, and vacant posts to ensure the safety of the children and young people. Children and young people still did not have timely access to a child psychiatrist outside of working hours in 2017. This had not changed since our previous inspection in 2016. The duty on call rota of adult psychiatrists did not cover young people who had to wait in hospital until Monday for assessments. To help address the lack of out of hours support for children and young people the team had implemented a number of initiatives. The newly appointed consultant
psychiatrist worked six out of hours shifts in the last year, the team ran training sessions for adult consultant psychiatrists, crisis team staff and staff in the accident and emergency department about the presenting concerns of young people. However, young people and their families continued to express concern about the lack of out of hours provision.

The team had a low vacancy rate. When the teams had vacancies, the manager actively tried to recruit staff. At the time of the inspection, they were in the process of recruiting an administrative manager and had one consultant psychologist vacancy. The manager had not been involved in agreeing staffing levels. However, they felt that the current levels were appropriate to meet the needs of the children and young. Sickness levels were low and the service did not use bank or agency staff.

*Nursing assistant data not submitted by the trust

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of substantive staff</td>
<td>30 September 2017</td>
</tr>
<tr>
<td>Total number of substantive staff leavers</td>
<td>October 2016 – September 2017</td>
</tr>
<tr>
<td>Average WTE* leavers over 12 months (%)</td>
<td>October 2016 – September 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vacancies and sickness</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total vacancies overall (excluding seconded staff)</td>
<td>30 September 2017</td>
</tr>
<tr>
<td>Total vacancies overall (%)</td>
<td>October 2016 – September 2017</td>
</tr>
<tr>
<td>Total permanent staff sickness overall (%)</td>
<td>October 2016 – September 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establishment and vacancy (nurses and care assistants)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment levels qualified nurses (WTE*)</td>
<td>30 September 2017</td>
</tr>
<tr>
<td>Establishment levels nursing assistants (WTE*)</td>
<td>NA</td>
</tr>
<tr>
<td>Number of vacancies, qualified nurses (WTE*)</td>
<td>30 September 2017</td>
</tr>
<tr>
<td>Number of vacancies nursing assistants (WTE*)</td>
<td>NA</td>
</tr>
<tr>
<td>Qualified nurse vacancy rate</td>
<td>October 2016 – September 2017</td>
</tr>
<tr>
<td>Nursing assistant vacancy rate</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Bank and agency Use</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)</td>
<td>October 2016 – September 2017</td>
</tr>
<tr>
<td>Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)</td>
<td>October 2016 – September 2017</td>
</tr>
<tr>
<td>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)</td>
<td>October 2016 – September 2017</td>
</tr>
</tbody>
</table>
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | October 2016 – September 2017 | Not submitted
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | October 2016 – September 2017 | Not submitted
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | October 2016 – September 2017 | Not submitted

*Whole Time Equivalent

The trust’s staff fill rates for registered nurses and care staff was not available through the trust website.

The service did not use bank or agency staff. This core service reported an overall vacancy rate of 9.4% for registered nurses from October 2016 to September 2017.

The highest number of vacancies within registered nurses was seen in the last six months of this 12 month period. August 2017 saw the highest number of vacancies with two (22%).

There were two other staffing groups within this core service which had a higher overall vacancy rate from October 2016 to September 2017 compared with registered nursing staff. Medical and dental staff had a vacancy rate of 22.0% and administrative and clerical staff had a vacancy rate of 20.3%.

This core service has reported a vacancy rate for all staff of 6.7% from October 2016 to September 2017. This is lower than the reported trust wide vacancy rate of 9.9% from October 2016 to September 2017.

Data broken down by team/ward was not sent in from the trust.

Bank and agency data for registered nurses and nursing assistants was not sent by the trust.

This core service had 0.9 (3%) staff leavers from October 2016 to September 2017.

This is higher that the reported turnover rate trust wide of 9%.

Data broken down by team/ward was not sent in from the trust.

Staff sickness in this service was well below the trust’s target. The sickness rate for this core service was 1.7% from October 2016 to September 2017. This was for registered nursing staff, as the trust did not submit data for any other staffing group within this core service. This was lower than the reported trust wide sickness rate of 4.3%. The most recent month’s data (September 2017) showed a sickness rate of 1.2%.

Community CAMHS team had an overall sickness rate of 1.6% from October 2016 to September 2017. Specialist CAMHS Medics had a higher overall sickness rate for this same period with 5.9%.

The trust set a target of 85% for completion of mandatory training.

The compliance for mandatory training courses from April 2017 to October 2017 was 93%. Of the training courses listed three failed to achieve the trust target and of those, two failed to score above 75%.

Key:

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service</th>
<th>Trust target %</th>
<th>Trust wide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Resuscitation - Non-Clinical Staff</td>
<td>100%</td>
<td>85%</td>
<td>74%</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>100%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>100%</td>
<td>85%</td>
<td>84%</td>
</tr>
</tbody>
</table>
The service provided mandatory training in key skills to all staff which was completed by the majority of staff. The overall score for staff completion on mandatory training services was high at 93%. The electronic rota system automatically told the team manager when a staff member's training was due for renewal. The manager and two staff were currently undertaking alternative therapy training so they could offer the young people cognitive behavioural therapy in 2018.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff undertook a risk assessment of every young person at the initial triage/assessment and updated them regularly. Staff members had received recent training in the assessment and management of risk. Risk assessments were evident in all 11 case notes we reviewed. Staff completed a risk assessment and crisis plan at the first appointment and then updated these over time when the risk changed.

High risk young people had clear crisis plans in place. The team discussed risk daily in a clinical meeting and their discussions were recorded in the individual clinical record. The meeting considered the risks holistically and included the involvement of parents, other agencies, and schools. Protective factors were discussed to keep the young person safe.

Management of patient risk

The staff team ensured that collaborative crisis plans that could be accessed by young people, families, and teams were in place in all 11 files reviewed.
Safeguarding
Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust only submitted information on safeguarding referrals at a trust wide level so this data cannot be reported per core service.

The staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. All staff spoken with knew about the trust’s safeguarding policy and could tell us how to make a safeguarding alert and when it was appropriate to do so. Records confirmed that 94% of staff had completed level 3 child protection training. The team had good links with the local safeguarding board. At the previous inspection in 2016 the electronic care records system did not highlight to staff young people who were subject to a child protection plan and safeguarding referrals were not clearly recorded. This had been addressed by the new electronic recording system.

The trust have stated that they have had serious case reviews in the last 12 months however the number, core service they relate to, location or ward information was not provided.

There were no serious case reviews relating to this core service in 2017.

Staff access to essential information
Staff kept appropriate records of children and young people’s care and treatment. All staff could access the electronic patient record. In 2017 and were trained on the revised electronic system.

Medicines management
The service ensured children and young people medicine management was appropriate and worked closely with the young people’s GP.

Track record on safety
The core service had suitable incident systems in place to record, monitor, and learn from incidents.

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 October 2016 and 31 September 2017 there were no STEIS incidents reported by this core service.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.
Reporting incidents and learning from when things go wrong

‘Prevention of future death’ reports

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no ‘prevention of future death’ reports sent that relate to this core service.

The service managed children and young people’s safety incidents well. Staff recognised incidents and reported them appropriately. During this inspection, we saw that all staff had received training on how they could report incidents on the trusts electronic reporting system. Staff could explain what to report and how they would do this to our team.

In 2016, we told the trust they must ensure the team acted any lessons learnt from incidents. The service now investigated incidents well and evidenced shared learning. We saw that there had been changes and learning made following an incident in 2017 where a letter with information intended for a young person was sent to the wrong address. The staff team asked for improvements to the electronic recording system called PARIS to populate all addresses electronically. They also set up a checking system within the team to ensure this did not happen again. A letter of apology was also sent to the young person.

Is the service effective?

Assessment of needs and planning of care

Staff had access to up to date, accurate and comprehensive information on young people’s care and treatment. Staff members ensured that comprehensive mental health core assessments were documented in each of the 11 care records we reviewed. They were carried out at the young person’s first appointment. This was a considerable improvement from our previous inspection in 2016, where we found there were only care plans in five of 12 case files reviewed and these were of a poor standard. Care plans contained evidence of discussions about treatment options, and had a record of physical health monitoring where appropriate. The plans were recovery focused, holistic, and updated appropriately at reviews or following the daily risk meetings. They contained sufficient information to assist safe care for young people and children.

At the 2016 inspection, staff members were inconsistent about the storage of care plans on the electronic record system and could not find records of consent, care plans, or risk assessments when we asked. At this inspection, all staff spoken to knew how to access records as they ensured they were all stored in the same place.

Best practice in treatment and care

The service provided care and treatment based on national guidance and evidence of its effectiveness. There were care pathways in place that showed current National Institute for Health and Care Excellence (NICE) guidance for staff to follow. The team followed NICE guidance when prescribing medication and in relation to psychosis and schizophrenia in children and young people. These included recognition and management NICE (2013); depression in children and
young people; identification and management in primary community and secondary care NICE (2015).

Staff did not routinely monitor young people’s physical health care unless, for example, the patient had an eating disorder. The young person’s GP completed any other physical health monitoring.

The service monitored the effectiveness of care and treatment and used findings to improve them. The service ensured analysis of outcome measures to inform service development. Staff used outcome rating scales like children’s global assessment scale. This is a numeric scale used by mental health clinicians to rate the general functioning of youths under the age of 18. Scores range from 1 to 90 or 1 to 100, with high scores indicating better functioning. They also used the strengths and difficulties questionnaire which is a self-reporting inventory behavioural screening questionnaire for children and adolescents aged two to 17 years old.

Clinical staff participated in a variety of clinical audits. For example, they completed audits on care plans, and young people with eating disorders.

The trust have detailed 15 Mental Health audits as part of their clinical audit programme. The time period was not provided.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Core service</th>
<th>Audit type</th>
<th>Date completed</th>
<th>Key actions following the audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention in Psychosis audit</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>Jul-17</td>
<td>Success: 4/8 standards met</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Concern: Clear documentation required for PARIS entry. Actions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Clear documentation of baseline readings (Weight, BP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Community health clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PARIS retraining classes</td>
</tr>
<tr>
<td>Section 17 leave <em>(annual)</em></td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>Sep-17</td>
<td>These remain unaltered from the previous audit as none have yet been implemented. 1) There are no obvious problems with the current form used to record leave authorisation. Guidance for Responsible Clinicians is printed on the reverse of the form. Revisions are overseen by the MHASC and are made in line with changes to Mental Health Legislation, Code of Practice guidance and local policy. The form was last revised in 2012 to reflect the latest change to the Trust’s name. 2) Revision of the Inpatient Care Review template to allow a more prominent and explicit record of discussions around leave, including considerations of risk and benefit to patients, might be helpful in facilitating more consistent record keeping. 3) A facility within the Electronic Patient Record (EPR) to record stand alone risk assessments would assist staff in recording</td>
</tr>
</tbody>
</table>
relevant risk issues when patients are due to go out on leave. It would also be easier to review and record changes in risk status generally.

4) Further development of the Mental Health Act functionality within the EPR would be extremely helpful in a repeat audit of Section 17 and indeed any audit of the use of the Mental Health Act. In particular, the ability to access historical data and the use of a structured record of leave granted - and actually taken - would greatly facilitate future audit and perhaps encourage more systematic record keeping. A fully developed electronic record might also make the current Section 17 paper record redundant.

5) The care record may be revised to include a section on the patient’s physical description. This should be prominently located on the ‘front page’ of the care record.

6) A policy on photographing patients was drafted in 2008/9 but was never implemented. There may be a case for revisiting this as it continues to be a recommendation in the Code of Practice.

<table>
<thead>
<tr>
<th>Learning Disability Mortality Review Programme (LeDeR)</th>
<th>Mental Health</th>
<th>Mental Health</th>
<th>Clinical</th>
<th>ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Physical and mental health care of mental health patients in acute hospitals</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme: Suicide by children and young people in England (CYP)</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme:</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td>Clinical</td>
<td>ongoing</td>
</tr>
<tr>
<td>Topic</td>
<td>Clinical</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide, Homicide &amp; Sudden Unexplained Death Mental Health Clinical Outcome Review Programme: The management and risk of patients with personality disorder prior to suicide and homicide</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK): Assessment of side effects of depot and LA antipsychotic medication</td>
<td>Mental Health/Pharma</td>
<td>Mental Health/Pharma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK): Use of depot/LA antipsychotics for relapse prevention</td>
<td>Mental Health/Pharma</td>
<td>Mental Health/Pharma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK): Prescribing for bipolar disorder (use of sodium valproate)</td>
<td>Mental Health/Pharma</td>
<td>Mental Health/Pharma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 136 Audit - Bi-Annual*</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>communication with gp*CQUIN</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality and unexpected death - Annual 2016 &gt;</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An Audit of Nurses Documentation of the Mental State Examination (MSE Documentation Audit)</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cardiometabolic assessment*x3</td>
<td>Mental Health</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Skilled staff to deliver care

The team consisted of a wide range of specialists to meet the needs of children and young people. This included mental health nurses, nurse practitioners, in-reach/outreach mental health nurses, systemic family psychotherapists, primary mental health practitioners, child psychotherapist, consultant psychiatrists and administration staff. The team had a variety of experience with some working for several years and others were new to the team.

The service made sure staff were competent for their roles. New staff completed an induction, which involved completion of all mandatory training during the probationary period. Staff had to confirm they had read and understood trust policies and procedures. Staff received monthly clinical supervision and held peer group supervision every two weeks with the consultant to discuss complex cases and share experience and knowledge. Staff received yearly appraisals, 86% of staff had received appraisals in the year 2016 to 2017. All members of staff had a personal development plan that was monitored, assessed, and modified during the annual appraisal process. All appraisals were recorded, were individualised and had objectives and training needs identified.

When staff started working at the service they completed an induction, which consisted of completion of all the mandatory training. New staff were required to complete a range of competencies during the probationary period.

The trust’s target rate for appraisal compliance is 100%. From October 2016 to September 2017, the overall appraisal rates for non-medical staff within this core service was 86%.

<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community CAMHS</td>
<td>21</td>
<td>18</td>
<td>86%</td>
</tr>
<tr>
<td>Core service total</td>
<td>21</td>
<td>18</td>
<td>86%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2,730</td>
<td>1,433</td>
<td>53%</td>
</tr>
</tbody>
</table>

The trust’s target rate for appraisal compliance is 100%. From October 2016 to September 2017, the overall appraisal rates for medical staff within this core service was 100%.

<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent medical staff requiring an appraisal</th>
<th>Total number of permanent medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist CAMHS Medics</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Core service total</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>135</td>
<td>90</td>
<td>67%</td>
</tr>
</tbody>
</table>
There were no clinical supervisions specific to this core service.

The manager did not consistently provide staff with regular managerial supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). At the previous inspection in 2016, no staff received one-to-one managerial supervision. At this inspection, there was some improvement with half the staff team receiving at least two supervision sessions in 2017. However, it remained irregular, with staff not having supervision for several months. The manager ensured that staff had access to regular team meetings to share information and develop learning.

**Multidisciplinary and interagency team work**

The service ensured staff worked effectively together. The service had regular multi-disciplinary meetings where they discussed the needs of young people. They discussed high risk cases, new referrals, alternative strategies and treatments for the young people. Staff discussed young people in a kind, professional and informed manner. Staff told us the multidisciplinary team worked well.

The service had made strong links with local schools. Staff, young people and their families told us that relationships between clinicians and school staff were well established. They worked together to manage risk and to aid young people in the school environment.

The team had good working relationships and handovers with social services and the inpatient ward on the mainland.

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

As of 9 October 2017, there were no staff listed, as having, or needing Mental Health Act training in this core service.

Staff understood their roles and responsibilities under the Mental Health Act 1983. All clinical staff we spoke with confirmed they had received in house training in the Mental Health Act and Code of Practice relevant to children and young people. Staff we spoke with were aware of their responsibilities when working with patients under the Mental Health Act. The Mental Health Act was rarely used by the specialist community mental health services for children and young people.

**Good practice in applying the Mental Capacity Act**

**Mental Capacity Act training figures**

As of 9 October 2017, there were no staff listed, as having, or needing Mental Capacity Act training in this core service.

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They understood it only applies to young people aged 16 years and over. For children under the age of 16, the young person’s decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were familiar with the principles of Gillick and stated they used this to include the patients where possible in decision making. They had worked hard over the last year to improve their recording of Gillick competency. In the 11 files we reviewed, there was evidence of consideration of capacity and consent where this was appropriate. There was a tick box on the consent form for Gillick competence that reminded staff to review Gillick competencies.
Mental Capacity Act training took place at induction and was ongoing throughout the year. In January 2018, staff received training from the trusts Mental Capacity Act lead. There was a Mental Capacity Act policy and staff knew who to approach in the trust if they need support or advice.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff cared for children and young people with compassion. All of the interactions we saw between young people and carers and the staff members were respectful and showed an understanding of the young peoples’ needs.

Staff directed young people to other services like counselling, and when appropriate they supported them to access those services.

All young people or carers we spoke with said staff were supportive and caring. All parents of the young people gave us positive feedback regarding the staff team.

The team respected patient confidentiality; they had soundproofing in interview rooms and used lockable bags to carry any information outside the office.

The involvement of people in the care they receive

Staff involved children and young people and those close to them in decisions about their care and treatment. The staff team had made improvements to ensure children and young people were involved in their care planning and risk assessments. At the inspection in 2016 young people said they were not always involved in decisions about their care, they were not encouraged to attend their review meetings and had not seen a copy of their care plan. Over the last year, the staff team had revised the way they compiled care plans. They now met with each young person to design a care plan together. All young people spoken with said they attended reviews and had copies of their care plan. Both young people and staff were positive about the new collaborative approach.

Involvement of patients

Young people were encouraged to give feedback on the service. They contributed to the services regular newsletter. Staff gathered the views of the patients at three points during their treatment at six weeks, six months and at discharge. There was also a questionnaire in reception, which informed the ‘you said we did’ board. The team had introduced new equipment in the waiting room after suggestions made by the young people.

Staff discussed responses to surveys at team meetings and used this information to develop practice and make changes where needed. For example, young people wanted a more accessible online site so the team arranged for a young person to train the staff team in exactly how they wanted the site to look.

Young people had access to advocacy services. There was evidence in the 11 files of that staff regularly discussed and arranged an advocate for young people.

Young people were involved with the recruitment of staff. They formed part of the recruitment panel for the psychiatrist in 2017.

Involvement of families and carers
Staff involved families in the care of the patient as appropriate. All parents spoken with said staff involved them in the care and treatment of their children. Teenagers often said they often chose to attend appointments alone and involved their parents or carers when they felt it was appropriate.

**Is the service responsive?**

**Access and waiting times**

Children and young people could access the service when they needed it. The service offered care and treatment within an appropriate timeframe. The team ensured urgent referrals were seen within the target of three days and non-urgent referrals within three weeks. Their open referral system was accessed by young people, their GP, or school. The referral was assessed by either the manager or the duty clinician. If the case was assessed as urgent there was an immediate response, otherwise the case was taken to the team at the daily risk review meeting or the weekly referral meeting. No patients waited 18 weeks for treatment, which was the team’s key performance indicator. The paediatric ward at the hospital rang the service if they had any young people that required an assessment; these referrals were reviewed at a daily risk meeting and then visited by a clinician.

The team were responsive to the needs of young people transitioning to adult services as they continued to work with young people aged over 18 dependant on need. They said they often worked with young people until their 19th birthday. However, they felt discharging young people was an area where they could further develop and establish stronger links with other teams.

In our previous inspection in 2016, we found there was no provision of CAMHS clinicians out of hours or at weekends. Young people in crisis were admitted to the paediatric ward in the acute general hospital. If a young person was admitted to the paediatric ward on a Friday then they were not seen by the team until the following Monday. At this inspection, this remained the case. Young people at both inspections said they found this wait difficult when they were admitted over the weekend. The contract with the clinical commissioning group stated that they expected out of hours crisis support to be in place by June 2016. However, this was not in place at the time of either inspection.

The service planned and provided services in a way that it met the needs of the majority of local young people. The service had clear criteria for which young people would be offered a service and there were no waiting lists. Staff members at the focus group told us their strengths lay in their signposting to other services. They ran workshops for young people that were easily accessed. They also ran workshops with parents so they could better understand the work the team completed with the young people with a psychosis, eating disorder, anxiety, or depression diagnosis so they could continue this work at home. The team had developed a new eating disorder service with transformation money from the clinical commissioning group. We got very positive feedback from parents of young people and young people themselves about this service.

However, as previously stated, at our inspection in 2016, we found that young people did not have access to timely treatment for autism spectrum disorder and attention deficit hyperactivity disorder after diagnosis. Not only did this remain the case but also in the middle of 2017 young people were no longer able to receive even a diagnosis as the independent provider withdrew this service. Following a miscommunication from the clinical commissioning group that the learning disability service would be providing this service, they received 28 referrals and 25 phone calls from parents anxious to establish who would be assessing their children.
In January 2018, the clinical commissioning group informed the trust that the referral pathway had changed from the original proposal that the GP’s would assess using a tool they had identified. The trust devised two models. A waiting list initiative to address the 147 young people on the waiting list from the previous provider or a National Institute for Health and Care Excellence (NICE) compliant service model to meet the demand of 400 referrals and 200 assessments. The trust was also in discussions about developing a whole life pathway that would meet the needs of island children and young people and include post diagnostic support in the future with the clinical commissioning groups support. However, it remained the case that children and young people still did not receive any treatment for autism spectrum disorder or attention deficit hyperactivity disorder and had not done so for several years.

The team responded promptly and adequately when young people phoned into the service. Calls were directed to either to the daily clinician on duty or to their own clinician if the case was open to the service.

The team took active steps to engage with young people who found it difficult or were reluctant to engage with mental health services. They would contact other services involved and see if they have methods of engagement that would be useful. The team contacted their schools and/or their GP to ensure the wellbeing of children and young people

The team took a proactive approach to monitoring and re-engaging with young people who did not attend. Staff in the administration team rang each young person to remind them of their forthcoming appointment.

Children and young people had flexibility in the times of appointments. For example, staff met them after or before school. Staff were not available at weekends.

The staff team ensured that appointments were only cancelled when necessary. Young people received an explanation and were given help to access treatment as soon as possible.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

<table>
<thead>
<tr>
<th>Name of team</th>
<th>Service Type</th>
<th>Days from referral to initial assessment</th>
<th>Days from assessment to treatment</th>
<th>Comments, clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Days</td>
<td>Days</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>National target</td>
<td>Actual (mean)</td>
<td>National target</td>
</tr>
<tr>
<td>CAMHS Consultant</td>
<td>-</td>
<td>126</td>
<td>14</td>
<td>126</td>
</tr>
<tr>
<td>CAMHS Community</td>
<td>-</td>
<td>-</td>
<td>20</td>
<td>-</td>
</tr>
</tbody>
</table>

Lost to Follow Up

The trust did not provide this data
The facilities promote comfort, dignity and privacy
The service took into account young people’s individual needs. The team used a range of different therapy rooms. The therapy rooms were comfortable with a range of equipment to assist clinicians in engaging young people. The reception was welcoming with comfortable furniture. The service had a sensory room with a range of interactive equipment. All of the therapy rooms were soundproofed so conversations could not be overheard.

Patients’ engagement with the wider community
The team helped young people to access employment, education, and training opportunities. Young people we spoke with explained how the team had worked with them at school, enabled them to access courses and look for employment.

Meeting the needs of all people who use the service
The service had disabled access with a ramp for wheelchair access, and an adapted toilet with grab rails. There was no lift but wheelchair users could be accommodated on the ground floor.

The waiting room contained information leaflets about local services and medication. Information leaflets about the service CAMHS were provided by the trust in age appropriate formats. Information included how to access counselling and substance misuse services, contact advocacy and how to make a complaint.

The service provided accessible, age appropriate information booklets regarding health issues and conditions, and produced accessible care planning information for young people with a learning disability.

Staff ensured children and young people had access to trust interpreters and signers when required.

Listening to and learning from concerns and complaints
The service mostly treated concerns and complaints seriously, investigated them and learnt lessons from the results. Staff members did not consistently follow the policy and procedures in place to allow children and young people to raise concerns. Staff told us they did not send out a complaints form with the welcome pack but often spoke about how to make a complaint at their first meeting with a client. However, information on how to make a complaint was also displayed in the corridor and office. This included information about the role of independent advocacy services in complaints.

The trust could not provide complaint data at core service level.
All formal complaints were investigated by the manager. Whilst complainants were sent a letter about the outcome of their complaint, none was recorded as ‘upheld’ or ‘not upheld’. The manager said they intended to review their system. Staff were not following up verbal complaints from young people or their families so there was no investigation or evidence about themes or trends. There were five verbal complaints in the last year about lack of treatment for children and young people with autism but these complaints were recorded in the daily records and not within the complaints system.

It was not clear from the data provided by the trust as to how many, if any, compliments were received by the core service.

There were five compliments in the last year about the service for children and young people
Is the service well led?

Leadership

Leaders had the skills, knowledge, and experience to perform their roles.

The manager had relevant experience to carry out their role. They were aware of the current challenges faced by their team and how they were working to meet young peoples’ needs. They had encouraged the team to meet the majority of the requirements and recommendations of the 2016 inspection report.

The teams knew who the senior managers were and told us that they visited the team.

There were leadership training opportunities for the manager. The manager told us they were taking an alternative therapy training course to develop both clinically and as a manager.

Vision and strategy

The manager promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All staff knew and understood the trusts visions and values and applied them to their work. Staff felt they showed these values in their work by offering young people choice and placing them at the centre of the care planning process. Records we reviewed showed this.

Staff gave feedback about services at team business meetings.

Staff could explain how they were working to deliver high quality care within the budgets available. For example, they completed a yearly benchmarking document (a document that compares their performance with other similar trusts) about discharge and young people who did not attend the service.

Culture

Most of the staff we spoke with felt positive about working for the trust and that they could approach manangers without concern. Staff morale was high they said they worked well together.

Staff told us there was not a bullying or harassment culture in the team. They knew how to raise concerns without fear of victimisation and knew how to use the whistle-blowing process if they had concerns.

The manager did not always ensure staff were competent for their roles because staff members did not all receive sufficient regular one to one managerial supervision or use key performance indicators to measure staff individual performance.

Governance

The trust had introduced consistent systems to check the teams’ performance and make changes when necessary at a local and trust level. Staff had implemented recommendations from reviews of deaths, incidents, complaints, and safeguarding alerts. They undertook or participated in clinical audits and acted on the results when needed. They understood arrangements for working with other teams, both within the provider and externally, to meet the needs of the children and young people.
However, the service did not ensure it met the needs of all children and young people, as they did not deliver all the psychological therapies recommended by the National Institute for Health and Care Excellence (NICE). There was no provision for young people with attention deficit hyperactivity disorder or autism spectrum disorder who were excluded from the service. Although there was discussion with the clinical commissioning group the actual situation had not improved since the last inspection in 2016.

There remained no out of hours provision for young people. Young people admitted to hospital at the weekend had to wait until the following Monday before being assessed by staff. Young people at this inspection and at our last in 2016 raised concerns about this issue.

The trust have not provided a board assurance framework for this inspection.

The trust have not provided a risk register for this inspection.

**Management of risk, issues and performance**

The service had an effective system for identifying risks. The trust kept a risk register on the electronic reporting system. The team manager could escalate risks to the trust wide risk register. There was not a separate risk register for the service. In 2017, all staff were trained in clinical risk and use of the electronic reporting system. The service had plans for emergencies like adverse weather which was known to all the team.

**Information management**

The service had a systematic approach to continually improving the overall quality of its service. The manager could quickly access a business performance report on the new electronic system. However the manager did not use key performance indicators to measure staff individual performance.

**Engagement**

The team engaged well with children, young people and their families. They listened to feedback from parents and young people, supported them and made changes because of the feedback. The team had developed more workshops based on feedback and made changes to the equipment in the waiting area.

**Learning, continuous improvement and innovation**

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No details were provided on relevant services within this core service that have been awarded an accreditation.

The service was not fully committed to improving services by research or innovation. The team was not working towards any quality accreditation scheme. However, since the last inspection in 2016, they had developed an eating disorder service and staff attended training to develop cognitive behavioural therapy skills.
# Community mental health services for people with a learning disability or autism

## Facts and data about this service

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team name</th>
<th>Number of clinics</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthur Webster Clinic Shanklin</td>
<td>Arthur Webster Clinic Learning Disabilities</td>
<td>-</td>
<td>mixed</td>
</tr>
</tbody>
</table>
Is the service safe?

Safe and clean environment
The service shared premises with other community health services. All areas were clean with good furnishings. Cleaning records were up to date.

Interview rooms had alarms fitted, although one was inaccessible to staff behind an examination couch. Staff had mitigated this by use of a personal alarm.

Safe staffing
The service currently had one vacant post that was being covered by an agency nurse. This was reported following the submission of data. The team manager was currently an interim post as the manager was backfilling another specialist post within the team. There was evidence of planning for future staffing issues. For example, the acting team manager discussed plans to cover two posts due to upcoming maternity leave.

Staff reported low, manageable caseloads. Nurses reported an average of 12 cases each. The team manager told us that caseloads were discussed in individual supervision. However there was no evidence of regular caseload management occurring, for example one record reviewed had no activity from April 2017 until a discharge letter was completed in December 2017, however it was still showing as an active case on the clinicians caseload.

Staff reported easy access to the psychiatrist when they need support or reviews. However, there were disagreements within the service surrounding the best use of the psychiatrists’ capacity that had not been resolved. For example, staff discussed the need for more outpatient clinics however the psychiatrist did not agree.

Staff reported that service users could see the psychiatrist quickly. We spoke to five carers and one service user, they confirmed that this was the case.

Definition
Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
<th>30 September 2017</th>
<th>20.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of substantive staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of substantive staff leavers</td>
<td>October 2016 – September 2017</td>
<td>2</td>
</tr>
<tr>
<td>Average WTE* leavers over 12 months (%)</td>
<td>October 2016 – September 2017</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vacancies and sickness</th>
<th>30 September 2017</th>
<th>0.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total vacancies overall (excluding seconded staff)</td>
<td>October 2016 – September 2017</td>
<td>4%</td>
</tr>
<tr>
<td>Total permanent staff sickness overall (%)</td>
<td>October 2016 – September 2017</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establishment and vacancy (nurses and care assistants)</th>
<th>30 September 2017</th>
<th>8.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment levels qualified nurses (WTE*)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Establishment levels nursing assistants (WTE*) NA X
Number of vacancies, qualified nurses (WTE*) 30 September 2017 0
Number of vacancies nursing assistants (WTE*) NA X
Qualified nurse vacancy rate October 2016 – September 2017 7.1%
Nursing assistant vacancy rate NA X

Bank and agency Use

Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) NA NA
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) NA NA
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) NA NA
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) NA NA
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) NA NA
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) NA NA

*WholeTime Equivalent

Staff Fill Rates

This core service reported an overall vacancy rate of 7.1% for registered nurses from October 2016 to September 2017.

April 2017 and May 2017 saw the highest vacancies in registered nursing and midwifery staff, with 2 vacancies in both months. These vacancies have now been filled and since July 2017, there have been no vacancies.

This core service has reported a vacancy rate for all staff of 4% from October 2016 to September 2017.

This has been influenced by the additional clinical services staffing group which had a vacancy rate of -1.1% from October 2016 to September 2017, demonstrating a surplus number of staff in this staffing group.

This core service had 2 (9.9%) staff leavers from October 2016 to September 2017. Both of these staff leaver were from the Nursing and midwifery staffing group. One left in February 2017 and one left in March 2017. This was similar to the core service average of 8.6% for this time period.

The sickness rate for this core service was 4.9% from October 2016 to September 2017. The most recent month’s data (September 2017) showed a sickness rate of 6%.

The sickness rate recorded for nursing and midwifery staff was 6% from October 2016 to September 2017.

This was higher than the trust’s overall sickness rate of 4.3% for this twelve month period.

The trust set a target of 85% for completion of mandatory training.
The compliance for mandatory training courses from April 2017 to October 2017 was 82%. This did not meet the trust's target of 85%. Of the training courses listed seven failed to achieve the trust target and of those, five failed to score above 75%.

Training courses with the lowest completion rates were people handling, with zero out of one eligible member of staff having completed this, and prevent training levels 1&2 with six out of 22 eligible members of staff having completed this (27%).

Key:

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service</th>
<th>Trust target %</th>
<th>Trust wide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance: A Beginners Guide</td>
<td>100%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>100%</td>
<td>85%</td>
<td>96%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>100%</td>
<td>85%</td>
<td>69%</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>100%</td>
<td>85%</td>
<td>98%</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>100%</td>
<td>85%</td>
<td>77%</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>95%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>95%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>95%</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>95%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>94%</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>92%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>90%</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>89%</td>
<td>85%</td>
<td>83%</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>88%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>86%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Fire Safety Part 1 – Theory</td>
<td>86%</td>
<td>85%</td>
<td>92%</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>85%</td>
<td>85%</td>
<td>93%</td>
</tr>
<tr>
<td>Load Handling</td>
<td>78%</td>
<td>85%</td>
<td>76%</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>77%</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>72%</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>67%</td>
<td>85%</td>
<td>73%</td>
</tr>
<tr>
<td>Adult Resuscitation - Non-Clinical Staff</td>
<td>50%</td>
<td>85%</td>
<td>74%</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>27%</td>
<td>85%</td>
<td>54%</td>
</tr>
<tr>
<td>People Handling</td>
<td>0%</td>
<td>85%</td>
<td>74%</td>
</tr>
<tr>
<td>Core Service Total %</td>
<td>82%</td>
<td>85%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Staff had not received sufficient mandatory training to support them to deliver their role safely. We saw evidence that the team were 86% compliant at the time of the inspection. However there were areas of mandatory training which were below 75%. Care planning and hand hygiene was 71%, fire safety 70%, mental health 58%, disability awareness was 50%, health and safety 50%, risk management training 50% and safeguarding adults' level 2 was 33%.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff within the service no longer used a recognised risk assessment tool. At our last inspection, staff had been using a standardised core assessment and all records had risk assessments as
part of that core assessment. The improvement program the trust was undertaking had led to the core assessment on the electronic record system being revised. However, when it was implemented it was found by staff not fit for purpose for people with a learning disability. Due to this staff were told not to use the core assessment by senior managers in an email sent in January 2018. This meant that new service users were not having standardised assessments and risk assessments completed. A clear picture of a service users risks was not immediately apparent despite evidence of risk being considered in the 12 electronic records we looked at. Staff commented on risk in their clinical notes and letters.

Staff discussed risk in multi-disciplinary team (MDT) meetings and responded promptly to the service users need. For example we saw evidence of urgent appointment being arranged following concerns raised at the MDT.

Management of patient risk
Staff responded quickly when services contacted them with concerns about any deterioration in service users’ presentation. We spoke with six carers and two service users who confirmed this to be the case. We also spoke with staff at two supported living placements who reported the same. However, two carers and one service user reported difficulties in getting through to talk to someone in the office as there was only one dedicated telephone number to contact the team.

There was evidence that the waiting list was monitored and patients were assessed and prioritised according to risk. Staff kept a spreadsheet that showed when service users were referred and how long they had been waiting. This included a summary of risk and what had been done so far.

Staff no longer had personal alarms for use in the community as staff in the service had not used them and they had been removed on cost grounds. The service had developed a buddy system that all staff said was effective. Where there were known concerns, staff worked in pairs to manage the risks. There appeared to be a good safety protocol in place that staff followed. Staff followed the trust lone working policy and kept their diaries up to date to reflect where they were.

Safeguarding
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust only submitted information on safeguarding referrals at a trust wide level so this data cannot be reported per core service.

Only 33% of staff were trained in safeguarding adults’ level 2, this training was renewed every three years. Staff told us that the training was not available until September 2018. Staff were able to demonstrate a good understanding of safeguarding and give examples of partnership working with the local authority to address concerns. Records reflected this.

Staff access to essential information
The electronic records system was where information about service users’ care was stored. Information was not easily accessible and was often stored in different areas of the electronic notes. The trust was working to address some of the issues in the electronic records and there
was a working group specifically looking at the needs of the learning disability service which some members of the service attended.

**Medicines management**

Medicine was not stored at the clinic as patients had this in their own homes or supported living placement.

There were regular reviews for service users prescribed medicine. These included recording behavioural observations as well as physical observations. For example, in the treatment of a service user with attention deficit hyperactivity disorder where a support worker completed observations in the service users home before the medicine review in line with guidance from the national institute for health and care excellence (NICE).

**Track record on safety**

There were no serious incidents reported in the last 12 months.

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

Incidents were reported on an electronic system. The team manager reported that staff were good at reporting incidents. Staff we spoke with were aware of how to report incidents. We saw evidence of incidents which had been reported and how they were managed. Staff were aware of the duty of candor and there was evidence of staff being open with patients and carers in the electronic notes we looked at.

Lessons learnt from incidents were discussed in the multi-disciplinary team (MDT) meeting.

**Is the service effective?**

**Assessment of needs and planning of care**

Staff completed comprehensive assessments of each service user. Since the trust had stopped staff using the core assessment, assessments were not always easy to find in the clinical records.

Staff were recording the assessments in different areas of the system. Clinical information about the service user was difficult to find.

Assessments considered physical health needs.

Care plans were not always easy to find on the electronic recording system. They were recorded in clinic letters or individualised plans that were then uploaded. However, they were personalised, holistic and considered the service user’s needs. Staff reviewed and updated them when necessary.

**Best practice in treatment and care**

Staff demonstrated a clear focus on service users physical health needs and considered its impact in their interventions in all records reviewed. On an observed review, the nurse knew which GP the service user was under when considering the possible impact of constipation on behaviour.

Service users did not always receive annual health checks and health action plans from their GP. Managers in the service were working to address this with local practices and the care commissioning group (CCG). We saw evidence that out of 912 patients only 120 (13%) of service users had an annual health check. The team manager also explained that not all services users would have registered with their GP as having a learning disability. The team manager was liaising with the CCG about this and there were efforts made by the service to ensure that the GP was monitoring service users’ physical health needs.
The service had a dedicated nurse working with service users to prepare them for physical health interventions. This also involved supporting carers with the process and liaising with acute health services. One supported living manager said that this was a major benefit to service users in helping them get medical care. Care plans and interventions for this were detailed, comprehensive and considered capacity and consent.

Staff delivered a range of evidenced based care and treatment interventions that were suitable for people with a learning disability. These were in line with National Institute for Health and Care Excellence (NICE) guidance. For example, care plans for behaviours that challenge were comprehensive and based on positive behaviour support. The care plan quoted the relevant NICE guidance (NG11). Care plans for service users with epilepsy included detailed risk assessments and interventions that referenced the 2012 NICE guidance and other research such as a medical journal article on sudden unexpected death in epilepsy.

**Skilled staff to deliver care**

The team were fully staffed and had all professions required for the service. Staff were experienced and qualified for their roles. Staff reported that the speech and language therapist was not based in with the rest of the team which meant it was more difficult to access.

Staff were offered supervision. However, in the six staff supervision records reviewed, none were having regular supervision. The supervision frequency varied and was not in line with trust policy. The quality of supervision record varied, for example, some were recorded on a standardised electronic template and others were hand written without following any agenda. We looked at six staff personal files that showed that supervision was not completed monthly. This was not in line with the trust supervision policy that stated that supervision should be completed monthly.

The trust’s target rate for appraisal compliance is 100%. From October 2016 to September 2017, the overall appraisal rates for non-medical staff within this core service was 67%.

At the time of the inspection all staff had received an annual appraisal. Staff appraisals included conversations about career development and how it could be supported. The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 90% reported in the previous year.

Staff felt that they had good access to training and development and that the trust supported the logistics to access courses and conferences.

<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD/Autism/ADHD</td>
<td>24</td>
<td>16</td>
<td>67%</td>
</tr>
<tr>
<td>Core service total</td>
<td>24</td>
<td>16</td>
<td>67%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2,730</td>
<td>1,433</td>
<td>53%</td>
</tr>
</tbody>
</table>

The trust’s target rate for appraisal compliance is 100%. There was no medical appraisal information provided for this core service.
Multidisciplinary and interagency team work

The team had weekly multi-disciplinary team meetings. There was evidence that these meetings were productive and followed an agenda. Staff were able to raise concerns, discuss risk and ensure that patients were receiving the correct care and treatment.

Records showed very good joint working and liaison with general practitioners and other health professionals. For example, staff used assessments and records from the community health service to help in the delivery of a continence intervention.

Staff had good working links with other partner organisations to support service users care. There were positive relationships between staff and the managers of local supported living provision. Staff in supported living environments said that staff in the community learning disability team treated them as equal partners and respected their knowledge of the service users and their skills.

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

MHA specific training was not completed by staff as the trust had not made this part of the teams mandatory training. However staff we spoke to appeared to have a good knowledge of the Mental Health Act. The trust intranet site had access to policies and procedures relating to the Act. Staff were able to navigate the trust intranet site and all staff reported that they could find the information when required.

There were no current services users on a community treatment order. Staff were able to explain how they had managed this previously in line with the code of practice.

As of 7 October 2017, no members of staff were listed as being required to complete or having completed Mental Health Act training.

Good practice in applying the Mental Capacity Act

Mandatory training covered the Mental Capacity Act (MCA), 91% staff had completed the training.

Staff we spoke to appeared to have a good knowledge of both the Mental Capacity Act. The trust intranet site had access to policies and procedures relating to the Act. Staff were able to navigate the trust intranet site and all staff reported that they could find the information when required.

The majority of service users had significant learning disabilities and did not have verbal communication skills. Staff considered this carefully in their interactions with service users and their carers.

Consent for interventions were considered on a decision specific basis. For example, the service arranged a capacity assessment for a service user with complex health needs who was refusing food and drink. A referral to an independent mental capacity advocate (IMCA) was completed to ensure the service user had an independent voice in the decision making process.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff spoke about service users and carers with dignity and respect. This was also evident in how they addressed them in assessments and correspondence.
In interactions with service users, staff gave patients time to respond and used their preferred communication methods. When faced with aggression from a service user who did not have verbal communication skills, staff correctly interpreted this as them not wanting to communicate at that time, and gave them the space they required whilst remaining calm and polite.

We spoke with two service users, one reported that they thought the service was excellent and the other said it was very good. The service users said that staff treated them with dignity and respect and understood their care needs. They also reported that the service was responsive to their individual needs.

We spoke with six carers, they all reported that they thought staff treated the service user professionally and support and was good overall. All of the carers we spoke with reported that staff appeared to understand the needs of the service users and that staff adapted their approach to communicate.

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

**Involvement of patients**

One service user said that they had needed their medication reviewing following a change in their circumstances, staff dealt with this quickly and efficiently.

Staff communicated with service users in a manner that they could understand. For example, for service users with literacy issues staff used simple wording or pictures to explain the care plan including the use of social stories.

**Involvement of families and carers**

Staff involved families and carers to understand service users likes, dislikes and specific needs where appropriate. For example, if the service user had significant communication difficulties.

Carers said that they felt staff involved in them in care planning and that they felt supported and involved. All of the carers we spoke with reported that they were able to contact the service users care coordinator. All carers reported feeling involved in the care of the service user.

Carers reported that they received copies of letters that were sent to the GP about the service users’ care.

**Is the service responsive?**

**Access and waiting times**

The service had a clear referral process that the team followed. Patients were seen within the trusts own referral criteria.

Service users were assessed quickly when referred to the service. However, there was a waiting list to receive treatment. At the time of the inspection, three service users had waited longer than the national target of 18 weeks for treatment. The three service users waiting for treatment were discussed weekly at the multi-disciplinary team (MDT) meeting and risk was assessed. We saw evidence of how the waiting list was managed and there was a clear understanding of the needs and risks of the services users. At the time of the inspection there were 22 service users waiting for treatment, 19 were waiting to see a psychologist.

External partners in social care said that the service was very responsive and staff were always available to give telephone advice if the young persons allocated worker was unavailable. If a
supported living environment requested a visit then this was facilitated quickly. However, one service user reported that they found it difficult to get through to the office to speak to staff as there was only one telephone number to contact staff.

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The core service had no referral to assessment targets or assessment to treatment targets for teams in this core service.

The attention deficit hyperactivity disorder (ADHD) and Autism service was run and reported on separately to the LD service.

<table>
<thead>
<tr>
<th>Name of team</th>
<th>Service Type</th>
<th>Days from referral to initial assessment</th>
<th>Days from assessment to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>National target</td>
<td>Actual (mean)</td>
</tr>
<tr>
<td>LD - PARIS Recorded</td>
<td>-</td>
<td>-</td>
<td>37</td>
</tr>
<tr>
<td>ADHD - PARIS Recorded</td>
<td>-</td>
<td>-</td>
<td>138</td>
</tr>
<tr>
<td>AUTISM - PARIS Recorded</td>
<td>-</td>
<td>-</td>
<td>195</td>
</tr>
</tbody>
</table>

The facilities promote comfort, dignity and privacy

The service had access to a range of rooms for interviews. However, they were rarely used as most service users were seen in their own homes. The interview rooms were sound proofed.

Meeting the needs of all people who use the service

The trust had made reasonable adjustments to the building. At our last inspection, we raised concern about the main door being difficult to open for wheelchair users. Although the door was still in place, a clearly marked bell had been installed at an appropriate height to enable wheelchair users to call for assistance in entering the building.

The building had large easy read pictorial signs for the reception and toilets.

Information about local services was readily available in the waiting room. Community staff had access to a range of accessible information that they would provide to service users and carers as appropriate.

The service provided information to service users in accessible format when required. For example, in the use of social stories to prepare them for hospital admissions.

Listening to and learning from concerns and complaints

The trust did not provide any data on concerns and complaints. The service manager said that there no current complaints about the service. Service users and carers we spoke with knew how raise concerns and how to complain.
There were no formal complaints reported for the service over the last 12 months.

There were no complimentary reported for the service for the last 12 months.

Is the service well led?

Leadership
The interim team manager had minimal management experience although had good knowledge of the team and service and was clinically experienced.

Vision and strategy
Staff were aware of and shared the trust's visions and values. The trust values and vision was available on the trust intranet which staff were aware of.

Staff expressed concerns that they had not been involved with the transformation plan and future relationship with the local authority services. Staff reported feeling out of the loop and did not know what was happening.

The service was not taking positive action to support the national Transforming Care programmes aim of reducing hospital admissions for people with learning disability or autism. The service was not effectively monitoring the progress of service users who had been placed out of area. Staff and managers were unable to confirm the numbers of service users in hospital when asked and had to review records to identify all cases. The lack of caseload management meant that there had been limited or no contact with some hospitals where service users were placed. One record had no care programme approach (CPA) documents since 2016 and the last entry had been in July 2017 when the service user had contacted the service to request to speak to the care coordinator and this had not been followed up. Another stated in November 2017 that a home visit to a potential new social living provider should occur in December 2017 to help facilitate a return to the island, but there were no further entries to say if this occurred. Staff had not attended any CPA meetings for another service user since 2016. Only one of the four records sampled showed ongoing engagement and monitoring to help facilitate a return to the local area.

The interim team manager was had limited management experience and had not been offered development opportunity by the trust. There were no leaderships course available for staff to develop skill within the trust.

Culture
Staff felt supported by leadership within the team. However, were a little unsettled about future management arrangements. The current team manager post was an interim post as the substantive team manager was seconded into a specialist role within the team. At the time of the inspection, staff did not know how long these arrangements would be in place.

Staff felt able to raise concerns without the fear of retribution. Staff reported feeling confident to raise a concerns through senior manager and knew how to raise concerns. Staff were aware of the whistle blowing process and how to use it. Staff were able to show me the process on the trust intranet.
Managers supported staff with health needs. For example, a sit-stand desk had been provided for a team member.

Staff were nervous about the upcoming joint transformation program with the local authority and did not feel fully informed or engaged with the process by leadership within the team or by the trust.

Staff still felt distant from the trust but did feel that communication from senior leaders had improved from both the chief executive and leadership within the mental health business unit. Staff reported senior managers being more visible and visiting the service over the past year.

Conflicts between staff were not managed quickly by senior managers. There were tensions within the leadership of the service. There was not clear understanding or appreciation of each other’s different roles and responsibilities.

During the reporting period there were no cases where staff have been either suspended or placed under supervision.

**Governance**

There was not a robust oversight of governance for the service. The acting manager did not have the experience and the trust did not offer the opportunities to develop.

The trust have not provided a board assurance framework for this inspection.

**Management of risk, issues and performance**

The service did not have any concerns which were on the risk register. Staff were aware of and had access to the trust risk register.

**Information management**

Information about service users’ care was not easily accessible and was often stored in different areas of the electronic notes. The trust was working to address some of the issues in the electronic records and there was a working group specifically looking at the needs of the learning disability service which some members of the service attended. The improvement program the trust was undertaking had led to the core assessment on the electronic record system being revised, however when it was implemented it was found by staff not fit for purpose for people with a learning disability. This meant that new service users were not having standardised assessments and risk assessments completed. Staff commented on risk in their clinical notes and letters, however a clear picture of a service users risks was not immediately apparent.

**Engagement**

Staff had access to the trust intranet and were able to keep up to date with developments, news and changes.

Staff have raised concerns that they do not feel involved in the transformation plan.

Service users and carers we spoke to were not currently involved in decisions about the service and were not involved in the transformation plan.

**Learning, continuous improvement and innovation**

The trust was participating in the Learning Disability Mortality Review Programme which was ongoing at the time of the inspection.

The trust have not been awarded any accreditations for this service.
The emergency and urgent care service (EUC) for the Isle of Wight Ambulance service is located on the site of St. Mary’s Hospital in Newport. The EUC ambulance station is located on the hospital campus but separate from the main hospital buildings.

During our inspection, we spoke with 33 staff, inspected three vehicles and observed three episodes of care.

The staff we spoke with included frontline ambulance crew, community practitioners, receptionists, clinical support officers, performance support officers and managers.

We inspected the whole core service and looked at all five key questions.

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive? and
- Is the service well led?
Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

In emergency and urgent care services, both allied health professional staff and estates and ancillary staff failed to meet the target, with allied health care staff having 82% and estates and ancillary staff having 63% compliance overall.

Mandatory Training Completion by module – Allied health professionals

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>45</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>45</td>
<td>97.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>45</td>
<td>97.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>45</td>
<td>97.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>45</td>
<td>95.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>45</td>
<td>93.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>45</td>
<td>93.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>45</td>
<td>93.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>44</td>
<td>93.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>45</td>
<td>91.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>44</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>45</td>
<td>86.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>45</td>
<td>86.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>45</td>
<td>84.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>45</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling</td>
<td>45</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>45</td>
<td>75.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>45</td>
<td>33.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>46</td>
<td>4.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Allied health professionals working in emergency and urgent care ambulance services met the trust’s target for 13 out of the 19 courses listed above. Training courses with the lowest compliance included prevent training levels 1 & 2 (15 out of 45 members of staff completed this) and the mental capacity act (two out of 46 members of staff completed this).

Mandatory Training Completion by module – Estates and ancillary

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Display Screen Equipment</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: A Beginners Guide</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load Handling e-Learning</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>48</td>
<td>87.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>48</td>
<td>87.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>48</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>44</td>
<td>81.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>48</td>
<td>79.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>44</td>
<td>77.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>48</td>
<td>72.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>44</td>
<td>68.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>48</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>People Handling</td>
<td>44</td>
<td>63.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>48</td>
<td>62.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Resuscitation</td>
<td>44</td>
<td>59.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>48</td>
<td>58.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>48</td>
<td>56.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>44</td>
<td>54.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>44</td>
<td>43.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Load Handling</td>
<td>4</td>
<td>25.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>48</td>
<td>8.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>27</td>
<td>7.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Estates and ancillary staff working within urgent and emergency care ambulance staff met the trust’s target for six out of the 22 training courses listed above. Training courses with the lowest compliance rates included prevent training levels 1 & 2 (four out of 48 members of staff completed this) and the mental capacity act (two out of 27 members of staff completed this).

(Source: Trust Provider Information Request)

Managers monitored compliance with mandatory training and reminded staff of upcoming training to complete every month. Ambulance crews kept track of their training using the trust learning management system. We saw mandatory training compliance was reviewed at clinical quality and effectiveness group meetings every month. Clinical education, which included mandatory training, was a standing agenda item; we saw minutes of meetings which confirmed managers discussed low compliance rates and measures for improvement.

Managers in the service recognised the challenges for frontline operational staff to achieve compliance with training rates. We saw an example of an email sent by managers encouraging staff to utilise time in between jobs to undertake online training. Staff told us they found it challenging to find time to access online training modules during their shifts. Managers told us there were operational challenges releasing staff for classroom or face-to-face training. However, both managers and staff told us that the situation was improving.
There was no hazardous area response team (HART) based on the island, an agreement was in place with the nearest HART based on the mainland. The expected response time of this team was two hours.

Prior to our inspection the service had been inspected by the National Ambulance Resilience Unit (NARU). At the time of our inspection the report from this inspection was not available; however the trust informed us of the verbal feedback they had received. They told us that the service was non-compliant against some national requirements including having suitably trained staff available to deal with chemical, biological, radiological and nuclear (CBRN) incidents. This was around the use of CBRN protective clothing and decontamination.

The trust had taken immediate action and was working with the NARU to ensure they provided the required training.

**Safeguarding**

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

**Safeguarding Training Completion by module – Allied health professionals**

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for allied health professionals is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>45</td>
<td>97.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>45</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>44</td>
<td>59.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>45</td>
<td>33.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Allied health professionals working within emergency and urgent care ambulance service met the trust’s target for one of the three safeguarding modules; safeguarding children level 1. Lower compliance rates were seen for the other two with only 26 out of 44 (59%) members of staff having completed safeguarding children level 2.

**Safeguarding Training Completion by module – Estates and ancillary**

A breakdown of compliance for safeguarding courses April 2017 to September 2017 for estates and ancillary staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>48</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>48</td>
<td>45.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>44</td>
<td>20.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Estates and ancillary staff working within urgent and emergency care ambulance services met the trust’s target for one of the three safeguarding courses; safeguarding children level 1. Notably, there were really low compliance rates seen for safeguarding children level 2 with only nine out of 44 (20%) members of staff having completed this.

(Source: Trust Provider Information Request)
Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, we were not assured safeguarding adults, children and young people was given sufficient priority as staff training rates for safeguarding adults level 1 and safeguarding children level 2 were low.

The ambulance safeguarding lead reported operational staffing challenges in releasing staff for safeguarding children level 2 classroom training.

Frontline ambulance staff we spoke with understood how to recognise safeguarding concerns and were aware of the warning signs that might make them raise a safeguarding alert.

Staff could describe the process for raising a safeguarding alert. Frontline staff were stood down from their shift to enable them to complete the safeguarding referral form.

Safeguarding policies were clear and the ambulance service had additional safeguarding protocols for vulnerable groups.

Information regarding safeguarding was displayed on a noticeboard in the crew room at the ambulance station. The noticeboard included contact details of the ambulance and the trust level safeguarding lead, adult at risk flowchart, child protection awareness information, domestic violence helpline and the Isle of Wight safeguarding newsletter.

**Cleanliness, infection control and hygiene**

At our last inspection, cleaning products were not stored securely and in line with the Control of Substances Hazardous to Health (COSHH) requirements. During this inspection we found all COSHH cleaning products to be in a locked store at the ambulance station.

All vehicles we inspected were visibly clean, tidy and well stocked. We saw records which confirmed the vehicles had been cleaned and re-stocked daily, and that they had a monthly deep cleans. However, the service was not auditing these records to ensure consistency and effectiveness.

Staff told us swabs were not routinely taken for testing to monitor the effectiveness of the deep clean. This is considered best practice. However, we were told by the make ready team that if the vehicle had transported a patient known to be infectious then the trusts infection prevention and control team would swab the vehicle to ensure there were no signs of any residual risk.

Staff had access to spare linen on the vehicle and were able to re-stock their vehicle with linen from the emergency department (ED). We observed staff cleaning stretchers with disinfectant wipes after handing over their patient to ED staff and refreshing linen stocks.

Make ready staff were responsible for cleaning and re-stocking vehicles from 7am to 11pm. Outside of these hours, ambulance staff would swap to another vehicle if theirs could no longer be used and needed to be cleaned. A notice would be placed on the windscreen if a vehicle was not available to be used operationally for any reason.

Different coloured cloths were used to clean the inside and outside of the vehicles and disposable mop heads to reduce the risk of cross infection.

Coloured waste bins were provided in order that staff could separate waste according to type, for example general waste from soiled waste. Waste bins, including the sharps bin, were kept locked to prevent unauthorised access. Porters collected the clinical waste from the station on a daily basis.
Staff were provided with sufficient uniform, so they could change during their shift if necessary. There was limited space for storage for staff which made it difficult to store spare uniform and personal belongings.

Staff were responsible for cleaning their own uniform. Should their uniform become soiled or contaminated during the course of their work then it could be disposed of in the clinical waste at the station.

We saw staff followed best practice and the trusts infection prevention and control policy to minimise the risk of the spread of infection between staff and patients. We observed staff cleaning their hands prior to and after providing care and wearing gloves. Staff used personal protective equipment, such as gloves and aprons to protect themselves from contact with infectious materials. These were provided for staff both on vehicles and at the station.

Most staff we observed adhered to the bare below the elbow guidance. However, there was some inconsistencies with staff wearing watches that did not adhere to trust policy. Trust policy stated ambulance staff should wear fob watches or a watch may be worn if the strap can be effectively cleaned.

The service did not have an infection prevention control policy specific to the ambulance service but worked with the trust policies. The service had a link to the hospital infection prevention and control (IPC) team. However, we were not assured the service had identified and mitigated risk regarding controlling infection, for example they did not have ambulance service specific policies for uniform and IPC.

**Environment and equipment**

At our last inspection, we found the ambulance station was not secure as a faulty garage door had been removed. During this inspection we found the door had been fixed and the station to be secure.

In addition, at our last inspection security of vehicles was a concern. During this inspection we found all vehicles locked when not being used by crews or being attended to by the make ready team. Operational staff kept keys with them and other keys were stored securely on the station. The service also carried out daily security checks on vehicles at the station. We saw records confirming these checks took place and that vehicles were secure at all times.

Each vehicle had the capability to transport children safely. There was access to a car seat and ambulance stretchers had additional straps so that children could be secured safely.

At the last inspection, there were issues with the mobile data terminal on vehicles. The issues included an unreliable network across the island. This meant that crews often found there mobile data terminals lost connectivity to the system while on a call and driving around the island.

During this inspection we found the issue remained as the service had yet to update its computer aided dispatch (CAD) system. Due to issues with the CAD system, the service did not have access to accurate real time information regarding the position of vehicles and crews. This was a risk to patients as there was a risk of a delay in dispatch of ambulance resources. The was because the dispatcher would need to radio crews to confirm their location before making a decision about which vehicle to dispatch.

This was also a potential risk to staff as the service, due to the unreliable network connectivity issues, they would not be aware of the exact location of crews at all times. This also affected the satellite navigation system used by the crews, which meant they had to rely on their local knowledge of the island or a map to find a patients address.
All vehicles had an up-to-date MOT, annual service and were insured. Vehicles had a safety inspection every six weeks.

As part of the NARU inspection, it had been identified that the CBRN suit decontamination did not meet NARU requirements. As a result the suits were immediately taken out of service and the trust suspended its CBRN capability through agreed national pathways. CBRN support was provided from another service based on the mainland.

There was not a full HART based on the island although the trust needed to be able to provide some aspects of this service. Following the recent NARU inspection NARU had donated some HART equipment and vehicles to the service to assist them in being able to provide a safe service to the agreed level. At the time of our inspection these vehicles were not in service, and therefore not inspected, however they included vehicles such as a command vehicle and a mass casualty vehicle.

Make ready staff used visual aids as a guide for re-stocking vehicles. This ensured consistency, as equipment was located in the same place in each vehicle. Crews were responsible for checking the vehicle and kit on their vehicle at the beginning of their shift. There were tamperproof tags on kit bags and storage within vehicles. This meant crews could be assured that the make ready staff had checked the contents and the kit was fully stocked.

Medical devices were maintained by the trusts Medical Electronics Department on an annual basis. If an item on a vehicle was found, or became, faulty staff told us that this would be reported using a defect form and would be repaired or replaced. During our inspection we saw staff reporting radio batteries that were losing their charge. These were replaced immediately and the crew were able to carry on with their shift.

An engineer from the manufacturer carried out an annual inspection of stretchers on vehicles. The engineer also inspected other manual handling equipment carried on vehicles. The engineer carried out repairs and maintenance on equipment inspected as required.

Manufacturers carried out an annually checks of the oxygen systems on vehicles and repaired or replaced equipment as required.

Assessing and responding to patient risk

Staff recognised and responded appropriately to the risks to people who use the service.

Staff used their training and clinical judgement to assess the patients’ condition. We saw crews carry out observations and assessments of patients using Joint Royal Colleges Ambulance Liaison Committee (UK) (JRCALC) protocols.

Patient, in the care of staff, were monitored patients using the modified early warning scoring system (MEWS). Staff used MEWS to detect signs of deterioration during their assessments.

Frontline crews had access to additional clinical support via the clinical support desk (CSD) should they need. We observed crews calling the CSD while on scene with a patient. We observed access to the CSD by frontline crews was timely and the conversation was held was concise and enabled the crew to manage the situation effectively.

Staff had access to care pathways and they could access these via the portal on their laptops. However, accessing the care pathways was sometimes unreliable due to poor network connectivity. If a crew saw signs of deterioration they contacted the emergency department, via the CSD using a pre-alert process, to escalate the priority level.

For example, there was a cardiac pathway based on the British Heart Foundation algorithm. We saw this pathway and escalation process being used effectively by crews during our inspection.
The service used co-responders and community first responders to support their service. We saw defined criteria regarding the type of call these volunteers could be sent to attend. The volunteers had clear parameters in which they could work. We were told that should they be faced with anything outside of these parameters, or their own experience, then they were advised to contact the CSD for further assistance.

During our observations of care we saw appropriate manual handling techniques used for the transfer of all patients. This ensured that staff and patient safety was maintained and injuries avoided.

Staff told us they were experienced at transporting patients experiencing a mental health crisis, although they had not completed specific training on this. Through the calls they responded to staff told us that they gained experience and understanding of support patients suffering a mental health crisis from colleagues and through dealing with the calls.

Staff told us that they would contact the police for assistance when responding to calls with a patient suffering a mental health crisis. The designated place of safety for adults in a mental health crisis was located at the main hospital site and for children the place of safety was located on a children’s ward within the hospital. All staff we spoke with were aware of what to do when transporting someone in a mental health crisis and where to take them when requested to do so by the police.

Emergency Operations Centre (EOC) staff and the electronic patient record form (ePRF) would flag addresses where there was known violence or aggression towards ambulance staff. For example, EOC staff would request the police to support frontline crews where appropriate.

**Staffing**

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 16% for allied health professionals working within emergency and urgent care services. Data for estates and ancillary staff was not sent by the trust.

(Source: Trust Provider Information Request)

**Turnover rates**

**Allied health professionals**

From October 2016 to September 2017, the trust reported an overall turnover rate of 8% for allied health professionals working within emergency and urgent care services.

**Estates and ancillary**

From October 2016 to September 2017, the trust reported an overall turnover rate of 1% for estates and ancillary staff working within emergency and urgent care services.

(Source: Trust Provider Information Request)

**Sickness rates**

**Allied health professionals**

From October 2016 to September 2017, the trust reported an overall sickness rate of 9% for allied health professionals working within emergency and urgent care services.

**Estates and ancillary**

From October 2016 to September 2017, the trust reported an overall sickness rate of 8% for estates and ancillary staff working within emergency and urgent care services.
There was no 24-hour Performance Support Officer (PSO) cover at the ambulance station. PSOs provided management, leadership and operational support to frontline crews during their shifts. PSOs worked 6.30am to 4.30pm and 1.30pm to 11.30pm on weekdays and 7am to 7pm during weekends. After 11.30pm until 6.30am during weekdays and between 7pm and 7am at weekends, there was a PSO on call. This meant that frontline crews and support staff, based at the station, did not have direct access to a manager at the station at all times.

The service planned to staff the service for eight double crewed ambulances; one paramedic and one Emergency Vehicle Operator (EVO) during the day; six ambulances starting from 6am in the morning and two ambulances commencing shifts from midday. This reduced to four ambulances at night and at weekends. Staff worked 12 hours shifts. We reviewed the rotas for the week of our inspection and found all shifts covered as planned with the exception of one late shift and one early shift across the 7-day period. Additional ambulance cover was provided by a private ambulance provider during the day.

The resource team used a messaging system to alert staff to outstanding shifts and unexpected available shifts such as due to sickness. The resourcing team worked with staff to cover shift with staffs being swopped or staff working additional hours. The total hours worked were monitored by the resourcing team.

Private ambulance providers were frequently used to provide additional frontline ambulance cover and to fill gaps in rotas. There was a regular private ambulance crew who worked for the service, which meant they were familiar with the trusts systems and processes. We were told the contract with the private provider stated that they would provide a double crewed ambulance (one paramedic and one EVO/Technician). We requested a copy of the contract after the inspection but this was not been provided.

Managers told us due to operational pressures and staff sickness, they had to staff an ambulance with a double EVO crew. The trust had a standard operating procedure for this eventuality, which we reviewed and which contained clear guidelines for EOC dispatch staff and for crews attending patients. The service had started to report this using the incident reporting system. At the time of the inspection there was no data available to demonstrate how often double-EVO crews had been deployed.

We requested the meal break policy from the service however, what we received took the form of a memorandum to all staff dated October 2016. Due to concerns raised by staff that the guidance was not being adhered to, for example breaks were being disturbed for non-emergency operational reasons, there had been an amendment issued by memorandum dated August 2017. This detailed when breaks should be taken and under what circumstances staff could reasonably be disturbed during their break. Staff told us, and we observed that they generally had a meal break during their shift.

All UK ambulance services have six levels of alert, based on demand and their ability to maintain an effective and safe operational and clinical response, which is known as the Resource Escalation Action Plan (REAP).

Normal routine operations would be at REAP Level 1 and at Level 6 there is potential service failure; at each level there are actions to protect every ambulance trust’s core services.

The service had an up to date Resource Escalation Action Plan (REAP). The current REAP level was displayed in the ambulance station. Contact numbers for escalation were displayed on the
walls with details of how to contact tactical commanders and tactical advisors, strategic commander, local ambulance trust, operational command.

During the week prior to our inspection, the service had been inspected by NARU to checking compliance against national resilience requirements. The service confirmed to us that they had been advised that they were non-compliant in some areas, including training staff in connection with CBRN responsibilities.

Immediately, and in response to this, the trust had liaised directly with NARU and other ambulance trusts to put in place an interim solution to cover the shortfall of appropriately trained staff. We were shown a tactical plan which outlined the trusts immediate response to become compliant against NARU's standards. We saw evidence of on-going discussion regarding the inspection and training plans which had been identified as part of the solution.

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

Ambulance staff recorded patient records on an electronic patient record (ePRF), which followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) 2017 guidance.

All ambulance staff received clinical supervision and had individual learning plans (ILPs). Audits of patients records were carried out as part of clinical supervision and the findings were detailed in ILPs for individual staff. We reviewed one ILP, and associated documentation audit, and found it to be completed comprehensively. The audit documentation included competency statements, expected level of competency, whether competency had been evidenced and detailed any subsequent actions or comments.

At the last inspection, we found concerns regarding the security of laptops which contained the ePRF. However, during this inspection we found vehicles locked at all times with laptops stored securely. We did not see any patient identifiable data on display on laptop screens and screens were locked when not in use.

Staff could access patient specific special notes via the ePRF. This gave staff important known information about the patient, for example if the patient had a do not attempt resuscitation order in place.

The staff told us they had some concerns regarding the availability of the system network which meant they did not always have access to the ePRF. If the system went down, staff completed a paper record and passed these to staff in the ED during handover/triage.

Each vehicle we inspected had blank paper records available for use. At the station we saw a locked metal box where copies of the paper would be stored securely prior to being filed.

**Medicines**

At our last inspection in 2016, we found that medicines were not stored appropriately at the ambulance station. On this inspection, we found that medicines storage had improved.

Security of the station had improved however, the medicines room and the ambulance storage spaces was still insecure. Staff were able to show us evidence that new security locks would be fitted within a week of the inspection. We saw that the new locks had been fitted when we returned for an unannounced inspection. These locks restricted access to authorised staff only.

The pharmacy department was monitoring room temperatures and fridge temperatures centrally. This ensured that medicines were stored at their optimum temperature.
We found that controlled drugs and controlled drug waste were managed appropriately both by staff on the ambulances and at the ambulance station. Drugs including controlled drugs were stored securely on vehicles in the medicines safe. Managers at the ambulance station carried out daily checks on controlled drugs and medicines, which ensured stock levels were maintained, recorded and managed correctly.

The paramedics and community practitioners used medicines covered by Patient Group Directions (PGDs). PGD is a written instruction, which allows healthcare professionals to supply and administer specified medicines to pre-defined groups of patients without a prescription. Staff received appropriate training in order to administer these medicines and there were guidelines available to them.

Paramedics signed out which morphine box they had taken. When paramedics administered morphine, they completed a form, which required them to record the quantity given and disposed of. This information was then transcribed into the controlled drugs book held at the station. The morphine box number was also recorded to enable the service to trace the number of vials that had been used from each tin.

Staff received additional and appropriate training in order to administer these medicines and there were JRCALC guidelines available.

We did not see staff administering medication to patients during our inspection. Staff told us they would explain to patients why they were giving a specific medication and they would document this in the patient electronic record. Staff did not provide written information to support these discussions.

Medical gases were stored appropriately at the ambulance station and on the ambulances. All medical gas bottles we inspected were in good condition and in date.

**Safety performance**

There were no clearly identified safety measures, therefore there was not a structured monitoring system and there was no information to demonstrate improvement against safety measures over time.

**Incidents**

Never Events

Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

From December 2016 to November 2017, the trust reported no incidents which were classed as Never Events for the emergency and urgent care service.

*(Source: Strategic Executive Information System (STEIS))*

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the emergency and urgent care ambulance service reported one serious incident (SI) which met the reporting criteria set by NHS England from December 2016 to November 2017.

This incident was reported as treatment delay meeting SI criteria.

*(Source: Strategic Executive Information System (STEIS))
Ambulance staff told us that they knew how to report an incident; however, staff did not always have time during their shift to report incidents on the trust system. Staff completed manual, paper-based documentation to record incidents and gave them to managers. Managers then told us these were then put on to an electronic incident reporting system used by the trust.

Managers told us, and ambulance crews confirmed that the feedback process from incidents was for staff to receive feedback through line managers. Managers would issues memo’s to all crews for issues and information relevant to the whole service.

We were not assured that staff used the incident reporting system to report risk to the service, for example with insufficient staffing levels on a shift or the lack of network stability. Staff told us that the feedback process was not always effective and so, in certain circumstances, they did not see the point of completing an incident form.

There was some evidence of local audit by the service of reported incidents to determine if there were any emerging themes. For example, audit had highlighted verbal abuse towards staff was a growing concern. An additional a manual process had been put in place prior to our inspection to capture specific instances of verbal abuse towards staff (including first responders) to allow for a more in-depth review.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency. It requires the providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Managers we spoke with were able to describe the requirements DoC and gave examples of when DoC had been invoked following an incident. We saw an example of DoC which had been invoked as part of a complaint raised by a relative of a patient. This demonstrated initial verbal contact with the relative, which was followed up by a letter. Once the complaint had been investigated a further letter detailing the outcome of the investigation was sent.

**Is the service effective?**

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

**Evidence-based care and treatment**

Ambulance service staff followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance when providing care and treatment to patients.

Staff were aware of ‘see and treat’ and the importance of maintaining a patient’s independence by not taking them to hospital if it was not clinically necessary. We observed a crew attending a patient in their own home. The crew did not convey the patient to hospital, as they were able to manage the situation. The crew placed a call to the clinical support desk and arranged a GP visit to the patient for the following day.

We saw all staff had been issued with and carried the 2017 JRCALC pocket guide. We staff referring to the guide when assessing patients.

Staff followed guidance and protocols if the police detained patients under section 136 of the Mental Health Act. The designated place of safety for both adults and children was located at the
hospital. Staff we spoke with were aware of their requirements and where the place of safety was for both adults and children.

Staff compliance with guidelines were assessed through clinical supervision and through their individual learning plan (ILP) review. We reviewed one ILP which contained evidence that adherence to JRCALC guidance had been checked.

Minutes of the ambulance clinical quality and effective governance meetings showed the following areas as standing agenda items: clinical outcomes and effectiveness, ambulance service clinical guidelines and clinical education. The service reviewed internal audits, national updates and clinical notices at this group and actions showed information was then disseminated to frontline staff accordingly.

The clinical support desk (CSD), located within the emergency operations centre, provided enhanced clinical advice and support via the telephone for crews. We observed crews calling the CSD for advice and support while attending a patient in their own home. The crew placed a request via the CSD for a GP to visit a patient the following day as the out of hours GP service had closed for the evening.

Evidence based care bundles and pathways were available in all the vehicles we inspected. These included specific pathways for patients presenting with symptoms of a stroke, patients suffering a mental health crisis and children presenting with signs of serious infections.

The trust submitted clinical performance indicator information to the National Ambulance Service Clinical Quality Group. This included information audited on measures against expected management of key conditions. This information was used to benchmark the service against other ambulance trusts and identify areas for improvement.

We saw copies of a clinical newsletter distributed to ambulance staff. This provided an updated on clinical matters, NICE guidelines, review of any procedures, information governance and details of both internal and external training courses that were available.

Pain relief

Paramedics were trained and able to give a range of pain medicines. These included medicines such as morphine and nitrous oxide gas.

We observed staff asking patients about their level of pain as part of their initial assessment. Staff asked patients to rate their pain level out of ten to enable them to gauge and record their level of pain.

We saw staff checking with patients, in their own home, if they had taken any of their own pain medication. As this meant, depending on when it had been taken, they may not be able to give any further medication.

We saw staff continue to check with patients if their pain score had altered and staff recorded the pain observations and medications on the electronic patient record form (ePRF).

Ambulances we inspected had a visual faces pain tool poster. This meant that patients who were unable to communicate verbally or did not speak English could point to the face which best represented their level of pain.

Response times

Category A calls
This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and measures that those patients who are most in need of an emergency ambulance gets one quickly.

- Category A, Red 1 (Cat A8 – Red 1): incidents may be immediately life threatening and should receive an emergency response within 8 minutes in 75% of cases.
- Category A, Red 2 (Cat A8 – Red 2): incidents may be life threatening but less time-critical and should receive an emergency response within 8 minutes in 75% of cases.
- Category A, Red 1 and Red 2 (Cat A19): incidents may be immediately life threatening and should receive an ambulance response within 19 minutes in 95% of cases.

**Category A calls**

![Graph showing proportion of Red 1 and Red 2 calls responded to within 8 minutes in England and ISLE OF WIGHT]

For the period from August 2016 to July 2017, the trust performed worse than the England average for Red one calls but better than the England average for Red two calls.

**Proportion of Red 1 calls responded to within 8 minutes**

From April 2016 onwards, Category A (Red 1 and Red 2) calls and Category C (Green 1, Green 2, Green 3, and Green 4) calls were replaced by the new Categories C1 to C4.

For these Trusts, from these dates, data for Category A (Red 1 and Red 2) calls are not available and are therefore not included in this chart and those that follow:

<table>
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<th>WMAS</th>
<th>EMAS</th>
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<td>8 Jun 2016</td>
<td>19 Jul 2017</td>
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From November 2016 to October 2017, the proportion of Red 1 calls responded to within eight minutes was in general similar to the England average. From May 2017 to October 2017, the trust’s proportion of Red 1 calls responded to within eight minutes was lower than the England average.

**Proportion of Red 2 calls responded to within 8 minutes**

Please note that until January 2016, for Isle of Wight the start time for Red 2 calls was the earliest of the following three possible trigger points:

- chief complaint or NHS Pathways initial disposition (Dx) code obtained;
- first vehicle assigned;
- 60 seconds after call connect.

For all other English ambulance trusts, the three in the list above changed to 240 seconds from October 2016 (before the start time for the data used in this report). For Isle of Wight, this changed to 240 seconds later, in February 2017. Therefore, Isle of Wight’s data for the period from November 2017 to January 2017 are not directly comparable with the data for England as a whole.

This change was based on clinical advice that allowing up to two additional minutes for triage, providing additional time to identify the clinical situation and take appropriate action, would be likely to improve the overall outcomes for ambulance patients.
Discounting the data from November 2017 to January 2017, as for these months the data is not directly comparable with the data for England as a whole, the trust has in general performed better than the England average. From February 2017 to October 2017, the proportion of Red 2 calls responded to within eight minutes was higher than the England average. April 2017 was the best performing month for the trust with 78% of Red 2 calls responded to within eight minutes, compared to the England average of 66% for the same month.

**Category A Red 1 calls**

95th percentile of time from call connect of a Red 1 call to an emergency response arriving at the scene of incident. A 95th percentile of 10 minutes means that 95% of emergency responses arrived in less than 10 minutes and more than 5% arrived in more than 10 minutes.

The data analysed was not in raw form, which did not allow us to calculate the 95th percentile of time from call connect of a Red 1 call to an emergency response arriving at the scene of incident. Category A calls responded with transport within 19 minutes

![Proportion of Category A calls responded with transport within 19 minutes](image)

From November 2016 to October 2017, the proportion of category A calls responded to with transport within 19 minutes was similar to the England average. However, the trust consistently failed to meet the standard (set at 95%) with the exception of two months; November 2016 and April 2017.
Proportion of Category A calls responded to with transport within 19 minutes by average over period.

The proportion of category A calls responded to with transport within 19 minutes by average the trust are performing similar to the England average.

Time to treatment of Category A calls

Time to arrival of a health professional dispatched by the ambulance service for Category A Red 1 and Red 2 calls, measured by median, 95th percentile and 99th percentile.

Time to arrival of an ambulance-dispatched health professional, measured by:

- Median time – the time below which 50% of incidents reported the arrival of an ambulance-dispatched health professional
- 95th percentile of times – the time below which 95% of incidents reported the arrival of an ambulance-dispatched health professional (for example “95% of incidents reported the arrival of an ambulance-dispatched health professional within [x] minutes”)
- 99th percentile of times – the time below which 99% of incidents reported the arrival of an ambulance-dispatched health professional (for example “99% of incidents reported the arrival of an ambulance-dispatched health professional within [x] minutes”)

[Diagram showing the proportion of Category A calls responded to with transport within 19 minutes by average, comparing the Isle of Wight to the England average.]
Time to treatment of Category A calls (Minutes)

Median

95th Percentile

99th Percentile
When comparing the trust to the England average for time to treatment of Category A calls using the median the 95th and the 99th percentile the trust were in general better than the England average from November 2016 to October 2017.

We saw performance information concerning response times to Red 1 and Red 2 calls displayed on noticeboards in the ambulance station. All staff we spoke with were aware of the targets and the how their role affected compliance against set targets. For example, they told us they understood the need for prompt handovers of patients at the ED so that they can become available for the next call.

Discussions regarding performance were held at trust executive meeting and reported on in the trust performance report.

The trust had declared the existing computer aided dispatch (CAD) system as outdated and not fit for purpose. This meant the service was unable to use reliable data to monitor its performance in a timely and efficient manner.

**Patient outcomes**

**Return of spontaneous circulation (ROSC)**

Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. The return of spontaneous circulation is calculated for two patient groups.

**ROSC Overall**

The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests.

From August 2016 to July 2017, the trust’s overall return of spontaneous circulation was in general lower than the England average. However, from January 2017, there was an increasing percentage trend from 5% to 56% in March 2017. March 2017 saw the highest proportion of patients who had return of spontaneous circulation on arrival at hospital, following resuscitation. From March 2017, this percentage has decreased to 10% in July 2017.
**ROSC Utstein comparator group**

The rate for the 'Utstein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls where the arrest was not witnessed, and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients, but are excluded from the Utstein comparator group figure.

From August 2016 to July 2017, the trust treated 22 patients in the Utstein comparator group. Of whom, 9 (41%) had a spontaneous return of circulation. This was lower than the England average across this 12 month period of 51%.

*(Source: NHS England – Ambulance Quality Indicators – Clinical Outcomes)*

**Acute ST-elevation myocardial infarction**

Heart attack, or ST segment elevation myocardial infarction (STEMI), is caused by a prolonged period of blocked blood supply. It is therefore vital that blood flow is quickly restored through clinical interventions such as thrombolytic ("clot-busting") treatment or primary percutaneous coronary intervention. In addition to these primary treatments, however, patients with STEMI need to be managed in the correct way, including the administration of an appropriate care bundle; that is, a package of clinical interventions that are known to benefit the health outcomes of patients. For example, patients should be administered pain relief medicines to help alleviate their ongoing discomfort. Early access to reperfusion (the restoration of blood flow) or thrombolysis and other assessment and care interventions is associated with reductions in STEMI mortality and morbidity.

This indicator reflects the three key interventions undertaken by ambulance services for these patients that are known to influence outcome: the indicator will define those patients who receive the appropriate care bundle, those who have timely delivery to the cardiac catheter lab for intervention, and those who have timely thrombolysis.

**Proportion receiving primary angioplasty within 150 minutes**

The trust did not have a primary angioplasty service on the island and therefore patients with an initial diagnosis of definite STEMI are required to be transferred off the island (either by air or ferry).

From August 2016 to July 2017, the trust treated 15 patients with initial diagnosis of definite STEMI who received primary angioplasty, where first diagnostic ECG performed is by ambulance personnel and patient. Of these, 8 (53%) received a primary angioplasty within 150 minutes. This was lower than the England average across these 12 months of 86%.
From August 2016 to July 2017, the proportion of patients with ST-elevation myocardial infarction who received an appropriate care bundle at this trust was worst than the England average for the first half of this 12 month time frame. From November 2016, the trust’s proportion of patients increased to 100% in May 2017, higher than the England average of 78% for the same month. From this peak of performance in May 2017, the trust’s percentage decreased to 67% in July 2017.

(Source: NHS England – Ambulance Quality Indicators – Clinical Outcomes)

Outcome from stroke

As set out in the NICE national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis.
From August 2016 to July 2017, the proportion of patients receiving thrombolysis within 60 minutes for this trust was in general better than the England average. March 2017 was the best performing month for the trust 86%, much higher than the England average of 55% for the same month.

**Proportion of suspected stroke patients assessed face to face who received an appropriate care bundle**

From August 2016 to July 2017, the trust’s proportion of suspected stroke patients assessed face to face who received an appropriate care bundle was similar to the England average. The trust’s average across this 12 month period was 98%, similar to the England Average of 97%.

*(Source: NHS England – Ambulance Quality Indicators – Clinical Outcomes)*

**Survival to discharge following cardiac arrest**

The presence of a paramedic (or doctor) significantly improves response to, and outcome from, a cardiac arrest, as the paramedic or doctor on scene can begin Advanced Life Support (ALS). By including both out of hospital and in-hospital periods of care, this measure reflects the effectiveness of the whole acute healthcare system in managing out of hospital cardiac arrest, reflecting the care delivered by both ambulance services and acute trusts.

Survival to discharge is calculated for two patient groups; the overall group, and the same Utstein comparator group.

**Proportion of patients discharged from hospital alive – all patients**

From August 2016 to July 2017, the trust treated 117 patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest. Of these 13 (11%) patients were discharged from hospital alive following a cardiac arrest. This was similar to the England average of 9% across this 12 month period.

**Proportion of patients discharged from hospital alive – Utstein comparator group**

From August 2016 to July 2017, the trust treated 22 patients in the Utstein comparator group. Of these, 7 (32%) patients were discharged from hospital alive following a cardiac arrest. This was similar to the England average of 28% across this 12 month period.

*(Source: NHS England – Ambulance Quality Indicators – Clinical Outcomes)*
Re-contact rate

The proportion of patients who re-contacted following treatment and discharge at the scene within 24 hours

From November 2016 to October 2017, the proportion of patients who re-contacted following treatment and discharge at the scene within 24 hours was lower than the England average than the England average over the winter months then was higher from February 2017 to August 2017.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)

The service supplied data on patient outcomes in line with national reporting requirements for ambulance trusts. Audit of individual staff competency, through clinical supervision and ILP process, took place with any concerns or issues addressed through further training and development. Information provided by the service indicated that there no systematic approach to auditing and benchmarking the quality of services outside of the national reporting requirements and individual monitoring.

Evidence from minutes of governance meetings showed patient outcome data was reviewed. However, it was not clear how the service used the data available to drive service improvement.

Competent staff

Appraisal rates

From October 2016 to September 2017, 49% of staff working within emergency and urgent care services at the trust had received an appraisal, not meeting the trust’s target of 95%.

A split by staff group can be seen in the graph below:

Appraisal Completion rates by staff group, October 2016 to September 2017
The data supplied by the service meant we were not assured all staff received an appraisal every year. Most staff we spoke with during the inspection had completed an appraisal although some staff said their appraisal had been cancelled due to operational reasons. Managers were aware appraisals and supervision was a challenge and were exploring ways to achieve a higher compliance rate with regard to appraisals for all staff. Where staffing levels allowed, rotas were adjusted to plan education time for staff. Staff were stood down from operational duties to enable appraisals and training to be completed.

Staff told us that previously there had been limited opportunity for staff to develop, for example from EVO to paramedic, however the situation was improving. At the time of inspection five members of staff were progressing through the paramedic training programme funded by the service. Managers told us the service had staffing and financial challenges but were working hard to identify courses and funds for staff to access.

The service had identified a gap within their training and employed an Ambulance Educator to oversee and manage the clinical governance and training for EVOs. At the time of our inspection the role was new and evolving. The educator had only been in post for two months and so there had been limited opportunity to make a significant difference.

The educator role was described to us as; observing practice against an agreed checklist and scope of practice approved by the ambulance clinical quality and effectiveness governance committee, provide support and assisting with professional development. We reviewed one observation report and found it was comprehensive and identified areas of good practice and areas for improvement for the member of staff observed.

The ambulance educator also provided preceptor support to Newly Qualified Paramedics (NQP) in line with the national agreed NQP program.

The role of the Community Practitioners (CP) was carried out by trained paramedics who received clinical supervision from an emergency department (ED) doctor. The ED doctor carried out individual audits and clinical observations against an agreed competency framework.

CPs received additional training in catheter care and syringe drivers, used to deliver end of life medication, so that they could attend known End of Life patients. There were good links with the local hospice and MacMillan nurses, who provided some end of life training.
The service recruited and utilised co-responders (retained fire-fighters) and community first responders (volunteers) to support ambulance crews. The service provided all the training and we saw records that confirmed each responder had received comprehensive initial training. Regular updates and training then continued on a monthly basis, with regular review of skills against an agreed set of competencies signed off by the ambulance clinical quality and effectiveness governance committee.

Clinical Support Officers (CSOs) provided clinical support to frontline ambulance staff. CSOs managed teams of up to 15 paramedics and carried out 1-2-1 training, appraisals and clinical reviews if a concern was identified with the clinical practice of a member of staff.

The service had staff trained in specialist areas such as marauding terrorist firearms attack (MTFA) and CBRN, however a recent inspection by NARU had found the service to be non-compliant against some national standards for CBRN. The service were working closely with NARU to expedite training for their staff and to achieve compliance. During our inspection we saw communications between the service and NARU detailing training plans.

**Multidisciplinary working**

Staff of different kinds worked well together as a team to benefit patients.

Ambulance crews told us that they had good working relationships with staff in the emergency department (ED). We observed patient handover between ambulance and ED nurses. These were efficient and concise and followed a proforma, to capture relevant patient information. However, staff told us the handover process could be disjointed and was dependent on who was on duty that day and how busy the department was.

Some ambulance crews we spoke with expressed a concern that the holistic assessment made of the patient, and they had updated on the electronic patient record (ePRF), was not always reviewed by ED staff. They felt ED staff did not trust the assessments they had carried out on the patient. For example, crews described a situation where they had performed an ECG assessment on a patient and the data was readily available for ED staff to review. Despite this staff in ED performed another ECG. Ambulance crews told us that ED staff would carry out assessments and tests on patients even though they had already done so and the information was available on the patient record. We were given an example of a patient who had been conveyed to ED that day were duplicate diagnostic assessments were carried out by ED staff.

There was a docking station at the triage desk in ED so that ambulance staff could upload the ePRF directly into the ED system. Administrative staff in ED told us not all patient records were printed and filed in the patient notes. This was done on a clinician by clinician basis.

There was an agreed process in place if a crew saw signs of deterioration with their patient. They contacted the emergency department, via the CSD using a pre-alert process, to escalate the priority level.

There were links with other emergency services including the coast-guard and Helimed services, who played a key role when transporting patients quickly on or off the island.

Staff were aware of ‘see and treat’ and the importance of maintaining a patients independence by not taking them to hospital if it was not clinically necessary. We observed a crew attending a patient in their own home. The crew did not convey the patient to hospital, as they were able to manage the situation. The crew placed a call to the clinical support desk and arranged a GP visit to the patient for the following day.
Health promotion

Staff were proactive in supporting people to live healthier lives and maintain independence. Clinicians could give ‘see and treat’ advice to patients if their condition did not need an ambulance transfer to hospital. Staff arranged referrals to other services, for example a GP, via the clinical support desk, based in the emergency operations centre.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff obtained consent to care and treatment in line with legislation and guidance. Mental Capacity Act training was part of mandatory training for staff. We reviewed training records and found that 6% of staff (4 out of 73) completed Mental Capacity Act training as of September 2017.

However, ambulance staff we spoke with could describe the Mental Capacity Act (2005) and how it applied when obtaining consent, including the assessment of capacity and completing a best interest assessment. Staff described to us when they could and should give treatment to patients without consent, such as in an emergency to preserve life. Staff used a form which was part of the ePRF to guide them in the assessment of a patient’s mental capacity.

If a patient did not have capacity and refused to transfer to hospital, ambulance staff would contact the police, via the clinical support desk, for support.

We observed staff, in non-emergency situations, explaining procedures, giving patients opportunities to ask questions and seeking verbal consent from patients before providing care or treatment. Staff recorded consent to treatment in the patient’s record.

Is the service caring?

By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.

Compassionate care

Friends and Family test performance

From October 2016 to September 2017, the trust did not have enough respondents for the emergency and urgent care Family and Friends Test in order to populate an analysis.

(Source: NHS England Friends and Family Test)

We saw ambulance staff were professional in their approach. We saw staff speaking politely to a patient when arriving at their house. They were respectful, kind and compassionate when providing treatment or care to the patient and when speaking to the patient’s relative on the phone.

Staff were considerate of patients, however handover between crews and ED staff took place at a desk near the entrance to the department. At the time of our inspection, we observed there were no cubicles for patients to wait while the handover took place. Crews had to wait with patients who were often on an ambulance stretcher or chair in a busy thoroughfare.

Staff told us this led to concerns regarding the privacy and dignity of patients arriving in the department. For example, we observed a patient being transferred by ambulance staff to a hospital trolley from an ambulance stretcher in the middle of the department. The patient was fully
clothed and the transfer was carried out safely, however this was in full view of other in the
department.

**Emotional support**

Ambulance crews reassured patients at all times while they were in their care.

Staff remained with patients and continued to provide emotional support with friendly, personal
interactions with patients and family members whilst waiting to handover their care at the ED.

We saw staff gave clear explanations to patients about the care and treatment they could provide.
Patients were involved in the decision making process regarding their own care. We observed
staff check with patients to ensure they understood the treatment offered, before they asked for
consent.

We observed a situation where a patient did not need treatment at hospital, ambulance staff
discussed their reasoning with the patient. They ensured the patient was happy with, and
understood, the decision. We heard staff telephoning family members, with the patient’s
permission, to inform them that a loved one was feeling unwell.

**Understanding and involvement of patients and those close to them**

Hear and Treat survey

The Isle of Wight NHS Trust did not participate in the latest 2013/214 CQC Hear and Treat.
(Source: CQC Hear and Treat survey)

We heard ambulance crew introduce themselves and ask relatives and carers how they would like
to be addressed. We observed staff modifying their language, tone, and pace of speech to
communicate with patients and their relatives to help them understand their care and treatment.

Staff were professional and ensured they informed patients and those close to them about what
was happening, along with information on any treatment or other interventions being provided.
They checked with patients to ensure they understood and agreed to the treatment offered.

During conveying patients to hospital ambulance crew provided reassurance and care for the
patient. We saw crew members offer patients reassurance and they explained what the care and
treatment they would be offered when they arrived at hospital.

**Is the service responsive?**

By responsive, we mean that services meet people’s needs.

**Service delivery to meet the needs of local people**

The ambulance service worked with commissioners of services on the island, such as the clinical
commissioning group (CCG) and local council to consider how the service could continue to best
meet the needs of local people.

The trust provided a Helicopter Emergency Medical Service (HEMS) 24 hours a day 7 days a
week and had a helicopter landing pad (Helipad) located on-site. The Helipad was provided for
medical emergency use for hospital purposes only and in particular for the operation of an air
ambulance service. The Helipad provided access to; the Hampshire & Isle of Wight Air Ambulance
(HIOWAA), other air ambulance services, the Police, HM Coast Guard, Army Air Corps and Royal
Air Force with helicopters of 12.8 tonne gross weight or less.
The trust acknowledged there were times when the service was not able to meet demand, particularly when patients required transfer to the main land. In such circumstances a private ambulance provider was contracted and this helped the service respond to the increase in demand. There was an escalation plan in place to manage these situations.

In response to a change in community nursing cover 18 months prior to this inspection, the trust had created a new role of community practitioner (CP). CPs were trained paramedics, who had received additional training and skills. They provided a resource to be used where it was identified they had the skills to meet the needs of the patient. They were allocated work by the clinical support desk, based in the operations centre, following agreed pathways and in liaison with the GP out of hours service.

The island hosted several major events during the year for example Cowes sailing week and music festivals. These events would increase the population on the island and elevate potential risk. The trust had developed a positive relationship with NARU who provided additional support and capability for events as and when they took place.

At the time of our inspection the service no longer deployed a rapid response vehicle (RRV) during the day shift. An RRV would normally be a single crew vehicle (one paramedic) used to attend a patient more quickly or flexibly than a double crewed ambulance. This had been due to an operational change so that the service could deploy more double crew ambulances on the road. As a result, the service now deployed more double crew ambulances onto the rota.

**Meeting people’s individual needs**

Each vehicle we inspected had an NHS Confederation Multi-Lingual phrase book to help staff communicate with patients and their families where English was not their first language. Interpreter services, via a language line, were also available for patients and relatives if their first language was not English.

We saw pictorial pain charts on ambulances to help staff support patients who were unable to communicate verbally.

All ambulances we inspected had stretchers which were designed to transport patients with a high body mass index (bariatric). Staff had access additional pieces of equipment to help transfer patients to the ambulance. This included a dedicated wheelchair for the larger patients and a specialised air filled cushion, used to help lift patients. If staff needed additional advice or support, they would liaise with the clinical support desk.

Ambulance staff and community practitioners told us they knew to look for a just-in-case medicines pack when they visited patients who were known to be end of life. The packs contained key medicines to help keep patients comfortable who are end of life. Although ambulance staff did not administer the medicines, they could request a GP or specialist nurse visit, rather than having to transport the patient to hospital.

Staff we spoke with knew where the nearest place of safety was for patients requiring, or subject to, a section 136 order under the MHA. They were aware that should contact the police, via the clinical support desk in the emergency operations centre, if required to assist these patients.

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.
The trust had identified it did not comply with the Accessible Information Standard (AIS). Their current IT systems did not support them to be compliant with the current AIS. The trust told us it was working with its own IT department to improve training and awareness amongst staff. Planned upgrades had been scheduled for future release which we were told would start to address the shortfalls.

**Access and flow**

The service recorded the time to arrival of a health professional dispatched by the ambulance service for Category A Red 1 and Red 2 calls, measured by median, 95th percentile and 99th percentile. When comparing the trust to the England average for time to treatment of Category A calls using the median the 95th and the 99th percentile the trust were in general better than the England average from November 2016 to October 2017.

**Handover delays**

The service had a 15-minute handover standard when a patient arrived at the hospital. Crews told us they did not always meet this as they also had to clean the ambulance and equipment within this time. Crews were able to contact control and make themselves unavailable if cleaning would take longer.

We saw evidence that handover times and delays were recorded but we were unsure how this data was analysed or used to improve performance.

The service utilised volunteers, both co-responders and community first responders, to support frontline crews. Responders were dispatched, using agreed criteria and protocols, by the EOC to certain types of calls in addition to an ambulance crew being dispatched. Responders would often reach a patient quicker than an ambulance, meaning they could commence an assessment and initial treatment.

**Learning from complaints and concerns**

**Summary of complaints**

From October 2016 to September 2017, there were five complaints about emergency and urgent care services. Three complaints were closed, and two (from August 2017 and September 2017) still remain open. The trust took an average of 58 working days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints. Two complaints took over 45 working days to close. Of these, one in April 2017 took 94 working days to close.

A breakdown by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>2</td>
</tr>
<tr>
<td>Admissions and discharges excluding delayed discharge due to absence of a care package - see integrated care</td>
<td>1</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>1</td>
</tr>
<tr>
<td>Transport (Ambulances)</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Provider Information Request)

We did not find information for patients on how to complain on the vehicles we inspected. Staff told us they would advise patients to look at the trusts website.
As part of the inspection, we reviewed one complaint which had been investigated as a serious incident (SI). The review was comprehensive, detailed and had included staff in the review of the case. The outcome of the review determined that there lessons to be learned by individuals concerned but also for the service as a whole. There were actions detailed for individual members of staff, which were to be addressed through the ILP process. In addition, clinical notes detailing specific clinical guidance and required actions were distributed to all ambulance staff as a result.

In addition, we saw Individual Learning Plan (ILP) documentation which had sections to be completed relating to lessons learnt, SI’s and clinical reviews.

Is the service well-led?

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

Leadership

There was a lack of stable leadership team for the urgent and emergency ambulance service. There was a lack of succession planning and development of new leaders. There was little representation of ambulance services at board level.

At the last inspection there were concerns regarding quality and stability of the leadership of the service. We found that some issues remained but that also there was some improvement.

The ambulance service was part of the ambulance, urgent care and community clinical business unit (CBU). The CBU had been running since November 2015. At the time of the inspection there were on-going discussions at executive level regarding the potential for the ambulance service to be managed as a separate clinical business unit led by a director of ambulance services.

The ambulance operations managers’ job description was a generic trust operations job description with no reference to the ambulance service. Therefore this was not actually reflective of what the job actually required or entailed. The operations manager was able to clearly describe the challenges faced by the service particularly the need for new computer aided dispatch system and the need to progress work on the new Ambulance Quality Indicators and the Ambulance Response Programme (ARPs).

Some local managers had continued in interim roles until December 2017. The service delivery manager for urgent and emergency care continued to be an interim appointment. Both staff and managers reported this had stifled the development of the service for the year prior to our inspection. Some staff reported that as some managers were in interim roles this inhibited their ability to make long-term decisions regarding the service. There was a lack of succession planning for managerial roles within the service.

Management of the emergency preparedness, resilience and response (EPRR) for the service was being covered on an interim basis by a trained paramedic with experience in resilience. The individual had extensive knowledge in this area but had received limited support from senior management. It was not clear how long this post had been covered on an interim basis or if there were any plans to fill the role on a permanent basis.
Staff were managed in teams by Performance Support Officers (PSOs) and received clinical supervision from Clinical Support Officers (CSOs).

The service benefited from clinical leadership from an emergency department doctor.

Despite concerns, ambulance crews described local managers as open and approachable. All staff were aware of the new CEO and, those who had met them, described them as easy to talk to.

Operational managers spoke positively of the changes in the management structure for the ambulance service during the last 12 months. They said the service was changing for the better but it was still very early to see benefits fully realised.

**Vision and strategy**

*At the previous inspection, there was no clear vision or strategy for the service. This had not improved at the time of the inspection.*

At the time of the inspection, there was no clear vision or strategy for the ambulance service.

An integrated improvement framework for the ambulance service was under development. The works streams included: capacity & demand, the computer-aided dispatch system, resilience, clinical standards, training, equipment, workforce, estates and lessons learned. These work streams were not, at the time of the inspection, underpinned by detailed, realistic objectives and plans for high quality sustainable care.

Following the inspection, the trust submitted a draft programme plan with timelines for completion of work streams tasks and staff responsible. The start date for identification of programme KPIs was 1 March 2018.

The trust also provided a document called the Ambulance Programme, dated 31 January 2018, the week following the inspection. This related to the integrated improvement framework, but did not have a clinical sponsor or sign off from the board. The document did not include measurable outcomes or project timelines.

The service did not have a specific project plan for the implementation of the Ambulance Quality Indicators or the full Ambulance Response Programme (ARPs). Some initial work had been completed to amend the operating model in response to the change required for implementing the ARP.

We requested the project charter for the Ambulance Response Programme but received the general ambulance project plan which made reference to the ARP in terms of the creating a communications plan for ARP, impact of ARP on identifying patient outcomes, ARP requirements for patient feedback. Work to plan for the ARP had not begun and was scheduled for February 2018 despite the programme being introduced in July 2017.

**Culture**

*Improving the culture was now seen as a priority. Staff development had not previously been given sufficient priority, this was improving but appraisal rates were still low.*

Managers at a local level were trying hard to change the culture within the service and there had been some improvement. However, managers were having to deal with historic management issues that were still affecting some staff.

Staff told us that there was still a reluctance to speak up about concerns. However, this was an improving picture with some staff reporting a more open culture starting to emerge.

The staff group within the service was not overly diverse, with most staff having classed themselves as white British. Staff did not tell us that there were any concerns with being treated equitably.
Staff told us that they felt morale was improving within the service. This was in part due to changes to local management and also the appointment of the new trust CEO. Staff told us there was a feeling of cautious optimism amongst frontline staff that things would change for the better.

The service had staff trained to use the Trauma Risk Management (TRiM) model in order to provide support to staff, for example after attending a distressing incident. TRiM originated in the UK Armed Forces and the model is based on ‘watchful waiting’, that means keeping a watchful eye on individuals who had been exposed to a traumatic event.

These TRiM trained staff had written a referral protocol for colleagues in the control room to use to identify staff who may require support.

Frontline staff told us that opportunities for development and training were improving due to recent changes in local management. Training days were now being allocated on the duty roster, which was an improvement, as previously staff were required to fit training around operational duties.

DoC training was made mandatory for all registered or professional staff at the trust in October 2016. At the time of the inspection we did not have training compliance rates for staff.

**Governance**

*Governance structures were complex and we were not assured of their effectiveness. There was a lack of action to mitigate risks identified.*

There was an operational management team meeting (OMT), which met on a Friday. The senior managers team (SMT) met every other Monday. Actions from the OMT needing second or final approval, or issues not resolved at OMT, were discussed at SMT. Anything needing escalation went to the clinical business unit meeting (CBU). There was also a clinical quality and effectiveness group (CQEG) which linked into the SMT and OMT, through the clinical quality lead, but had a direct link the CBU.

The CBU head of nursing and quality attended the CQEG. However, there was no ambulance specific governance structure. We requested an ambulance governance structure and received the generic trust governance structure in draft form.

We reviewed the last three operational management team minutes and found 999 & 111 performance report, risks, and issues for escalation for SMT were standard agenda items. The EOC service delivery manager, the rostering manager and the ambulance operational manager attended the meeting along with representatives from the PTS service and Urgent care. While things were reported and there was some evidence of discussion, it was not always clear what action was to be taken when issues were identified for example when performance was below expected.

We reviewed the last three clinical quality effectiveness group minutes and found clinical risk management, clinical outcomes and effectiveness, ambulance service clinical guidelines, clinical education, patient safety and experience were standard agenda items. The clinical director, clinical support officers, performance support officers and representatives from the ambulance CBU attended the meeting.

We requested the last three weekly ambulance urgent and community clinical business unit (CBU) meeting minutes and we were provide with minutes that related to the community part of the CBU and there was no reference to ambulances services. We also requested CBU quality meeting notes for the last three meetings and received one incomplete set of notes with no representative from the ambulance service present. There was no assurance quality and risk issues relating to the ambulance service were monitored at CBU level.
We reviewed the records of the last three ambulance urgent and community clinical business unit performance review meeting and found that ambulance performance, issues with the computer-aided dispatch system and recruitment of call-handlers were discussed. It was possible to track action from one meeting to the next with an up dated action log in place after each meeting in two out of the three reviewed.

We reviewed the board report from December 2017 and found the operational report included an update on ambulance performance and assurances as to why performance targets were not being met. It was noted that small numbers can swing the targets and that the implementation of the new computer-aided dispatch system would improve response times.

We were advised of an incident which occurred shortly before our inspection. A member of staff covering the clinical service desk in the EOC became unwell during a night shift. There was no appropriate cover available within the EOC. This meant a paramedic, and therefore an ambulance resource, had to be taken off the road to provide cover. We were told this was a rare occurrence however there was no contingency or SOP in place for this eventuality. There was a risk this could happen again and we were not assured the service had identified this as a risk.

We reviewed the policy register and found 28 out of 102 procedural policies were out of date at the time of the inspection. Policies were reviewed at the operational management team meeting and sent to the clinical quality and effectiveness group for approval. Minutes of the 12th January 2018 operational management meeting showed that the service had agreed to organise a quarterly meeting to review standard operating procedures on an ongoing basis due to the number of procedures that needed to be reviewed.

Management of risk, issues and performance

At the last inspection, the risk register was not reflective of current risk. We found this had improved and the risk register did reflect current risks. The risk register included the CAD, ambulance business continuity plans in case of fire, training of strategic commanders, poor staff morale, and failure of the trust switchboard.

However, while the risk register reflected current issues and concerns there were limited updates and progress against issues and timelines.

There was a governance structure which included a process for escalation. However, through discussion it was clear identified risks may not have been given the attention and priority they required to ensure the provision of a safe service. For example, there was a concern that the ambulance service used trust wide policies that did not include allowance for frontline ambulance staff and the delay in the service being able to comply with the implementation of the Ambulance Quality Indicators and the Ambulance Response Programme (ARPs).

There was no clear audit program to monitor the quality of the service provided. There was a heavy reliance on the audit of the use of NHS pathways. There was no evidence of using the other available information to drive improvement such as response times, incidents and complaints.

We saw evidence of audit of hand hygiene in individual learning plans for clinical staff. However, we were unable to determine if there were any service-wide audits carried out regarding compliance with infection control policies, for example hand hygiene or bare below the elbow audit. The service had a link to the trust infection prevention and control team. However, no dedicated time was allocated for this role and issues or concerns were dealt with only on an ad hoc basis.

The service had an up to date Resource Escalation Action Plan (REAP) and a member of staff covering the role of EPRR manager on an interim basis. The current REAP level was displayed in...
the ambulance station. Contact numbers for escalation were displayed on the walls with details of how to contact tactical commanders and tactical advisors, strategic commander, local ambulance trust, operational command.

The service has recently failed a compliance inspection with regard their ability to deal with a CBRN incident. The service was working closely with NARU to fulfil their requirements to be compliant. In the interim, the trust was receiving support from another ambulance trust to provide cover should a CBRN incident occur on the island.

**Information management**

*The information used to monitor performance was inaccurate or unreliable due to the out-dated CAD system.*

The service complied with and contributed to national ambulance reporting requirements. The service had identified that their CAD system was outdated, and were aware that data collected could be unreliable. The service had identified that it was unable to drive improvement from data collected and they could not assure themselves it accurately reflected the situation within the service.

However, information collated at a local, for example individual staff performance data, was accurate and did not rely on the CAD system.

The service told us they were non-compliant with some EPRR requirements following a recent NARU inspection. Prior to this inspection, the service had completed a self-assessment led by the Director of Quality Governance with executives briefed on the anticipated non-compliance.

Systems and meetings were in place to monitor performance and data. Senior managers told us the management and governance structure for the service was complex. Actions had been taken to define and refine the meeting structure to gain efficiencies. These changes were too recent to see any definitive improvements at the time of our inspection.

**Engagement**

*There was minimal engagement with people who use services.*

At the previous inspection we found there was no formal process for engaging with patients. This had not improved at the time of the inspection.

The service held regular staff meetings to promote engagement. Managers told us that these were a relatively new and they had had 6 or 8 meetings over a period of 12 months. We were told by managers that there was good attendance. Staff we spoke with confirmed the meetings took place and that they attended. They also told us that they found the meetings to be informative and a useful way to share and discuss ideas and raise concerns.

All staff we spoke with were positive about the new CEO and described how they had visited the ambulance station on Christmas day with a bowl of fruit for the staff. We saw a card from the CEO to the ambulance service thanking them for their hard work and efforts.

We were shown feedback letters that managers give to staff following a positive outcome of patients they attended and conveyed to hospital. The letter is usually sent several weeks after the incident and describes the positive impact that member of staff has had on the patient and that of their family. Staff told us that they liked getting these letters as it showed their hard work made a difference.

**Learning, continuous improvement and innovation**
New ambulance educator role for the trust had identified and secured funding for paramedic top-up learning (distance learning with university of Cumbria). The educator had also created links with Portsmouth University regarding in-house access courses to prepare potential staff for the paramedic course.

Community First Responder programme had been recognised by Resus Council UK in response to resuscitation training programme carried out across the island.

Paramedics were finalists of the ITV Good Britain Morning Health Star Awards 2017. They were recognised for delivering life-saving high dose antibiotics to patients with suspected Sepsis before they reached hospital.
The Patient Transport Services (PTS) for the Isle of Wight NHS Trust (the provider) is located on the site of St Mary’s Hospital in Newport on the Isle of Wight.

The PTS shares its vehicle cleaning services and parking garages with the provider’s emergency ambulances (inspected and reported on separately), located on the same site.

The PTS completed 8842 patient (adult and children) transport journeys in the year from January 2017 to December 2017. These journeys included collecting and returning patients to their home addresses for routine hospital appointments as well as returning patients’ home following medical treatment at the hospital.

During our inspection we spoke with 13 staff including the service’s Head of Operations for Ambulances, Fleet and Operations Manager, PTS dispatcher, and contracted and bank patient transport staff. We also spoke with an additional three staff members who worked closely with the PTS; two patient discharge assistants and the provider’s Risk Management Facilitator.

We spoke with two patients asking for their experiences when receiving support from the PTS. We reviewed six patient records including risk assessments relating to patient’s individual needs. We reviewed policies and procedures and documents relating to the running of the PTS. These included one complaint, the service’s risk register and staffing rota for dates between 14 January 2018 and 28 February 2018 and viewed 72 customer feedback reports relating to the quality of service provision.

We inspected two ambulances assessing their ability to meet patient’s needs. During the inspection we were present during three patient transport journeys observing patient and staff interaction.

This was a short notice announced comprehensive inspection. The provider was given six weeks’ notice of our inspection to ensure staff were available to be spoken with. During this inspection we reviewed the following five key questions;

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive? and
- Is the service well led?

Is the service safe?

**Mandatory training**

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**
Mandatory training completion rates

The provider set a target of 85% for completion of mandatory training.

In PTS staff exceeded the provider’s target with an 87% overall compliance rate.

### Mandatory training completion by module

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Resuscitation</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance: An Introduction</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling (Online)</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution Refresher</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 - Theory</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 2 - Extinguishers</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling</td>
<td>13</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training Levels 1 &amp; 2</td>
<td>13</td>
<td>69.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>13</td>
<td>53.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution Introduction</td>
<td>13</td>
<td>38.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff working in the PTS met the provider’s target for 12 out of 16 training courses listed above. Courses with the lowest compliance rates recorded were hand hygiene (seven out of 13 members of staff completed this) and conflict resolution introduction (five out of 13 members staff completed this).

Conflict resolution training however was prioritised for staff who had no previous experience and training of de-escalation techniques. Staff we spoke with who had not received this training had previously worked in an emergency service role including the Prison, Police and Fire Service. As part of their previous role they told us they had received conflict resolution training and were confident in using de-escalation techniques to calm aggressive patients if required.

Staff participated in hand hygiene training as part of their annual review process which staff were in the process of receiving at the time of the inspection. Once the annual review processes were complete, the number of staff who had undertaken hand hygiene would increase.

Team leaders monitored staff’s compliance with mandatory training using an online training management system. This information was also reviewed monthly with the service’s Commercial Training Department. Where training needs were identified this meeting allowed for staff’s enrolment in the relevant courses to be discussed and completed in a timely manner.

Staff received training in both face to face and electronic learning packages. The service had supported staff to meet their training needs by purchasing an additional computer which had been...
placed in a remote waiting site for staff. Staff were able to access their online training courses whilst working away from the hospital site and awaiting deployment.

**Safeguarding**

Safeguarding training completion rates

The provider set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses April 2017 to September 2017 for staff working in patient transport services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>13</td>
<td>92.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>13</td>
<td>61.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff understood how to protect patients from abuse. The provider had a ‘Safeguarding Children and Young People’ and a ‘Safeguarding Adults at Risk’ policy in place which provided guidance and support to staff on how and when to raise a concern.

Through discussion staff demonstrated a good understanding of the physical and emotional symptoms patients could display if suffering from abuse. Staff were also aware of who they would speak with internally and externally if they needed to raise their concerns.

Staff described how they would take action if they identified potential concerns with patients living environments and felt they were at risk of neglect. This included returning patients to the hospital until appropriate help and support could be sought via social services to ensure the patients were safe to return home.

Staff working within the patient transport service met the provider’s target for one of the two safeguarding courses reported; safeguarding children level 1. There was a low compliance rate recorded for safeguarding adult’s level, 1 with only eight out of 13 members of staff having completed this.

There were no figures available for staff completing Safeguarding Children Level 2 training. Team leaders were aware of the provider wide need for this training and had booked staff to complete this training in April 2018. This training had not previously been made available to PTS staff.

**Cleanliness, infection control and hygiene**

Staff were seen to follow safe infection control processes to keep patients safe, however, the service did not routinely and accurately monitor staff adherence to best practice guidelines. The provider had an Infection Prevention Control team however at the time of the inspection the service did not have a policy relating to infection prevention and control issues. The PTS were in the process of developing their own policy.

Staff completed Infection Prevention and Control training on an annual basis and we observed safe infection control practices being followed. Staff routinely cleaned the ambulances following patient transport journeys using decontamination wipes to minimise the risk of patient’s exposure to potential cross infection.

Staff had access to appropriate equipment and facilities to wash their hands. Adequate supplies of hand sanitiser gel were available for each member of staff and were seen to be used before, during and after patient transport journeys. Staff were bare below the elbows and we observed them regularly and routinely wash their hands.
However, the service did not routinely complete hand hygiene audits to ensure staff were following safe and effective hand washing practices. Staff received annual infection prevention and control training and hand hygiene training. As part of this training staff completed a practical hand hygiene check to ensure their cleaning processes were safe.

The service had completed its first infection control audit on 2 January 2018 on the PTS crew room environment. During this audit it was identified there was no pest infestation however, there were ‘droppings, feathers or mites’ visible in the environment. Noticeboards required action to laminate longer term information for staff and old items to be removed. The audit identified areas for improvement however, an action plan had not been developed to manage the identified risk.

Staff had access to cleaning products to manage patients suffering from a communicable infection. The PTS dispatcher situated in the Emergency Operations Centre made staff aware of patients who were suffering with a communicable infection prior to being transferred. Ambulances contained infection control packs for staff to use which contained additional personal protective equipment including aprons and gloves for staff to use in these circumstances. On these occasions PTS staff would complete an initial clean using appropriate cleaning materials including decontamination wipes. The ambulance would then be removed from service until it had received a deep clean.

The PTS team used joint cleaning facilities with the emergency ambulance service which was situated with the PTS ambulance parking area. The provider’s washer/stocker staff were responsible for completing cleaning of the ambulances. They also completed regular deep cleans to ensure the ambulances remained safe for use. We saw appropriate cleaning facilities and materials were used to clean the ambulances. Cleaning records for December 2017 and January 2018 showed ambulances were cleaned daily with a deep clean completed every three days. The washer/stocker staff were also responsible for ensuring the ambulance equipment such as stretchers, splints and blood pressure cuffs were cleaned. Observations confirmed equipment on the ambulances viewed were clean and ready for use.

The provider’s washer/stocker staff worked shift systems aligned with the PTS. This was to ensure in the event of a concern or contamination risk the ambulance involved in the patient transport journey could be immediately subjected to a deep clean. This minimised exposing patients to any cross infection risks.

Staff were aware of the measures in place to minimise the risk of cross infection between patients. Staff wore clean uniforms and kept a spare uniform at work and in the event of contamination would dispose their affected clothing and change into a clean uniform. Staff told us they washed their uniforms in accordance with Department of Health uniforms and workwear best practice guidelines at a very high temperature and if soiled would dispose of and seek a new uniform from the provider.

**Environment and equipment**

The service had sufficient numbers of ambulances in order to meet patients’ needs. The service had 10 ambulances available for patient transport. These ambulances were stored at the ambulance base on the hospital site with easy access to cleaning and stock replenishment items.

In the event of an ambulance defect being identified staff told us they would make senior staff aware on the radio and return to base to complete a vehicle defect form. The provider used an external commercial garage service to complete required mechanical tasks. Ambulance defect forms were used to inform the Fleet Administrator if ambulances were unavailable for use.
Sufficient numbers of ambulances were available for use in the event that an ambulance was awaiting repair.

Ambulances were mechanically maintained to remain safe for use. The Fleet Administer maintained records which evidenced all ambulances were serviced, had in date MOT certificates and ambulance tail lift servicing in line with manufacturers recommendations.

Maintenance of ambulances and equipment was completed by an external commercial garage and equipment providers. Servicing records confirmed ambulances and equipment such as oxygen and associated equipment including defibrillators were serviced in accordance with the equipment’s service provider.

The provider did not have safe systems in place to identify when routine maintenance and replacement of items would be required. This placed patients at risk of receiving support with equipment which was not fit for purpose. The provider did not hold an equipment register detailing the dates when equipment required servicing. The provider relied on staff reviewing all equipment within the ambulances before commencing their shift to ensure it remained in date and available. During the inspection we identified a carry chair on one ambulance to be out of date of its service and there were no maintenance records indicating the stretcher had been serviced as required. On another ambulance it was identified a wheelchair had not been subject to regular maintenance. We brought this to the attention of the provider and the it items were removed from use.

Immediately following the inspection the provider said they had put in place a service schedule for all equipment and a replacement programme for service wheelchairs. At the time of the inspection however, the service was unable to evidence all patient equipment was safe for use.

Staff said mobile data terminals used to display patient details had improved since the last inspection however; they did not always provide them with all the information required. For example, if a patient had a risk assessment relating to any aspect of their moving and handling or health matters this would be highlighted on the mobile data terminal screen. The detail would be available to the dispatcher who would have a copy of the risk assessment and would be aware of the patient’s needs. Staff would have to return to the ambulance base to read the relevant risk assessment. The provider was aware of this limitation and a new booking system was being introduced to the PTS. This would allow for this information to be immediately available to staff and would minimise delay in the patient being collected or returned to their home address.

Staff said the satellite navigational systems supplied in the vehicles had also improved since the last inspection. Staff said previously they would not work however they had been reprogrammed which had resulted in better operation.

Each ambulance had emergency equipment which supported staff to provide basic lifesaving treatment to patients of all ages including a defibrillator. Records evidenced staff checked this equipment daily. We inspected the emergency equipment on two vehicles and found all equipment was in date and in working order.

Equipment to maintain electrical or battery powered equipment was available for staff. Spare batteries for equipment such as radios were available at the crew office based at the hospital site.

Staff had radios which gave access to the emergency operations centre and their colleagues however, told us they often used their personal mobile phones to communicate directly with other staff. This was due to radio signal in some areas on the Island not being sufficient to allow for easy communication. The provider was aware of this concern and staff confirmed the provider was in the process of seeking their opinion about the future purchase of smart phones or minicomputer tablets to allow for greater ease of communication.
Whilst equipment was not standardised across the ambulances, the service was able to meet patient’s needs. The dispatcher, in conjunction with PTS staff, assessed the needs before deployment of the most appropriate ambulance. Three of the ambulances had additional equipment which included oxygen to allow the ambulances to be used in the event of emergencies to support the emergency ambulance service. The emergency ambulance service had ambulances which contained baby and child carrying equipment which allowed both services to interchange ambulances and staff when required to enable them to meet the needs of the patients requiring transport.

Despite completing few children patient transfer journeys, the provider had purchased child harnesses for safe transport; however, staff were awaiting training before they were placed within the ambulances. In the event of transporting babies, not requiring an incubator, parents were asked to provide a suitable chair or restraint for use in the ambulance. Staff were able to safely transport babies in an incubator using the stretcher securing systems in each ambulance.

All but three of the ambulances had additional capabilities with suitable moving and handling equipment to allow for the transport of patients weighing over 127 kilograms or 20 stone.

The PTS did not transport patients who were detained under the mental health act or needed restraining, for example, patients displaying aggressive behaviour or self-harming activity. In the event patient restraint was required the emergency ambulance services would be used to transport these patients.

Assessing and responding to patient risk

Information about patients’ needs were collected at the point of booking. Only identified and trained health and social care professionals could make a PTS booking. Booking details requested included information about the patient’s level of mobility, their medical needs and any physical needs which would require the use of additional equipment to support them safely. This information was communicated to staff via their radio and mobile data terminals. This allowed staff to complete dynamic risk assessments prior to patient transport to ensure they had the appropriate ambulance to meet these individual needs. Patients’ wellbeing was visually and continuously assessed by staff travelling with patients during their travel to ensure they remained fit for transport.

Staff followed a clear pathway to manage patients who became ill during their journey. All staff were appropriately trained to administer basic life support and emergency first aid. In the event of an unplanned health related incident staff informed us they would stop the ambulance as soon as it was safe to do so and seek assistance from the emergency ambulance service. Staff told us they would not hesitate to take this action if they felt they were unable to meet the patients’ needs.

Staff told us if a patient required immediate medical support they would inform the PTS dispatcher in the emergency operations centre. The dispatcher for the PTS and emergency ambulance service worked alongside each other which allowed for the coordination of resources and the dispatch of an emergency ambulance if required.

Staff were able to use the ambulances blue lights to provide an immediate emergency transfer if it was felt there would be a delay waiting for an emergency ambulance to become available. Team leaders and PTS staff were trained to drive ambulances when using the emergency blue light.

Team leaders and experienced staff completed risk assessments which were detailed and individualised. The risk assessments included specific information regarding patients’ risks.
including their moving and handling needs and home environment which could hinder their transport journey. Risk assessments included remedial action to be taken to manage the risk safely including the number of staff required to appropriately respond to the patient risk and a date the risk assessment required updating. Staff evidenced through discussions they understood and knew patients individual risks and how to manage these safely. A patient spoke positively of the staffs ability to meet their moving and handling risks and told us, “(I) feel confident in their (staff) ability when being moved to and from the ambulances”.

**Staffing**

There were sufficient staff available to meet patients’ needs. Staff were rostered to work day, late or evening shifts to meet patient demand. At the time of the inspection the service was operating with an additional 9pm – 2am shift to help with the additional demand on services due to winter pressures. The service bi monthly reviewed the level of demand on the service in order to identify the most appropriate numbers of staff required for each shift to meet patient needs. This information was placed into a ‘Heat Map’ which was used by the resourcing team to determine safe staffing numbers.

The resourcing team coordinated and planned staff rotas approximately 12 weeks in advance. The manager and team leaders held discussions with staff and a work pattern was agreed which to ensure unsociable hours were balanced across the team.

Additional bank staff were available for use to cover unforeseen events such as an emergency or staff sickness. In the event of staff sickness a ‘fast text’ would be sent to bank staff asking for their availability to cover shifts. The availability and flexibility of bank staff also supported patients who needed to complete longer journeys to receive their care including journeys to the mainland to other hospitals for treatment.

There were discussions being held to introduce an on-call mainland transfer system to support short notice patient journeys to and from the island. This would minimise the impact on daily staffing levels as it would not require a crew to be unavailable for the minimum two and a half hours required for an off island transfer.

The service had 18 members of permanent staff including a senior team leader and team leader, manager and 16 bank staff who were available to cover both pre-planned and short notice shifts when required. Bank staff told us they identified in a book in the crew office their availability for work which was taken into consideration by the Resourcing Team. We saw staffing figures were consistent and in line with the identified patient demands.

Staff were supported out of hours by the PTS and emergency ambulance service dispatchers. When the PTS dispatcher finished their shift the emergency ambulance service dispatcher took responsibility for any last minute PTS journeys request. Managerial support was offered by the emergency ambulance service Performance Support Officer. Staff said they always felt support was available to them when working out of hours and included their team leader as a point of contact. One member of staff told us they had, “Not at all felt alone” when working out of hours which was a view shared by other staff.

The service supported new staff to ensure they were confident in their role before they were asked to work as part of a PTS crew. This included participating in ten ‘third manning’ shifts where they accompanied an existing two person team as an observer. Staff said they found this a useful process and could have sought additional ‘third manning’ shifts but felt this had not been necessary.
Staff were provided with protected mealtimes to ensure they received a break from driving and were able to maintain their wellbeing. We observed staff take their meal breaks in the crew office without disruption. Staff were also able to seek shorter comfort breaks between patient transport journeys. Records showed staff were rostered to receive an 11 hour rest period between shifts as per the requirements of the Working Time Directive. If staff were unable to achieve these due to unforeseen circumstances this was taken into consideration by the team leaders. Team leaders were available for deployment if required to ensure staff remained safe to complete their role.

Records

The dispatcher and PTS staff collected information about patients’ individual needs from completed booking reference forms. This included information regarding a patient’s medical condition, age and gender. This ensured staff were aware of the patient’s condition allowing them to plan appropriately for the journey.

Staff were made aware of a patient’s do not attempt cardiopulmonary resuscitation (DNACPR) status prior to their transfer. This was highlighted on the patients’ records so PTS staff were able to provide this information during handover with health and social care professionals when the patient concluded their journey.

Staff completed patient information on the mobile data terminals. They contained information relating to whether there were any risks associated with the patient including their moving and handling or any conditions which could affect the patients’ ability to offer consent to treatment. Most mobile data terminals were stored securely at the crew office when not in use to maintain patient confidentiality. During the inspection however, a mobile data terminal was seen open in a parked and secured ambulance on the hospital site. This displayed a patient transport request and the name and address of the patient due to be transferred. Members of the public and other staff members not involved in the PTS would have been in a position to view this confidential information. This was brought to staff attention and we did not observe a repeat incident during the inspection.

Medicines

Staff did not take ownership or responsibility for transporting patient medicines. If patients required medicines to be carried with them, they, or their escort would maintain possession and control of these at all times.

We observed oxygen stored appropriately on two of the ambulances however, this was available for use by emergency ambulance service staff only. Emergency ambulance service staff maintained responsibility for securing the oxygen cylinders safely on site. If a patient required oxygen during their transfer this was organised and commenced by the hospital prior to the patient being discharged. PTS staff were not trained therefore did not become involved in administered oxygen to patients.

Safety performance

There were no clearly identified safety measures, therefore there was not a structured monitoring system and there was no information to demonstrate improvement against safety measures over time.

The service did not have key performance indicators agreed with the commissioners of the service. The service did not report on the national key performance indicator for arrival and collection time for patients attending for dialysis for example. The service did monitor patient arrival and collection times manually, for pre-arranged transfer but not for those arranged on the day from the hospital. Therefore this only related to part of the service.
Incidents

Never Events are serious incidents which are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

From December 2016 to November 2017, the provider reported no incidents which were classed as Never Events for the patient transport service.

(Source: Strategic Executive Information System (STEIS) – taken from SHIPP intelligence pack)

In accordance with the Serious Incident Framework 2015, the patient transport service reported no serious incidents which met the reporting criteria set by NHS England from December 2016 to November 2017.

(Source: Strategic Executive Information System (STEIS) Taken from SHIPP intelligence pack)

The service had policies and guidance to help staff identify an adverse incident and the correct action to take when one occurred. The provider’s policy ‘Incident Management Policy’ outlined the arrangements for reporting, managing and learning from incidents.

Records showed these incidents had been reviewed and investigated however; the records had not been completed fully. The service could not demonstrate they had learned from incidents taking action to minimise reoccurrence. The Behavioural Insight Team reviewed lessons to learn and how processes could be improved. Records, however, did not document or demonstrate actions had been taken forward to prevent incidents from reoccurring. Staff told us they completed incident reports however never received details of an outcome which records confirmed.

Staff knew how to report incidents and took action to keep patients safe. They reported incidents to the service verbally and online using incident reporting forms. Staff who were not in the crew office were able to report incidents online using a remote terminal or the cyber café terminals situated within the hospital. There were 27 incidents recorded from January 2016 to December 2017 which related to the emergency ambulance service and PTS.

Staff were aware of their legal responsibilities to patients when incidents occurred. The Duty of Candour is a regulatory duty which relates to openness and transparency. The duty requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that patient.

Staff told us they were aware of the need to be open and transparent with patients when a notifiable incident had occurred. This had been supported by the training information packs provided to all staff. At the time the inspection there had been no incidents which had required the Duty of Candour to be followed for this service.

Is the service effective?

Evidence-based care and treatment

Staff had guidance available to complete their role effectively; the provider had a number of policies and procedures in place to support staff in their role. During the inspection we observed staff providing care in line with the Joint Royal Colleges Ambulances Liaison Committee clinical practice guidelines and the National Institute for Health and Care Excellence.

Through discussion with manager and team leaders it was evidence there was no formal system for the review of the service provided against best practice and national guidance. There was no
assurance staff were always providing care in accordance with the most recent national guidance and best practice.

Staff confirmed they had access to the provider’s policies and procedures and were made aware when new policies were produced. The service emailed new guidance to staff using a system which identified when information had been received and read by staff. Policies and procedures were also discussed at team meetings and displayed within the crew office.

Staff evidenced through discussions and observations they were aware of the location and content of the service policies and procedures. The service assessed staff understanding and application of policies and procedures by completing observations of staff practice to ensure staff completed their role following the guidance provide to them.

Patient’s eligibility for the service was assessed by the booking system used to request services. Only identified and trained health and social care staff were afforded access. The booking system clearly detailed whether the PTS ambulances were the most appropriate method of transport. This also contained information about other transport services which could be used such as taxis or volunteer drivers if patients did not meet the eligibility criteria for PTS support. The booking system allowed for patients to receive the most effective and appropriate service to meet their needs.

**Nutrition and hydration**

Staff ensured people had enough to eat and drink to ensure their wellbeing. During the inspection one patient was advised that there would be a small wait before they would be taken home. As a result PTS staff had requested the discharge team to support the patient with having a drink and some lunch prior to their journey. The patient was happy with this arrangement and we saw them moved from a busy waiting area to the discharge lounge so they could wait in a quiet area with drinks and food available to them.

Staff ensured patients who had a long journey, such as to the mainland for example, had a packed lunch organised by the ward to have during their journey. Discharge staff told us, and patients, confirmed PTS staff made sure patients had a drink available to them before leaving their home address. Staff also routinely carried water in the summer months to ensure patients were kept comfortable during their journeys.

**Response times/Patient outcomes**

The service did not have a robust system in place to ensure response times and patient outcomes were being monitored. There were no defined key performance indicators for the trust monitor the service against.

To capture patient waiting times and to create their own performance indicators, the service was introducing a new computer aided dispatch and patient record system. This would enable the service to automatically review whether or not staff were meeting patients’ response times and allow them to assess their performance against other similar services. Following the inspection the provider submitted an action plan stating they would agree quality and performance indicators for measurement, consistent with other patient transport services by April 2018.

Through a manual collection of data the service monitored patient arrival and collection times. This information allowed managers to identify whether there were any delays in patient transport and take action to minimise future delays. However, the service did not record the time a ward or department stated a patient would be ready for same day transport against staffs response to this request. This did not enable the service to identify if patients were experiencing delays in their journeys during same day requests for transport. A new monitoring system was being introduced
which would capture more specified data allowing the service to identify if response times were appropriate.

Late patient transport journeys were reviewed by senior staff and a reason sought to identify whether this was due to an avoidable delay (for example late staff departure to location) or an unavoidable incidents (such as traffic incident).

**Competent staff**

New staff received an induction which followed the services ‘PTS local induction procedure V2’. This included ensuring staff completed their mandatory training courses including driving courses and worked ten ‘third manning’ shifts as an observer. New staff were required to complete an operational competency assessment observed by the team leaders which assessed their knowledge and ability to perform their role. Records provided during the inspection related to operational competencies completed in 2013. A new member of staff who had started in the last 12 months discussed a good induction but they were no documented evidence to support this. Despite requesting more recent evidence of completed inductions the service had been unable to provide this. Therefore, we could not assess whether these competencies continued and the service was following their procedure around the induction of new staff.

Staff received refresher training in line with the provider’s identified timescales to ensure their knowledge remained up-to-date. This included annual training in subjects such as infection prevention and control, safeguarding adults’ level one, people handling and adult resuscitation. Records confirmed staff completed these courses in line with the identified timescales.

The service completed, as part of the annual appraisal process, staff driver licences checks. This was to ensure staff had the sufficient driving category and experience allowing them to drive the ambulances. Records showed these checks were current and up to date.

Staff were encouraged to undertake further training in order to enhance their role. Staff spoke positively about the training provided and the opportunity to develop within the service. Some staff had completed emergency vehicle operator training which allowed them to support both PTS and emergency ambulance service.

Records confirmed contracted and bank staff had received an appraisal in the previous year. Most staff we spoke with said these were a useful process in particular with furthering their requests for additional training.

**Multidisciplinary working**

Staff worked in conjunction with other health and social care providers such as doctors, nurses and social care staff to ensure patients’ needs were met before, during and after their transfer.

PTS staff had a positive working relationship with GPs and the hospital which had developed from training provided by PTS staff on how to use the operational booking system. Discharge staff based in the hospital spoke highly of PTS staff and felt they demonstrated teamwork in ensuring patients’ needs were met at the time they were required.

Staff told us they worked well with the emergency ambulance service and gave examples where both services supported each other in their roles. This included responding to emergency ambulance service requests where a single paramedic had responded and could not transport the patient safely without an escort.
**Health promotion**

Staff sought, and supported patients to seek additional health and social care support if required to maintain their health and wellbeing.

We observed staff supporting people to retain their independence by encouraging patients to walk to and from their hospital appointments where they were able. Staff took their time to support people to walk safely between the ambulance and hospital enabling them to retain an element of independence and encourage their overall fitness.

The provider had a Crisis Response Team available to support patients if identified they required additional support or health or social care intervention. If staff were unhappy with a patient’s ability to manage independently at home or had concerns regarding their physical or mental wellbeing they would seek support from the crisis response team. This service would organise emergency respite for the patient to ensure their health needs were met.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguard**

Staff had received training and were able to demonstrate they complied with the requirements of the Mental Capacity Act 2005 (MCA) when supporting patients appropriately. Staff told us they had completed the training however the course had not yet been uploaded onto staffs individual training files. As a result the provider was unable to identify the overall completion rate for this training.

The service had guidance in place (Mental Capacity Act 2005 – Guidance for staff in Health and Social Care) describing staff responsibilities when supporting patients who were not always able to make their own decisions. Staff were able to provide clear examples of when and how to seek patient consent and had a good working knowledge of the need for capacity. Patients told us and we saw staff sought consent prior to starting a journey. If staff identified a patient did not have capacity to agree to their transport they discussed the need for transport with a family member, health or social care professional who knew the patient. A decision made in the person’s best interest would then be made to transport the patient with an escort know to the patient to minimise any distress they could experience by being in an unfamiliar environment.

The provider did not regularly transport patients under the age of 18, only two child patient transfer journeys had been completed in the previous year. Any patient under this age were required to have an escort for their journey which would have to be arranged prior to booking the service.

The PTS did not transport patients suffering from a mental health condition which could adversely affect their behaviour, displaying behaviour which could physically challenge for example. On these occasions emergency ambulance service staff would be required to support the patient with their transport needs. If a patient did not initially display behaviour which could cause themselves or other harm however this changed during their journey staff said they would take appropriate action. Staff were confident they would seek the support of the emergency ambulance service or police if required. Staff told us they would not have been be responsible for restraining patients to minimise the risk of them exhibiting behaviours which could harm themselves and others.
Is the service caring?

Friends and Family test performance.

From October 2016 to September 2017, the trust did not have enough respondents for the Emergency and Urgent care Family and Friends Test in order to populate an analysis.

(Source: NHS England Friends and Family Test)

Compassionate care

Patients and hospital staff spoke positively of the caring nature of the PTS staff offering examples where staff had gone the extra mile to ensure the wellbeing of their patients they supported. Discharge staff told us PTS staff had recently returned a patient home however there had been an error with the patients care company. Not willing to leave the patient alone and without support PTS staff provided the patient with drinks, prepared a meal and waited with them until the patient’s carers arrived. Discharge staff said, “They (PTS staff) go over and above, they stayed for two hours to make sure the patient was safe”. Another member of discharge staff said, “If they (staff) had taken the patient home and left them they could have fallen, it’s the care I would want for my family”.

Written feedback provided by patients consistently praised staff highlighting their ability to offer compassionate which exceeded their expectations. One patient had written, ‘(member of PTS staff) was extremely helpful and made the whole trip bearable, he was more than helpful in everything, he was a great guy and an asset to the NHS’. Another patient wrote, ‘Exceptional service’ and a further feedback form stated, ‘I found the care from the hospital to my home immaculate, two very friendly drivers, thank you so much to all concerned’. One patient told us, “They (staff are) caring, I’ve been pleased with them, they’re very good”. Another patient told us, “(staff are) Excellent, they’re caring, friendly and they’re very thoughtful”. This patient continued “They (staff) ask if you’re ok, ask how you are, how you’re feeling, if everything is ok, just very careful and thoughtful, they’re always asking how you are”. We observed kind and compassionate interactions with patients throughout their journeys.

Staff had built familiar, professional and comfortable relationships with regular clinic patients. Discharge staff told us staff knew patients by name and we observed people being called by their preferred name whilst they were being moved through the hospital. One patient said they would often see and speak to staff outside of the hospital and transport environment. They told us staff always took the time to speak with her outside of work, spoke to her kindly and asked after her wellbeing. This patient told us, “I’ve always got on with them, (staff) they’re very good”.

Emotional support

Staff spoke positively about ensuring patients had both emotional and physical support available to them upon their return home. Discharge staff told us when returning patients home PTS staff would ensure carers, a friend or relative was available to meet them if the patient wished.

Patients told us staff would ensure they were taken into their home safely and were comfortable and happy before they left. One patient told us staff had taken extra time to support them when they had been experiencing difficulties completing tasks prior to their journey, “I was pretty bad, I had a job of doing things but they (staff) were very, very, very good”. Staff asked patients throughout their journeys if there was anything else they could do to help them.
Staff demonstrated they understood how to meet people’s emotional needs and ensure their wellbeing was maintained during longer transport journeys. For example, during one transport journey the patient, who was living with dementia, began to show signs of emotional distress. To offer reassurance the member of staff sang with the patient during the journey which calmed their anxiety and ensured their emotional wellbeing.

**Understanding and involvement of patients and those close to them**

We saw staff continually interact with patients before, during and after their journeys to ensure patients knew where they were going in the hospital and the reasons for their journey. We observed a detailed handover where the patients’ needs were clearly and respectfully explained to hospital staff showing a clear understanding of the patients’ health and wellbeing.

Patients were unable to book the PTS independently; service bookings could only be made by health or social care professionals. Information was available to patients on the provider’s website to offer advice on eligibility for the service and alternative guidance on the transport options available to patients. This guidance supported decision making on the patients behalf so they received the most appropriate service to meet their specific needs.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The PTS provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition.

The service was able to meet patients’ needs at the time it was required. At the time of the inspection staff were available to support patients seven days a week from 7.45am to 2am Monday to Friday and from 9am – 6.30pm Saturday and Sunday.

As part of the services winter planning measures, in order to maintain a service which would meet the needs of the local population the service had added an additional late shift. This allowed for additional transfer journeys to be made minimising patient waiting times.

There were no key performance indicators set by the clinical commissioning group which would allow the service to provide evidence they were reaching any identified contract targets. The service, however, could evidence their ability to meet patients’ needs. 43% of the patient transfer requests completed in December were same day requests which were met by the service. This was documented within the provider’s monthly spreadsheet of all journeys requested and completed. The service continually reviewed transport requests aligning staff to identified periods of high demand. As a result they were able to meet this high proportion of same day journeys whilst continuing to conduct off Island transfers and regular routine planned work.

**Meeting people’s individual needs**

The service did not always comply fully with the Accessible Information Standard (AIS); patients did not always receive information regarding their care in a format they could understand. The AIS aims to make sure patients who have a disability, impairment or sensory loss receive information they can access and understand from health and care services.

Each ambulance had a patient communication booklet in accessible formats to help patients understand the care available to them. The service also supported patients to communicate their
needs with staff. This communication booklet contained pictures to aide communication. This was aimed primarily at patients living with dementia. We did not view any information available in a large print or braille format for patients with vision difficulties. Staff told us they had not transported people who did not have English as their first language. However, there had been no future planning to ensure the service had access to a language line interpreter system. This placed people at risk of not being able to communicate clearly with staff if they were unable to speak English.

Staff told us patients with learning disabilities or those with complex medical needs would be transported by the emergency ambulance service as they had the ambulances with appropriate seating systems with patient safety harnesses and medical equipment to keep people safe. The transport booking system made clear to the health and social care professional which mode of hospital transport would be the most appropriate to meet their patients’ needs. If patients did not meet the criteria for the PTS service they would be referred to the volunteer driver service or it would be suggested a taxi service would be the most appropriate form of transport if the patient had no specific health needs.

Patients living with dementia were supported by staff who were aware of how to manage their needs appropriately. All staff completed mental health act training which also included information relating to dementia. Staff were able to discuss how they would approach a patient living with dementia. This included how they would speak to, encourage and ensure the patient had additional support from a family member, friend, health or social care professional during their journey if staff felt this was necessary. An escort would provide familiarity and help support a patient who may suffer heightened anxiety when in an unfamiliar environment with unrecognisable faces.

All but three of the ambulances had additional capabilities with suitable moving and handling equipment to allow for the transport of patients weighing over 127 kilograms or 20 stone. This equipment included a special stretcher, chairs and winches in the ambulances to ensure patients could safely and comfortably complete their journey.

**Access and flow**

Requests for transport journeys were continuously reviewed to ensure the demand for work could be met by staff. The dispatcher and team leader reviewed booking requests and organised staff dependent on the patients’ needs in a timely way. This ensured the service was able to respond appropriately to patient demand.

In the event of a same day request for an off Island transfer the team leader, in conjunction with the dispatcher worked together to reallocated staff workload. Team leaders were also available during the day for patient transfer journeys and would join with staff to ensure patients did not have to wait unnecessarily for their treatment or care.

Systems were in place to monitor the location of ambulances available for use. Staff told us the dispatcher could track the mobile data terminal situated in each vehicle. Staff also informed team leaders when they were going to experience an anticipated delay of 15 minutes as soon as possible. As a result when a same day request was made or a delay anticipated the dispatcher could quickly identify an alternative crew with the most appropriate equipment to manage these requests so patients did not have to wait unnecessarily.

The service had a number of ambulances available in the event of an ambulance breakdown. This would enable patients to continue their journey with familiar members of staff. This is particularly important for patients living with dementia as changes in routine and unfamiliar faces can cause
distress. This system of ambulance replacement minimised the risk of disruption to patients’ routine supporting them to make their hospital appointments at the required time.

Requests for the PTS were made on an internet based system by health and social care professionals appropriately trained to complete. The booking system required the requesting individual to complete a number of questions regarding the patients’ needs to allow the service to allocate the right ambulance to meet their needs. The requester of services had to answer questions on the patients level of mobility, weight, GP details, reason for transfer request and the type of ambulance required, for example an ambulance with a bariatric wheelchair a stretcher ambulance. It also asked whether or not the patient was diabetic, had a ‘Do Not Attempt Cardiopulmonary Resuscitation’ notice in place or was suffering from an infectious disease. This information allowed the dispatcher and team leader identify the most appropriate crews and plan the most appropriate routes for staff so waiting time for patients were kept to a minimum.

As a result of a review of late patient transport journeys it had been identified an increase in transport delays was due to patients not being ready to depart their home address. As a result the PTS dispatcher rang patients 24 hours in advance of their journey. This enabled them to remind patients of the time they would be required to be ready and whether there had been any changes in their condition or mobility staff would need to anticipate. Staff told us this had decreased the number of late journeys as a result of patients not being ready however were unable to provide figures to support this.

**Learning from complaints and concerns**

Patients had access to information on how to make a complaint. During the inspection we saw patients were provided with information on how to complain if required. We observed patient information leaflets available on the ambulances and passed to patients during their journey. The leaflet contained contact details for the provider’s Patient Experience Team (part of the Patient advice and Liaison Service) and an independent health complaints advocate to support patients with making a formal complaint. Patients told us while they did not know how to make a formal complaint; they had not had the need to do so. In the event of a complaint the patients told us they would speak with staff who they had confidence would resolve the situation

Complaints were not always responded to within the timescales identified in the provider’s policy as necessary. The provider had a ‘Complaints, concerns and compliments’ policy which identified all the processes required to be completed when a complaint was received. This included the timescales for which a complaint would be investigated and resolved.

From October 2016 to September 2017, there was one complaint received about the PTS which we saw had been investigated thoroughly. The response however, had not been provided to the original complainant within the identified timescales. The provider’s policy stated formal complaints will be responded to within 20 working days with an additional 40 working days allowed for a more complex complaint to be resolved. The complaint, which related to the parking of the ambulance and staff behaviour, took 87 days before an explanation was offered to the complainant. The service offered their apologies for the delay when providing their response.

Following investigation the learning from the complaint was shared with staff to minimise the risk of reoccurrence. We saw the circumstances of this complaint had not been repeated after staff had been made aware of the complainants concerns.
Is the service well-led?

Leadership

The service operated within the providers’ clinical business unit (CBU) which included ambulance, urgent care and community services. The Head of Operations for the CBU had joined the service 11 months prior to the inspection and the Clinical Director was holding an interim position until March whilst a replacement was sought. Whilst the CBU was developing their management structure a number of managers were holding interim positions. However, staff told us this had not had a negative impact on their role.

Staff told us the new management structure was positive and they felt they were being listened to. New managers were felt to be proactive with their approach and had implemented positive change. These changes included reviewing the ambulance fleet; aligning staff pay to meet equivalent roles and involving staff in discussions around a new vision for the service.

Staff felt supported by a visible and supportive immediate managerial team. This included the team leaders and fleet and operations manager. Staff felt confident they could speak with managerial staff at any time if they wished to. One member of staff told us, “They’re (managers) quite easy to access any additional support directly and even if you’re off for a week there’s always an opportunity to give (them) a ring”.

The service did not ensure effective succession planning was in place when leadership roles became vacant to ensure continuity of management for staff. One senior team member was leaving the service and staff told us the service would suffer as a result as there was nobody to replace them. One member of staff told us, “They (the service) would be lost without (senior team member)” which two other members of staff agreed. The member of staff was a well-respected and knowledgeable member of staff who confirmed they had not been replaced and no action had been taken by the provider to ensure their role was filled. This member of staff took proactive action to improve the quality of the service, such as driving forward self-imposed performance indicators and the effective use of computer systems. There was a risk improvements in the service would slow as there was no identified person in a position to take their place and continue their work.

Vision and strategy

At the time of the inspection staff could not recognise or discuss the provider's and clinical business units vision and values. These are clearly defined identifiable phrases or statements which indicate how the provider wished patient care and support to be delivered. The service was in the process of developing a vision and set of values for the PTS which some staff said they had been asked their opinion and involved in.

Not all staff we spoke with recognised and understood the overall future strategy for the PTS. Only two staff we spoke with recognised the strategy was to operate a three tier system introducing a high dependency transport service to support the emergency ambulance service. Other staff were unable to discuss the services strategy for future service.

Senior managerial staff acknowledged vision and values for the service had not been fully developed and there was no written strategy with measurable outcomes. Following a previous CQC inspection however, action plans to improve the service were included in the Trusts Integrated Improvement Framework. The plan was for this to address all the actions required by
the ambulance services. This was still under development at the time of the inspection but senior managerial staff said they were in the process of sharing this information with staff and seeking their feedback.

**Culture**

Staff told us they felt respected and valued by their team members and their immediate managers and felt they worked within a supportive environment. One member of staff told us, “Good team and people offering a champagne service on lemonade money” another member of staff said, “The whole crew is good. The management is very good.” The service identified good work and ensured staff recognition by documenting in staff records and displaying thank you cards and positive patient feedback in the crew office. A recent ‘thank you’ card had been received by the provider’s Chief Operating Officer thanking staff for ‘Doing such an amazing job over the working weekend, you all worked so hard to support our patients and caring through what were, at times challenging periods of uncertainty’. Staff said the change in management within the clinical business unit including the recruitment of the new Head of Operations had led to an increase in morale as staff felt they were being listened to and positive action was being taken on their behalf.

Most staff felt they were part of the bigger organisation. Staff told us they felt they were integrated with the trust, enjoyed being part of the NHS and working closely with their emergency ambulance service colleagues. This was not a view shared by all however and one member of staff felt that whilst there had been improvements in staff morale the PTS felt a standalone service which did not feel part of the trust. The member of staff continued they had different uniforms and a different base to the emergency ambulance service and felt they were separated despite being part of the clinical business unit.

Staff felt managers and colleagues demonstrated openness and honesty with their daily interactions. We saw this during conversations between staff and senior team members. These were honest conversations and staff felt comfortable to express concerns about the service in an open forum with senior staff being present.

Staff felt their wellbeing needs were met. Staff had protected lunch and regular breaks planned into their workload which we saw were adhered to. Bank staff were offered shifts which met their needs and there were no pressures placed upon them to take additional work if they did not wish to work. One member of staff told us, “Overall they (the service) do try and look after staff” and another staff member said, “No complaints from that point of view, they (the managers) have our best interest at heart”.

**Governance**

The provider could not evidence systems in place to support the management of the service were always effective.

At the time of the inspection there had been a change of staff at director level for the service. The provider’s ‘Ambulance, Urgent Care and Community – Community Quality Patient Safety and Risk Meeting’ held 8 January 2018 identified the provider was in the process of compiling a new governance structure which was awaiting completion before being shared with staff. This would support staff in identifying clear lines of leadership and governance within the trust. Staff told us, “Above (team leaders and manager) we don’t really see them”, another member of staff said, “I’m not sure that we’ve met (staff above their manager) messages go up and down I think”.

A weekly performance meeting was held with representatives from the ambulance clinical business unit (including the emergency ambulance service and PTS), emergency department and community services. Senior staff acknowledged these meetings were not always effective as they
focused on identified key performance indicators in place for other services and not on overall performance. The need to change the content of the meetings had been identified and senior staff had been asked to provide their views on what they wished to see discuss the week before the inspection. However, at the time of the inspection the reviewed format had not come into place.

There was an operational management team meeting (OMT), which met on a Friday which included a representative from the PTS. Actions from the OMT needing second or final approval, or issues not resolved at OMT, were discussed at a fortnightly senior management team (SMT) where governance issues were a standing agenda item. Any actions requiring agreement or escalation went to the CBU meeting. Senior staff, however, told us they were not challenged at the SMT meetings about the PTS service’s ongoing performance.

A monthly CBU performance review meeting was held, however, related to the emergency ambulance and community CBU service only. The SMT meeting minutes reviewed identified there was not an ongoing quality monitoring system in place for the PTS. The provider could not evidence these meetings were an effective way of monitoring the services performance identifying where improvements could be made.

Senior staff agreed they participated in one to ones with the manager to discuss the services performance. These meetings, however, were not minuted therefore they could not evidence the content discussed and where actions had been identified as necessarily for completion.

Staff told us they had staff meetings and informal discussions with team leaders on a regular basis. We asked to review copies of staff meeting minutes however; these were not provided therefore we were unable to assess the effectiveness of these meetings. Staff told us they felt the meetings were, “Useful, very much so”, and they had been kept updated with the changes relating to the use of the mobile data terminal and the new operating system which was being introduced. Staff told us the team meetings were well attended and were an opportunity to discuss potential changes in the service such as the potential introduction of the three tier system to support emergency ambulance staff.

The service ensured staff who worked with other departments such as the emergency ambulance service did not work excessive hours which could impact on their ability to provide safe care. The provider’s resourcing team utilised an electronic system to monitor staff working hours. They informed team leaders and the manager if staff were not receiving 11 hours between their shifts. Rotas evidenced staff were receiving sufficient breaks between their shifts with staff being moved from early to late shifts to ensure they received a break period.

Management of risk, issues and performance

The service did not always operate an effective service to clearly identify, document and review risks to ensure they were monitored appropriately with mitigating action taken to minimise risks to the service provision.

The risk register documented identified risk, the triggers which would commence the risk, an identified risk owner and a risk rating. Risks were reviewed according to their level of severity and possible impact on the quality of the service provided. They were colour coded to make it clearly identifiable when they required reviewing. Red risks were reviewed monthly, orange risks quarterly and green risks twice a year, the system allowed for automatic reminders being provided to risk owners to make them aware action and an update was required. An action plan was in place to support each of these risks and documented action to be taken to minimise the identified risk.

The risk register was not aligned with operational risks, for example the lack of safeguarding children level 2 training. The risk register for the clinical business unit documented 19 risks
however; the only risk identified for the PTS was titled ‘insufficient fleet to meet demand and activity in the ambulance service’. At the time of the inspection staff told us there was no oversight of these risks to ensure progress was made where required. Immediately following the inspection the provider submitted an updated risk register. This identified a meeting had been held with the Operations Manager and the Fleet and Operations manager to review the risk, identify any gaps in managing the risk and nominated additional actions.

There were few systems in place to monitor the quality and safety of the service provided. Audits, when used, were not always completed fully when shortfalls were identified. Staff told us the provider’s infection control leads would be responsible for conducting infection control audits however, none had been completed since the last Care Quality Commission Inspection completed 22 and 24 November 2016.

Records identified PTS vehicle inspection booklets were audited monthly to ensure staff completed and documented their daily checks as required. We saw the audits were completed and staff provided with feedback to identify where improvements were required.

The service had a Business Continuity Plan in place to provide guidance to staff on the action to take in the event of an unplanned situation. This included documented actions in the event of an information technology failure or loss of staff resources which could impact on service delivery. This was reviewed annually to ensure the guidance provided remained appropriate.

Staff completed e-learning in chemical, biological, radiological and nuclear events. However, an inspection by the National Ambulance Resilience Unit immediately prior to this inspection identified the provider was not meeting all the areas of compliance for managing these types of incidents. In immediate response a new tactical plan had been written by the provider on how to manage these incidents whilst they took action to meet the required compliance level.

**Information management**

The service did not have key performance indicators which would identify if the PTS was working within nationally recognised and published guidelines such as specific collection times for patient response. It also did not allow the service to record the time provided by a hospital ward or department a patient would be ready for transfer and how long it took PTS staff to respond. Information relating to patient waiting times had to be monitored and inputted manually into a spreadsheet which took time to organise.

The service had recognised their existing computer programmes did not meet the needs of the service. To address this need the service were developing their own performance indicators which would be included within their new electronic computer aided dispatch system. This would allow the service to monitor and immediately identify if patients were waiting an excessive time (over 30 minutes) for collection.

**Engagement**

The service sought patient feedback on how to develop and improve the quality of the service they received. The ambulances contained details on how patients could provide their views on the service received. We saw ‘I Want Great Care.org’ leaflets being handed to patients during their journeys to seek their feedback. Patient feedback forms were available for patients to complete online so they could complete anonymously if they preferred.

Patient feedback received was very positive of the service received. From December 2017 to the date of the inspection we saw reviewed 72 completed feedback forms. Patients were asked to rate the likelihood of recommending the service to friends and family, what was good about their care and what could be improved. Of the 72 responses 66 patients said they would be ‘highly likely’ to
recommend the service, five said they would be ‘likely’ and one patient had not responded to this question. Positive comments were reviewed and included, ‘I am reliant on hospital transport, everyone is so helpful and cheerful a real godsend to me’, ‘You are all very nice, I wouldn’t manage without you’, ‘Friendly caring polite staff, made us feel at ease in this difficult time, thanks’, ‘Exceptional service’, ‘I cannot think of any improvements as far as I’m concerned is excellent’.

The service took action when suggestions were made on how to improve the service provided. GP services asked the service to create an information leaflet which they could place at their receptions for patient access. It was requested the information explain the available and most appropriate transport options available to patients. This made the requesting and booking process via the GP more appropriate as patients were aware if they met the criteria to receive this support. We saw these leaflets were detailed and included information as requested by the GPs.

Staff felt supported in raising concerns with senior staff and managers about service practice and were aware of the concept of whistleblowing. Whistleblowing is when an individual raises concerns, usually to their employer or a regulator about a poor or illegal work place which could affect others. Staff told us they would have no hesitation in raising issues if they felt they had observed poor or unsafe practice.

**Learning, continuous improvement and innovation**

Patient feedback and staff discussions evidenced staff continually provided high quality care to the patients they supported.

In order to continuously improve, the service was implementing a new operating system which would include identified key performance indicators. These would allow staff to measure if they were meeting key minimum standards and identify what action would be required to improve the quality of service provision.

The service had created a heat map to map their resources to ensure they had the right staff at the right place at the right time. This also allowed for seasonable trends such as the summer with the increase in visitors to the island and winter pressures where demands on services were often greater. This piece of work had been identified as necessary and driven by the PTS and the service was proud at the success of this work which meant staff were better placed to meet patients’ needs.

The provider recognised and highlighted when staff provided a high quality service. Thank you letters received by staff were copied to the Head of Operations who responded to the staff members in writing in response.
Emergency operations centre

Facts and data about this service

The emergency operations centre (EOC) for the Isle of Wight Ambulance service is located on the site of St. Mary’s Hospital in Newport. The EOC is located in a multidisciplinary hub office that contains desks for other trust services such as community health services, and 111 services. The emergency operations centre took 17,949 calls in the year January 2017 - December 2017. The EOC takes 80 – 110 emergency 999 calls a day on an average day and 200 – 400 at the weekend.

During our inspection, we spoke with 22 staff and listened to twelve 999 calls and six 111 calls. We spoke with 22 staff including, five call handlers, three clinician, one dispatcher, two clinical support officers and three performance support officers.

We inspected the whole core service and looked at all five key questions.

Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

In the emergency operations centre, both administrative and clerical staff and additional clerical services staff failed to meet the target with administrative and clerical staff having 70% and additional clinical services staff having 80% compliance overall.

Mandatory Training Completion by module – Administrative and Clerical

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People Handling (Online)</td>
<td>3</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>People Handling</td>
<td>3</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Control of Substances Hazardous to Health</td>
<td>42</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (Online)</td>
<td>42</td>
<td>95.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Part 1 – Theory</td>
<td>42</td>
<td>90.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Telephone Conflict Resolution</td>
<td>39</td>
<td>89.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>42</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Borne Virus Training</td>
<td>41</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>42</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Display Screen Equipment</td>
<td>42</td>
<td>81.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>42</td>
<td>81.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Administrative and clerical staff working in the emergency operations centre met the trust’s target for eight out of the 20 training courses listed above. Training courses with the lowest compliance levels included paediatric resuscitation (eight out of 38 members of staff completed this) and adult resuscitation (ten out of 41 members of staff completed this).

**Mandatory Training Completion by module – Additional clinical services**

A breakdown of compliance for mandatory courses from April 2017 to September 2017 is shown below:
Additional clinical services staff working in the emergency operations centre met the trust’s target for 13 out of the 21 training courses listed above. Training courses with the lowest compliance rates included paediatric resuscitation four out of 12 members of staff completed this) and people handling (one out of three members of staff completed this).

(Source: Trust Provider Information Request)

Staff received effective training in safety systems, processes and practices. Staff had protected time to complete classroom training and completed mandatory e-learning courses at quieter times during night shifts.

Compliance with mandatory training was not as expected for all subjects for example compliance with adult and paediatric resuscitation for staff working in the EOC was low. Staff working in the EOC were not frontline workers so this did not pose a significant risk to patients.

Managers monitored compliance with mandatory training and reminded staff of upcoming training to complete every month. Staff kept track of their training using the trust learning management system. Mandatory training compliance was reviewed at clinical quality and effectiveness group meetings every month.

Safeguarding

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Safeguarding Training Completion by module – Administrative and clerical staff

A breakdown of compliance for safeguarding courses from April 2017 to September 2017 for administrative and clinical staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>42</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>41</td>
<td>56.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>41</td>
<td>4.9%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Administrative and clerical staff working in the emergency operations centre met the trust’s target for one of the three safeguarding courses; safeguarding children level 1. Notably, there was a really low compliance rate recorded for safeguarding children level 2, with only two out of 41 members of staff having completed this.

Safeguarding Training Completion by module – Additional clinical services

A breakdown of compliance for safeguarding courses April 2017 to September 2017 for staff working in additional clinical services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Lev 1</td>
<td>17</td>
<td>94.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 3</td>
<td>8</td>
<td>87.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>15</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Additional clinical services staff working within the emergency operations centre met the trust’s target for two of the four safeguarding training courses; safeguarding children level 1 and safeguarding children level 3.

(Source: Trust Provider Information Request)

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, we were not assured safeguarding adults, children and young people was given sufficient priority as staff training rates for safeguarding adults level 1 and safeguarding children level 2 were low.

Staff we spoke with understood how to recognise safeguarding concerns. Call handlers were aware of the warning signs that might make them raise a safeguarding alert. Examples we were given included calls from intoxicated children or care homes who had given a resident an incorrect dose of medicine.

Staff could describe the process for raising a safeguarding alert. Call handlers would record the safeguarding on the electronic system and make the clinical support desk aware. There was not an automatic referral system. Clinicians and ambulance crews reported safeguarding concerns to the local authority by phoning the local authority safeguarding team and submitting an electronic form.

A noticeboard with information about safeguarding was displayed in the control room. The noticeboard included contact details of the ambulance and the trust level safeguarding lead, adult at risk flowchart, child protection awareness information, domestic violence helpline and the Isle of Wight safeguarding newsletter. A reminder to EOC staff about listening out for potential safeguarding issues was included on the digital noticeboard screen. Staff were aware of the ambulance safeguarding lead and could access them for advice.

The ambulance safeguarding lead reported it was a challenge to release staff for safeguarding children level 2 classroom training. The training rate for administrative and clerical staff for safeguarding children level two was 4.9% of 41 staff.

We requested current safeguarding compliance levels for safeguarding adults level 1 and safeguarding children level 2 as of 31st January 2018 – (IOW294)

<table>
<thead>
<tr>
<th>Competency Name</th>
<th>Number Required</th>
<th>Number Achieved</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Lev 1</td>
<td>61</td>
<td>46</td>
<td>75%</td>
</tr>
<tr>
<td>Safeguarding Children Lev 2</td>
<td>61</td>
<td>13</td>
<td>21%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>122</td>
<td>59</td>
<td>48%</td>
</tr>
</tbody>
</table>

Clinicians working in the EOC were level 3 safeguarding children trained. Mandatory training records we received showed 87.5% of additional clinical services staff had had completed this training.

Safeguarding policies were clear and the ambulance service had additional safeguarding protocols for vulnerable groups. We reviewed the clinical notice for ‘Conveyance and safeguarding of patients under 18 presenting with self-harm or intoxication’ effective 1st July 2016 and the standard operating procedure ‘Under 18 Self Harm’, effective August 2016 and found the policies were appropriate and current.
Safeguarding was a standard agenda item for the clinical effectiveness group. We reviewed three sets of minutes for the clinical effectiveness group and found there was no evidence of discussion of safeguarding issues.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff informed ambulance crews of infection risks.

Staff working in the hub achieved the trust target of 85% of staff trained in infection prevention and control – 85.7% of administrative and clerical and 88.2% of additional clinical services staff had completed infection prevention and control training.

Call takers told us if they need infection prevention and control advice they would speak with clinical staff. Clinical staff said they would seek additional advice from the infection prevention control team.

Clinicians passed information to dispatchers regarding infection prevention control. For example if a patient had diarrhoea and vomiting. Clinicians we spoke with told us if there was an infection outbreak, clinicians would contact the emergency department and local care homes.

We observed staff in the hub wore uniforms and had access to hand sanitiser gel.

The service did not have an infection prevention control policy specific to the ambulance service but worked with the trust policies. These policies were not relevant to the EOC.

**Environment and equipment**

The emergency operations centre had suitable premises. However, the computer-aided dispatch system (CAD) was slow and did not always provide accurate information on the location of crews and business continuity plans were passed their review by date.

The EOC was a suitable working environment. Information was displayed on seven large screens in the emergency control room. The screens displayed the following information – a staff noticeboard, CCTV of the island provided by the local authority, hospital CCTV, live performance data, a map of the island with the location of ambulance vehicles, tracking of call activity and the national news. Contact details were displayed in the hub of the helpdesk for the software used to triage and record 999 calls.

The EOC was secure and only accessible to staff with a key card. However, inspectors were let into the hub building twice without staff checking passes.

The computer-aided dispatch system was slow to load addresses. This was a potential risk as it impacted on the speed of the triage. We observed delays of 30-40 seconds whilst call-takers waited for demographics information to load.

Due to issues with the computer-aided dispatch system, the service did not have access to accurate real time information regarding the position of vehicles and crews. This was a risk to patients as there was a risk of a delay in dispatch of ambulance resources. This was because the dispatcher would need to radio crews to confirm their location before making a decision about which vehicle to send. For example, at 10:24 on Wednesday 24th January two out of six vehicles were out of signal range for the system and therefore did not appear on the map. There was also a potential safety risk for the ambulance crews as at times the service would not be aware of the exact location of crews.
We reviewed the asset register of equipment, found safety testing was carried out yearly. Business continuity plans were available on staff desks. However, we reviewed these plans and found they had passed their review by date of March 2017. The folder included flow chart instructions for the following events - in case of fire, telephone failure, radio failure, power supply failure, system failure. Staff had access to paper log books for use in the event of system failure. Laptops loaded with Solo2 NHS Pathways triaging software and paper forms were available in the event of system failure.

Staff completed Display Screen Equipment risk assessments as part of their mandatory training. 81% of administrative and clerical staff and 94% of clinical staff had completed the training. Staff we spoke with were aware of how to access occupational health through their manager.

Staff had access to up to date satellite navigation systems to support the dispatch of ambulance resources. A performance support officer told us the system received updates from Ordnance Survey every six months and the local council emailed the service updates regarding new roads. The trust confirmed the maps were hosted by Ordnance Survey and therefore were constantly updated.

Assessing and responding to patient risk

Staff recognised and responded appropriately in the risks to people who use the service.

Staff used NHS Pathways, a nationally accredited triage system to assess the level of risk for a patient. Call handlers asked a series of questions prescribed by the pathway, which start with life threatening issues such as whether the patient was breathing and conscious. These helped to assess whether the patient was in a life-threatening situation. The aim was to ensure prompt dispatch of an emergency ambulance if the patient's life was at risk.

Staff checked the ‘special notes’ on the patient record to assess and respond to patient risk and arrange appropriate care. Most ‘special notes’ were on the 111 rather than the 999 software system, but staff were trained in both systems and clinicians routinely checked both systems for information. We observed a situation where a dispatcher was aware a patient was known to be violent only because they had managed a call out to the same location recently. If this dispatcher had not been on duty staff may have been sent without the required back up.

Staff we spoke with demonstrated a good awareness of the signs and symptoms of sepsis. If call handlers suspected sepsis they would get advice from a clinician. ‘Think Sepsis’ prompts were displayed on computer screens.

Clinicians and dispatchers listened in to 999 calls to guide the call handler when necessary and ensure appropriate support was dispatched as quickly as possible. Staff could contact each other through instant message during calls. Dispatchers listened into 999 calls to ensure a crew with the appropriate skill mix was arranged.

Clinicians carried out welfare check calls to people waiting for an ambulance on a half hourly basis or sooner depending on risk. Clinicians liaised with the dispatcher and kept track of the condition of patients waiting for an ambulance to arrive on the scene. We observed a call being re-triaged as when the clinician carried out a welfare check the patient’s condition had changed. This led to a change in response.

The service had a policy in place for contacting crews for outstanding red1, red 2 and multiagency calls. If there were calls requiring an emergency response but all ambulance crews were with
patients or on the road, the dispatcher would call on an open channel asking crews to respond if they were able to clear the patient immediately and attend the emergency call.

**Staffing**

**Vacancy rates**

From October 2016 to September 2017, the trust reported an overall vacancy rate of 16% for additional clinical services staff working within the emergency operations centre.

Data for administrative and clerical staff was not provided by the trust.

(Source: Trust Provider Information Request)

**Turnover rates**

**Administrative and clerical staff**

From October 2016 to September 2017, the trust reported an overall turnover rate of 0% for administrative and clerical staff working within the emergency operations centre.

**Additional clinical services**

From October 2016 to September 2017, the trust reported an overall turnover rate of 14% for additional clinical staff working within the emergency operations centre.

(Source: Trust Provider Information Request)

**Sickness rates**

**Administrative and clerical staff**

From October 2016 to September 2017, the trust reported an overall sickness rate of 8% for administrative and clerical staff working within the emergency operations centre.

**Additional clinical services**

From October 2016 to September 2017, the trust reported an overall sickness rate of 5% for additional clinical services staff working within the emergency operations centre.

(Source: Trust Provider Information Request)

At our last inspection it was identified that staffing levels in the EOC consistently did not meet the planned levels and staff worked flexibly to manage this risk. Whilst we found some improvement in the staffing levels of call-takers, the staffing of the performance support officers, clinical support desk and dispatchers remained a significant risk.

Rotas and shift patterns were aligned with demand. There were four call-takers on duty weekdays (four until midnight, three after midnight) and seven or eight on duty at weekends. There were a minimum two call handlers at night. A rostering team managed staff rotas and monitored the hours staff worked to ensure they did not work excessive hours. Cover for staff absence was arranged by sending fast texts to staff asking them if they could cover shifts at short notice.

Some call-handlers were trained to answer the hospital switchboard as well as respond to 999 and 111 calls. The service did not monitor how many staff were triple-trained or how often they were used to staff the switchboard. We observed a 999 call handler covering the switchboard for a short period to cover a lunch break. This was a risk as staff working on the hospital switchboard were not able to respond to 999 calls as the desk was the other end of the room and not connected to the NHS pathways system needed to triage calls. The service was not monitoring to see if the hospital switchboard was impacting on the ambulance performance.
Actual versus establishment staffing levels for the EOC at the time of the inspection were 60.70 planned WTE staff versus 60.77 WTE staff. At the time of the inspection 73 staff were employed in the EOC. The establishment for call handlers was 28 WTE staff.

Actual vs. establishment WTE staffing by job role in the EOC:

<table>
<thead>
<tr>
<th>Job role</th>
<th>WTE actual</th>
<th>WTE funded establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call handlers</td>
<td>33.05</td>
<td>33.58</td>
</tr>
<tr>
<td>Dispatchers</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Service Desk</td>
<td>10.28</td>
<td>10.03</td>
</tr>
<tr>
<td>Performance Support officer</td>
<td>6 (with 4 in seconded roles)</td>
<td>6</td>
</tr>
</tbody>
</table>

There was a clinician on the clinical service desk at all times during our visit to provide medical advice. This is a licensing requirement of NHS pathways. At the time of the inspection 10.28 WTE clinicians were employed. Clinicians worked day shifts 07:30 – 19:30, late shifts 11:00 – 23:00 and night shifts 19:30 – 07:30. Between 7:30am and 11pm two clinicians worked in the hub. There was only one clinician in the hub 11pm to 7am.

There had been an incident on the 16th January 2018 when the night clinical support desk shift could not be covered due to short-term sickness of a staff member. A paramedic was called in to staff the clinical support desk but they were not NHS pathways trained. The paramedic staffed the clinical support desk for four and a half hours, alone, until appropriate cover was restored. This was a breach of the NHS pathways licence as the paramedic was not trained in NHS pathways.

There was one dispatcher on duty per shift. The performance support officer whose role it was to manage the hub was able to cover the dispatcher role. The rostering system did not capture the times when the performance support officer was being used to cover the dispatch desk. At the time of the inspection there were four dispatchers, against the planned establishment of six. However, we were told one dispatcher was just finishing training and one was starting in the next two weeks. These two dispatchers would bring the service back up to the planned levels.

There were six full-time performance support officers at the time of the inspection against a planned establishment of six. However, four performance support officers were on secondment to other roles and there was no backfill. The four performance support officers on secondment carried out other roles including rostering and working on the computer-aided dispatch replacement project. In order to provide the required cover those on secondment were working additional shifts, with the rostering team monitoring total hours worked. Performance support officers worked 7am to 7pm and 6pm to midnight on weekdays and 1pm to midnight during weekends. After midnight until 7am there was a performance support officer on call. Call handlers told us there had been shifts with no performance officer on shift. In this case dispatch and CSD would cover and contact silver or bronze command.

The service did not use bank or agency staff at the time of the inspection. The service relied on existing staff to pick up extra shifts to provide cover for staff absence.

We were told staff got two 10 minute paid breaks and one 30 minute unpaid break during their shift. The service had incentivised call handlers to achieve 95% in their pathways audit by offering breaks up to 15 minutes if the monthly 111 target was achieved at 95%. During the day, staff from the audit team were able to cover breaks of call handlers when required. There was no rest break policy for staff in the EOC. We requested the rest break policy and were provided with a memorandum to staff dated August 2017 which did not refer to the EOC staff. We were concerned
that overnight there was no break cover for the clinical support desk or the dispatch so staff had ‘working breaks’ and were on-call when they went to the toilet or made a drink.

In the event of the call centre being at capacity calls would be diverted to another trust’s call centre.

The service had an up to date Resource Escalation Action Plan (REAP). The current REAP level was displayed in the hub. Contact numbers for escalation were displayed on the walls with details of how to contact tactical commanders and tactical advisors, strategic commander, local ambulance trust and, operational command.

The service had a flowchart for mitigating the risk of reduced staffing cover. The process included sending fast text messages to staff to cover shifts and cancelling non-urgent meetings and training course. The rostering manager escalated to the hub service delivery manager or tactical commander on duty once all avenues exhausted.

The service did not have a formalised workforce plan with details of their approach to recruitment and retention of staff. Since the last inspection, the service had submitted business cases to the trust to improve the establishment of staff.

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

The service recorded all calls for patient safety and performance monitoring. This was a requirement of NHS pathways licensing. The EOC handled 999 and 111 calls. There were separate software systems for recording patient notes according to the call type and staff were trained in using both. The priority and response of the call was recorded when the triage was complete.

We observed call handlers and clinicians updating patient records during and immediately after calls in a timely manner. All non-conveyances of patients were recorded in the 999 record with a reason recorded for the non-conveyance.

Calls were audited on a regular basis as part of the NHS pathways license agreement. Staff we spoke with were positive about the audit process and learning identified for them following audits.

Special notes were flagged on patients with information regarding do not attempt cardio pulmonary resuscitation (DNACPR) forms, anticipatory care plans, chemotherapy care plans and frailty care plans. Clinicians checked both 999 and 111 software systems for special notes so they could effectively triage patients. The service had no flagging for looked after children. Clinicians could see from the address if child was from a residential care home. Staff could access details of previous calls to 999 and 111 based on the name of the caller.

Notes were stored securely on the electronic system. We saw staff locked their computers when away from their desk to prevent unauthorised access.

**Medicines**

Staff gave callers advice on medicines well.

Call handlers we spoke with were aware of the advice they could give callers to self-medicate and the limits of the advice they could give. Call handers only advised patients to take paracetamol,
ibuprofen or medicines prescribed to the caller following the instructions on the prescription. We observed call handlers referring to clinicians when callers needed further medicines advice.

Clinicians had access to a national poisons database. We observed clinicians using the database to check medicines callers had taken or to check how toxic things were, for example when a caller had swallowed some cleaning fluid.

**Safety performance**

There were no clearly identified safety measures, therefore there was not a structured monitoring system and there was no information to demonstrate improvement against safety measures over time.

**Incidents**

Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

From December 2016 to November 2017, the trust reported no incidents which were classed as Never Events for the emergency operations centre.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the emergency operations centre reported one serious incident (SI) which met the reporting criteria set by NHS England from December 2016 to November 2017.

This incident was reported as treatment delay meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

From December 2016 to November 2017, staff for the whole ambulance service reported 75 incidents. This represented 1.7% of the total incidents reported by the trust. Of the 75 ambulance incidents, 28 incidents were reported that related to the ambulance ‘call/ control centre’. Of these 20 were classified as no harm and two were classified as low harm. None of these incidents resulted in moderate/severe harm or death.

(Source: National Reporting Learning System (NRLS))

Staff we spoke with were aware of how to report incidents through the electronic reporting system and by informing the performance support officer on duty. Staff gave examples of incidents they had reported including an abusive caller and the loss of an ID pass. We were not assured staff reported all risks relating to staffing levels within the hub. Staff had accepted it as normal for the PSO to act as a dispatcher if this role was not covered and staff who were unable to take breaks did not report this as an incident. However, a clinical support desk shift was left vacant in June 2017 and this was reported as an incident.

We requested a copy of incidents relating to staffing that had been reported through the electronic reporting system. We found that 14 staffing incidents were reported in the year before the inspection, of these two were graded as major, five were graded as minor and seven were graded as no harm. Of the 14 staffing incidents, seven related to the clinical service desk these related to the CSD not having the required level of cover. Two related to staffing of call handlers being at critical level even though this had continued over a period of time the number of reported incident was not reflective and the issues reported by staff.
Staff were aware of learning from incidents. A call handler gave an example of learning from a recent serious incident where there was a difficulty triaging a patient with breathing difficulties. Following the incident managers reminded staff to speak with the patient so they could assess their breathing. A notice with learning from the serious incident was displayed on the hub noticeboard. Managers emailed staff ‘don’t trip up’ reminders with how to avoid common mistakes. These notices were also displayed on the hub noticeboard.

We requested the root cause analysis for the last two serious incidents relating to the hub and found that incidents had been investigated and learning identified.

The duty of candour is a regulatory duty that relates to openness and transparency. It requires the providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Staff we spoke with understood that duty of candour related to being open and honest with people. Information provided by the trust stated the ambulance service had applied duty of candour three times in the year October 2016-September 2017. The two serious incident root cause analysis reports we reviewed did not contain evidence that duty of candour had been applied. The senior management team meeting minutes for 12 December noted that Duty of Candour had not been followed for some serious incidents.

We reviewed three sets of meeting minutes for the clinical effectiveness group and found incidents, including serious incidents, were standard agenda items on the clinical effectiveness group.

**Is the service effective?**

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

**Evidence-based care and treatment**

The service could not be assured that it met the licensing requirements of the NHS pathways requirements at all times due to lack of sustainable staffing of the clinical service desk.

The emergency operations centre managed calls in line with current evidence-based guidance. Staff used NHS pathways, an accredited software system, to triage calls. Call-takers could access clinical advice from the clinical support desk. Clinicians were able to listen into calls which we observed and saw they gave advice to call handlers to help them triage a call effectively. The service was planned so there was an NHS pathways-trained clinician based in the EOC at all times. However, there had been two recent incidents where the clinical support desk shifts had not been covered due to short-notice sickness. Frontline paramedics were used to cover the shifts but these staff were not trained in NHS pathways.

The service was monitored to ensure consistency of practice. The audit team sent out audits of calls on a regular basis according to how staff performed in previous audits. The number of audits varied according to staff performance, staff had four audits a year if they scored 86% - 93% and three audits a year when they reached an average 94% or above. Staff who scored 95% or above, received a certificate which was displayed on the EOC noticeboard. The audit team discussed audits with call handlers every three months face-to-face. Audits were carried out the second Thursday of the month in line with the commissioner’s requirements.

The audit process for calls was a reflective process, call-takers were asked to identify what went well and what didn’t go well in the call before talking it through with the auditor. Call handlers and
clinicians we spoke with were positive about the audit process for calls. Records and staff feedback confirmed discussion took place about the audit outcomes with positive as well as negative feedback given. Staff had protected time off the phone for discussion of their call audits with the team. If clinicians failed a call audit, they would have a clinical review with a learning plan and an episode of reflective practice. We observed evidence this process had been followed after a serious incident. An incident could lead to a themed audited or the selection of calls for audit was based on historical errors or feedback from crews.

At the end of 999 calls, call handlers told callers what help had been arranged and advised the caller to call 999 if the condition of the patient deteriorated to access further assistance.

The trust scored 100% in their audit of compliance against national institute of clinical excellence clinical guideline CG176 Head injury: assessment and early management and QS161 Sepsis.

**Pain relief**

People’s pain was assessed effectively in order to arrange appropriate care.

Staff assessed people’s pain using the NHS pathways triage system. We observed staff recording pain on the body map included as part of the pathway.

Call handlers asked to speak with patients directly to help them to assess the patients pain level using non-descriptive signs such as if they could hear if they were wincing with pain for example.

**Response times**

**Time to answer call**

Time to answer calls (emergency and urgent), measured by median, 95th percentile and 99th percentile. Time to call answering, measured by:

- Median time spent between Call Connect and call answer (i.e. the time below which 50% of calls were answered)
- 95th percentile of times from Call Connect and call answer (i.e. the time below which 95% of calls were answered)
- 99th percentile of times from Call Connect and call answer (i.e. the time below which 99% of calls were answered)
When comparing the trust to the average of all ambulance trusts for time to answer call using the median, the 95\textsuperscript{th} percentile and the 99\textsuperscript{th} percentile the trust are performing better than it. The trust’s median time to answer has consistently been one second which is less than the England average.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)

**Call abandonment**

This indicator is designed to ensure that ambulance services are not having problems with people phoning 999 and not being able to get through. This indicator measures the percentage of 999 callers who have hung up before their call was answered in an emergency control room.

**Percentage of calls abandoned before being answered:**

![Graph showing the percentage of calls abandoned before being answered from November 2016 to October 2017. The graph shows that the percentage of calls abandoned was lower than the England average from November 2016 to March 2017. From March 2017, the percentage of abandoned calls increased higher than the England average to a peak of 3% in June 2017. June 2017 was the worst performing month for the trust, with 3% of calls abandoned compared to the 2% England average. From June 2017, the percentage of calls abandoned has decreased to more in line with the England average of 1% in October 2017.](image)

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(Source: NHS England – Ambulance Quality Indicators – System Indicators)

Real time performance of response times was monitored by the performance support officer in the hub. They were responsible for recording the reasons when red 1 targets for dispatch of an ambulance was missed.

The trust board report included the following Ambulance metrics –

- re-contact rate following discharge from care by telephone
- re-contact rate following discharge from care at scene
- time to answer call (in seconds) – median
- time to answer call (in seconds) – 95th percentile
- time to answer call (in seconds) – 95th percentile

The trust reviewed performance data on dispatch for red 1 and red 2 calls and these were included in the board report we reviewed for December 2017. The performance reported at the December 2017 for September 2017 was red 1 – 64.3% and red 2 - 69.8%.
The Chief Operating Officer carried out a deep dive into failure to meet current performance standards, completed in September 2017. We reviewed this and found the report confirmed the ‘significant unreliability’ of the computer-aided dispatch system.

At the time of the inspection on Tuesday 23rd January at 12:30 for the 999 service there were 0 calls waiting, 999 calls answered, average ring time was 0:09 seconds, 0 calls had been lost and 999 calls answered with 5 seconds was at 80%.

The service monitored call handler ‘wrap up times’, the time between finishing a call and being ready to take another one. Staff were expected to be available and ready to take calls 85% of the time when they were not taking calls. The service ran monthly reports against this metric which the performance support officer reviewed.

The trust had been granted deferment from the Department of Health for implementation of the Ambulance Response Programme until the 1st April 2018. We reviewed the project charter for the Ambulance Response Programme and found that the full schedule and work stream scope was to be confirmed at the end of February 2018. Form the information provided there was a lack of assurance the trust would be able to meet the agreed deadline.

Patient outcomes

Calls closed with telephone advice

This indicator reflects how the whole urgent care system is working, rather than simply the ambulance service or A&E, as it reflects the availability of alternative urgent care destinations (for example, walk-in centres) and providing treatment to patients in their home.

**Percentage of emergency calls resolved by telephone advice:**

![Graph showing percentage of emergency calls resolved by telephone advice from November 2016 to October 2017.](image)

From November 2016 to October 2017, the percentage of emergency calls resolved by telephone advice at the trust was in general lower than the England average. The percentage was lower than the England average from November 2016 to August 2017. From March 2017, there was a trend of improvement for the trust as the percentage increased from 4.3% to 11.4% in September 2017 and dropped slightly to 10.8% in October 2017. For these latter two months, the trust performed slightly better than the England average.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)

Re-contact rate
This indicator measures patients re-contacting 999 within 24 hours of original emergency call; the following calls are excluded from the numerator:

- Re-contact for different patient
- Patients transported after first attendance on scene

**Percentage of patients who re-contacted following discharge of care, by telephone within 24 hours:**

From November 2016 to January 2017, the proportion of patients who re-contacted the service within 2 hours following discharge by telephone was lower than the England average. From January 2017, the proportion for the trust increased to greater than the England average. July 2017 was the worst performing month for the trust with 8% of patients re-contacting the service, compared to the 5% England average for the same month. From August 2017 to October 2017 the trust performed similar to the England average.

*(Source: NHS England – Ambulance Quality Indicators – System Indicators)*

Outcomes for people who use services were below expectations compared with similar services. At the last inspection the proportion of emergency calls resolved by telephone advice was lower than expected. The service did not demonstrate a sustained improvement against this indicator. For most of the year November 2016 – October 2017 the percentage of emergency of calls resolved by telephone advice remained lower than expected. When asked staff were unable to describe any particular action which had been taken to improve this, other than using the directory of services.

**Competent staff**

**Appraisal rates**

From October 2016 to September 2017, 23% of staff working within the emergency operations centre at the trust had received an appraisal, not meeting the trust's target of 100%.

A split by staff group can be seen in the graph below:
There were gaps in management and support arrangements for staff. Appraisal rates for staff working in the EOC were low.

Staff did not have an assigned line manager but were line managed by the performance support officer managing the hub during their shift on a day by day basis. Staff did have a named person identified who would complete their appraisal. The last inspection identified there was a lack of assurance staff received an annual appraisal and developed learning plans as part of this process. We were still not assured all staff were receiving an appraisal every year. Most staff we spoke with during the inspection had completed an appraisal although some staff said their appraisal had been cancelled due to short-staffing.

Appraisals included documentation of achievements, goals, objectives, performance, conduct, behaviour, training required or completed, staff comments and line manager comments. We reviewed the current appraisal log for staff in the EOC and found 27 out of 58 staff had not completed a yearly appraisal. Of the 27 who had not completed an appraisal, eight were new staff, two staff were on long term sickness leave and one person was on maternity leave. Of the remaining 16 staff who had not completed an appraisal, only two staff had booked appraisal dates.

Call-takers were well-supported during induction. Induction for call handlers included two weeks of NHS Pathways training, one week of training on standard operating procedures and systems and five weeks of coaching and mentoring. Call handlers were signed off as competent on completion of five weeks of mentored call handling. Call handlers we spoke with had a mentor to buddy them during their induction.

At the time of the inspection arrangements for mentoring call-takers had recently been reviewed. The service had developed a mentoring action plan – this action plan was triggered by conversation around getting call handlers signed off as competent. The service was investing in supporting call-takers through the training process in a structured way.

Staff had limited opportunities to develop in their roles or access further training. There was no career pathway for call-takers to develop into other roles such as dispatch in EOC. A clinician we spoke with said it was a challenge to find the time to complete objectives. Some staff we spoke
with felt the development plan was a tick box exercise, as requests for development were not acted upon due to staffing pressures. Clinical support desk did not have formal supervision. Clinicians could access clinical support from the ambulance service clinical lead.

Poor or variable staff performance was managed through the call audit process. If staff failed call audits they were offered an intense support package to enable them to retrain. This programme included a coaching plan with mentor for three shifts who reviewed calls and gave feedback to the call handler. Staff were encouraged to highlight any issues they were having early so audits, mentoring and support could be increased. The service had a standard operating procedure for call audits detailing the performance levels and the level of call auditing associated with them. Performance levels included – probationary period, exemplary performance, good performance, level 1 close monitoring and level 3 performance evaluation.

At the last inspection there was no formal system for ensuring Community First Responders registering for duty were competent in their role. During the inspection we found this issue had been resolved. Community First Responders (CFRs) were trained by the first aid team. Monthly updates of the current training levels of CFRs were inputted into a spreadsheet. Dispatchers had access to confirmation of the competency on a spreadsheet displayed on their screen that was updated every month.

We requested the project charter for workforce and training and the trust did not submit anything.

**Multidisciplinary working**

Staff of different kinds worked well together as a team to benefit patients. We observed good teamwork and supportive working relationships between call-takers, clinicians, dispatchers and performance support officers in the hub.

The EOC was located in a multidisciplinary hub. At the time of the inspection social services, district nurse co-ordinator, a tele-health emergency pendant service, pharmacy advice, the hospital car co-ordinator of PTS volunteer cars, Age UK, frailty crisis team and the hospital switchboard were co-located in the EOC. EOC staff had good working relationships with other staff and gave examples of how they co-ordinated care for callers with non-emergency care needs.

The EOC pre-alerted the emergency department of patients the ambulance service was conveying and reported ambulance capacity issues. The performance support officer reported outstanding ambulance jobs to the hospital bed manager five times a day. On Wednesday 24th January 2017 at 10:45am the report to the bed management stated 40% of red 1 calls and 59.8% of red 2 calls were responded to within the target. We requested the trust policy for pre-alerting the emergency department of ambulance arrivals. The hospital pre-alert policy was out of date and was due for review in November 2017. This policy stated that ambulance crews must not pass pre-alert information directly to the hospital. The service also submitted a memorandum dated 26th January 2018 (the day after the inspection visit) reminding ambulance crews to contact the EOC in the first instance to send pre-alert information to the emergency department. Staff were reminded only to pre-alert direct to the emergency department if they experienced significant delays to get through to the EOC, as for monitoring purposes the messages need to passed on, from a line where the conversation would be recorded.
We observed calls where GPs and other healthcare professionals requested urgent ambulance transfers for patients. GPs could request an ambulance response within one hour, 2 hours or within four hours.

The trust had a helicopter transfer procedure and a standard operating procedure for air ambulance response. Call handlers we spoke with described good working relationships with the fire and police services. We observed EOC staff record police or fire service reference numbers for incidents and kept staff informed of the estimated time of arrival time on scene. The use of “special notes” for certain patients including do not attempt cardio pulmonary resuscitation forms facilitated effective working across teams.

We observed a call where the caller was known to be violent. This issue was escalated to tactical commander and operational commander. The police were called and then fire service, in line with the standard operating procedure, as the door needed to be broken down.

Health promotion

Staff were proactive in supporting people to live healthier lives and maintain independence.

Clinicians could give ‘hear and treat’ advice to patients if the caller’s condition did not need an ambulance response. Staff had access a directory of services so they could refer patients to the most appropriate service to meet their care needs.

The service had close links with crisis team for frail elderly patients. They were piloting offering older patients who had suffered a fall a 72 hour trial of an emergency pendant in order to prevent a hospital admission and arrange care for people at home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard

Staff obtained consent to care and treatment in line with legislation and guidance.

At the last inspection we found call handlers did not receive training on the Mental Capacity Act. Mental Capacity Act training was now part of mandatory training for hub staff. We reviewed training records and found that 72.8% of staff (51 out of 70) completed Mental Capacity Act training as of the 31st January 2018.

Staff we spoke with understood the principles of the Mental Capacity Act for example, staff were aware of the principles of acting in the best interest of patients and people can have the capacity to make unwise decisions. Call-takers were aware of the impact of drugs and alcohol on people’s capacity to make decisions.

We observed call handlers always tried to speak direct with the patient wherever possible and explained to callers why they needed to ask them certain questions in order to arrange appropriate care.

Is the service caring?

Compassionate care

Hear and Treat survey

The Isle of Wight NHS Trust did not participate in the latest 2013/214 CQC Hear and Treat. *(Source: CQC survey)*

Staff cared for patients with kindness, dignity, respect and compassion.
We observed call handlers treating callers with dignity, kindness and compassion. Call handlers had a polite and calm manner and demonstrated a sensitive and supportive attitude to people. Staff empathised with patients in pain or in stressful situations. Staff reassured callers that they would organise appropriate care in a timely way.

Staff understood that callers to 999 could be distressed and were clear about how they would speak to callers in a calm and respectful manner at all times, including when people were abusive. Call handlers we spoke with were aware of the standard operating procedure for aggressive callers – the policy was to give callers three warnings and then terminate the call if necessary. Call handlers described how they would try to calm callers down by using phrases such as “help me, to help you”

Positive feedback from callers to the 999 service was displayed on a noticeboard outside the EOC. For example, callers had written to the service to thank them for the support the call handler had given them whilst giving instruction to carry out CPR. One caller had written to thank the call handler who “could not have looked after me better.”

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Staff provided emotional support to patients in distress by using active listening techniques and reassuring them that they would arrange appropriate support.

Staff could access trauma risk management – a counselling service for support following distressing situations. Call handlers could talk to the performance support officer for a referral to occupational health. Call-takers we spoke with told us managers were very supportive after distressing calls and would give call-takers the opportunity to take five minutes time out.

**Understanding and involvement of patients and those close to them**

*Staff involved patients and those close to them in decisions about their care and treatment.*

We observed staff involved patients directly in the call whenever possible and when it was not possible liaised with family members, carers, or members of the public making the call.

Staff gave information over the phone on how to keep patients safe until the ambulance arrived. For example, we observed a call where the call-handler located a defibrillator close to the scene of the incident so a patient could be treated for a heart attack as quickly as possible.

**Is the service responsive?**

By responsive, we mean that services meet people’s needs.

**Service delivery to meet the needs of local people**

The service was planned on a continuous basis. There was no specific variation for demand except for weekends and bank holidays when extra call handlers were on duty.

Dispatchers could deploy community first responders to reach patients in rural areas where there may be a delay in an ambulance arriving on scene.

Staff provided ‘hear and treat’ advice to patients who were not in life-threatening situations. Clinicians could triage and advise patients on self-management where callers needed medical
help but not an ambulance. Staff accessed a directory of services including pharmacies and GP surgeries. This meant more patients could be treated and assessed in their home and which in turn would help the service to ensure the best use of ambulance resources.

The trust met with commissioners to discuss the ambulance service every month. We reviewed the past two months of minutes for the meeting with the clinical commissioning group and found that the quality and performance of the service was discussed.

**Meeting people’s individual needs**

Emergency calls from patients for whom a frequent caller procedure is in place should be reported by the trust. Frequent caller procedures should be locally determined; these procedures should relate to individual patients and be agreed with that individual and the main care provider (e.g. GP, Mental Health Service).

**Proportion of calls from patients for who locally agreed frequent caller procedure is in place:**

![Graph showing proportion of calls from patients for who locally agreed frequent caller procedure is in place.](image)

From November 2016 to October 2017, the proportion of calls from patients for whom locally agreed frequent caller procedure is in place was consistently lower than the England average. However, from September 2017 to October 2017, this percentage slightly increased to more in line with the England average.

*(Source: NHS England – Ambulance Quality Indicators – System Indicators)*

Staff we spoke with were aware of people with frequent caller plans in place. Call handlers us they would triage the call to ensure the caller was not in immediate danger and then pass the call to a clinician to assess the caller. Clinicians gave an example of a person who called 999 every day, EOC staff worked closely with the local district nursing team to ensure the person was safe and cared for.

The service ensured that it was accessible to all. Deaf, hard of hearing and speech-impaired people could access 999 through an emergency text service. Call handlers we spoke with adapted their way of speaking in order to ensure they were understood by callers. Staff had access to a telephone translation service to support callers for whom English was not their first language.

Staff had access to dementia awareness e-learning modules. As of 31st January 2017, 18.3% of staff (13 out of 71) had completed tier 1 dementia awareness training. Call handlers described how they would adapt their call-taking style to support a person living with dementia and try to
speak to a carer if possible. If the call-handler did not think it was safe to triage the call, or if the caller responded as unsure to three questions, they would pass the call to a clinician.

Staff were aware of how to support callers with mental health needs. Call-takers described how they would ensure callers felt listened to by using active listening techniques. Staff could refer callers with mental health needs to the ‘Serenity team’ a partnership between the mental health team and the police.

**Access and flow**

People had timely access to the 999 service. Emergency 999 calls were prioritised over 111 calls. The 999 calls were identified by a unique telephone number to differentiate them from the 111 calls. A bell rang in the EOC when a 999 call was received; if a call-handler was not available the clinical support desk, dispatcher or performance support officer could answer the call. The trust’s median time to answer (November 2016 – October 2017) has consistently been one second which is less than the England average.

Calls were triaged and coded according to the disposition of the patient and the response needed. Performance support officers monitored the service in real time using information displayed on screens in the hub. All staff had details of the outstanding jobs displayed on their screens so they were aware of whether an ambulance had arrived at the scene. Clinicians did ‘welfare check’ calls to people waiting for an ambulance every half an hour to check on the condition of the patient and ensure the most appropriate care was arranged.

Performance support officers recorded the reason category A calls (requiring a response to an immediately life-threatening situation) response targets were missed. For example, at 10:05am on Wednesday 24th January – outstanding Red 2 in Shanklin – one transporting, two at A&E less than 30 minutes, one mobile to category A call and two on scene under 30 minutes.

We observed the performance support officer monitored missed category A, response times on a daily basis and these were reviewed weekly by the hub service delivery manager. If the missed category A call was due to an incorrect triage leading to the wrong pathway being followed the call would be audited and an incident reported.

The operational report delivered to the trust board in December 2017 reported ‘the Ambulance service targets were not achieved in October; a review of all the missed Red 1 calls was undertaken daily and confirmed that there were significant failures and shortfalls in the current CAD’s ability to provide live management of ambulances and accurate retrospective review of data.’

**Learning from complaints and concerns**

At the last inspection we found that complaints were not always responded to in 25 days. We found this had not improved and at the time of the inspection the trust took an average of 55.7 working days to investigate and close complaints.

From October 2016 to September 2017, there were five complaints about the emergency operations centre. Three complaints were closed and two (from April 2017 and May 2017) still remain open. The trust took an average of 55.7 working days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed within 20 working days or 45 working days for more complex complaints. One complaint from October 2016 took 108 days to close. All five of these complaints were related to transport (ambulance).

(Source: Provider Information Request)
Staff we spoke with were aware of the complaints process. Call handlers referred patients to the patient advice and liaison service if they wanted to make a complaint about the service.

Staff we spoke with were not aware of learning from complaints. They told us if a complaint related to a call they had handled they would hear about it through the audit team. The audit team were responsible for auditing calls relating to complaints.

We reviewed how the service had managed the last three complaints and found the trust took, 44 days, 139 days and 164 days to respond to the complaints. This was not in line with their complaints policy. The complaints related to delays in dispatch of an ambulance crew and poor communication regarding delays as well as delayed conveyance off the island.

Is the service well-led?

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

Leadership

There was a lack of stable leadership team for the ambulance service and little representation of ambulance services at board level. The trust did not have a succession plan for the development of new leaders.

At the last inspection we found that staff felt there was insufficient knowledge and experience among the managers within the clinical business unit to effectively manage the service. Staff raised concerns about the number of managers in interim roles and their ability to make decisions. We found that some progress had been made on these issues. Staff we spoke with were positive about the operations manager and hub service delivery manager.

The ambulance service was part of the ambulance, urgent care and community clinical business unit (CBU). The CBU had been running since November 2015. At the time of the inspection the trust was considering the current structure this included plans for the ambulance service to be managed as a separate clinical business unit led by a director of ambulance services.

A service delivery manager led the EOC and a resourcing officer managed the rotas for the EOC. The service delivery manager for the EOC reported to the ambulance operational manager who reported to the CBU Head of Operations, who reported to the CBU Clinical Director.

The Ambulance operations managers’ job description was a generic trust operations job description with no reference to the ambulance service. Therefore this was not actual reflective of what the job actually required or entailed. The operations manager was able to clearly describe the challenges faced by the service particularly the need for new computer aided dispatch system and the need to progress work on the new Ambulance Quality Indicators and the Ambulance Response Programme (ARPs).

Whilst there were still interim roles within the ambulance service the EOC service delivery manager’s role had been made substantive. The resourcing manager was still an interim position after nearly two years. At the time of the inspection the new job description for the service delivery manager had been re-written to reflect their role and agreed.

Staff we spoke with found the operations manager for the ambulance service and the hub service delivery manager to be visible, supportive and approachable. Staff were not aware of more senior leaders within the trust. Some staff spoke positively about the new chief executive and their approach to improving the recognition of the ambulance service in the trust.
Performance support officers who oversaw the daily management of the hub were overstretched. At the time of the inspection during one shift the performance support officer was undertaking frontline duties as the dispatcher rather than managing the control room. We observed that the performance support officer role included - first line management, appraisal, sickness management long and short term, probationary reviews, facilitating pathways training and dispatch cover. Covering the dispatch role was not in the performance support officer job description. The hub service delivery manager acknowledged that this large workload role was diluting the skills of performance support officers.

Call handlers did not have an assigned manager but were managed by the performance support officer on duty that day. This resulted in a lack of cohesive teams within the control room. The operation manager was considering the benefits of implementing a team approach although discussions with the wider staff group had not yet taken place.

There was little attention given to succession planning in order to provide effective and sustainable leadership. We requested the workforce plan for the service and the trust did not submit anything.

**Vision and strategy**

At the previous inspection there was no clear vision or strategy for the service. This had not improved at the time of the inspection.

Staff we spoke with were not able to describe a defined vision or strategy for the service.

At the time of the inspection there was no clear strategy for the ambulance service and the EOC.

An integrated improvements framework for the ambulance service was under development. The work streams included: capacity & demand, the computer-aided dispatch system, resilience, clinical standards, training, equipment, workforce, estates and lessons learned. These work streams were not, at the time of the inspection, underpinned by detailed, realistic objectives and plans for high quality sustainable care.

Following the inspection, the trust submitted a draft programme plan with timelines for completion of work streams tasks and staff responsible. The start date for identification of programme KPIs was 1st March 2018.

The trust also provided a document called the Ambulance Programme, dated 31/01/2018, the week following the inspection. This related to the integrated improvement framework, but did not have a clinical sponsor or sign off from the board. The document did not include measurable outcomes or project timelines.

The computer-aided dispatch replacement project plan submitted to us was not fit for purpose. Actions were not assigned to staff and tasks had been RAG rated as green when work had not started. At the time of the inspection the project should have been at the ‘Build, Configuration & Testing Phase 1’ but work on this phase had not started and previous steps were not complete. The completion date was still projected as the end of April 2018 despite the lack of progress. The service delivery manager told us the new computer-aided dispatch system was unlikely to be installed as originally planned although this information had not be shared with the wider staff group.

The service did not have a specific project plan for the implementation of the Ambulance Quality Indicators or the full Ambulance Response Programme (ARPs). We requested the project charter for the Ambulance Response Programme but received the general ambulance project plan which made reference to the ARP in terms of the creating a communications plan for ARP, impact of ARP on identifying patient outcomes, ARP requirements for patient feedback. Some initial work had been completed to amend the operating model in response to the change required for
implementing the ARP. Additional work required to plan for full implementation the ARP was scheduled for February 2018 despite the programme being introduced in July 2017.

Culture

Local managers were respected. However, improving the culture was seen as a high priority and staff development was not given sufficient priority.

Most staff we spoke with said they felt comfortable raising concerns with a performance support officer or the service delivery manager. Staff said the service delivery manager had an open door policy and had confidence in their leadership. Staff were not aware of who they could raise concerns with in the trust outside of managers in the ambulance service

Some staff spoke of doing their best for patients and being driven to provide a patient-centred service in line with the trust values ‘quality care every time.’ We observed that staff were a supportive and resilient team that managed well even when staffing levels were challenging.

There was little room for progression, access to training and development. For example, there was no clear career pathway for call-takers to develop into other roles in the EOC.

No formal action had taken place following a cultural review of the ambulance service in November 2016. The trust submitted a copy of the ambulance review action plan, this document was in draft form and had executive leads assigned but no assigned ambulance leads or dates for completing follow up actions.

The ambulance operations manager wrote to staff in November 2017 to acknowledge the lack of action following the cultural review. Staff were asked to anonymously respond to the question ‘How confident do you feel to speak up at work?’ They also organised three drop in sessions for staff to discuss anything with them. The outcome of these focus groups was not available at the time of the inspection.

Through discussion with staff it was evident there had been some changes in culture and being open and honest, but equally it was clear not all staff had been included in discussion and plans about development of the service.

Governance

Governance structures were complex and we were not assured of their effectiveness. There was a lack of action to mitigate risks identified.

There was an operational management team meeting (OMT), which met on a Friday. The senior managers team (SMT) met every other Monday. Actions from the OMT needing second or final approval, or issues not resolved at OMT, were discussed at SMT. Anything needing escalation went to the clinical business unit meeting. There was also a clinical quality and effectiveness group (CQEG) which linked into the SMT and OMT, through the clinical quality lead, but had a direct link the clinical business unit meeting (CBU). The CBU head of nursing and quality attended the CQEG. There was no ambulance specific governance structure. We requested an ambulance governance structure and received the generic trust governance structure in draft form.

We reviewed the last three operational management team minutes and found 999 &111 performance report, risks, and issues for escalation for SMT were standard agenda items. The hub service delivery manager, the rostering manager and the ambulance operational manager attended the meeting along with representatives from the PTS service and Urgent care. We also reviewed the last three operational management team minutes. Standard agenda items were
review of procedures and escalation from operational management team. While things were reported and there was some evidence of discussion, it was not always clear what action was to be taken when issues were identified for example when performance was below expected.

We reviewed the last three clinical quality effectiveness group minutes and found the risk register and mandatory training compliance was reviewed and incidents and complaints were discussed. There was also evidence of approval or review of clinical notes and some guidelines.

We requested the last three weekly ambulance urgent and community clinical business unit (CBU) meeting minutes and we were provide with minutes that related to the community part of the CBU and there was no reference to ambulances services. We also requested CBU quality meeting notes for the last three meetings and received one incomplete set of notes with no representative from the ambulance service present. There was no assurance quality and risk issues relating to the ambulance service were monitored at CBU level.

We reviewed the records of the last three ambulance urgent and community clinical business unit performance review meeting and found that ambulance performance, issues with the computer-aided dispatch system and recruitment of call-handlers were discussed. It was possible to track action from one meeting to the next with an up dated action log in place after each meeting in two out of the three reviewed.

We reviewed the board report from December 2017 and found the operational report included an update on ambulance performance and assurances as to why performance targets were not being met. It was noted that small numbers can swing the targets and that the implementation of the new computer-aided dispatch system would improve response times.

We reviewed the policy register and found 28 out of 102 procedural policies were out of date at the time of the inspection. Policies were reviewed at the operational management team meeting and sent to the clinical quality and effectiveness group for approval. Minutes of the 12th January 2018 operational management meeting showed that the service had agreed to organise a quarterly meeting to review standard operating procedures on an ongoing basis due to the number of procedures that needed to be reviewed.

Management of risk, issues and performance

While there was a governance structure which included in theory a process for escalation. However, through discussion it was clear identified risks may not have been given the attention and priority they required to ensure the provision of a safe service. Examples include the time it had taken for the process to replace the CAD system to being implanted and the delay in the service being able to comply with the implementation of the Ambulance Quality Indicators and the Ambulance Response Programme (ARPs).

There was no clear audit program to monitor the quality of the service provided. There was a heavy reliance on the audit of the use of NHS pathways. There was no evidence of using the other available information to drive improvement such as response times, incidents and complaints.

At the last inspection the risk register was not reflective of current risk. We found this had improved as the risk register had been reviewed and revised and did include the current risks identified during this inspection. The risk register included the computer-aided dispatch system, ambulance business continuity plans in case of fire, training of strategic commanders, poor staff morale, and failure of the trust switchboard.
Risks relating to the EOC included – inability to respond to an emergency as ambulance business continuity plans are not in place in all areas, computer aided dispatch not fit for purpose and failure to meet ambulance performance standards. The risk register detailed the controls in place to manage the risks and the gaps in the controls. However, controls in place were not dated so it was not clear whether risks had been reviewed regularly. The risk register had been updated with latest actions in December 2017. For example, the failure to meet performance standards was discussed at the ambulance risk workshop in December.

There were significant gaps in some of the controls identified. For example there was no training or testing of major incident plan.

The risk register did not include the chronology of action taken to mitigate risk. For example risk with the computer-aided dispatch system was a historic risk that was an issue at the time of the last inspection.

Performance metrics for the EOC were reviewed regularly at an appropriate level. Red 1 and Red 2 performance was reviewed in the weekly operational management meeting. The minutes for 12th January 2018 reported performance as - Red 1s – 35.29%, Red 2s – 60.53% and for the 26th January meeting performance was Red 1 – 41.9 and Red 2 – 60.1%.

The trust board report included the following Ambulance metrics –
- re-contact rate following discharge from care by telephone
- re-contact rate following discharge from care at scene
- time to answer call (in seconds) – median
- time to answer call (in seconds) – 95th percentile
- time to answer call (in seconds) – 95th percentile

Dispatch for red 1 and red 2 was included in the board report we reviewed for December 2017. The trust target of 75% of category A calls responded to within 8 minutes was met in 2 out of 12 months November 2016 to October 2017.

**Information management**

The information used to monitor performance was inaccurate or unreliable due to the out-dated computer-aided dispatch system.

The service complied with and contributed to national ambulance reporting requirements. The service had identified that their computer-aided dispatch system was outdated, and were aware that data collected could be unreliable. The service had identified that it was unable to drive improvement from data collected and they could not assure themselves it accurately reflected the situation within the service.

However, information collated at a local, for example individual staff performance data, was accurate and did not rely on the computer-aided dispatch system.

Systems and meetings were in place to monitor performance and data. Senior managers told us the management and governance structure for the service was complex. Actions had been taken to define and refine the meeting structure to gain efficiencies. These changes were too recent to see any definitive improvements at the time of our inspection.

**Engagement**

There was minimal engagement with people who use services.
At the previous inspection we found there was no formal process for engaging with patients. This had not improved at the time of the inspection.

The trust did not participate in the national Hear and Treat survey. Limited feedback from the public was gathered through surveys.

The service delivery manager for the hub held a monthly staff meeting. Representatives from call handlers, clinicians, and dispatch attended. Staff were able to raise issue for discussion at the meeting. Staff we spoke with received minutes and actions from the team meeting.

At the time of the inspection there was a plan for a staff survey for ambulances – going out in January

Staff we spoke with were positive about the new CEO and some staff had attended ‘Meet Maggie’ sessions.

**Learning, continuous improvement and innovation**

There was little innovation or service development.

The call audit team had been empowered to improve the mentoring process for newly recruited call handlers. Staff spoke highly of the audit team and were confident to request for a call to be audited to support their learning and development.