Isle of Wight NHS Trust

Evidence appendix

St Mary's Hospital
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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

Isle of Wight NHS Trust is the only integrated acute, community, mental health and ambulance health care provider in England. Established in April 2012, the trust provides health services to an isolated offshore population of 140,000.

Acute Care Services

The acute services at the trust are provided at St Mary's Hospital in Newport, with 246 beds and 22,685 admissions each year. Services include Accident and Emergency (A&E), the urgent care service (by referral only), emergency medicine and surgery, planned surgery, intensive care, comprehensive maternity, neonatal intensive care unit (NICU) and paediatric services. The trust also delivers a number of planned care services including chemotherapy and orthopaedics.

Community Care Services

The trust provides a number of community services delivered in patients' homes, in a range of primary and community settings and from St Mary's Hospital. Community care services include district nursing, health visiting, community nursing teams, a primary dental care service and orthotics, as well as inpatient rehabilitation and community post-acute stroke wards.

Mental Health Services

The trust's Mental Health services provide inpatient and community based mental health care. The trust's mental health service has 46 beds alongside community mental health teams supporting a caseload of 1683 patients. Services include specialist child and adolescent metal health services (CAMHS), early intervention in psychosis and memory service.

Ambulance Service

The Island's ambulance service delivers all emergency and non-emergency ambulance transport including the Jumbulance for the Island's population. With 21,712 emergency calls and 25,292 emergency vehicles dispatched each year the service operates from a single base across the Island. The service is also responsible for transporting patients to mainland hospitals when required.

(Source: Trust Website)

Acute hospital sites at the trust

A list of the acute hospitals at Isle of Wight NHS Trust is below.

Name of acute hospital site	Address	Geographical area served
St Mary's Hospital	St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG	Isle of Wight

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

Is this organisation well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the key priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

As part of the inspection we interviewed members of the board, both the executive and non-executive directors, and some senior staff across the trust. We looked at a range of performance and quality reports, audits and action plans. We reviewed previous board meeting minutes, risk registers, board assurance framework and papers to the board. We looked at investigations of deaths, serious incidents, complaints and sought feedback from staff and key stakeholders, such as the local authority, clinical commission groups (CCGs), and Healthwatch.

Since the last inspection in 2018 the trust had appointed to and developed a senior leadership team. The chair and chief executive had continued in post since their appointments in 2017 along with directors of finance, governance and human resources. The medical director joined the trust in June 2018. They were supported by several new non-executive directors (NEDs) as well as a recently appointed director of nursing, midwifery, allied health professionals and community services who joined the team in February 2019.

There was informal succession planning for senior roles for example, the chief financial officer was also the deputy chief executive. Additional plans were under discussion for other supportive leadership roles. There was no chief operating officer as responsibilities had been shared across directors for the integrated trust. There was no deputy medical director and care group directors were called upon as required to cover on an informal basis. We were told a review of support for the medical director was underway. All senior and middle managers were in a trust leadership programme; we had feedback that it was a helpful development programme for management skills.

Services were managed in four divisions consisting of mental health and learning disabilities, community services, integrated urgent and emergency care and acute services. The divisional management teams were run according to their services having either a care group director or in the case of community a deputy director of out of hospital services reporting to the division director, whom each reported to the chief executive. We were told the newly formed integrated urgent and emergency care division was a pilot for the emergency and department and medical assessment unit and same day emergency care service to been included with the ambulance and urgent care services to alleviate the pressure on the acute services division. The integrated urgent and emergency care division director was on a short term contract until July 2019 and the trust had not at the time of inspection announced its intentions going forward; we were told the pilot was due evaluation.

The NEDs were responsible for oversight of all the trust services encompassing committees which included; quality and patient safety, performance against budgets and national/local targets, planning and strategy for services, workforce and organisational development. The NEDs and executive leaders informed us of the financial challenge and discussed the financial special measures status of the trust imposed by NHS Improvement since earlier in 2019. Other areas the NEDs noted to us were about information management systems, information governance controls

and cyber security risks with workforce and impact of this being an underlying issue for achieving improvement.

There was a Patient Council; with a membership of patients who provided representation to the board and trust committees.

The trust board members met every month. The trust published a monthly board report on its website which provided both the board and the public with an overview of performance. The trust had restarted its patient story to the board in September 2018, which had been received well. With NEDs travelling to the Isle of Wight some committee's and board were run over two days and they had held the quality and performance committees back to back to ensure alignment.

We reviewed the personnel files for the non-executive directors and those of the executive team. Appropriate checks had been carried out in accordance with 'Fit and Proper Person' requirements. The executive team had an appropriate range of skills, knowledge and experience.

Board Members

Of the executive board members at the trust, at the time of information submitted none were Black and Minority Ethnic (BME) and 66.7% were female. However, in early 2019 there were three NEDs appointed with experience to support the trust; one of the NEDs had BME characteristics.

At the time of submission of information, the non-executive board members 5.6% were BME and 55.6% were female.

Staff group	BME %	Female %
Executive directors	0.0%	66.7%
Non-executive directors	11.1%	44.4%
All board members	5.6%	55.6%

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Vision and strategy

The service had a vision for what it wanted to achieve but did not have a strategy to turn it into action. There was however a sustainability plan developed with all relevant stakeholders for the Isle of Wight which aligned to local plans within the wider health economy. Leaders had not yet found a way for staff to understand the trust approach and know how to apply the plans to a trust strategy and monitor any progress.

There was a clear statement of vision and values known to staff and available on the trust website:

"Our vision: working with our island partners and others, we will be national leaders in the delivery of safe, high quality and compassionate integrated care, putting those who use our services at the centre of all we do".

In the trust annual report 2018/2019 this details the vision was underpinned by five strategic objectives:

- Provide safe, effective, caring and responsive services – "Good" by 2020
- Ensure efficient use of resources
- Achieve NHS constitutional patient access standards

- Achieve excellence in employment, education and development
- Lead strategic change on the Isle of Wight

There were revised values as part of the trust seeking ways to improve care and services for the benefit of patients and staff. During 2018/2019 there was a culture and leadership improvement programme. With the engagement of over 600 staff and patients / service users to understand more about the trust culture the organisational values were restated; with the heading “CARE is the golden thread through everything we do” and the values of compassionate, team working, improving and valued:

- **C**ompassionate

To provide compassionate care by creating a climate that encourages actively listening to each other, understanding each other’s perspectives, empathising, and taking appropriate action to help and support each other. Working with our patients and service users in joint decision making.

- Te**a**m working

To encourage teams to listen carefully to each other, understand all perspectives, and offer support and help to each other.

- Imp**r**oving

To continuously develop, learn and try new things to become more efficient.

- Valu**e**d

Treating people as individuals, recognising staff contribution and the needs of those who use our services.

However, there was no trust wide strategy. The annual report 2018/2019 explained that since April 2017 the trust was rated inadequate and placed in special measures, the trust board in February 2018 made the decision to pause the existing strategy to allow for review.

The trust was under enhanced financial oversight in 2018 and, in March 2019, was placed in financial special measures following a further deterioration in the financial position. The trust stated the direction of travel had therefore been driven by the need to achieve clinical and financial stability. There were other various strategies such as for workforce and education which leaders felt reflected the trusts overall direction. There were also some clinical strategies and divisional strategies seen.

Organisations had come together as the Isle of Wight Local Care Board to work and plan on the integrated development and delivery of health and care services on the Isle of Wight. The result was an Isle of Wight Health and Care Sustainability Plan for the challenges in delivering health and care on the Isle of Wight over the next three years, for example in Phase One 2019 the priorities were:

- Supporting return to home
- Onwards care and independent living
- Trust productivity
- Council social care productivity

Culture

Staff did not always feel respected, supported and valued. The service had not yet promoted equality and diversity in daily work, and effected views of opportunities for career development. The service had an open culture where patients, their families could raise concerns without fear, but this was less so for some staff. Staff were focused on the needs of patients receiving care.

The trust had a human resources strategy, vision and values to underpin a culture which was patient centred. The culture was variable from the perspective of staff, with some groups finding it positive, open and honest where staff were listened to and heard however this was not the view of all staff. There were systems for performance management of staff through the annual appraisals, which were aligned to the values. However, the slow uptake of supervision and appraisals across the trust would question if action had been timely enough.

The appraisal target set by the trust had been 85% for whole organisation 77.11 % was achieved as at 31 March 2019. This was a decrease on the previous year of 0.3%. Data analysis was to change for the trust to measure compliance monthly – starting at 0% for all departments from 1 April 2019. Additional training and support for appraisers was scheduled and targeted to the leads of departments with the lowest achievement.

The trust had appointed a Guardian of Safe Working Hours (GSWH). They provided assurance to the trust board, the General Medical Council (GMC) and Health Education England (HEE) and to the doctors themselves that doctors in training were safely rostered and working hours were reported as compliant with their terms and conditions of service. The guardian was required to raise concerns to the trust board and potentially to external bodies. The GMC and HEE for Wessex had visited the trust in 2018 and the GMC put the trust in enhanced surveillance, which continued following a further visit in 2019. The areas of most concern were junior doctors support and supervision. Junior doctor's forums were regularly held but were no longer attended by the medical director; additionally, attendance by doctors varied and could range from 8 to 20 attendees but most commonly was a low attendance. There were concerns raised with job plans and rota management. Exception reporting was not representative of the actual situation as extra hours were worked and recorded and paid as locum hours. The GSWH informed us that incidents were raised by doctors on first working at the trust and would tail off during their placements and rose again towards the end of their stay at the trust. The GSWH said the current Hospital at Night procedures to support junior doctors had been in use since February 2019 for a 10-minute handover at 8pm and 8 am. There was a multidisciplinary attendance, however not all processes were effective such as the registrars were not always taking calls out of hours. The issue were the number of registrars due to leave in August and the medical assessment unit had the highest safety concern. However, we were told that cover was better than a year ago and junior doctors were happier now than previously.

The trust had developed greater awareness of the needs of Allied Health professionals across the trust, the teams had been encouraged to develop services and we were told they felt listened to and supported by leaders.

The trust was aware of the need to develop the equality and diversity in the trusts day to day work and for supporting opportunities for career progression. There was no Black, Asian and Minority Ethnic (BAME) network. We invited all staff to a BAME focus group which had a limited attendance. Staff said they had not felt they were treated equitably by the trust. They said they felt there were obstacles to their development and engagement with the trust. We were told the trust had employed a consultant to review the development of an improved culture in support of equality

of staff from a BAME background. The focus group did not feel this had yet made any significant difference. Other staff spoken with during our core service inspection were happy working at the trust; however, we were told that staff suffered from racial abuse by patients and relatives and felt this had not been proactively dealt with by the trust.

There was a newly appointed equality and diversity lead. They informed us the trust had a new strategy to meet the equality and diversity needs of the staff. We were told since publishing the strategy, the trust had celebrated Black History month with a series of social events and cultural food in the staff restaurant. There was a new Equality Impact Group with representation from all clinical and non-clinical divisions of the trust. Equality and diversity training and awareness had been delivered to clinical divisional boards and the trust board. There was refreshed equality and diversity training for line managers including unconscious bias awareness and trust's e-learning module had been updated. The trust had not established a disability group however, had told us they supported staff requiring reasonable adjustments. There was support offered by the chaplaincy for staff as well as patients and visitors.

To improve the culture the trust had a freedom to speak up guardian (FTSUG). The FTSUG lead was appointed in October 2016, and had attended national training. 50% of their working time was allocated for this role and there were FTSUG advocates and anti-bullying advisors. There had been National 'Speak Up' October month in 2018 which we observed the communication boards for on an engagement visit and spoke with staff about the service on offer. We had been told the Raising Concerns (whistleblowing policy) was updated in January 2019. The FTSUG was on the culture and leadership programme for the trust and had been involved in the development of the trust's Behaviours Framework to create a compassionate workforce. Poor behaviours were described as the biggest issue coming to the attention of the FTSUG. It was felt there was still a cohort of people who did not speak up. The FTSUG met with chief executive each week in an open surgery and met also with a non-executive director to review progress and a quarterly report was presented to the trust board.

Staff Diversity

It was noted the trust did not have a diverse workforce at senior leadership level. The current information the trust provided showed the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group:

As of December 2017, the trust employed 3,579 people, of which:

- 74.3% are women
- 30.3% are in the 46-55 age group and 21.1% are in the 36-45 age group
- 9.7% of staff are from Black Minority and Ethnic Communities, with 95.1% of staff reporting their race
- 2.7% of staff have disclosed that they consider themselves to have a disability, 48.3% of staff have told us they don't consider themselves to have a disability with the remainder either unknown or have chosen not to disclose
- 61.6% of staff have disclosed as Heterosexual and 1.0% as Lesbian, Gay or Bisexual with the remainder unknown or chose not to disclose
- 41.8% of staff considers themselves Christian, 9.2% as Atheists and the third biggest group at 7.6% choosing to define their religion as 'Other'
- 30.7% chose not to disclose their religion or belief

(Source: Diversity and Inclusion Workforce Report 2017/18)

NHS Staff Survey 2018 results

The staff survey results for 2018 showed trust staff engagement had remained lower than average. The human resources director told us this was disappointing but took into account the survey was taken six months previously and felt there had been changes since; a local survey Pulse Check was undertaken to gauge progress on how staff were feeling regarding advocacy motivation and involvement, with three months data showing positive responses.

The trust said to mitigate risks related to staffing they had employed a range of strategies to focus on making the trust an attractive employer including recruitment of nurses from the Philippines. The trust used flexible and temporary staff frequently to maintain basic staffing levels, however was working on reducing agency staff. Apprenticeship schemes were launched to support the trust 'grow our own' future workforce strategy. For example, there were Registered Nurse Degree Apprenticeships (RNDA) with 14 that started in September 2018 and Trainee Nursing Associate Apprenticeships with 10 that started in February 2019. Further recruitment was arranged for both apprenticeships to commence in September 2019.

The paediatric service leads at St Mary's Hospital were enthusiastic about the recent recruitment successes and were now at full complement for doctors which meant they could now participate in audit and improvement processes.

The human resources director included the main themes from the staff survey as communications and engagement and bullying and harassment. We were told "if you keep on telling people you have a bullying and harassment culture you will retain one. In order to shift it you need to not focus on it." There were processes and procedures for managers to follow if staff did not meet performance expectations. We were told of examples where the procedures had been applied where staff had not met the trust values. The staff side representatives confirmed a positive working relationship with the human resources team however they felt restricted by the hours budgeted for this service given the workload with which they were presented.

We were told about poor behaviour by the consultant body being called out, which was being dealt with by the medical director with five doctors being released from the trust employment. There was a grievance processes described as getting better but still not as timely as needed. There were four staff currently suspended, however we were told it was in double figures when the human resources director arrived at the trust in 2017. The team worked to a tracker of about 150 cases, the historical issue in the team was slow processes as they had assumed everything was going to tribunal. The team had just recruited a deputy director of human and had human resources business partners in the four divisions.

Health Education England confirmed the view that there had been a particularly challenging year for recruitment and retention which they said had remain problematic. There have been open days and careers events to promote the island as an excellent NHS employer. The trust provided leadership development opportunities for managers, and on-line learning to create a virtual learning environment. The trust had launched a number of initiatives for staff development, including professional development frameworks for clinical staff in bands 2–8, education pathway for clinical staff in bands 2–4. The trust had implemented a two week clinical induction for registered and non-registered staff which commenced January 2019. The Preceptorship Programme for newly registered practitioners, had been refreshed.

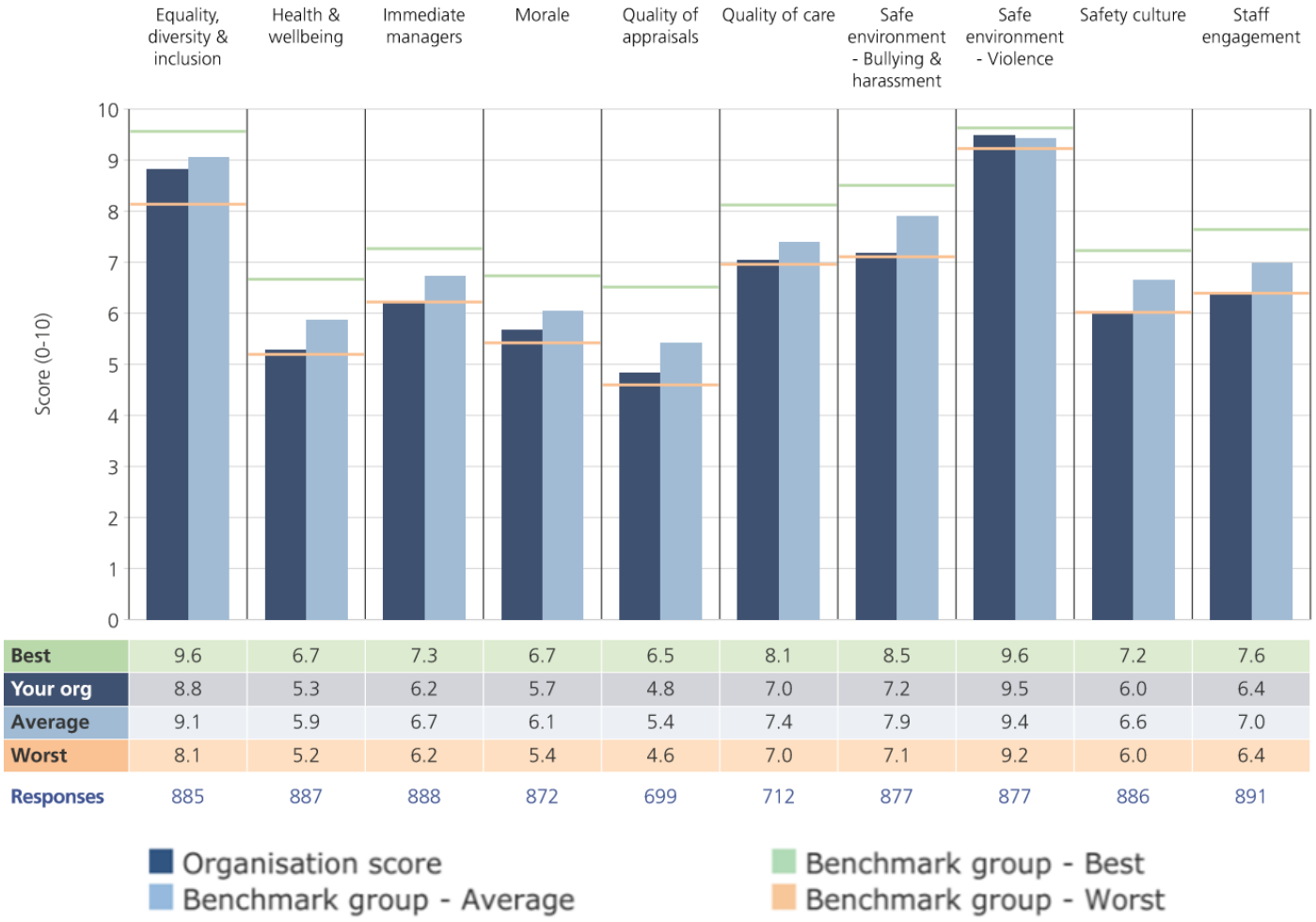
To promote health and wellbeing in the previous business year 2018/2019 the trust had invested in occupational health (OH) services to provide dedicated support to staff that have experienced

stress, anxiety and depression. An OH mental health practitioner had focused on improving and providing resilience support to help prevent absence and by providing early interventions to staff during episodes of sickness absence.

Working in partnership with physiotherapy teams, through the OH service staff had physiotherapy support. Over 300 employees have been referred to the rapid access physiotherapy service during 2018/2019 and the majority of staff had reported this service had helped prevent them going off sick and had a positive effect on both their work and home life. We were told there was an active health and wellbeing group engaged with staff on a range of initiatives and during 2018 / 19 this included the relocation of the trust outdoor gymnasium at St. Mary's Hospital site, promotion of healthy eating, holding health and wellbeing events including health checks, access to exercise classes, cycle to work schemes and referrals for weight management.

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	8.8	5.3	6.2	5.7	4.8	7.0	7.2	9.5	6.0	6.4
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
Responses	885	887	888	872	699	712	877	877	886	891

(Source: NHS Staff Survey 2018)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

WRES Indicators from ESR (HR data) (*)	BME Staff	White Staff	Are there statistically significant difference between…	
			BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	0.5%	4.6%	●	0.5% ○
1b. Proportion of non-clinical staff in senior roles, band 8+	4.3%	6.4%	○	4.3% ○
2. Proportions of shortlisted staff being appointed to positions	5.4%	7.6%	●	4.0% →
3. Proportion of staff entering formal disciplinary processes	1.0%	1.5%	●	1.0% →
4. Proportion of staff accessing non-mandatory training and CPD	63.6%	59.8%	Not assessed	

WRES Indicators from the NHS staff survey (**)		Proportion of respondents answering "Yes"			Are there significant differences between…		
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	31.9%	28.2%	31.8%	●	●	2.7% →
	Peer group	*29.9%*	*27.9%*	*28.7%*			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	34.7%	38.1%	38.7%	●	●	1.4% →
	Peer group	*30.1%*	*26.0%*	*27.0%*			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	53.2%	79.2%	74.7%	●	●	-22.6% ↓
	Peer group	*69.8%*	*86.3%*	*83.3%*			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	22.5%	8.7%	10.0%	●	●	7.2% →
	Peer group	*15.9%*	*6.7%*	*8.5%*			

Trust staffing numbers (*)	2018		2017	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[0]	●	[0]	●

Key

- ● Statistically significant or negative finding
- ● Not statistically significant
- ● Positive finding
- ○ Statistical analysis not undertaken as less than 30 BME staff responded
- ↑ Statistically significant improvement
- → No statistically significant change
- ↓ Statistically significant deterioration

As of March 2018, of the ESR staffing indicators shown above (indicators 1a to 4) the following indicator showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (0.5% of BME staff compared to 4.6% of White staff).

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

7. 53.2% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 79.2% of White staff. The score had decreased by 25.2% when compared to the previous year, 2017.
8. 22.5% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey which was significantly higher when compared to 8.7% of White staff. The score had increased by 6.9% when compared to the previous year, 2017.

There were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

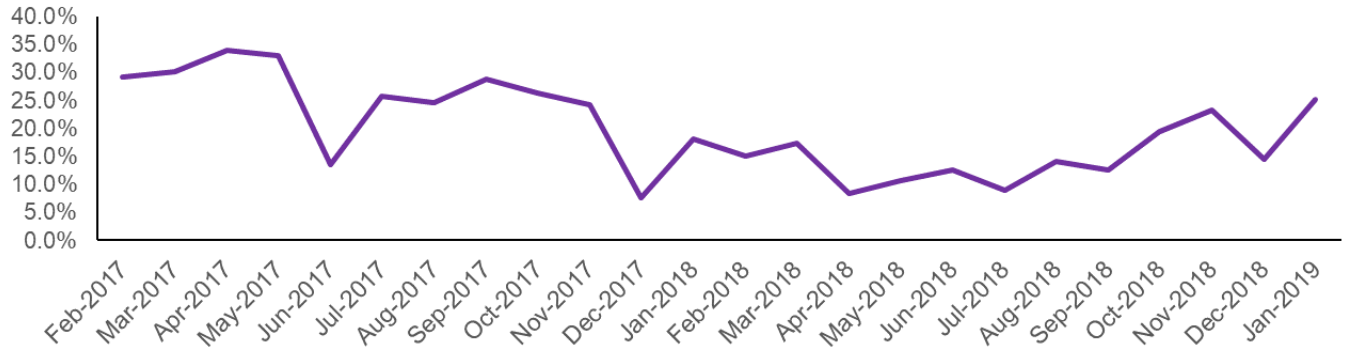
(Source: NHS Staff Survey 2018; NHS England)

Friends and Family test

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 91.4% and 98.9% between February 2017 and January 2019.

The data appears to be stable with only random variation over the whole period. Response rates can be found in the chart below.



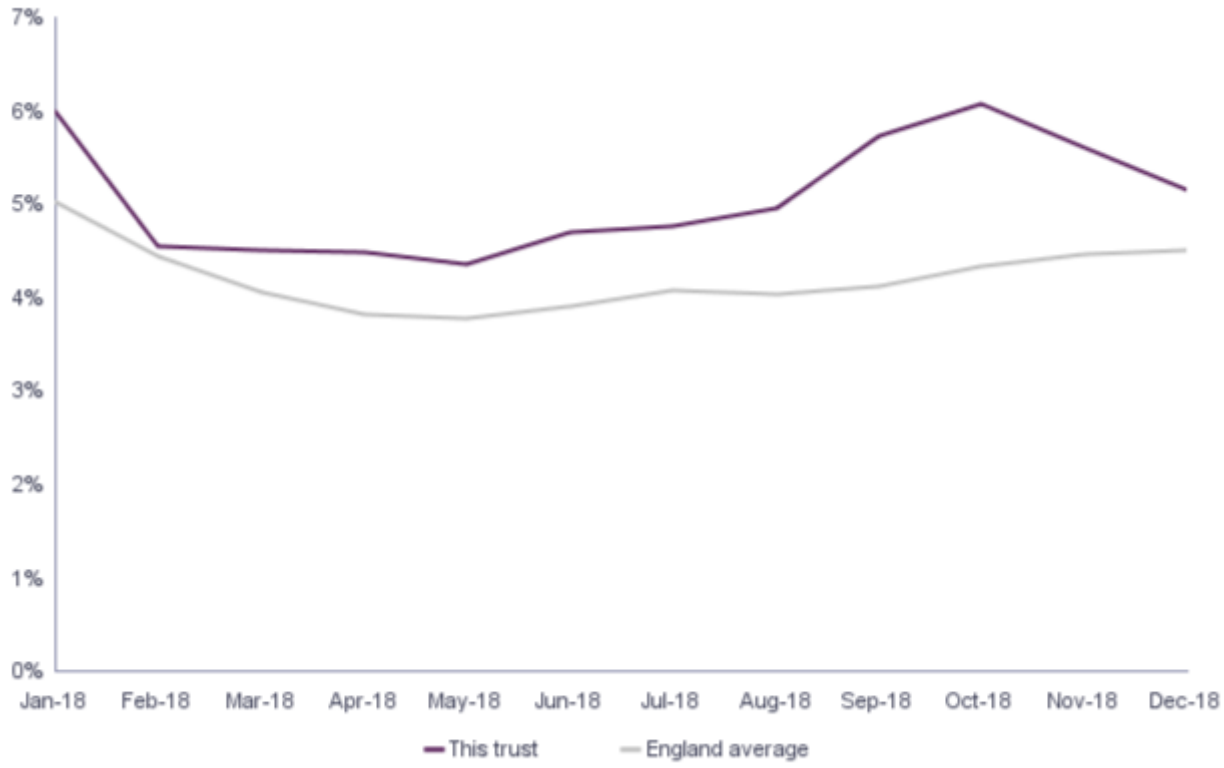
(Source: Friends and Family Test)

In April 2019 the trust moved to using Membership Engagement Services (MES) to support with the collection of real time patient experience feedback. The system aimed to enable the trust services to review and learn from the feedback at an early stage in the feedback process.

Other mechanisms for patients to feedback to the trust were recognised as via the NHS Choices and Care Opinion website, via Healthwatch Isle of Wight, the Care Quality Commission or using social media. The trust and Healthwatch Isle of Wight regularly shared information including themes of complaints, concerns and issues raised to ensure wider lessons are learnt and key themes identified.

Sickness absence rates

The trust's sickness absence levels from January to December 2018 were higher than the England average. Sickness rates increased in every month from May 2018 to October 2018 before decreasing in November 2018 and December 2018.



(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed better than expected for none of the indicators, worse than expected for 12 indicators (see below) and the same as expected for the remaining six indicators.

Better than expected Same as expected Worse than expected

Survey area	RAG
Curriculum coverage	○
Educational governance	◆
Reporting systems	◆
Rota design	◆
Teamwork	◆
Overall satisfaction	◆
Clinical supervision	◆
Clinical supervision out of hours	◆
Handover	◆

Induction	◆
Adequate experience	○
Supportive environment	◆
Work load	○
Educational supervision	◆
Feedback	◆
Local teaching	○
Regional teaching	○
Study leave	○

(Source: General Medical Council National Training Scheme Survey)

Governance

Leaders had developed new governance processes, throughout the service and with partner organisations. Staff awareness varied across the trust, staff were not always clear about their roles and accountabilities. The trust were reviewing opportunities to meet, discuss and learn from the performance of the service.

There were structures, processes and some systems of accountability to operate a governance system designed to monitor the service and provide assurance**.** Quality governance was overseen by the director of quality governance. Throughout the last year since the previous inspection a series of 10 week quality improvement plans had been undertaken in areas across the trust to drive change and improve the quality of services. The trust including the medical director and chief executive recognised there was more to do for quality improvement.

In June 2018 a revised governance structure was introduced with the four divisions and since the last inspection the trust had demonstrated quality improvements especially in end of life care, ambulance and community services. In 2018 the trust produced a framework, “Quality Governance Standards and Structures”, detailing an understanding of what quality governance was, expectations, roles and information sources.

At some interviews staff told us they were not always clear about what was in their accountability for governance arrangements. From June 2019 were told a revised holding to account process was to be introduced, with monthly divisional performance meetings chaired by executives.

Divisional meetings reported into the quality and performance committees and up to the board committees, where clinical teams were invited to present key challenges as well as successes as part of the quality strategy implementation.

The Quality Committee reported to the trust board and had been restructured. There were five subcommittees reporting through to the Quality Committee which included patient safety, patient experience, clinical effectiveness, clinical safety, human resources and organisational development and patient council.

The divisions had their own quality strategies, for example, in the acute services division the quality strategy although undated provided the structure for staff to follow from subcommittee to trust board via the executive quality and governance board. There were quality priorities for the deteriorating patient, sepsis, learning from events, right patient right place right time; best clinical outcomes, learning from experience, end of life care and dementia care. Similarly, in the community division the strategy identified how they would address key priorities of learning from events, improving clinical standards and embedding NEWS2 scoring to help identify the deteriorating patient. The ambulance service had priorities for sepsis identification and treatment and the embedding of NEWS2 scoring to help clinicians identify a patient who is deteriorating. The mental health and learning disabilities division had developed a quality strategy which they said aligned with the wider trust strategy and ensured that the improvements planned were specific to service users and their families. Allied health professionals were aiming to be part of an Allied health professionals framework similar to nursing for governance in order for change to be at the desired level.

The trust defined their quality improvement priorities and published this in the Quality Account 2018/2019 stating the 2019/2020 priorities were:

- Patient safety: releasing time to care
- Clinical effectiveness: right person, right place, right time
- Patient experience: dementia care

The trust had also listed in the Quality Account 2018 /2019 the current priorities were establishing and promoting a recognised governance process for Getting it Right First Time (GIRFT), planning for change of service provision in urology; assurance of service provision around services not provided by trust and to understand pathway changes that may negatively impact demand on radiology service.

The director of quality governance told us 480 staff had been trained in the Plan-Do-Study-Act (PDSA) model for improvement. Three members of staff were undertaking the Quality, Service Improvement and Redesign (QSIR) training aimed at providing the know-how to design and implement more efficient and productive services and processes, with a plan for further evaluation and implementation in the trust.

There were board walkabouts with executive and non-executive board members visiting clinical and no clinical services to focus on patient related quality and safety issues.

At inspection we discussed the Hospital Standardised Mortality Ratio (HSMR), the ratio of observed to expected deaths and a measure of healthcare quality and the Standardised Hospital Mortality Index (SHMI), the ratio between actual and expected deaths following hospitalisation. It includes deaths which occurred, inside and outside of hospital, within 30 days of discharge. The latest mortality indicators for the trust Dr Foster report January 2019 was that the HSMR remained statistically ‘significantly lower than expected’ and the most recent SHMI for the trust on 23 May 2019 was 0.99 which was a continued reduction on the previous quarter at 1.05. The directors were satisfied the data was correct.

Safeguarding was overseen by a head of safeguarding and designated nurse reporting to the director of nursing accountable for safeguarding adults, children and looked after children. In the previous 12 months the clinical commissioning group gave professional leadership and operational support during the period of vacancy at the trust. The adult safeguarding lead was more recently established than for children’s safeguarding lead. The teams were small and were said to be

adequate for the needs of the trust. There were opportunities for multi-agency working with the local authority and the police.

The challenge was compliance with the safeguarding training of staff, including ensuring that staff completed the correct level for their job role; the target was 85%. In the past year, level one achieved 95%, level 2 82% and level 3 84%.

Infection control had taken a higher profile since our last inspection, improvements included a report that went to board for the first time. The director of nursing was the lead director for infection prevention and control for the whole trust and had been driving to improve culture such as the need for bare below the elbows in clinical areas and correct use of trust uniforms. Surgical site infections were monitored and had shown an increase, the findings were reviewed and linked to theatres cleaning issues which were addressed as a result.

Governance of medicines management was taken seriously by the trust. The chief pharmacist led the department. The trust board received annual updates on medicines optimisation via the trust's medicines workplan. The Drugs Advisory Committee (DAC) monitored the medicines optimisation within the trust team. The chief pharmacist was line managed by a care group manager and met with the medical director monthly to allow communication directly to the board. During our inspection a new Chief Pharmacist was appointed. Medicines incidents were reported through an electronic recording system. A senior member of the pharmacy team was the Medicine Safety Officer (MSO). The MSO role was created following an NHS England Patient Safety Alert. The MSO automatically received and reviewed notifications of medicine incidents. A multidisciplinary team at the medication safety group reviewed these incidents.

We spoke with the interim lead for estates who reported to the director of finance, they confirmed there was governance of the trust sites although not a specific estates strategy. Their view was that South Block needed demolishing and a new was build required. We were told the clinical areas identified their own priorities, for example, in the midwifery department they had risk scored 16 for the airflow and ventilation to be improved. Maintenance was carried out during less busy times, and there was works scheduled for corridor floors, painting and lighting. The emergency department was to be refurbished in September. A challenge was waste disposal which was expensive for removal off the island. There was engagement with the local authority for recycling options to be developed.

Health and safety governance was taken seriously with good fire safety management described. Security matters had been addressed such as access to the special care baby unit. In 2018/2019, eight incident reports were submitted to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. There was a zero tolerance approach towards violence and abuse directed at staff however during the year there were 293 physical assaults reported on staff an increase on the previous year.

Board Assurance Framework

There were effective arrangements to ensure the trust executive team discharged their specific powers and duties. The board of directors had various committees reporting to it, including around the topics of: charitable funds, remuneration and terms of service, finance and performance, quality assurance, workforce and education as well as the risk and audit committee. The board was informed about performance, governance and assurance. This included a look at operational performance, safety and quality of care. The trust board was provided with information regarding financial performance. This included the current performance, income and activity, with progress on the cost improvement plan, cash, and capital expenditure.

We reviewed the board assurance framework (BAF) provided by the trust; this had been reviewed and developed in recent times; with the November 2017 version superseded for a 2019/20 version which would benefit from more detail.

An internal audit of the BAF was published by the trust in May 2019 which set out the reasons and recommendations for improvement:

- All areas need to routinely review and update their risk register.
- Greater use made of outcome measures to give assurance that risks are being managed effectively in practice.
- Risk management training needs to be delivered across the trust, and is key to the proper completion of risk register and BAF entries.
- Actions to address gaps in control and assurance need to be time-bound and monitored against the defined deadlines.
- Risk definitions are not always sufficiently clear.

Source: TIAA Assurance Review of the Board Assurance Framework (BAF) & Risk Management May 2019, provided by the trust.

The trust board assurance framework detailed five strategic objectives and accompanying strategic risks. A summary of these:

ID	Risk	*Risk score (current)	*Risk score (target)
1	**Provide safe, effective, caring and responsive services – Good by 2020**		
1-1	Inability to achieve and maintain regulatory compliance	12 (4 x 3)	12 (4 x 3)
1-2	Non-delivery of the outcomes of the Quality Strategy	12 (4 x 3)	8 (4 x 2)
1-3	Failure to deliver safe care	12 (4 x 3)	8 (4 x 2)
2	**Ensure efficient use of resources**		
2-1	Expenditure incurred exceeds income by greater than agreed control total	25 (5 x 5)	15 (5 x 3)
3	**Patient standards**		
3-1	Failure to deliver patient standards of care including constitutional and contractual levels	16 (4 x 4)	12 (4 x 3)
4	**Excellence in employment**		
4-1	Attract and recruit the right staff	20 (5 x 4)	12 (4 x 3)
4-2	Develop and retain the right staff	20 (5 x 4)	12 (4 x 3)
4-3	Driving cultural change	16 (4 x 4)	12 (4 x 3)
5	**Lead strategic change on Isle of Wight**		
5-1	The future strategy for the provision of health services on Isle of Wight is not sufficiently led by the Trust	12 (4 x 3)	8 (4 x 2)
5-2	Failure to set out and implement an analytics and digital technology strategy/plan	16 (4 x 4)	8 (4 x 2)
5-3	Failure to set out and implement an estates and	16 (4 x 4)	6 (3 x 2)

	facilities strategy/plan		

*The values in the brackets indicate how the risk scores have been calculated for each risk (impact x likelihood). The maximum possible risk score is 25 (5 x 5). Impact and likelihood is given a score between 1 and 5.

(Source: Trust Board Assurance Framework – March 2019)

Management of risk, issues and performance

Leaders and teams had limited systems to manage performance effectively. However where known they identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust recognised and reported in 2018/2019 that key issues and risks had included a failure to deliver some national access targets including in the emergency department. On inspection of acute services at St Mary's Hospital we found not all patients had documentation completed that would alert staff quickly enough for the deteriorating patient. When asked we were told this was related to high staff turnover of staff on wards and units. There were limited development for seven day working and we were informed of the risks for patient outcomes during out of hours however areas such as cardiology for chest pain and stroke care had been successful. The frailty pathway was under development and therefore remained a risk until established. We reviewed information related to deaths and serious incidents, we were aware before inspection of the challenge the trust had received from the Isle of Wight coroner in providing detailed information in a timely manner. This had resulted in the trust accepting a fine earlier in the year. The serious incident review process had been reviewed and amended to include terms of reference for senior clinicals within the division to lead all serious incidents involving the death of a patient. The process was seen to be much clearer however learning from deaths had not yet been shown when we reviewed documentation at the trust.

A risk management policy was introduced in May 2018 followed by the risk management strategy in June 2018 that set out the strategic direction for the next three years. In March 2019 the trust said the assessment of the first year of the strategy demonstrated that all key milestones had been achieved by the end of the financial year and milestones had been proposed and agreed for 2019/20. Each of the board committees were responsible for managing the strategic risks aligned to them, with oversight at the Assurance Risk and Compliance Committee and ownership at trust board level. Operational risks were considered at specialty and clinical business unit level in the first instance, and then escalated to the Operational Risk Sub-Committee and the Assurance Risk and Compliance Committee if required.

Operational risks had been identified across a number of services/specialties linking to issues around increasing referrals, system capacity and delayed transfers of care. The trust had implemented daily reviews to assess system capacity and patient flow, escalation requirements aligning capacity plans with the wider system. However, the pace of change was slow and relied on external partners to resolve.

An external review was completed of the maternity unit with the initial conclusion was that the ability to react to declining observations was poor, action was taken and subsequently review had demonstrated improvement. Following the allegations of equipment tampering security had been stepped up and the board had received four reports to keep them informed. In respect of the

special care baby unit the director of governance felt the trust had gone above and beyond to ensure it was safe whilst recognising that they had a primary responsibility for patients.

The clinicians in the medical assessment unit (MAU) and the same day emergency assessment unit (SDEC) reported that at times the responsiveness of other clinical teams to review patients in these units wasn't as good as it could be and that further work was required to reinforce internal professional standards. The SDEC has recently been launched and staff felt it was proving to be a success but there were concerns from clinicians that it would be used to bed down patients. There had been ongoing issues with over occupancy and patients being nursed in non-patient bed spaces, known as one upping, risked patient safety as well as had compromised privacy and dignity of patients impacted upon.

The rate of referral for treatment was a risk with all surgical specialities with the exception of ENT showing worsening performance for the 18 week target. There was a 2018/2019 recovery plan, however were told this was difficult to achieve due to the pressures on elective beds for emergency admissions and unexpected increased activity over summer 2018. Performance for A&E treatment, cancer care, planned operation and care access to psychological treatment such as counselling were all reported as below national average.

NEDs confirmed the trust was continuing to embed systems and processes for recognising and responding to the acute deteriorating patients. The National Early Warning Score (NEWS2) had to be implemented before the required date of 31 March 2019. To achieve this an implementation group was formed and the trust were proud that they went live on the 15 December 2018 across community, acute, ambulance and mental health services. There was a new monthly auditing process of NEWS2 compliance across all services that use NEWS2. The Critical Care Outreach Service (CCOS) had expanded the sepsis liaison service and to maternity and paediatric services. Two Acute Illness Management (AIM) courses had been run or new junior doctors and acute healthcare professionals. The integrated sepsis policy had been updated to reflect new evidence-based approaches to sepsis. The ambulance service had revised the pre-hospital antibiotic protocol and continued to give intravenous antibiotics to patients in their own home if they meet the sepsis criteria. Sepsis recognition and response pocket guides have been developed and given to key staff to raise awareness of the local process. A new initiative called 'Time to Act' had been launched, led by the CCOS sister, to bring together a multidisciplinary group of staff to champion the deteriorating patient agenda in clinical areas. When we inspected acute core services we found the systems were not followed putting patients at risk.

The resuscitation service had launched cardiac arrest huddles. These took place on a daily basis during the hospital at night meetings. During these huddles the teams allocate roles to specific team members in the event of a cardiac arrest. The had also been implementation of an Acute Kidney Injury (AKI) care bundle sticker to promote consistent care for this patient group. New in-patient intravenous and fluid charts were developed and implemented in line with national institute for health and care excellence (NICE) guidance.

Delayed patient discharges were seen as a significant cause for the impact on the patient flow cresting risk for other patients, however we were told discharge planning had now commenced on the day of admission. There was a dedicated patient pathway navigation team on all wards to support patients and staff with discharge planning. Consultant discharge stickers had been introduced to identify patients fit to leave an acute hospital bed. The trust had been working with partners to reduce delayed transfers of care for people that were awaiting admission to care homes.

The trust had commissioned several external expert reviews to inform the process of mortality reviews and serious incident management. We were told that the national learning from deaths framework and relevant process were embedded throughout the trust, policies were updated and the structured judgment tool was in use. There was a serious incident coordinator; there were regular weekly meetings with the CCG for advice and support.

The trust had completed an internal audit published March 2019, setting out the progress made on the management of serious incidents. This audit included the recommendations and reasons for improvement such as:

- Although there are robust policies in place to govern the process, there are no detailed process notes to support policy and to set out the required actions of the Incident Lead, Quality Managers and others to help ensure that any incidents are managed in line with the Policy.
- Practices varied across the Divisions visited, and to ensure a uniform approach, Trust-wide/cross Division training sessions could be rolled out to cover each stage of the process.

(Source TIAA Assurance review of Serious Incident Management March 2019, provided by the trust.)

We were told there was difficulty in getting staff to complete serious incident investigations resulting in delays. On inspection we reviewed 15 serious incident reports; the process was clear however the completion of these varied, not all were well written, timely or covered the key principles expected with appropriate action plans and learning for improvement. Lessons learnt were not always clearly recorded; however, the Mortality Review Group April 2019 notes included a learning points for the need for reviewing the protocol around sedation and anti-coagulation. The notes also included the top three themes for the board in June as part of regular reporting to the board: end of life could it have been recognised earlier, do not resuscitate protocol (DNACPR), and recognition of deterioration (NEWS2). It was not clear how these points were translated into action plans for the trust. The trust mortality group was chaired by a consultant physician reporting to the medical director and more recently a NED had been identified to oversee the process.

The Patient Safety Sub-Committee was responsible for reviewing themes and trends arising from serious incidents including sharing the learning arising following an investigation. The new director of nursing had made changes for all new incidents, moderate rated and above, to be discussed at a weekly patient summit meeting which we observed. The purpose of the meeting was to determine if a serious incident or not had occurred and to allow for timely review of serious incidents in the week and for action planning with a multidisciplinary approach. The Never Events framework was to be aligned with a new Serious Incident framework. There was one Never Event reported in 2018/19 with the unintentional connection of air instead of oxygen.

All inpatient deaths were screened and if required a serious incident process was commenced. In mental health service processed had been refined to include the Royal College of Psychiatrists structured judgment tool. We were told the community and ambulance service divisions had aligned procedures to the framework. In line with guidance child, maternity and learning disability patient deaths were reviewed and deaths in the community within 30 days of discharge were also reviewed. There was a new inquest team and newly introduced process of liaison to ensue awareness of any serious incidents underway for the deceased patient. The role of the medical examiner had been advertised but was not yet appointed to. All inpatient deaths were reviewed daily as new process.

There was participation in clinical audits during 2018 / 2019, with 65 national clinical audits, and two national confidential enquiries.

The chief pharmacists managed the pharmacy risk register, which also hosted corporate medicines risks. Consideration was being given to separating the pharmacy and trust wide medicines optimisation risks. The medicines use and safety team reviewed national safety alerts. They would review the alert and in conjunction with the specialist nurses create a task and finish group to manage the implementation of the alert. Monthly medicines dashboards were produced by pharmacy for care group board meetings. However due to capacity and scheduling constraints there were limited opportunities for senior members of the pharmacy team to attend these meetings.

The trust understood its risks in terms of business continuity and planned for major incidents**.** There was a major incident response plan, which set out its responsibilities and roles in the event of an incident. NHS England required trusts to have suitable and up to date plans when faced with disruptions, but recognised these needed to be proportionate. Disruptions could be, for example, from severe weather, failure of systems or power, or an outbreak of an infectious disease. The trust had in recent months needed to invoke the major incident plan ensuring the safety of patients; following a road traffic incident requiring the emergency services and impact on the emergency department.

Finances Overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (2016/17)	Last Financial Year (2017/18)	This Financial Year (2018/19)	Next Financial Year (2019/20)
Income	£171.1m	£171.4m	£172.8m	£179.4m
Surplus (deficit)	(£11.0m)	(£23.3m)	(£30.1m)	(£26.3m)
Full Costs	£182.1m	£194.7m	£202.9m	£205.8m
Budget (or budget deficit)	(£4.6m)	(£18.8m)	(£17.1m)	(£26.3m)

The deficit reported in 2017/18 was higher than the previous year. Projections for 2018/19 indicated that the deficit will increase.

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

There was a use of resources inspection by NHS Improvement during our inspection period which is reported separately.

As part of our inspection we were joined by a financial reviewer from NHS Improvement who informed us:

This was a financially challenged trust that recorded a deficit in 2018/19 of £30.1m, having previously recorded a deficit in 2017/18 of £23.3m.

The financial governance and sustainability of the trust remained a concern to both CQC and NHS Improvement and the trust was placed into formal Financial Special Measures, by NHS Improvement, in March 2019.

Significant risks remained to the trust achieving both its in-year plan and its longer-term financial sustainability. The view was that the focus on addressing this issue must be renewed and the trust must ensure that appropriate processes are in place to ensure there is financial ‘grip and control’.

We heard some concern over what would be regarded as routine financial governance processes. For example; the follow up and completion of management actions from internal audit reports and

the use of single tender waivers. The view was the trust's underlying financial processes were key to assuring the trust operates to the highest standard of financial governance and ensuring these were effective to support the trusts financial delivery in the future.

At the time of the inspection the trust was moving to a revised performance management framework encompassing an integrated performance report for each of its Business Units/Divisions.

The trust was able to describe the work it had undertaken with partners to develop a sustainability plan. The governance of this integrated work needed to be confirmed and a robust programme plan developed; clearly identified roles and responsibilities along with the resources required to ensure delivery.

Further work was required to ensure the Programme Management Office (PMO) was supported to maturity and enabled to focus on delivering key workstreams to achieve the Cost Improvement Programme.

A financial improvement director was appointed in March 2019.

Trust corporate risk register

The trust provided a document detailing their 19 highest profile risks. Each of these have a current risk score of 15 or higher (out of a maximum possible risk score of 25).

Date risk identified	ID	Description	*Risk score (current)	*Risk level (target)
28/08/2018	1401	Risk of failure to deliver the current year agreed financial plan	25 (5 x 5)	8 (4 x 2)
28/08/2018	1405	Risk of failure to plan effectively for future financial sustainability	15 (3 x 5)	9 (3 x 3)
28/08/2018	1400	Risk of failure to secure SLA contractual income from commissioners	25 (5 x 5)	9 (3 x 3)
28/08/2018	1402	Risk of inadequate identification and implementation of cost improvement programme.	20 (4 x 5)	9 (3 x 3)
11/02/2019	1519	Failure to set out and implement an analytics and digital technology strategy/plan.	16 (4 x 4)	8 (4 x 2)
30/01/2019	1499	Failure to attract and recruit the right staff	20 (5 x 4)	12 (4 x 3)
31/01/2019	1520	Develop and retain the right staff	20 (5 x 4)	12 (4 x 3)
01/10/2018	1426	Condition: Significant shortages in nurse staffing across the organisation	16 (4 x 4)	6 (3 x 2)
21/11/2018	1462	37% of workforce within community services could retire in five years	16 (4 x 4)	6 (3 x 2)
28/11/2018	1478	Demand of diabetes/ insulin administration on community nursing	16 (4 x 4)	6 (2 x 3)
21/12/2018	1475	Inadequate capacity within paediatric ADHD service	15 (3 x 5)	6 (3 x 2)

01/06/2017	1187	High risk to patients with airway issues if no anaesthetist is available with potential to lead to a catastrophic incident.	16 (4 x 4)	9 (3 x 3)
12/12/2017	1291	Non-compliance against Standards for Children and Young People in emergency care settings	15 (3 x 5)	6 (3 x 2)
12/12/2017	1288	Non-compliance with EPRR Standards – emergency department (ED) lock down.	20 (4 x 5)	4 (4 x 1)
06/09/2018	1410	Risk of ED and Medical Assessment Unit monitoring equipment.	16 (4 x 4)	4 (4 x 1)
25/09/2018	1421	Inability to deliver financial plan due to need to use agency / locum staff. There is a potential that the division cannot deliver safe services in line with the financial plan.	16 (4 x 4)	8 (4 x 2)
25/09/2018	1427	Inability to recruit and retain sufficient staff to deliver safe, effective services There is a potential that the division cannot deliver safe services in line with the financial plan.	16 (4 x 4)	8 (4 x 2)
31/12/2018	1479	Insufficient resources allocated to Adult ASD/ADHD resulting in excessive waiting times and limited post diagnostic support	15 (3 x 5)	6 (3 x 2)
25/09/2018	1423	Insufficient admin capacity across MHLD.	16 (4 x 4)	8 (4 x 2)

*The values in the brackets indicate how the risk scores have been calculated for each risk (impact x likelihood). The maximum possible risk score is 25 (5 x 5). Impact and likelihood is given a score between 1 and 5.

(Source: Trust Corporate Risk Register - Trust Leadership Committee February 2019)

Information management

The service had limited reliable data for analysis. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The director of finance had accountability for information management and technology with support from the NED chair of the performance committee. There was a deputy director of information and a deputy director of information management and technology.

The NEDs during a focus group collectively told us that there was much to improve and investment needed for information management technology, information governance and cyber security. The trust medical director recognised the systems had been in need of investment and modernisation as they hampered efforts to review data for quality improvement. The trust board was in receipt of reports on performance across a range of information each month. There was no apparent digital strategy and there was concern from the NEDS that was no chief information officer for the trust, which was outside of current recommendations for NHS trusts.

Across the trust there were different IT systems for different services that did not interface and there was the intention to revise and bring some systems together. There was a move to becoming paper light across the trust with electronic patient records.

In late 2018 the ambulance service implemented the new Computer Aided Dispatch (CAD) system. The new system replaced software which had been in use for nine years.

We were told by the safeguarding leads that IT system issues caused delay in accessing integration with multiagency meetings with the local authority and the police service.

IT systems had been used to deliver on the 'tele swallowing service' with speech and language therapy video consultations; this was a pilot. The Allied health professionals had linked with a trust in Blackpool for delivery set up ideas and arrangements.

During 2018/2019, there were nine level two information governance incidents that were reported to the Information Commissioners Office. A new incident reporting tool for data security and protection incidents had been launched reflecting the revised reporting requirements of the General Data Protection Regulations (GDPR). The Information Commissioners Office (ICO), completed an audit and had not taken any action however the ICO was due to return for a follow up audit in August 2019.

There was an electronic prescribing system used in inpatient areas. Via a pharmacy robot, ward based electronic medicines cupboards and the significant roll out of electronic prescribing and medicines administration systems the trust was regarded as a beacon site for the automation of medicines optimisation.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Most staff felt engaged with through team meetings, and the senior leadership team had regular interactions with line managers. For instance, there were regular manager meetings, a staff survey, team briefs and chief executive sessions were held. Leaders were visible in the main hospital site and known to staff. There were new non-executives undertaking walkabouts to meet staff.

The trust pharmacy team worked with the pharmacy teams in adjacent trusts and local clinical commissioning groups through networking groups. These included the Isle of Wight Medicines Optimisation Committee, chief pharmacist, antimicrobial stewardship, aseptic and sustainability and transformation groups. Benefits for staff included an increased awareness of other services' challenges and priorities. Staff from an adjacent trust via a service level agreement answered medicines enquiries.

Whilst there was limited engagement with equality groups the trust had participated in the first Isle of Wight Pride event held in September 2018.

The trust was actively engaged in collaborative work with external partners, such as involvement with Sustainability and Transformation Plans.

We contacted some key stakeholders as part of our inspection to see how well engagement was progressing and the trust directly approached stakeholders for the end of year report. The local authority and the clinical commission group each spoke of the improved communication with the trust leadership team.

Healthwatch Isle of Wight had undertaken an enter and view visit in January 2019, following their input extensive refurbishment had improved the environment on Shackleton ward for mental health patients although it was noted by Healthwatch this ward saw the highest number of complaints and variation in feedback on patient experience. Healthwatch collated feedback from

patients and the public about their experiences on the island and reports were regularly shared with the trust.

The Policy and Scrutiny Committee referred to the improvements shown and described the journey to good to be at an early stage.

The Isle of Wight Clinical Commissioning Group (CCG) had worked closely with the trust and had undertaken visits of services such as in the emergency department. The CCG noted that of the three quality priorities that had been identified for 2018 /2019 there has been improvements within end of life care and the recognition and care of the deteriorating patient, however commissioners continued to see there was as an overarching safety theme arising from serious incidents.

The Patient Council members for the trust attended board meetings, they had a logo for identification within the local community. The council was accessible via social media and had requested members of the public shared their experience of trust services. The Patient Council informed the trust there was now a more open and honest culture and welcomed further work however to evidence the learnings gained and changes implemented in practice from incident reports and further development of gaining staff views of working at the trust.

One of the non-executive directors appreciated the patient story being reintroduced at the board meetings and had agreed to attend patient forums and attend the Patient Council and Medicine for Members Meetings in the coming months.

Volunteering was important to the trust and had the support of 300 volunteers who gave their

time to assist patients, visitors and staff across all divisions. There were monthly newsletters with details on trust-wide news, training opportunities and quarterly drop-in sessions, which were supported by directors.

Learning, continuous improvement and innovation

There was a keen interest in continually learning and improving services, however staff levels and work pressures meant not all staff had time to focus on this to date. There was variable understanding of quality improvement skills and methods. There was innovation and participation in research.

The structure of quality improvement leadership had changed since the last inspection; however, the staff were not always clear about the approach to follow or whom report to; there was no method of recording quality improvement actions or projects that all staff could know about and learn from.

Research studies and clinical trials were established at the trust led by a consultant physician reporting to the Clinical Effectiveness Group, a six month report was presented to the trust board by the medical director. There was strong links with the University of Southampton as well as a Wessex hub for governance of projects. For 2019/2020 there were plans for recruiting a new manager to build on current strengths and develop new opportunities on the Island and with local mainland partners.

The trust reported in the year to March 2019, 1275 patients were recruited to participate in research approved by a research ethics committee. There were 23 studies granted research governance approval by the trust with a further 31 studies remaining open from previous years. These covered the following clinical specialties; asthma and allergy, cancer, cardiovascular disease, children, dementia and degenerative diseases, diabetes, gastroenterology, orthopaedics, mental health, metabolic and endocrine disease, ear nose and throat, ophthalmology, reproductive

health and childbirth, respiratory disorders, stroke and health service management. This work was supported by an allocation of £384,100, from the regional Clinical Research Network, which covered clinician sessions, research nurses and associated staff, NHS service support (pathology, radiology and pharmacy) and research set-up and management; in total 21 staff members.

We had been told on inspection that there were examples of innovation and we were presented with a comprehensive list of which this is a sample of entries:

The community children and you people team had been awarded £2000 for their innovation to support children with constipation, they had developed POO BAG, trialled with 40 children. The bag contained information on treatment causes and solutions to constipation including a distraction toy. Following attendance at a conference six areas across the UK were undertaking an evaluation of this resource.

The trust participated in the Prescribing Observatory for Mental Health (POMH-UK) a subscription based project that helps specialist mental health services across the UK improve their prescribing practice. This provided benchmarking data and analysis of aspects of mental health prescribing practice.

In pharmacy they had a service called MOTIVE that allowed communication between the trust and community pharmacies for a patients medicine regimen. This included telephone follow up for patients at higher risk.

In radiology the diagnostics team used a triage tool in the emergency department to assist the junior doctor workforce.

An innovation from the critical care outreach team was “call for concern” for patients and relatives to speak to a member of the team if they were concerned about their condition.

For improvement in dementia care a new memory lounge was created for patients to relax in alongside one of the wards.

The ambulance service offered free resuscitation (CPR) training to local school children as part of government plans for health education to be taught in every school.

Complaints process overview

During 2018 / 2019 reporting of complaints data was part of the performance report to trust board and the monthly quality report which was reviewed at the Quality Committee, as well as being reviewed quarterly via the Patient Experience Subcommittee.

The trust’s quality strategy had placed a renewed focus on improving complaints handling and ensuring that learning from experiences occurred. Key performance indicators included managing complaints within timescale, reducing complaints regarding staff attitude, dignity and respect and communication and increasing the compliments received. We reviewed several reports and found the timescales for response were often not met. The trust had reported at year end overall, of all complaints closed only 35% of these were within agreed timescales. However, improvements had been made included for new complaints, as there was now an investigation and review directly with the staff involved. The patient and/or family members were involved from the beginning of the complaint investigation to ensure lessons learned. We spoke to patients at a focus group one of whom had a letter explaining that their complaint response was overdue and when to expect an update; the person wanted to speak directly with someone at the trust but at that time had not

been offered an option to do so. Once responses were made we saw these were clear and sufficiently detailed to answer concerns raised and an offered an apology where indicated.

Themes of complaints were noted as communication and, values and behaviours of staff and waiting times.

At the last inspection the oldest complaint had taken 265 days to close. The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Target performance
What is your internal target for responding to complaints?	3 working days	100%
What is your target for completing a complaint	30 working days	75%
If you have a slightly longer target for complex complaints please indicate what that is here	60 working days	75%
Number of complaints resolved without formal process in the last 12 months?	916 (January to December 2018)	

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

Number of complaints made to the trust

From January to December 2018, the trust received a total of 405 complaints. The highest number of complaints were for surgery, with 22.5% of total complaints. This was followed by urgent and emergency care (20.0% of complaints) and medical care (13.8%).

The trust took an average of 41.9 days to investigate and close complaints, and 35.6% were closed within 30 working days. This was not in line with their complaints policy, which stated that 75% of complaints should be closed within 30 working days.

Core Service	Number of complaints	Percentage of total
AC - Surgery	91	22.5%
AC - Urgent and emergency services	81	20.0%
AC - Medical care (including older people's care)	56	13.8%
MH - Community-based mental health services for adults of working age	30	7.4%
CHS - Community health services for adults	17	4.2%
AMB – Emergency and urgent care	14	3.5%
Other	14	3.5%
AC - Maternity	14	3.5%
MH - Acute wards for adults of working age and psychiatric intensive care units	12	3.0%
AC - Critical care	11	2.7%
Provider wide	9	2.2%

AC - Diagnostics	9	2.2%
AC - Services for children and young people	8	2.0%
AC - Gynaecology	8	2.0%
MH - Mental health crisis services and health-based places of safety	7	1.7%
AMB - Emergency operation centre	5	1.2%
MH - Specialist community mental health services for children and young people.	4	1.0%
CHS - Children, young people and families	3	0.7%
AMB - Patient transport services	3	0.7%
AC - End of life care	3	0.7%
AC - Outpatients	2	0.5%
CHS - Community inpatients	2	0.5%
MH - Community-based mental health services for older people	1	0.2%
Total	**405**	**100.0%**

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

Compliments

From April to December 2018, the trust received a total of 1,385 compliments. The highest number of compliments were for acute services. The trust was unable to provide the number of compliments split by core services. However, a broad breakdown can be seen in the table below:

Core service	Number of compliments
Acute services	1,179
Community services	107
Ambulance services	97
Mental Health	2
Total	**1,385**

The trust had started to move towards the capture of compliments on Datix, and this was still in its infancy. The trust has identified the following themes from compliments received:

- Staff Behaviour: staff are described, through individual experiences, to behave in a manner that is kind, patient, friendly, professional, courteous, caring, compassionate, helpful and understanding.
- Specific praise for consultant care
- Treatment with dignity and respect
- Effective and Responsive emergency department
- Excellent care

- Helpful, friendly and efficient administrators and receptionists.

Regarding compliments received by staff working in the ambulance services the trust stated that staff were acknowledged as being caring, informative, compassionate and polite. Patients, carers and relatives often stated that even in the most difficult of circumstances, staff adopted a calm manner which did not go unnoticed.

(Source: Routine Provider Information Request (RPIR) – Compliments)

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.

Accreditation scheme name	Service accredited	CQC core service
Joint Advisory Group on Endoscopy (JAG)	Endoscopy due a 5-year visit for renewal of accreditation in October 2019 - status at present is deferral awaiting further information to be uploaded	AC - Medical care (including older people's care)
Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189	The Cellular Pathology department maintained ISO 15189 accreditation on 25/01/2019. The Microbiology department was awarded ISO 15189 accreditation on 31/01/2019. Blood Sciences (Chemical Pathology and Blood Transfusion) achieved ISO 15189 accreditation on 27/09/2018 with a surveillance visit occurring on 25/02/2019.	Other
CHKS Accreditation for radiotherapy and oncology services	The trust is not a centre for radiotherapy. Oncology service commissioned from the tertiary centres by Specialist Commissioning. Chemotherapy service is quality assured by QSIS annually in June with annual self-assessment (Operational Policy, Annual Report and Work Programme)	AC - Medical care (including older people's care)
ECT Accreditation Scheme (ECTAS)	Accredited July 2017	N/A
BS EN ISO 13485:2016	25/07/18 to 09/07/19	AC - Critical Care
MDD 93/42/EEC	09/07/16 to 09/07/21	AC - Critical Care
Accreditation for Inpatient Mental Health Services (AIMS) - Working Age Units	Previously accredited June 2017 and awaiting overdue outcome of latest panel review.	MH - Acute wards for adults of working age and psychiatric intensive care units

Accreditation for Inpatient Mental Health Services (AIMS) - Psychiatric Intensive Care Units	Previously accredited June 2017 and currently undertaking the self-assessment and review process.	MH - Acute wards for adults of working age and psychiatric intensive care units

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

Acute services

St Mary's Hospital

Parkhurst Road
Newport
Isle of Wight
PO30 5TG

Tel: 01983524081

www.iow.nhs.uk

Urgent and emergency care

Facts and data about this service

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.

The department has three adult resuscitation bays, 10 majors bays, three rapid assessment bays, three minors cubicles and a mental health assessment room that is ligature risk compliant. The department has two dedicated paediatric rooms suitable for minors, majors and resus cases.

Children have a separate waiting room and are treated in two rooms adjacent to the major treatment area. There are separate rooms for mental health assessment, eye examinations and application of plaster casts.

Radiology services are located next to the department.

The ED is led by four substantive Consultants, a Matron and seven Sisters/ Charge Nurses.

The unit cares for both adults and children with approximately 50,000 attendances per year (25% of these patients are children).

The ED is not a trauma centre but is part of the regional trauma network and is a primary point of arrival for non-major trauma and occasionally major trauma awaiting transfer to a major trauma centre. Air-Ambulance or coastguard helicopter services assist the transfers to mainland trauma centres.

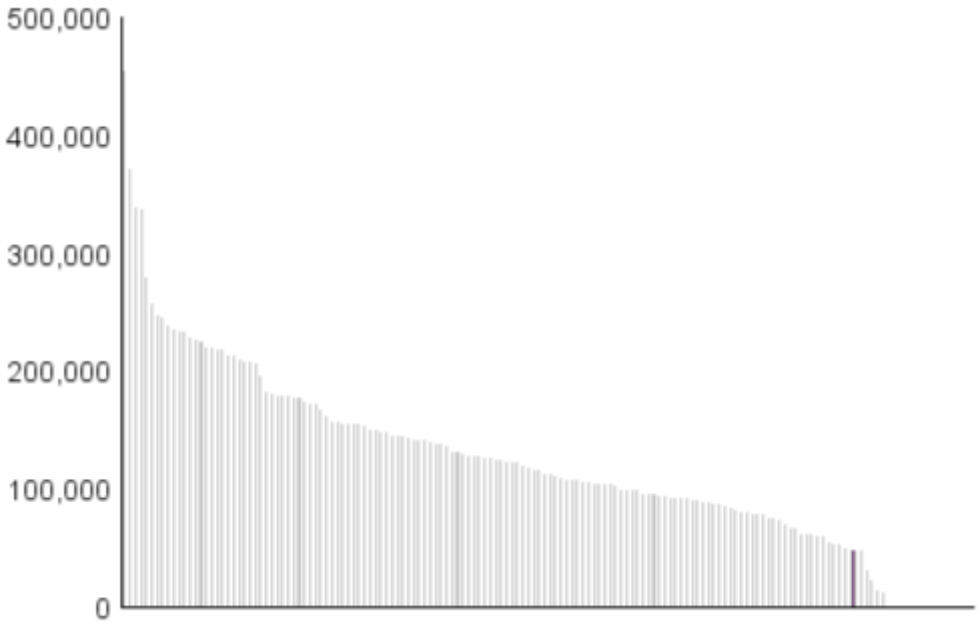
(Source: Routine Provider Information Request (RPIR) – Acute context)

We last inspected the department in January 2018 and we undertook a winter pressures inspection in January 2019 which focussed on a proportion of the key lines of enquiry.

We carried out an announced inspection from 21-23 May 2019. During our inspection, we spoke with 18 patients and 5 family members, reviewed records of 9 patients and spoke with 54 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

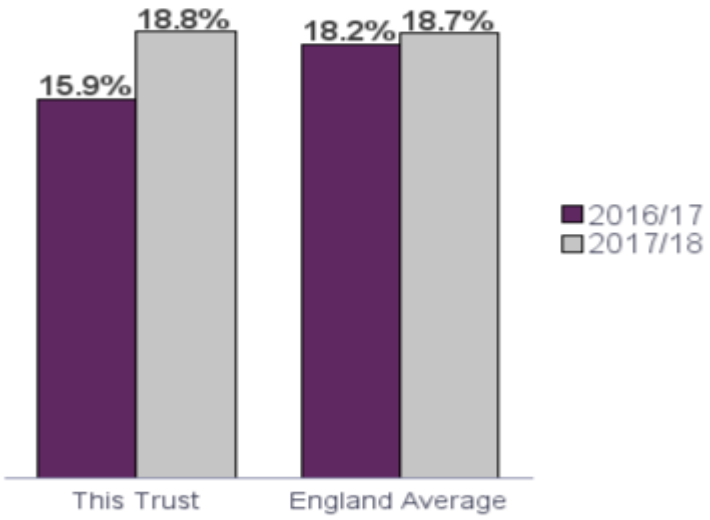
Total number of urgent and emergency care attendances at Isle of Wight NHS Trust compared to all acute trusts in England, January 2018 to December 2018



From January 2018 to December 2018 there were 47,935 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

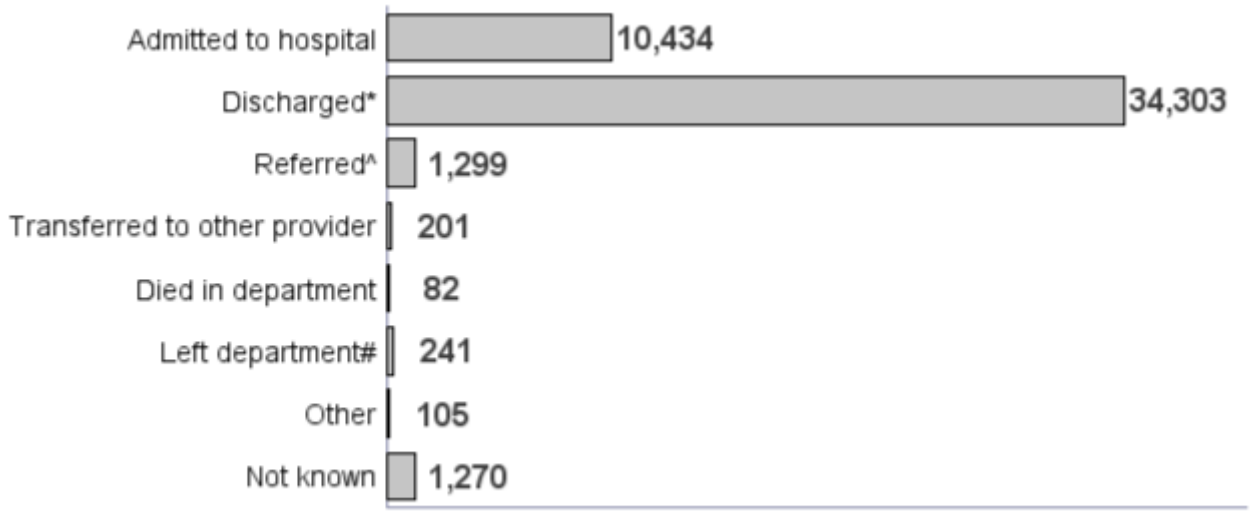
Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission increased in 2017/18 compared to 2016/17. In 2016/17, the proportion was lower than the England average, and in 2017/18 the proportion was similar to the England average.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from January 2018 to December 2018



* Discharged 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 including the highest level of life support training to all staff but not all staff completed it.

This was largely unchanged from the inspection In January 2018. The service acknowledged that the mandatory training compliance required improvement and with the increase in staff numbers had plans to ensure staff were booked onto all the mandatory training to ensure safety.

Mandatory training completion rates

The trust set a target of 85.0% for completion of mandatory training.

St Mary's Hospital

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for

registered nursing staff in the urgent and emergency care department at is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety Part 1 - Theory	32	32	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	32	32	100.0%	85.0%	Yes
People Handling	31	32	96.9%	85.0%	Yes
Medicines Management Theory	59	62	95.2%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	30	32	93.8%	85.0%	Yes
Health, Safety and Welfare	30	32	93.8%	85.0%	Yes
Adult Resuscitation	28	31	90.3%	85.0%	Yes
Information Governance	28	32	87.5%	85.0%	Yes
Hand Hygiene	27	32	84.4%	85.0%	No
Paediatric Resuscitation	25	30	83.3%	85.0%	No
Infection Prevention & Control Level 2	25	32	78.1%	85.0%	No
Adult Resuscitation - ILS	20	30	66.7%	85.0%	No
Medicines Management Practical Assessment	20	31	64.5%	85.0%	No
Paediatric Resuscitation - PILS	19	30	63.3%	85.0%	No

In the emergency department the 85.0% target was met for eight of the 14 mandatory training modules for which registered nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for medical staff in the emergency department is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection Prevention & Control Level 1	12	13	92.3%	85.0%	Yes
Fire Safety Part 1 - Theory	11	13	84.6%	85.0%	No
Health, Safety and Welfare	11	13	84.6%	85.0%	No
People Handling	2	3	66.7%	90.0%	No
Load Handling	6	10	60.0%	90.0%	No
Adult Resuscitation	5	9	55.6%	85.0%	No
Fire Safety Part 2 - Extinguishers	6	13	46.2%	85.0%	No
Information Governance	6	13	46.2%	85.0%	No
Adult Resuscitation - ILS	3	7	42.9%	85.0%	No

Infection Prevention & Control Level 2	5	13	38.5%	85.0%	No
Paediatric Resuscitation	3	8	37.5%	85.0%	No
Hand Hygiene	2	13	15.4%	85.0%	No
Paediatric Resuscitation - PILS	0	6	0.0%	85.0%	No

In the emergency department the 85.0% target was met for one of the 13 mandatory training modules for which medical staff were eligible. The trust was close to meeting the completion target for the fire safety part 1 (theory) and health, safety and welfare training modules. A completion rate of 84.6% was reported for both modules.

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

The service provided more recent data on mandatory training following our inspection, this did not demonstrate compliance levels broken down by training module. The overall compliance rates were as follows:

Department	Total Required	Total Achieved	Compliance %
ED - Non Clinical Staff	330	281	85%
ED Medical staff	403	262	65%
Emergency Department	1347	1090	81%

The medical staff mandatory training compliance had increased from 51% overall to 65%.

Further demonstrated that registered nurses were 97% compliant for paediatric immediate life support which ensured the service was assured that there were always nurses on duty with this essential training.

Training, where possible, was provided in a multidisciplinary approach, including training in trauma and emergency calls. To ensure staff were up to date and aware of their roles in trauma calls and other incidents, there were regular simulations of these events. These events were attended by all required staff members of varying clinical roles. Learning and action points from these simulations were then feedback to staff. We also observed senior staff members observing real life trauma calls to identify any learning or changes to practice from these events.

Staff were aware of the management of sepsis. Staff received annual training on sepsis management through the basic life support mandatory training and induction.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had previous training on how to recognise and report abuse, and they knew how to apply it, but staff accessing the training updates did not meet the 85% target.

There was a standard operating procedure for referrals to the hospital children's safeguarding team, which outlined the responsibilities of all staff and detailed the associated policies and procedures staff should follow. There were lead nurses identified for adult and children's safeguarding, although not all staff could identify these individuals. The lead children's nurse was also the safeguarding lead for children.

Nursing staff we spoke with demonstrated a good understanding of their responsibilities to safeguard vulnerable adults and children and had received the appropriates levels of training. Some staff told us they would report concerns on line, others told us they would discuss their concerns with the nurse in charge or the children's nurse. There was a flow chart with contact details for staff to refer to when necessary, and the ED checklist included safeguarding referral.

Staff were alerted to children with multiple ED attendances via the electronic patient records system. This also flagged children who were on the child protection register or children in care. The records system prompted staff to ask questions related to safeguarding, although this section was not mandatory. The lead children's nurse told us they did not have oversight of all children's records, but the trust's children's safeguarding lead reviewed all records of children attending ED to assess whether staff had asked all appropriate questions and taken appropriate actions to safeguard vulnerable children. We were told that they would follow up any omissions or concerns with the relevant staff.

Safeguarding training completion rates

The trust set a target of 85.0% for completion of safeguarding training.

St Mary's Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for registered nursing staff in the emergency department is shown below:

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1	31	32	96.9%	85.0%	Yes
Safeguarding Adults Level 1	30	32	93.8%	85.0%	Yes
Safeguarding Children Level 2	30	32	93.8%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	29	32	90.6%	85.0%	Yes
Safeguarding Adults Level 2 Part 2	26	32	81.3%	85.0%	No
Safeguarding Children Level 3	25	31	80.6%	85.0%	No
Safeguarding Adults Level 2 Part 1	25	32	78.1%	85.0%	No
Preventing Radicalisation Level 3	18	32	56.3%	85.0%	No

In the emergency department the 85.0% target was met for four of the eight safeguarding training modules for which qualified nursing staff were eligible.

The trust had increased the training requirements for training in safeguarding with the expectation that nursing staff should achieve level for adult safeguarding and level 3 for children. However the compliance at levels 2 and above fell short of the 85% compliance for safeguarding training at level 2 for adults and level 3 for children. Compliance for preventing radicalisation level 3 was well below the required level.

The staff relied on the trust's children's safeguarding lead to identify risks when they reviewed the records each day.

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for medical staff in the emergency department is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1	12	13	92.3%	85.0%	Yes
Safeguarding Adults Level 1	10	13	76.9%	85.0%	No
Safeguarding Children Level 2	9	13	69.2%	85.0%	No
Safeguarding Children Level 3	8	12	66.7%	85.0%	No
Preventing Radicalisation Level 1 & 2	7	13	53.8%	85.0%	No
Safeguarding Adults Level 2 Part 1	4	13	30.8%	85.0%	No
Safeguarding Adults Level 2 Part 2	4	13	30.8%	85.0%	No
Preventing Radicalisation Level 3	1	10	10.0%	85.0%	No

In the emergency department the 85.0% target was met for one of the eight safeguarding training modules for which medical staff were eligible. This remained similar to this standard at the time of the inspection in January 2018.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Staff used 'I am clean' labels on commodes and other equipment.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. We did not see any high or low dust areas. The cleaning schedule was visible in the corridor and was up to date. Domestic staff used colour coded bags to segregate infected linen from clinical waste, and colour coded mops were used in the same way. We saw a nurse call for cleaning in a rapid assessment bay following a patient who had an accident.

Sharps disposable bins were located throughout the department. Lids were noted to be closed and no bins were found to be overflowing, therefore reducing the risk of needle-stick injuries to staff. Staff followed infection control principles including the use of personal protective equipment (PPE), and followed the bare below the elbows policy

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Infection control screening was included in the emergency department checklist and isolation facilities were available when needed.

The service provided recent data on compliance with training in infection prevention and control in March as follows:

Nursing staff 58% compliant; medical staff 38% compliant.

The service provided the compliance results of recent hand hygiene audits:

Month	Nurses	Medical staff
February	83%	78%
April	78%	84%

The figures did not reflect our observations during the inspection.

Single use items of equipment were available for patient treatment and these were stored and disposed of safely after use. Staff had emergency infection control kits, which included isolation gowns, spillage sets and zipped body bags, available to them when required.

Staff managed the control of substances hazardous to health well; hazardous materials such as bleach powder and high concentrate cleaning materials were locked in a cupboard. The nurse in charge carried the keys.

Environment and equipment

The maintenance and use of existing facilities, and equipment kept people safe. Staff were trained to use equipment properly. Staff managed clinical waste well.

However, the design of the emergency department did not comply with national standards to keep people safe.

During the winter pressures inspection in January 2019 there were several examples of patients having to be treated and cared for in the central corridor running through the middle of the major treatment area. This was not the case during our inspection as all patients were being cared and treated for in designated patient areas.

The trust had acknowledged for some time that the design and layout of the emergency department did not comply with national standards (Hospital Building Note 15-01: Accident & emergency departments and RCPCH Facing the Future) and there were plans shown to us in the spring of 2019 to reconfigure the department and to create a dedicated children's area. The trust told us this work would commence in September 2019.

There was not a separate waiting area for children, although there was a small play area. Staff told us where possible, children would be taken directly to the children's treatment area, which was located in a corner of the major treatment area (majors).

We saw children sometimes waited in the relatives' room. This was adjacent to the children's treatment area, but it was the only relatives' room available for the whole department and would sometimes be used to accommodate anxious or bereaved relatives.

The children's treatment area had three cubicles large enough for a patient trolley and equipment for immediate assessment and treatment. One was appropriately equipped for the resuscitation of small babies and a second for the resuscitation of all other children. The rooms were child-friendly and safe, but not fully secure, and children were not overlooked by adults in this area.

The service had a visit from NHSI's national children's lead in January 2019. The visit was requested by the service in response to the findings reported following the CQC winter pressures inspection in January 2019. The report referred to the following:

- The lack of space and poor estate.
- Lack of signage or information for families at a time when they may be anxious and require more help and support.
- The two paediatric resuscitation areas were small, and close the staff kitchen, the quiet room where there may be relatives who have received bad news, compromising the dignity of both the children and relatives, and near the adult resuscitation area.
- No-one identified as the executive lead for children and young people.

The feed back from this visit recognised the actions in place to address the concerns, though this was high level and some of the actions were ongoing, for example the physical space/location was unchanged.

The adult 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. However, the batteries on the patient monitoring equipment were poor, meaning that they could not be used for transferring patients to other areas such as for scans. The staff manage this by using the defibrillators from the resuscitation areas in order to transfer patients. We noted that this had been on the department risk register as a high risk since September 2018.

There was a designated room for seeing patients who required a mental health assessment. This had been re-furbished since our last inspection. However, there were two doors in the room which opened inwards and guidance suggests they should be outward opening. There were viewing panels on one of the doors, but one had recently been broken and replaced with non toughened glass. There was a blind spot in the corner of the room and only one alarm, guidance states that the alarm should be installed as a strip around the room. It was not clear from the department reconfiguration plans that this was included, however this will be partly addressed by the plan to provide all staff with pinpoint alarms placed on their identification badges, ensuring all staff, including agency, will carry personal alarms in the emergency department.

The waiting room was laid out to ensure staff had sight of patients and visitors waiting; there was good access to patient toilets and refreshments.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and in most cases, updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

The assessment of patients was an improvement on the findings in the inspection in January 2018 and January 2019. In previous inspections a warning notice had been issued which required significant improvement in respect of our findings as patients were not always assessed in a timely or safe manner or assessed by staff who were suitably qualified.

Patients who self-presented registered at the reception desk. Receptionists had received training to recognise 'red flag' symptoms and were able to show us a list of the presentations which would prompt them to seek urgent clinical attention. We saw during our visit a number of occasions when

patients with potentially serious conditions were quickly attended to and taken to the majors area for assessment.

There was a streaming nurse employed, who was able to direct patients to the most appropriate clinical area or signpost them to other services, such as primary care or pharmacy. Staff told us they were sometimes able to secure an appointment at the patient's GP surgery when the patient had failed to secure one. We observed appropriate streaming and triage, for example, one patient was directed to majors for an ECG (echocardiogram). The nurse had asked relevant questions such as allergies, pain level and assessed vital signs. Staffing shortages meant the that the streaming nurse was not always available.

The triage nurses assessed patients using a nationally recognised triage system in order to identify or eliminate any serious or life-threatening illness or injury and prioritise patients' treatment. During our inspection we saw that triage was done in a timely way within 15 minutes on each occasion.

Patients arriving by ambulance were taken straight to the initial assessment area, which was staffed by a registered nurse, a healthcare assistant and a doctor. There were three cubicles and a seating area; we found this area could quickly become crowded, even though the department was not busy. One staff member told us, at times there are up to 15 patients in this area, which is designed for a quick assessment and turnaround. When there was a delay elsewhere preventing the flow of patients these patients remained there waiting to move to a more suitable treatment area.

The nurse took the handover with the paramedics and entered the patient information onto the computer. This was done following a quick look at the patient's condition but did not constitute a full face to face contact with the patient and staff could not be assured that the current assessment was still the same as earlier assessment by the paramedic. The nurse we observed therefore did not complete clinical details such as pulse and respiration before entering the current status on the computer. This practice was identified during the January 2019 inspection as not in line with the guidance produced by the Royal College of Emergency Medicine (RCEM) and the Royal College of Nursing (RCN), which guidance 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. The pathway for patients arriving by ambulance had improved but did not fully meet standards.

Staff completed a safety checklist for all patients in majors. This contained prompts to perform hourly checks of patients' safety and wellbeing. The checklist included hourly observations of patients' vital signs. The department used NEWS 2- a nationally recognised system to assess acutely ill and deteriorating patients. We saw that observations were recorded regularly; however, there were some unexplained gaps in the safety checklist for a small proportion of patients, so we could not be assured that all observations took place as required. The standard operating procedure for timely patient assessments had been improved since the inspection in January 2019, but practice wasn't consistent.

An improvement since the last inspection was that safety rounds had become more established. The nurse in charge performed two hourly safety rounds, to ensure oversight of activity in the department and to check that regular safety checks were up to date. They applied blue stickers to patients' records to show that they had reviewed the records and to highlight any omissions. The two hourly rounds included NEWS 2 scores, administration of medicines, and hourly clinical observations and monitoring had been completed by the staff. Checks also included patients had identification wristbands, pressure areas were checked, and sepsis screening had been

completed. Safety rounds were recorded in a book held at the nurses' station. It was evident from this book that sometimes a detailed review of records was not possible when the department was busy and the nurse in charge had numerous other tasks to perform. However, during the inspection, we saw this process provided a good oversight and assurance of safety. The nurse in charge told us they escalated any concerns to the consultant in charge and from time to time they held 'huddles' by the patient information board to review and prioritise patients in the department.

There was a multidisciplinary safety briefing at the start of each shift. This was a brief run through of the status of the department and identifying any risks, such as patients at risk of falls, at risk of absconding and any other alerts in place. This was also an opportunity to discuss any recent incidents or complaints and timely reminders of safety processes.

The service had just developed a comprehensive document which was due to be agreed and launched into the service. The document combined in one place the documents in current use and prompted staff to complete rapid assessments across a range of health measures including physical observations, falls risks and skin integrity, sepsis screening, peripheral cannula insertion records and visual infusion phlebitis management. The document also incorporated the hourly safety checklists which prompted staff to consider pain management, vital signs, level of consciousness, nutrition and hydration needs and speciality referrals for those who were identified as being vulnerable for example.

All the pathways and protocols we observed the staff using were relevant and appropriate for ensuring patients were assessed and treated quickly and monitored to ensure safety.

We observed timely attendance of clinical specialities to the emergency department when pre-alert calls were received from the ambulance service. This was an improvement on the findings at the inspection in January. Staff told us the stroke team responded to all stroke calls, even if medical history suggested the patient was outside the optimal window for thrombolysis. We saw physiotherapists in the department daily dealing with cases of patient frailty.

Staff in the emergency department completed a triage assessment with patients and if they were at risk of self harm or suicidal, staff contacted the mental health liaison worker or staff from the inpatients ward on site for support. If a child or young person under the age of 18 presented at the emergency department with risks of suicide or self harm, staff contacted the paediatric nurse and the child and adolescent mental health service (CAMHS). There was no CAMHS consultant available out of hours which meant delays for young people admitted over the weekend.

We did not see any patients requiring assessment by the mental health teams during our inspection.

The service used volunteer staff to escort patients to the imaging department for scans

Emergency Department Survey 2016

The trust scored better than other trusts for all five of the Emergency Department Survey questions relevant to safety.

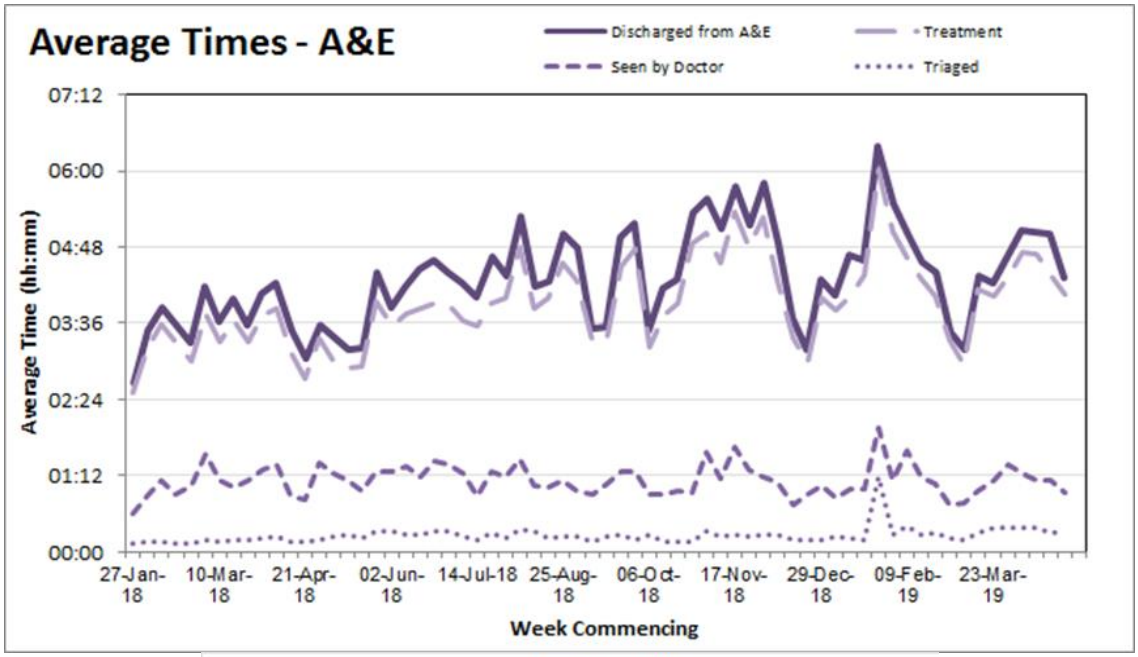
Question	Score	RAG
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.3	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	7.0	About the same as other trusts
Q9. Sometimes, people will first talk to a nurse or	7.0	About the same as

doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?		other trusts
Q33. In your opinion, how clean was the emergency department?	8.9	About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.8	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

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

The trust has not reported any data relating to median time from arrival to initial assessment since March 2018. However they provided the following data upon request during the inspection



Avg Times (hh:mm)

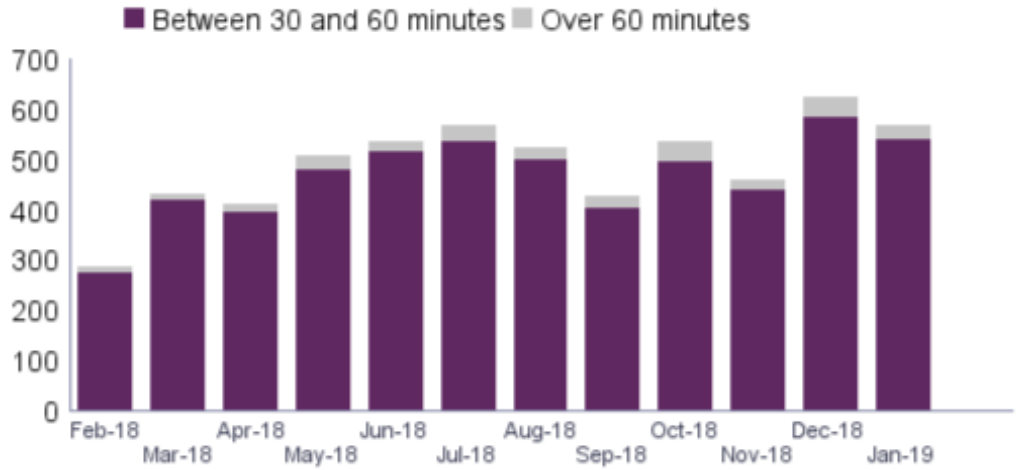
	Triage	Triage to Seen by Doctor	Seen by Doctor to Treatment	Treatment to leave Department
Mar-18	00:10	01:01	02:16	00:20
Apr-18	00:11	00:55	02:16	00:20
May-18	00:15	00:55	01:59	00:19
Jun-18	00:18	01:00	02:27	00:30
Jul-18	00:15	00:58	02:34	00:31
Aug-18	00:16	00:52	03:07	00:23
Sep-18	00:14	00:49	02:53	00:19
Oct-18	00:11	00:46	02:56	00:23
Nov-18	00:15	01:07	03:33	00:28
Dec-18	00:13	00:45	02:58	00:25
Jan-19	00:12	00:46	03:18	00:20
Feb-19	00:30	00:55	03:16	00:21
Mar-19	00:17	00:40	02:42	00:11
Apr-19	00:21	00:48	03:17	00:24

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

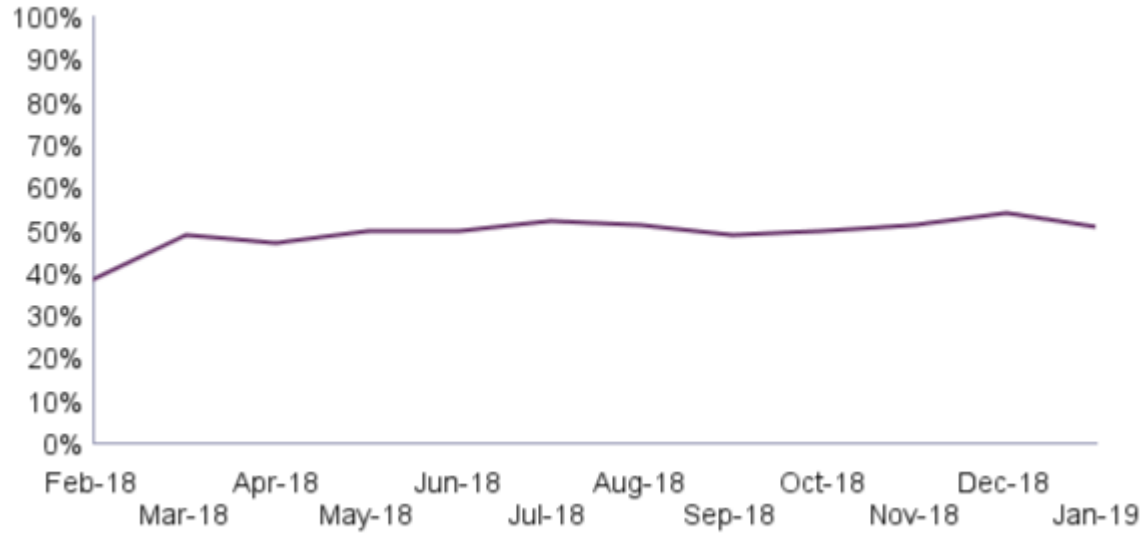
St Marys Hospital, Isle of Wight

From March 2018 to January 2019, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at St Marys Hospital, Isle of Wight. This stable trend followed on from an increase in journeys with a turnaround time of over 30 minutes in March 2018.

Ambulance: Number of journeys with turnaround times over 30 minutes - St Marys Hospital, Isle of Wight



Ambulance: Percentage of journeys with turnaround times over 30 minutes - St Marys Hospital, Isle of Wight

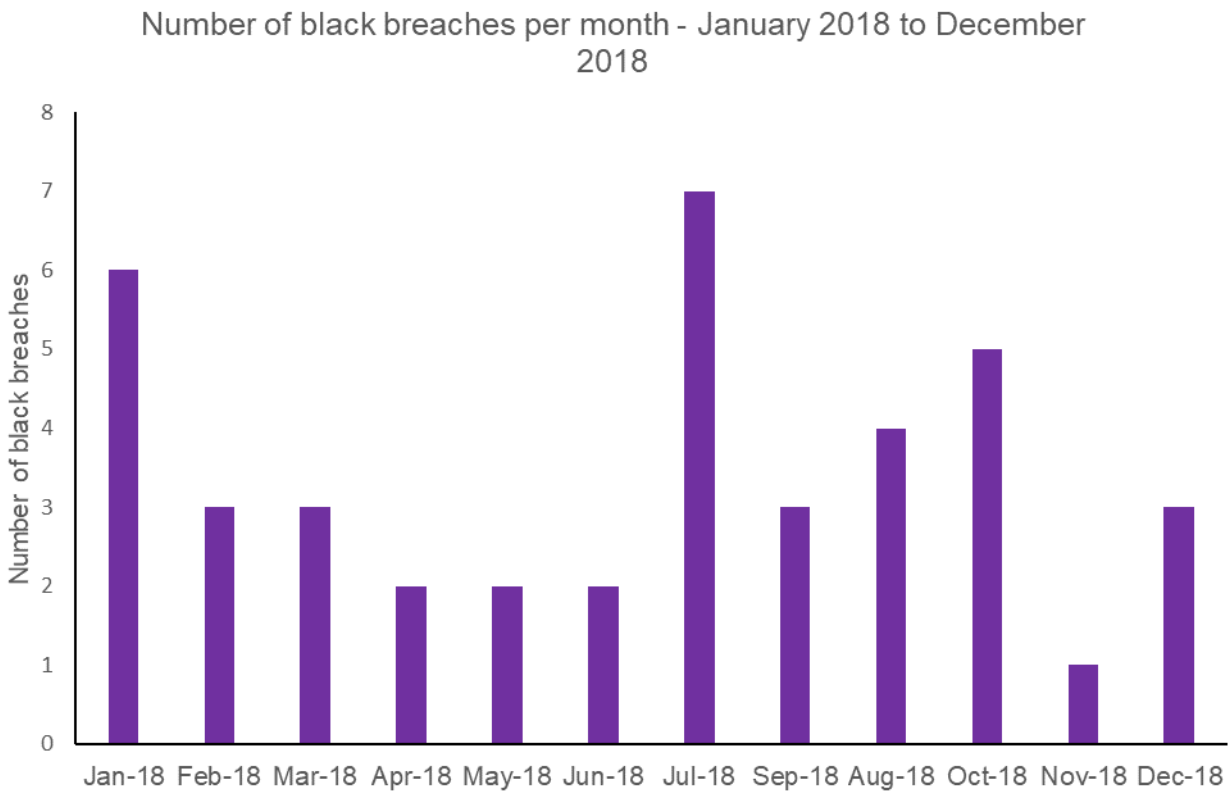


(Source: National Ambulance Information Group)

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 to December 2018 the trust reported 41 “black breaches”. The months with the greatest number of black breaches were July 2018 (seven black breaches), January 2018 (six black breaches) and October 2018 (five black breaches). The trust reported that all of the black

breaches were a result of crowding in the emergency department leading to a lack of assessment space to receive handovers.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Nurse staffing

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

There was however, some improvement on the findings in the inspections carried out in January 2018 and January 2019 where a warning notice was issued This required significant improvement in respect of our findings that there were insufficient numbers of staff on duty to deliver safe care and treatment to patients.

The ED nurse staffing numbers continued to fall short of the required number to meet the guideline for caring for children. There were four registered children's nurses (RCNs) employed. This did not enable the ED to ensure there was adequate cover. National guidance, Facing the Future: Standards for Children and Young People in Emergency Care Settings (RCPCH June 2018), states there should always be two children's nurses on duty in emergency departments which treat children. The staffing numbers, before taking in to account annual leave and other staff absences did not yield sufficient cover for one children's nurse per shift, leaving a minimum of two shifts per week uncovered. We looked at the staff rotas for the last two months (31 March to 27 April and 28 April to 25 May 2019). There were 11 and eight shifts respectively which were not covered by a children's nurse. The service did not routinely audit or report on this.

The lead children's nurse was responsible for producing the rota for children's nurses and the nurse in charge of the department was responsible for covering gaps on the day. We saw that adult-trained nurses were deployed from other parts of the emergency department. Support was also requested for the children's ward, although this was usually only provided when the department received a critically ill or injured child. There was a paediatric emergency bleep to

request specialist medical and nursing support from the children's ward. Staff told us these staff were very responsive in an emergency situation.

The emergency department was taking steps to mitigate the risk associated with short staffing. When there were insufficient RCNs to cover the entire 24-hour period, the department tried to ensure the twilight shift was covered as this was the busiest time. In the absence of an RCN the ED deployed adult-trained registered nurses to staff the children's area. Most registered nurses had undertaken paediatric immediate life support training and some staff had undertaken further training to achieve paediatric competencies to support them to care for sick and injured children.

The emergency department reported the following WTE nursing staff numbers for the periods below for urgent and emergency care.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
Emergency department	30.7	37.6	81.8%
A and E medics	1.6	10.9	14.6%
Total	**32.3**	**48.5**	**66.7%**

From April 2018 to March 2019, the nursing staffing rate within urgent and emergency care at St Mary's Hospital was 66.7%.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Staffing numbers were displayed in the department each day during our inspection; we saw that for each shift the planned and actual staff numbers and skill mix matched. This was an improvement since the inspection in January. There was a staffing ratio of 1 nurse to 5 patients in major and 2 nurses for 3 patients in resus.

The nurse staffing establishment for the department was provided as follows:

ENP band 6	5.47 WTE	There were 4 WTE out to advert and 3 in training
Band 7	6.58 WTE	1 WTE vacancy
Band 6	11.16 WTE	0 vacancies
Band5	19.81 WTE	7 vacancies
EDAs Band 2 and 3	14.35 WTE	2 vacancies

The trust had recruited 4 band 5 nurses from overseas due to start in the coming months and 2 of the student nurses were starting when they qualified.

The emergency department and the medical assessment unit had been granted a £1.8 million uplift to the staffing budget. Managers were in negotiation with mainland trusts to consider shared roles. The nursing establishment had increased significantly since October 2018; the numbers had risen from 33.9 WTE to 51.9 WTE. We saw positive evidence of adequate staffing levels and future planning for recruitment and retention, which was much improved since the inspection in January.

Vacancy rates

St Mary's Hospital

From January to December 2018, St. Mary's Hospital reported a vacancy rate of 19.9% for nursing staff in urgent and emergency care. The trust did not set a target for vacancy.

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

Turnover rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a turnover rate of 6.7% for nursing staff in urgent and emergency care This was higher than the trust target of 5.0%.

A breakdown of turnover rates by ward/team is below.

Ward / team name	Annual turnover rate
ED medics	38.5%
Emergency department	3.7%

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

Sickness rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a sickness rate of 5.7% for nursing staff in urgent and emergency care. This was higher than the trust target of 3.5%.

A breakdown of sickness rates by ward/team is below.

Ward / team name	Annual sickness rate
ED medics	9.0%
Emergency department	5.4%

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

Bank and agency staff usage

The table below shows the numbers and percentages of nursing hours in urgent and emergency care at St Mary's Hospital from January to December 2018 that were covered by bank and agency staff or left unfilled.

Of the 58,992 total working hours available, 5.4% were filled by bank staff and 34.0% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, none of the available hours were unable to be filled by either bank or agency staff.

Of the 17,394 total working hours available, 24.0% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, none of the available hours were unable to be filled by either bank or agency staff.

Staff group	January to December 2018			
	Total hours available	Bank usage	Agency usage	Not filled by bank or agency

		Hrs	%	Hrs	%	Hrs	%
Qualified staff	58,992	3,203	5.4%	20,031	34.0%	0	0.0%
Non-qualified staff	17,394	4,180	24.0%	0	0.0%	0	0.0%
All nursing staff	**76,385**	**7,383**	**9.7%**	**20,031**	**26.2%**	**0**	**0.0%**

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

Bank and agency staff working in the emergency department all worked regularly in the department and were familiar with routine practice.

Medical staffing

The service mainly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, but numbers did not meet the Royal College of Medicine standards for adults or children.

Risks remained particularly when there were not enough medical staff trained in paediatrics to meet guidelines, and the consultants were available remotely out of hours. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

St Mary's Hospital reported the following WTE medical staff numbers for the periods below for urgent and emergency care.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
Emergency Department Medics	18.0	26.0	69.2%

From April 2018 to March 2019, the medical staffing rate within urgent and emergency care at St Mary's Hospital was 69.2%.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From January to December 2018, St Mary's Hospital reported a vacancy rate of 26.9% for medical staff in urgent and emergency care. The trust did not set a target for vacancy.

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

Turnover rates

From January to December 2018, St Mary's Hospital reported a turnover rate of 10.7% for medical staff in urgent and emergency care. This was higher than the trust target of 5.0%.

A breakdown of turnover rates by ward/team is below.

Ward / team name	Annual turnover rate
ED medics	10.7%

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

Sickness rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a sickness rate of 0.7% for medical staff in urgent and emergency care. This was lower than the trust target of 3.5%.

A breakdown of sickness rates by ward/team is below.

Ward / team name	Annual sickness rate
ED medics	0.7%

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

Bank and locum staff usage

St Mary's Hospital

The table below shows the numbers and percentages of medical hours in urgent and emergency care at St Mary's Hospital from January to December 2018 that were covered by medical and locum staff or left unfilled.

Of the 51,688 total working hours available, none were filled by bank staff and 15.7% were covered by locum staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 11.7% of the available hours were unable to be filled by either bank or locum staff.

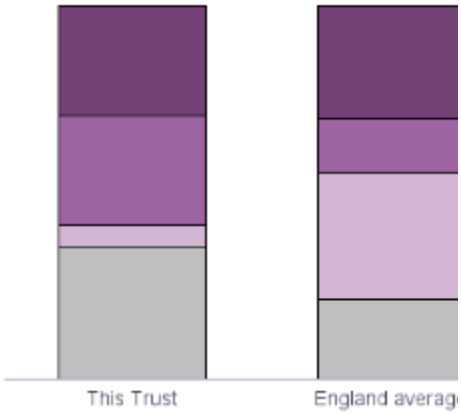
Team name	January to December 2018						
	Total hours available	Bank usage		Locum usage		Not filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Emergency medicine	51,688	0	0.0%	8,116	15.7%	6,061	11.7%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Staffing skill mix

In December 2018, 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 17 whole time equivalent staff working in urgent and emergency care at Isle of Wight NHS Trust.



	This Trust	England average
Consultant	29%	30%
Middle career^	29%	15%
Registrar group~	6%	34%
Junior*	35%	21%

^ 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)

The medical team were led by four permanent consultants, one locum (temporary) consultant and an associate specialist. The permanent consultants were included in the specialist register of the General Medical Council. However the emergency department did not employ a consultant in paediatric emergency medicine as recommended by the RCPCH in *Facing the Future.*

The rota allowed one consultant to be in the department from 8am to 8pm on week days and 8am to 4pm at the weekends. This was less than the 16 hours a day recommended by the Royal College of Emergency Medicine. We noted that the permanent consultants usually worked the 8am-4pm shifts which could mean that they had a reduced awareness of issues that arose during the evenings.

When there was no consultant on site a senior middle grade (ST4 or above) was on duty with a consultant on call from home during the night. The ST4 was supported by two junior doctors at night which improved safety and speed of response.

All junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and accessible. In-house teaching took place twice a week and was comprehensive and well organised.

The department had introduced multi-disciplinary handovers (safety huddles) at 8am and 8pm when nursing teams changed over. We observed one that took place at 8am which was attended by the emergency physician in charge (EPIC) the ED lead consultant, the nurse in charge for the night shift, the ED nurse in charge and a junior doctor. The handover was led by the care group director. Items handed over were the safety status of the department, medical and nursing staffing levels, nutrition and hydration of patients, the bed capacity of the hospital and how many beds were available for emergency admissions.

Records

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

Although we found that records had improved since the inspection in January 2019 practice continued to be inconsistent.

The hourly safety checks were not recorded consistently. One patient, who had been in the emergency department for 10 hours had seven checks recorded, with a gap of three hours, where no checks had been recorded. A second patient, who had been in the ED for four and a half hours had only one check recorded. A third patient who had been in the ED for nearly eleven hours had eight checks recorded and a period of two hours where nothing was recorded. A safety round by the nurse in charge had identified some omissions, including a failure to check the patient's pressure areas. This patient had been identified as being at risk of developing pressure sores but when we asked the nurse looking after them to show us where pressure area checks were recorded, they could not. There was no documentation to show that this was done.

We reviewed nine paper records. We found there was a full and detailed level of documentation and assessment completed. This included compliance with NEWS, pain scores, pressure ulcer assessment, capacity, safeguarding and the care plans or pathways to be followed.

Medicines

The provider had systems in place for the safe storage, administration, prescribing and disposal of medicines. However, the service lacked a process for the management of high dose antipsychotic medicines prescribing.

The trust pharmacy department supplied medicines and medicines related stationary as stock. Medicines and medicines related stationary (FP10s) were stored securely and adequate stock held.

The room was locked at all times and authorised staff had identification pass access. There was an automated machine prescription server; during the inspection we observed nurses access the patients prescription on a computer and then dispense the medicine prescribed.

We found the controlled medicines were locked separately within the locked medicines room. The contents of the controlled drugs cupboard and fridge were checked twice daily; we saw the records for April and May 2019 and found that the checking procedures were completed properly and without exception.

We found the room was generally cluttered with several boxes of intravenous fluids on the floor, this was not in line with best practice and hindered proper cleaning of the room.

Medicines requiring refrigeration were stored within their recommended temperature range. There was a clear monitoring process for FP10 prescription forms.

The fridge in the resuscitation room required daily checks to ensure temperature levels were correct for the safe storage of medicines. The fridge was locked at all times during the inspection with a coded padlock. We found that the daily temperature checks were not completed consistently; there were 10 days in March 2019, 26 days in April 2019 and 7 days in May 2019 when the checks were not completed by the emergency department staff. This was a significant issue of safety; the fridge contained medicines for intubation, medicines for seizure control and for diabetic emergencies. We found the medicines in the fridge were all in date.

We reviewed the crash trolleys in the department and found that all checks had been completed and the medicines were in date.

Whilst most medicines were prescribed by doctors, nursing staff within the emergency department were able to supply and or administer medicines to patients via patient group directions (PGD). PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment by specified registered

healthcare professionals. The PGD file held with the emergency department related to previous editions of the PGDs and staff told us they would access the PGDs on the trust intranet. However, they struggled to locate the PGDs on the intranet. Once located we identified that one published PGD was not compliant with the legislation. Therefore, we were not assured of the governance processes concerning the use of PGDs.

To aid the transfer of paediatric patients', staff could access retrieval guidance provided by the specialist paediatric hospitals for calculating medicines doses. However, a selection of superseded guidance had not been removed and was still available for staff to use in the treatment room and therefore could lead to former guidance being followed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff were aware of their responsibilities regarding the reporting of incidents. Staff reported they felt confident in using the incident reporting system and senior staff supported them and actively encouraged them to raise them. When incidents occurred and were reported they were investigated. However, staff absence had led to a backlog of investigations. Until the head of nursing for the care group took up the lead for serious incidents and investigations. During the 3 months prior to our inspection 40 staff had been trained to undertake investigations. The emergency department had a backlog of 54 incidents requiring investigation dating back to April 2018, so the service had some way to go to reduce this backlog.

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 January to December 2018, the trust reported no incidents that were classified as a never event for urgent and emergency care. However in March 2019 a never event was declared by the emergency department; a patient was administered medical air instead of medical oxygen. As a result the department checked all the medical gas ports and capped off the medical air to reduce the risk of further incidents.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from January to December 2018.

A breakdown of incidents by incident type are below.

Incident type	Number of	Percentage of

	incidents	total
Treatment delay meeting SI criteria	9	52.9%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	3	17.6%
Sub-optimal care of the deteriorating patient meeting SI criteria	3	17.6%
VTE meeting SI criteria	1	5.9%
Surgical/invasive procedure incident meeting SI criteria	1	5.9%
Total	**17**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

The division held a weekly meeting for serious incidents requiring investigation (SIRIs); representatives from the meeting reported to the local governance group and then to the acute care board. This review group reviewed investigation reports and looked at the outcomes for moderate incidents.

Learning from investigations was shared through newsletters and displayed on the hot topics bulletin with any changes to practice. We were told that themes had a cluster review and were shared with the medical assessment unit and with wider teams as appropriate. An example of learning we saw was around the management of a patient with a known cancer diagnosis who remained in ED for 11 hours and then transferred to an inappropriate ward. The lead cancer nurse was approached to lead some training on the management of patients arriving in the department who had a diagnosis of cancer.

Senior staff acknowledged that sharing outcomes needed strengthening; this has been mitigated by the recruitment of the lead investigators from across the trust.

We saw examples of shared learning via ‘hot topics’ following an incident in March 2019. A patient had received air instead of oxygen in the emergency department; this was declared as a never event by NHSI and has been reported as such. The trust took immediate action and now all air flow meters have been removed and the ports covered.

Another ‘lessons learned’ reported in the urgent and emergency care quality newsletter related to insulin drawn up from a pen vial. Staff were reminded that insulin must only ever be given from pen vials with the patient’s own device. This was a ‘near miss’ incident where no harm came to the patient concerned.

We reviewed the investigation report following the death of a patient in the emergency department due to a ruptured abdominal aortic aneurysm. Following the root cause analysis of the event, there were numerous changes put in place. Changes included, a comprehensive action plan for immediate and longer term change, such as the following; emergency department internal professional standards; initial assessment and treatment action card; a flow chart for abdominal pain management in the emergency department in patients aged over 50; and the working day professional standards for the shop floor which introduced an improved handover at eight o’clock in the morning and evening, enhanced roles for the nurse in charge and the emergency physician in charge, and a ‘scrum meeting’ with a set agenda to include for example, escalation status and clinical priorities.

Staff we spoke with were all aware of the incident and the changes to practice put in place.

Staff had differing awareness of duty of candour. Duty of candour is a duty whereby, as soon as reasonably practicable after becoming aware a notifiable safety incident has occurred a health service body must notify the relevant person the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff undertook duty of candour training as part of their initial induction into the organisation. Most staff, although not always aware of the terminology were aware of the importance of being open and honest when things went wrong.

The service audited compliance with the duty of candour we saw that in March 2019 compliance was 70.3% and in April 2019 76.1%. The service acknowledged that this needed to be improved.

Safety Thermometer

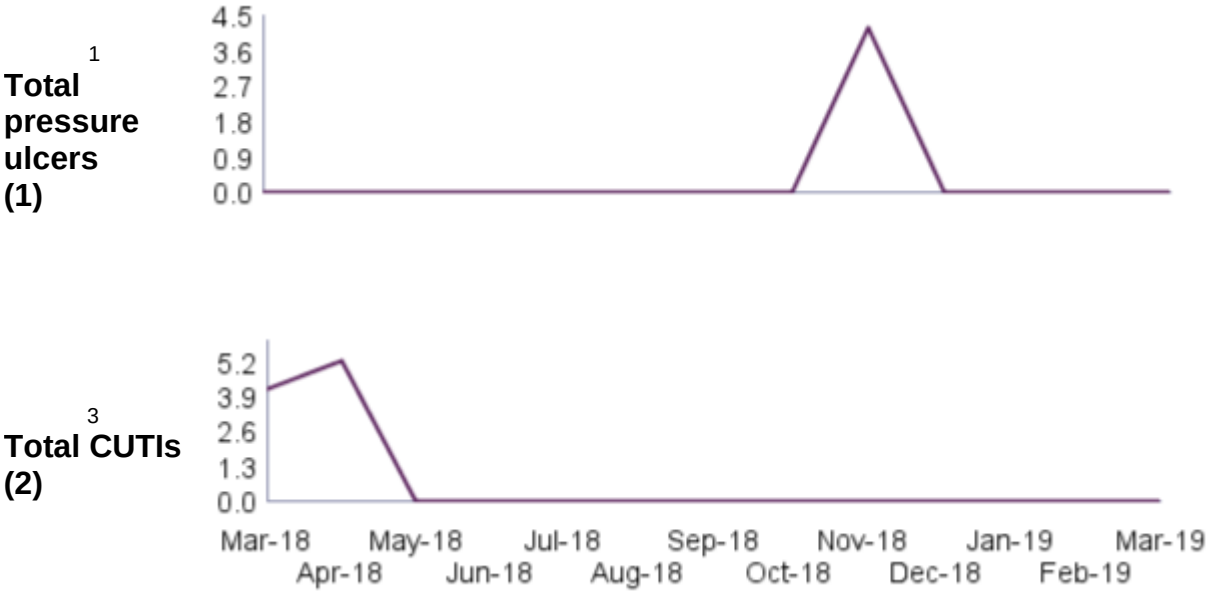
The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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 took place one day each month. A suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, no falls with harm and two new urinary tract infections in patients with a catheter from March 2018 to March 2019 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Isle of Wight NHS Trust



1 Pressure ulcers levels 2, 3 and 4
2 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

This was an improvement on the findings of the inspection in January 2018.

People's care and treatment was planned and delivered in line with up to date evidence-based guidance and standards set by organisations like the National Institute for Health and Care Excellence (NICE), Surviving Sepsis Campaign, British Thoracic Society and the Royal College of Emergency Medicine.

During the May 2019 inspection we observed 12 patients arriving and triaged. Each one was triaged within 15 minutes by a competent nurse and the clinical pathways used were appropriate for the patients. This was an improvement since the inspection in January. Pathways were available to the staff in the triage area and included a red flags protocol. This protocol included symptoms such as; chest pain, major bleeding, severe pain, significant burns. We noted that the protocol did not have a review date since 2012 but the details remained relevant and in line with current guidelines.

The triage nurses used the Manchester Triage System. This system enables nurses to assign a clinical priority to patients, based on presenting signs and symptoms, without making any assumption about the underlying diagnosis. One patient arrived with potential sepsis and we saw the sepsis pathway utilised effectively and in a timely way.

In the children's' area we viewed clinical pathways available for the following: head injury, renal colic, uterine infections, and major haemorrhage. There was a fast track protocol for children on chemotherapy and radiotherapy and there was a criteria document for referral to the trauma team. All protocols were in date and in line with NICE guidance.

We reviewed the clinical pathways used by the staff in the triage area and found they were in line with NICE guidance with the relevant exclusion criteria. We saw two patients processed according to best practice through to the majors and rapid assessment areas in a timely way using correct clinical pathways.

The service liaised with the local commissioning group, keeping them informed of progress in relation to care standards. For example, the department had agreed to deliver a new Commissioning in Quality and Innovation (CQUIN) relating to how staff in the emergency department manage patients over the age of 65 with uterine tract infection. Patients should be treated according to the symptoms they present with and not on the basis of the urine dipstick test.

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. This was an improvement on the findings of the inspection in January 2018.

'Refreshments offered' was included on the emergency department checklist for patients at two hours and each hour after for the duration of the patient stay in the department.

Patients and relatives, we spoke with confirmed they had been offered food and drink throughout their stay in the emergency department.

There was a vending machine for snacks and cold drinks in the waiting room and a water fountain. There were sales outlets close by for a variety of food and drinks.

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 (October 2016 to March 2017; published October 2017)

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. This was similar to the findings at the inspection in January 2018.

Staff assessed patients' pain regularly. We saw staff assessing patients' pain and offering pain relief according to need. This was an improvement since the inspection in January 2019, when the department was particularly busy, and we found patients were not always asked about pain regularly.

Patient records showed that patients' pain levels were assessed and recorded as part of the emergency department check list. 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 observed timely pain relief administered to a child. The results of the pain relief were monitored in accordance with the Royal College of Emergency Medicine (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.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patient outcomes

The service did not consistently monitor the effectiveness of care and treatment. They did not consistently use the findings to make improvements and achieve good outcomes for patients.

The department had a consultant lead for clinical effectiveness who reviewed the patient outcome data, which was discussed at the monthly quality meeting. Capacity to participate in local and national audit was also agreed at this meeting.

We learned that national and local audits were discussed and agreed for 2019 with doctors in training specifically assigned to conduct them. The service was contributing to two national audits for the coming year, but the quality committee minutes did not identify what these were.

We learned local audits and re-audits were presented at weekly Friday morning training sessions. We did not see what these were or any results from clinical audits undertaken in the previous 12 months, however there was one audit result on the notice board for the month of May 2019. This was a re-audit which showed that staff had achieved 97% compliance with correct completion of the NEWS2 documentation and any escalation actions taken, an improvement on the audit in February when staff achieved 90% compliance.

The trust has an excellent system of pre-hospital assessment and initial treatment of patients with possible sepsis, resulting in the administration of IV fluids and antibiotics by paramedics prior to arrival in the emergency department.

The details of the RCEM audits the trust participated in are below. We did not see evidence of work done to improve the results of these audits or details of a program to ensure this happened, from the minutes of the monthly quality meetings.

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, the emergency department at St Mary's Hospital failed to meet any of the national standards.

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

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 60.0%; UK: 25%.

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

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 0.0%; UK: 26%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
- Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
- Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
- Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 0.0%; UK: 19%.
- Standard 5b (fundamental): within 4 hours (moderate). This department: 0.0%; UK: 28%.

The department's results for the remaining three standards were all within the middle 50% of results.

- Standard 1a (fundamental): O_2 should be given on arrival to maintain saturations 94-98%. This department: 26.0%; UK: 19%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 73.3%; UK: 77%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
- Adults 16 years and over: 40-50mg prednisolone for 5 days
- Children 6-15 years: 30-40mg prednisolone for 3 days
- Children 2-5 years: 20mg prednisolone for 3 days

This department: 57.1%; UK: 52%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

The trust did not participate in the RCEM consultant sign off audit 2016/17.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, the emergency department at St Mary's Hospital failed to meet most of the national standards. However, the department was in the upper UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 82.0%; UK: 64.6%.

The department's results for the remaining seven standards were all within the middle 50% of results.

- Standard 1: Respiratory rate, oxygen saturations (SaO_2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 56.0%; UK: 69.1%.
- Standard 3: O_2 was initiated to maintain SaO_2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 25.7%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 54.0%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 45.7%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 35.0%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 27.8%; UK: 44.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 18.4%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

Sepsis management was re-audited in 2017, this audit showed that screening of patients for sepsis had improved from 70% in October 2017 to 100% in December 2017.

We saw two patients arrive with suspected sepsis during our inspection, both were screened on arrival according to NICE guidance and in line with best practice. Antibiotics prescribed, blood cultures completed, and lactate completed within the hour.

Trauma Audit and Research Network (TARN)

St Mary's Hospital

The table below summarises St Mary's Hospital's performance in the 2016 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

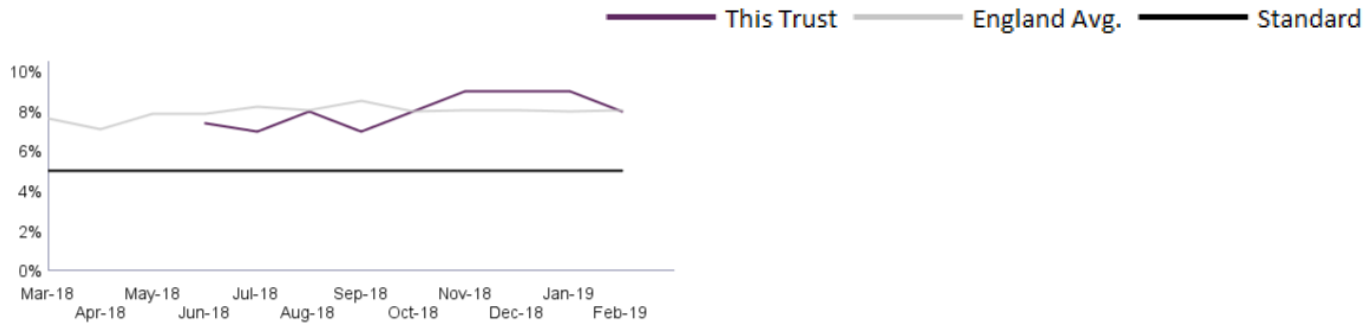
Metrics ***(Audit measures)***	**Hospital performance**	**Audit Rating**	**Meets national standard?**
Case Ascertainment *(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)*	67.3 – 78.7%	n/a	✘
Crude median time from arrival to CT scan of the head for patients with traumatic brain injury *(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)*	12 mins	Takes less time than the TARN aggregate	✓
Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury *(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding*)	100.0%	Higher than the TARN aggregate	n/a
Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care *(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)*	Not eligible	Not eligible	Not eligible
Risk-adjusted in-hospital survival rate following injury (*This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.*)	0.8 additional deaths	Similar to expected	✘

(Source: TARN)

Unplanned re-attendance rate within seven days

From June 2018 to February 2019, the trust's unplanned re-attendance rate to ED within seven days was worse than the national standard of 5%. No data is available for the trust in April 2018 and May 2018. In February 2019, trust performance was 8.0% which was the same as the England average of 8.0%.

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



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

Competent staff

Managers had not ensured all staff were appraised for work performance, appraisal rates in ED did not meet the trust expected level of 85%. Supervision meetings with staff to provide support and development in a timely way were increasing.

However, there were some improvements on the findings of the inspection in January 2018.

Until very recently the service leaders acknowledged that releasing staff for training over and above the mandatory training requirements has been very difficult. As staffing increased training opportunities had improved; staff completed training in groups and bespoke training completed during the previous six months included triage and trauma courses for example. We saw records showing that 32 nurses had completed all the training and skills courses to fulfil their roles.

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

There was protected pre-planned training time for junior doctors each week on Friday mornings which was open to all staff. Specialty doctors in training told us the department was a good place to work with approachable and supportive consultants, good supervision and good access to practical teaching and learning and development opportunities.

The trust supported continued professional development of its staff, including formal qualifications, practical training, conference attendance, secondments, team days, mentoring and shadowing opportunities with other specialties. There were opportunities for leadership and management training for senior nurses and clinicians.

Senior nursing sisters told us that clinical supervision took place monthly and the department used the Nursing and Midwifery Council competency booklet.

At the time of our inspection, there were four nurses in training for qualification as emergency nurse practitioners.

The service provided a training programme for emergency department staff which included the following: early management and resuscitation in sepsis; mortality and morbidity, surgical

emphysema in a child; the children's observation and severity tool (COAST) score; sepsis; ENT emergencies; paediatric and adult medicine, some differences; allergy in paediatrics. We were not provided with details for the numbers of staff who had accessed the training

The service had recruited nursing staff from abroad and were due to start over the coming months; an induction package had been developed for them to include a competency framework for the new recruits to complete. There was supernumery time built into the programme to ensure the recruits gained competency while under supervision.

Appraisal rates

St Mary's Hospital

From April 2018 to February 2019, 57.7% of staff within urgent and emergency care department at the trust received an appraisal compared to a trust target of 85.0%.

A breakdown by staff group is shown below:

Staff group	April 2018 to February 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional Clinical Services	4	4	100.0%	85.0%	Yes
Nursing and Midwifery Registered	25	31	80.6%	85.0%	No
Estates and Ancillary	5	7	71.4%	85.0%	No
Administrative and Clerical	5	16	31.3%	85.0%	No
Medical and Dental	2	13	15.4%	85.0%	No

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

The staff were not compliant with the trust appraisal target but there was significant improvement on the previous year.

At the time of our inspection in May 2019 the figure for nursing staff had increased slightly to 83% and all the nursing staff we spoke with said they had received an appraisal within the last year. The updated data for the medical staff in the emergency department showed that 14 out of 15 doctors had received an appraisal (93%). Administrative staff compliance had reached 86%

The department was not meeting Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future' (June 2018) as there was no paediatric emergency medicine consultant in the department. The service was beginning to consider the standards outlined in 'Facing the Future' by undertaking a self-assessment to identify what further work needed to be done to mitigate the risks associated with failing to meet the RCPCH standards. We noted that this did not feature in the top six priorities on the risk register.

Training on mental health was not mandatory within the trust, however, staff did receive regular training on dementia and the Mental Capacity Act 2005 (MCA 2005). If staff needed specialist information about a mental health issue, they contacted the learning disability team, the memory team or the lead for mental health within the trust or the lead in the department. Security staff did not receive training in mental health but received regular training in physical intervention.

Multidisciplinary working

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

This was similar to the findings of the inspection in January 2018.

Staff delivered and reviewed care in a coordinated way. Staff felt confident in seeking support from other members of the department. We observed staff members contacting others for additional advice or to transfer patients to different areas of the hospital. We also observed positive and effective handover of patients from ambulance staff to emergency department staff. We spoke with ambulance staff who spoke of positive relationships with the department.

There was good multidisciplinary working to support patients with mental health needs. In the emergency department, staff completed a two hourly safety round, which meant that any patients who might be experiencing depression or distress were identified and referred for a mental health assessment. Patients with dementia were discussed at handovers and huddles. A multi disciplinary team attended handovers where patients' emotional wellbeing was discussed. This meant that if a patient was low in mood, they could be seen by the most appropriate person.

There were improved supportive relationships between the emergency department with the rest of the hospital since previous visits, including the paediatric wards. Staff we spoke with talked of collaborative relationships with the different areas of the hospital and there were doctors from the medical specialties frequently in the department. This was an improvement since the winter pressures inspection in January. There were concerted efforts by the emergency department staff to improve the flow of patients through the hospital. Staff spoke of flow being a hospital wide issue rather than a departmental one.

The department had recently introduced a frailty assessment led by an FY3 doctor in training supported by a consulta for stroke medicine. The FY3's role was to assess all patients with high frailty scores – early figures showed that 25% patients could be discharged to their usual place of residence from the emergency department. Development of a 'front door' frailty team was part of the plans for the 2019/20 year.

Seven-day services

Most key services were available seven days a week to support timely patient care.

Emergency department 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 in the hospital.

A seven day clinical pharmacy service operated in the ED. There was an on-call pharmacy service outside of normal working hours.

The service had out of hours and emergency arrangements, known to all staff on duty, to meet patients' urgent or emergency mental healthcare needs. If a child or young person under the age of 18 presented at the emergency department with risks of suicide or self harm, staff contacted the paediatric nurse and the CAMHS (Child and Adolescent Mental Health team) out of hours.

Children and young people were admitted to the paediatric ward and had to wait until the CAMHS team were back on duty before receiving a mental health assessment. This meant that they were often left waiting over the weekend without mental health support.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff provided health related information directly to patients, and there was some information guiding patients to access support externally. However we found some leaflets were out of date and provided inaccurate information on clinical management. For example the 'head injury discharge advice' leaflet

The service had relevant information promoting healthy lifestyles and support.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This formed part of the emergency department nursing assessment and care plan which was launched in May 2019.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

The staff in the emergency department did not meet the trust target for training, however, we observed staff explain procedures and seek patients' consent to, for example an examination or a clinical intervention such as taking blood. Staff were able to describe the process they would go through to assess a patient's capacity to consent to care and we saw this documented in patients' records.

Staff were knowledgeable about gaining consent surrounding children. Consent from parents was gained in the treatment and triaging of children. This consent was gained verbally and where possible, the child was also involved to ensure they were aware of what was happening and happy with the decisions made. We did not observe any care where consent was refused by the parent or child.

Training on mental health was not mandatory within the Trust. However, staff did receive regular training on Dementia and the Mental Capacity Act. If staff needed specialist information about a mental health issue, they contacted the learning disability team, the memory team or the lead for mental health within the Trust.

Mental Capacity Act and Deprivation of Liberty training completion

St Marys Hospital

The trust set a target of 85.0% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to January 2019 at St Mary's Hospital for registered nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to January 2019

	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	19	32	59.4%	85.0%	No

In urgent and emergency care the target was not met for the MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	5	10	50.0%	85.0%	No

In urgent and emergency care the target was not met for the MCA/DOLS training module for which medical staff were eligible.

The trust has reported that the Mental Capacity Act training module incorporates Deprivation of Liberty Safeguard training.

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During the winter pressures inspection in January 2019 we found some patients were cared for in the central corridor. During this inspection May 2019 the service was not busy on any of the days we were there, and we found staff cared for patients well. Staff were discreet and responsive when caring for patients and took time to interact with patients and those close to them in a respectful and considerate way. We observed all staff introduce themselves and explain who they were and their role. Staff also wore name badges and badges which indicated which area of the emergency department they were working in.

The tone of voice used was one of respect and care and an understanding of both the patient's and relatives' situations. Staff treated patients with compassion. We saw a nurse in the initial assessment area reassuring an anxious patient, using comforting gestures, such as rubbing their arm, while listening to their concerns.

Patients said staff treated them well and with kindness. Feedback from people who used the service was continually positive. Patients we spoke with all spoke positively about the care they had received. Comments we received included: "I have received brilliant care", "the staff had been wonderful", "couldn't fault the care", "the doctors were fabulous"

Two sets of parents we spoke with said they had visited the emergency department several times in the last couple of years and were very happy with the care their children had received on each occasion.

Staff were motivated to offer care which promoted the dignity of patients. People's privacy and dignity were always respected during physical or intimate care. Staff ensured curtains were pulled and doors shut when undertaking care.

We observed a doctor examine a teenager, who had presented following a fall. Following an examination, the doctor gave clear and straightforward to the patient and their parent and took time to reassure them that they had not wasted staff time and that they could return at any time if they were concerned.

Friends and Family test performance

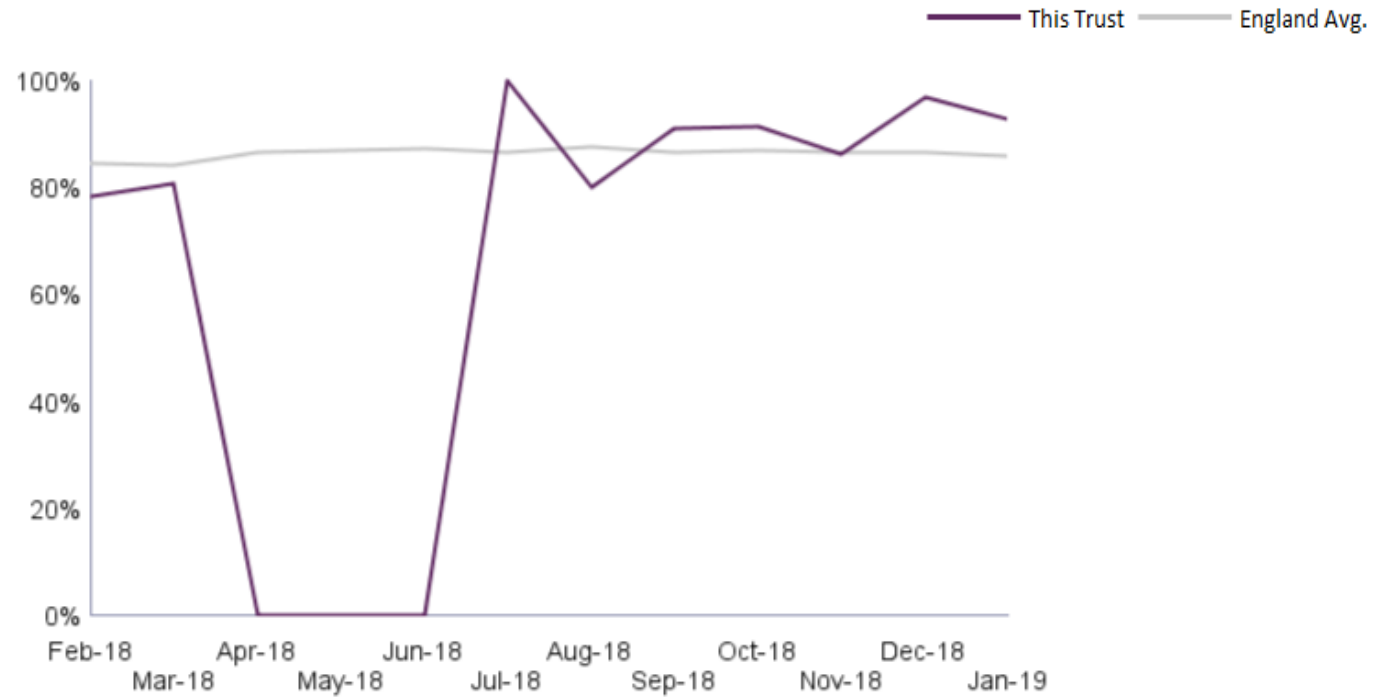
The trust's urgent and emergency care Friends and Family Test performance (% recommended) fluctuated between 78.4% and 100.0% from February 2018 to January 2019. For the same period, the England average performance ranged from 84.3% to 87.7%. No responses were received by the trust from April to June 2018.

From February 2018 to January 2019, the response rate at the trust for the A&E Friends and Family Test was 1.6%, which was lower than the England average of 12.5%. Caution be taken when interpreting these results due to the low response rate reported by the trust.

Feedback data for the month of April showed that 100% of patients who responded would recommend the emergency department (56 returns); and for May there were 60 returns and 95% would recommend the department. 97% of patients said they felt safe in the emergency department.

The service displayed a 'You Said We Did' board; patients had complained that the corridor was cold, so an identification badge access was put on the door which meant it was never left open causing the draft. We saw that patient feedback was a regular agenda item on the care group monthly quality meeting

A&E Friends and Family Test performance - Isle of Wight NHS Trust



(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

The department had recognised it was often busy and staff did not always have the time to provide the level of emotional or additional support they wanted to give to patients. To help address this issue, the department had a small team of volunteers who offered comforting words and would remain with patients in the department or accompany them to other parts of the hospital for investigations and provide the support they needed.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There was a quieter room where patients who became distressed could stay.

Staff had access to communication aids to help patients become partners in their care and treatment; hearing loops, picture boards, photographs and emoticons were available to staff to aid communication.

The department collated the compliments they received; we saw those received in March 2019 which included “The compassion and understanding has been superb in the most difficult of circumstance”.

Understanding and involvement of patients and those close to them

Emergency Department Survey 2016

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. The survey had not been issued and updated since the inspection in January 2018.

Staff were available to speak with family members to explore treatment options where appropriate, including the use of ‘do not attempt cardiopulmonary resuscitation’ orders. We saw staff talking to patients in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

The trust scored better than other trusts for all 24 of the Emergency Department Survey questions relevant to the caring domain.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	3.8	About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.5	About the same as other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.0	About the same as other trusts

Question	Trust 2016	2016 RAG
Q14. Did the doctors and nurses listen to what you had to say?	8.8	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.5	About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	9.3	About the same as other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	7.5	About the same as other trusts
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	8.6	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	7.8	About the same as other trusts
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?	8.8	About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.9	About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	9.1	About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	6.8	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	6.8	About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.5	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	8.6	About the same as other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.6	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.2	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	5.3	About the same as other trusts
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?	5.1	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	4.8	About the same as other trusts

Question	Trust 2016	2016 RAG
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	5.5	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.1	About the same as other trusts
Q45. Overall... (please circle a number)	8.1	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?

Service delivery to meet the needs of local people

The department had plans to improve services in respect of the emergency department design to meet the needs of local people. This was an improvement on the findings of the inspection in January 2018, when we found there was no agreed, co-ordinated plan to improve safety and quality in the department.

Some reconfiguration had already taken place, such as for the initial assessment of patients brought in by ambulance and for separate assessment areas for children.

During this inspection we saw plans to reconfigure the premises further, to enable improved flow from the front door. The design incorporated repositioning of the initial assessment area, with consideration for improved access and assessment of frailty. The plans also included improvements in the ability for staff to keep children separate from the adult areas.

Premises were not entirely appropriate for the service delivered. We saw from data provided that the emergency department was frequently crowded, and patients spent too long there.

The waiting room was spacious and had adequate seating. There were adequate toilet facilities, including facilities for disabled people and facilities for nappy changing. There were no specific facilities for breastfeeding mothers, but staff told us they would identify a suitable private space.

Patients who used a wheelchair had good access to the waiting area, toilet facilities and the clinical areas. There were no wheelchairs provided for patients who did not have their own, but these were available in the main hospital.

There was a water dispenser in the waiting area and a vending machine where patients could purchase snacks. There was a limited supply of reading material provided. A television screen displayed waiting times for triage and treatment we saw that the this displayed wait times were 15 minutes for triage and one hour to see a doctor. However, this did not change during our visit.

During our inspection we saw that the initial assessment area, where ambulance handovers took place, sometimes became crowded and when the three cubicles were full, patients were assessed in an open space in sight and hearing of other patients and visitors. Several patients we spoke to on the morning of our first day of inspection, told us they had been assessed in an open space with no curtains to preserve their dignity.

Patients were not accommodated in the corridor during our inspection, but staff told us this had been a frequent occurrence. We reviewed a complaint reviewed received in February 2019 from

the relative of a patient who was in the emergency department for more than 19 hours. During this time the patient was cared for in the corridor and was one of 30 patients who spent the night in the emergency department.

There was good access to radiology services for urgent CT (computerised tomography), MRI (magnetic resonance imaging) and ultrasound.

There was a small separate waiting area for children just off the main waiting room, but although we saw several children attend during our inspection we did not see any choose to use the area. Staff told us that children and parents were sometimes distressed at having to go through the adults' treatment area in order to reach the X-Ray department. The trust had for some time acknowledged that the design and layout of the emergency department did not comply with national standards (Hospital Building Note 15-01: Accident & emergency departments and RCPCH Facing the Future) and there were plans to reconfigure the department and to create a dedicated children's area.

At the time of our inspection staff were usually able to accommodate people who were who may be approaching the end of their life, who were in vulnerable circumstances, or who had complex needs. On the third day of our visit, we were told of a patient at the end of life, who attended the department during the evening and staff were able to ensure privacy and dignity to the patient and the family, who were able to stay with the patient throughout the night.

We were aware that reasonable adjustments could not always be made in such circumstances if the department was busy and appropriate information was not always accessible to all people.

Meeting people's individual needs

The service was not always able to provide a service to meet the needs of individuals.

The ED did not have a strategy or tools to support patients with complex needs, including those living with dementia and those with a learning disability. There was a dementia lead nurse in the emergency department, but staff could not identify this individual or describe what steps the department had taken to support patients with dementia, learning disability or other forms of cognitive impairment.

There was a hospital wide dementia team and a learning disability team who could be called upon for support Monday to Friday. Staff told us volunteers who worked frequently in the department often sat with patients who were confused, disorientated or distressed. One nurse told us they offered patients twiddle muffs to help distract patients who were agitated. Twiddle muffs are designed to keep the hands of patients with dementia busy. They contain strands of textured ribbons, beads, and various fabrics attached both inside and outside. People with dementia often have restless hands and like to have something to keep their hands occupied. The twiddle muff provides a wonderful source of visual tactile and sensory stimulation and keeps hands warm at the same time.

Patients known to have additional needs were identified, using a flag on the electronic patient records system. However, these were not visible to visiting staff or volunteers who may interact with these patients.

Staff told us that interpreters could be accessed to support patients whose first language was not English and for deaf people.

The service had arrangements, known to all staff on duty, to meet adult patients' urgent or emergency mental health care needs at all times, including outside office hours and in an

emergency. During weekdays, staff contacted the psychiatric liaison worker or the relevant mental health lead in the trust, such as the dementia team, the learning disability team or the CAMHS (children and adolescent menta health service) team for emergency support.

Staff contacted the adult mental health crisis team out of hours for support. This included responding to children and young people under the age of 18, as the Trust did not have an on call CAMHS consultant.

There was no specific support from other mental health teams out of hours. We observed one assessment where the local adult mental healthcare professional was not able to access a second psychiatrist that day to carry out a mental health assessment.

There was a social worker seconded to and based in the emergency department Monday to Friday. All staff we spoke with were clear that the position should be made permanent as this type of support in the department had proved very successful in arranging appropriate care packages for patients to avoid admission to hospital.

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

The trust scored about the same as other trusts for all three of the Emergency Department Survey questions relevant to the responsive domain.

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

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow

People could access the service when they needed it but did not always receive the right care promptly. Expected standards were often not met for waiting times to admit, treat and discharge patients.

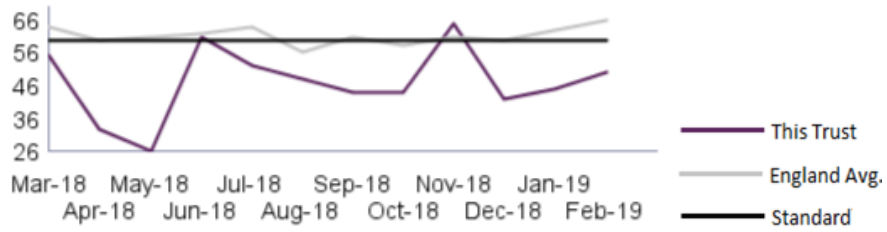
We found during the inspection that the inability to move patients through the hospital accounted for the length of stay many patients experienced in the emergency department.

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 should be no more than one hour. The trust met the standard for 10 months over the 12-month period from March 2018 to February 2019.

From March 2018 to February 2019, performance against this standard was consistently better than the England average with a lower median time from arrival to treatment in all months other than November 2018.

Median time from arrival to treatment from March 2018 to February 2019 at Isle of Wight NHS Trust



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

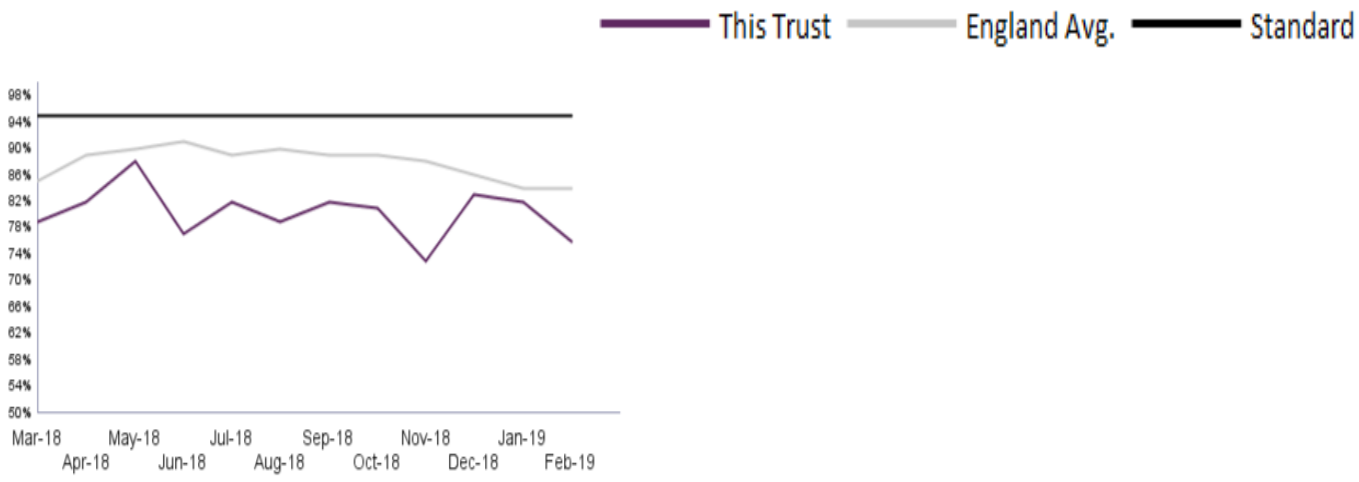
Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

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 emergency department.

From March 2018 to February 2019, the trust failed to meet the standard and performed worse than the England average in all months.

From March 2018 to February 2019, performance against this metric ranged from 73% (November 2018) to 88% (May 2018). This compares to the England average which ranged from 84% (January 2019) to 91% (June 2018) for the same period.

Four-hour target performance - Isle of Wight NHS Trust



(Source: NHS England - A&E Waiting times)

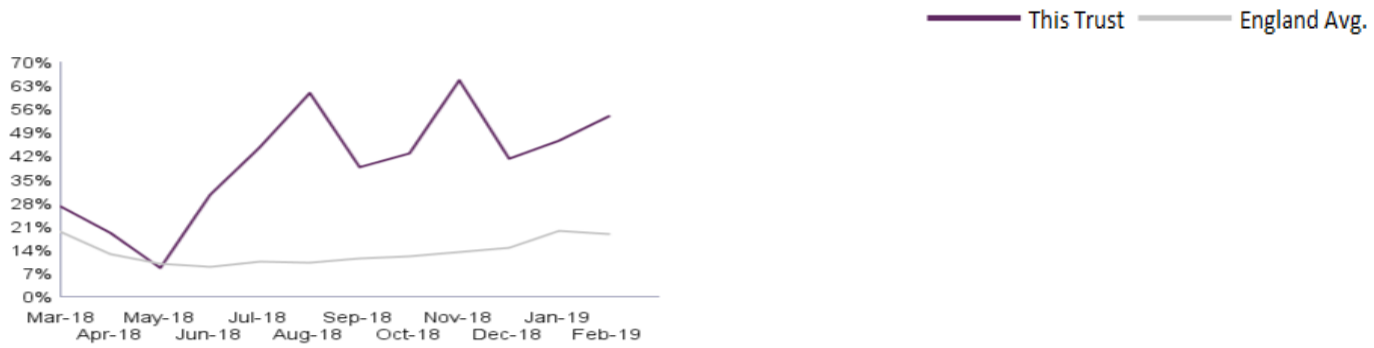
Percentage of patients waiting more than four hours from the decision to admit until being admitted

From March 2018 to February 2019, the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average in all months other than May 2018.

Between May 2018 to August 2018, there was a sharp increase in the number of patients waiting more than four hours from decision to admit to admission, and the performance was worst in July 2018 and November 2018.

During the three days of our inspection the trust performance was poor against this target which was breached on each day. On the first day there was 65% compliance on day two 51.4% compliance and day three 77.6% compliance.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Isle of Wight NHS Trust



(Source: NHS England - A&E SitReps)

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

Over the 12 months from March 2018 to February 2019, 15 patients waited more than 12 hours from the decision to admit until being admitted. The instances of patients waiting over 12 hours were in reported in March 2018 (two patients), December 2018 (one patient), January 2019 (three patients) and February 2019 (nine patients).

Month	Number of patients waiting more than four hours to admission	Number of patients waiting more than 12 hours to admission
March 2018	255	2
April 2018	164	0
May 2018	83	0
June 2018	267	0
July 2018	394	0
August 2018	536	0
September 2018	345	0
October 2018	404	0
November 2018	626	0
December 2018	370	1
January 2019	440	3
February 2019	440	9

(Source: NHS England - A&E Waiting times)

During the three days of our inspection we saw between 5 and 10 patients with a decision to admit, who waited more than 4 hours the longest waited over 10 hours.

Percentage of patients that left the trust's urgent and emergency care services before

being seen for treatment

From March 2018 to February 2019, the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was generally better than the England average.

From April 2018 to February 2019 there were no patients at the trust who left the trust's urgent and emergency care services before being seen for treatment.

This could be accounted for by the improved streaming of patients to other providers. Staff told us that they were often able to get patients appointments at their GP surgery (just under 12%)

Percentage of patient that left the trust's urgent and emergency care services without being seen - Isle of Wight NHS Trust

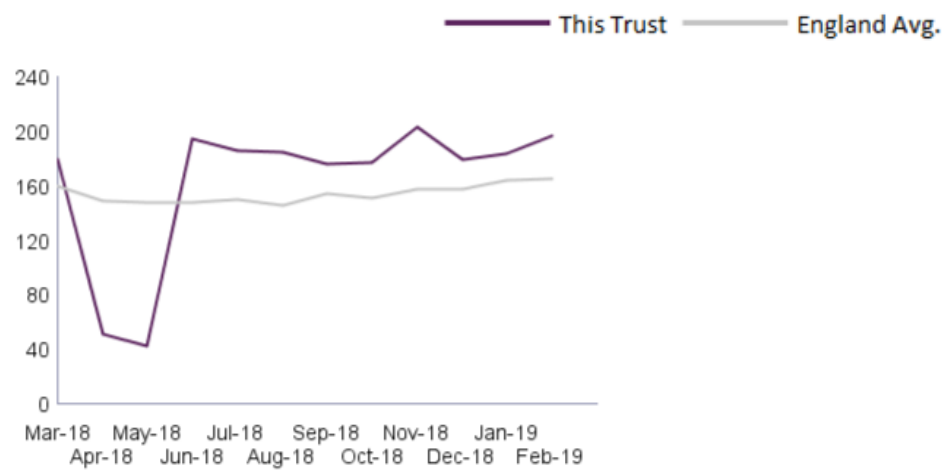
(Source: NHS Digital - A&E quality indicators)

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

From March 2018 to February 2019, the trust's monthly median total time in A&E for all patients was generally higher than the England average, with worse performance in all months other than April and May 2018.

From March 2018 to February 2019, performance against this metric was fairly stable and was worse than the England average in all months other than in April 2018 and May 2018 where the median time in A&E at the trust was much lower than the England average. In February 2019, the trust's monthly median total time in A&E for all patients was 196 minutes compared to the England average of 165 minutes.

Median total time in A&E per patient - Isle of Wight NHS Trust



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

There was full capacity protocol which set out the steps the ED and the rest of the hospital were required to take when the ED became crowded. The ED was represented at regular bed meetings during the day so that the hospital's site management team was well sighted on the pressure within the department. Some senior staff in ED felt that more could be done by the rest of the hospital to share the risks associated with crowding.

We attended a bed meeting at 3pm on the first day of the inspection, at the time there were 2 patients in the emergency department for more than 12 hours. and after data cleanse there were 30 remaining. There were 16 discharges expected from the wards and 10 patients with decision to admit, still waiting for beds.

The nurse in charge and consultant in charge were responsible for management of patient flow in the emergency department. They were supported by an administrator who performed the role of flow coordinator. This involved chasing up specialist review, and the availability of beds. This role was not available 24 hours a day, seven days a week which senior nursing staff felt was needed.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. The service did not always complete investigations and respond to complainants in a timely way in line with the trust policy.

There were no leaflets or information displayed in the emergency department to direct people who wished to raise concerns or make a complaint. A receptionist told us they would always summon a senior nurse to speak with patients or visitors with concerns and to try to resolve them. The nurse in charge confirmed this and told us only if the individual remained concerned would they refer them to the Patient Advice and Liaison Service (PALS), who were in the hospital and were available from Monday to Friday.

One of the sisters had recently taken over responsibility for managing complaints, following the departure of the interim matron but at the time of our inspection was not able to access complaints records. However, we were able to access the system with the support of administrative staff outside of the department. We randomly selected and reviewed two recent complaints. The first complaint was investigated and responded to within less than 30 days and was not upheld. The second complaint was investigated and responded to in just under two months and was upheld. The letter of response from the chief executive was sensitively worded and apologetic. There was a detailed explanation of what went wrong and a list of actions which arose from the complaint investigation. These included a discussion of the issues raised at staff safety briefings.

Summary of complaints

St Mary's Hospital

From January to December 2018 the trust received 81 complaints in relation to urgent and emergency care at St Mary's Hospital. The trust took an average of 43.0 days to investigate and close complaints, and 27.5% were closed within 30 working days. This is not in line with their complaints policy, which states that 75% of complaints should be closed within 30 working days. This was worse than the findings at the inspection in January 2018.

A breakdown of complaints by type is below.

Type of complaint	Number of complaints	Percentage of total
Clinical treatment - Accident and Emergency	30	37.0%
Values and behaviours (staff)	18	22.2%
Communication	8	9.9%
Waiting times	7	8.6%
Patient care	7	8.6%
Admissions and discharges excluding delayed discharge due to absence of a care package	6	7.4%
Staff numbers	3	3.7%
End of life care	1	1.2%
Transport (ambulances)	1	1.2%
Total	**81**	**100.0%**

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

The service provided data for the month of April 2019, this showed that there were 11 concerns raised. These included:

4 x patient care

2 x communication

2 x admission and discharges

1 x clinical treatment

1 x values and behaviours

1 x waiting times

There were also seven formal complaints about the service submitted in the month of April 2019 and six in March.

Number of compliments made to the trust

From April 2018 to December 2018 the trust received 1,179 compliments regarding acute services at the trust. Due to the way in which compliments are captured by the trust, it has not been possible to split the number of compliments by team or core service.

The service provided data for March and April 2019 which showed that there were 38 compliments received relating to the emergency department

The trust identified the following themes:

- The main compliment received is with regard to staff behaviour. Staff are described, through individual experiences, to behave in a manner that is kind, patient, friendly, professional, courteous, caring, compassionate, helpful and understanding.
- Specific praise for consultant care

- Treatment with dignity and respect
- Effective and responsive emergency department
- Excellent care
- Helpful, friendly and efficient administrators/receptionists.

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

Managers shared lessons learned with all staff.

The sister with responsibility for complaints management told us they met fortnightly with the senior quality manager to review complaints. There was a weekly flash report which identified open complaints, and complaints (and incidents) were reported to the critical care incident review group.

Themes from complaints and concerns were displayed on a noticeboard in the emergency department and learning was briefly discussed at daily safety huddles. The main theme at the time of our inspection was around poor discharges. The service was reminding staff to make sure discharge documentation was fully completed and risk assess the appropriateness of sending patients home at night. Staff were also reminded that there was a checklist to be completed when returning patients to a care home.

Is the service well-led?

Leadership

The leadership had the capacity and capability to deliver high-quality, sustainable care.

There had been a change in the leadership of the emergency department (ED) since our previous inspection in 2018. The department was part of the newly formed integrated urgent care division. The lead consultant, matron and operational manager were supported in the department by the new care group director and the associate director of operations. These two positions had been filled in the autumn of 2018 and were added to the leadership of the department to drive quality improvements. The department was also supported by the head of nursing for the emergency department and the medical assessment unit. The department leadership team were accountable to the interim head of urgent care.

The ED leadership team worked well together, they were visible and approachable. We observed the leadership team relationship with the staff teams. They knew all the staff by name and the role they undertook. The leaders clearly supported staff in management of the of the sickest patients and dealing with the more complex situations that arose.

The introduction of an emergency physician in charge (EPIC) had been introduced to create clear individual senior responsibility, and to help junior staff make rapid clinical decisions.

Coaching and leadership courses were offered to all band 7 nurses.

All staff in the department were allocated to a multidisciplinary group, each group included one of the nursing sisters and took responsibility to lead the department in different management areas. For example, safeguarding, audits, tissue viability, incidents and complaints.

During our visit, the matron’s time was spent in the medical assessment unit, therefore her presence and experience was not easily accessible to staff in the emergency department.

Each shift, a nursing sister was the designated nurse in charge. This member of staff was expected to undertake the two hourly clinical safety rounds and co-ordinate the department activity. The department was not busy during our inspection, but we felt that this could be unsustainable during busy periods, as patients remained in the department for long periods.

Vision and strategy

The trust was in special measures and focussed on medium term service improvements.

At the time of our previous inspection in January 2018 there was no strategy for the emergency department. Since then, the emergency department had developed a strategy for improving patient safety and flow and we saw the plans for physical changes to the environment to support these improvements.

The strategy and vision for the department had been led by the new care group director and the associate director of operations. It was developed with input from all members of the leadership team.

The staff in ED were supportive of the changes that had taken place, such as the environment changes for attending to children and the development of the rapid assessment area.

We saw high levels of commitment from all the staff we spoke with, they were keen to improve the service provision for their patients and support the trust in the “Getting to Good” improvement journey.

There was a trust vision to ensure that high quality care was delivered safely and compassionately. We saw that the staff in the emergency department demonstrated the trust values of compassion, improving, and team working.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff were very much valued and respected by one another and their line managers. This had been achieved by recognising the need for additional staff, and staff had opportunities to grow and develop new skills and talents. Consultants and senior nurses said they felt valued by the executive team.

The culture within the department was very much focused on meeting the needs of patients and ensuring their experiences were as good as possible, without compromising their safety or that of staff. This was evident in our observations of staff’s interactions with one another and the people who came into the department. The department was not busy which meant the service could comfortably accommodate and care for the patients according to need. This did not compare with the findings of the inspection in January when patients were cared for in corridors. The increased staffing meant that staff were well supported to provide care as required with enhanced skills available to them, for example increased number of paediatric nurses and enhanced training to develop the emergency nurse practitioner role.

Staff were proud to work for the trust and many had worked in the department for some years. One of the administrative staff told us she had worked in the department some years before and then went elsewhere but came back. Other staff said whilst it was hard work, the support in the

team was very good. There had been a significant focus on training and development, ensuring staff were, and felt competent and confident in their work.

Junior doctors reported that senior doctors acted as role models and those we spoke with were keen to tell us how much they learned whilst working in the department and about the opportunities they had been given. Senior nurses were described and observed to be “Hands-on” with extensive experience of working in emergency care.

Nursing staff told us there were generally good relationships between doctors and nurses, although some staff felt that some senor medical staff could be more engaged and forthcoming. Concerns had been reported to the matron and the operations manager that that substantive consultants generally left at 4pm leaving locum consultants on duty between 4pm and 8pm. Nursing staff reported to us that some of the locum consultants were less engaged and helpful than they would like**.**

We saw that, due to efforts made to improve flow through the hospital, links with the medical assessment unit had improved.

There were systems to support staff who wanted to raised concerns. The trust had a freedom to speak up guardian. The role of the guardian was to be a point of contact for staff who wanted to whistle blow or raise a concern and staff in the ED were encouraged to speak up if they had concerns.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care although the systems needed further development.

Systems for identifying risks and planning to eliminate or reduce them had improved since the last inspection. The senior team understood the role of governance for the service, they recognised how they needed to be reactive to concerns, incidents and developments in practice. Senior staff recognised the need for strong quality and safety systems, but changes were still evolving, and the integrated urgent care division had only been operating for five months at the time of our visit.

The divisional governance board met monthly and received combined reports on quality, risk and performance from the emergency department (ED) and the medical assessment unit (MAU), which included the same day emergency care service and the urgent care service. The emergency department performance was include in the wider Acute Operational Performance Report which was presented to the trust board on a monthly basis. The department activities to improve the performance was monitored and included; the implementation of safer staffing requirements for ED; relocation of the minors cases into vacated outpatient space to free up extra majors capacity.

The trust joint quality and performance committee meeting had recognised in 2018 that enhanced leadership was required to improve the working practices in the emergency department and subsequently appointed the new care group director and the associate director of operations to implement changes. Performance against national targets was poor; at the time of our inspection, the uplift in staff and changes to operational procedures were still new. We found that the service was doing as much as possible to improve performance internally and needed to work with other areas in the trust to improve flow for patients who required admission. This was recognised by trust directors who had asked the associate director of operations to look at the wider issues and lead the transformation of flow.

The ED and MAU shared a monthly quality meeting which fed into the divisional governance board meeting. The agenda for these meetings included a patient safety report which focussed on incidents raised via the trust electronic reporting system. The safety report also included review of the risk register, patient safety alerts, safeguarding reports, medicines and the status of staff mandatory compliance.

The meeting also included reports and discussions around patient experience and feedback and the clinical effectiveness of the service, which focussed on local and national audit plans and outcomes.

One of the emergency department consultants was the clinical effectiveness lead and the department had a regular programme of audit. Junior doctors told us they were included in the programme and had the opportunity to undertake and present audits.

Staff received feedback from governance work, and actions were taken. Information and actions from governance meetings and other interdepartmental meetings were fed back to staff in a variety of ways. There were internal news letters, so staff had the information in writing and a “Hot Topics” bulletin was produced to feedback any immediate concerns staff needed to be aware off.

We reviewed a recent newsletter that had been sent to staff and found it contained clear information about the learning identified from an incident relating to use of an insulin pen. There were also immediate actions taken that staff must follow as a result of a never event.

Other items included themes from complaints and compliments, appraisals and infection prevention and control.

Recent hot topics included; use of air and oxygen ports, diazepam checks, and use of ibuprofen for children with chickenpox.

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.

During the previous inspection in 2018 we found that the systems for identifying risks and planning to eliminate or reduce them were poorly developed, and the ED did not have its own risk register.

During this inspection we found that the ED had developed a risk register which was reviewed at the monthly quality meeting. We reviewed the top risks and found that they included issues that had been brought to our attention, such as the patient observation monitors not being fit for purpose. Others included not meeting the 4-hour performance target, transfer of critically ill patients off the island and nurse staffing. The top risks were displayed on the noticeboard for staff to see.

The risk register contained the date when the issues were added and identified some actions that were in place to mitigate. We did not see assurance through the overarching governance process of those risks of the highest levels being fully addressed and managed.

The leadership team had worked on and actioned a number of developments in an attempt to improve the management of patient safety and flow. These included professional standards documents; a series of action cards such as the one for ambulance handover and initial assessment and treatment; and a number of standard operating procedures to be followed by staff in a range of circumstances, for example, patients being cared for in the corridors.

We were told that a consultant reviewed all deaths in the department and that monthly mortality and morbidity meetings were held, we saw that any issues arising were mentioned during quality meetings.

The department took part in an external review to assess its performance and identify areas where improvement may be required. GIRFT (Getting It Right the First Time) Emergency Medicine (October 2018). GIRFT is a national programme to help improve the quality of care by identifying and reducing differences in service and practice. The service was working to address some of the issues raised during the review, for example, reducing the high proportionate spend on ED bank and agency staff through recruitment of permanent staff. There was less progress towards addressing the issue of high levels of completed care within two hours in ED, the four, six and twelve hour data showed that practices within the wider hospital were impeding timely flows of patients requiring admission.

Information management

The service used data to understand performance and make decisions about improvements.

Performance information was used to measure how effective the department was functioning and how targets were met or not. Live information was available and accessible to staff through the IT system.

A large display screen installed near the staff base displayed 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.

The service was able to provide the data we requested from the systems in use. For example, the average time from arrival to triage for a patient; the service target was for triage within 15 minutes. Data showed that for nine of the 14 months (64%) between March 2018 and April 2019 this was achieved.

The associate director of operations provided weekly transformation reports to the “front door” delivery group. Emergency department performance data was included in the trust performance dashboard for scrutiny.

Engagement

Staff told us that since the National Staff Survey results for 2018, engagement with managers and colleagues had improved.

We were told that there were monthly staff meetings, however the service was only able to produce minutes for one meeting during 2019. Staff explained that it was rarely easy for staff to leave clinical duties to participate in staff meetings. Clinical duties were prioritised as were training, governance meetings, and multidisciplinary meetings which focussed on designated responsibilities such as infection prevention and control or safeguarding.

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.

We saw an urgent and emergency care quality newsletter issued in March 2019 which referred to the monthly staff pulse check survey. Staff were encouraged to engage with the survey and provide their feedback.

The National Staff Survey results for 2018 revealed that the trust performed poorly against other trusts and below average in many areas for staff satisfaction; 39.5 % of staff would recommend the organisation as a place to work, well below the average 62.6 % and the highest at 81.0%. The results were not broken down by department.

The senior leadership were actively engaged with NHS organisation on the mainland to negotiate the potential for improved staffing rotations and for shared learning. The team were also working with mainland trusts to develop shared care.

Patients who self-presented in the emergency department were given a feedback form to complete at the end of their visit and there was a box where they could post their form. The most recent results of the latest Friends and families test were displayed on the wall. The service had received 60 responses 95% of patients would recommend the service to others. The response rate was low, and mainly positive; staff monitored the responses and acted on suggestions when possible.

There were plans in place for reconfiguration of the department environment, it was not clear if the plans involved staff and the local community.

Learning, continuous improvement and innovation

The social worker seconded to the department Monday to Friday was successful in arranging for care packages that meant some patients could avoid hospital admission.

Introduction of the emergency physician in charge (EPIC) has attempted to create clear individual senior responsibility, to help junior doctors make rapid appropriate clinical decisions.

The system of pre-hospital assessment and initial treatment of patients with possible sepsis, resulting in the administration of intravenous fluids and antibiotics by paramedics prior to arrival in ED.

The service had recruited senior level support to review the ED environment and the practice. This had resulted in improvements to the patient safety within the emergency department, with ongoing plans to improve patient flow through the hospital.

Medical care including older people's care

Facts and data about this service

The Isle of Wight NHS Trust currently provides medical care across six inpatient areas at St Mary's Hospital. Details of these inpatient areas can be found below.

- The Medical Assessment Unit consisting of 24 acute beds and the provision of ambulatory emergency care Monday to Sunday and is managed as part of the Urgent and Emergency Care Group.
- The following five clinical areas, Appley Ward, Colwell Ward, the Stroke Unit, the Coronary Care Unit and Compton Ward were managed by the Medical Care Group:

- Appley Ward is a general medical ward consisting of 28 beds with designated provision for respiratory, diabetes and endocrinology.
- Colwell Ward is a general medical ward consisting of 28 beds, with designated provision for gastroenterology.
- The Stroke Unit consisting of 24 beds, with the provision of a four bedded hyper-acute stroke service within.
- The Coronary Care Unit (CCU) has six beds and stepdown ward with 12 beds supported by the provision of cardiology diagnostic testing and outpatient care.
- Compton Ward consisted of 15 beds, and at the time of the inspection was being used for patients that awaited discharge. This ward supports the trust as part of winter resilience for medically fit patients, aiding patient flow throughout the system and cohorts medically fit patients who are awaiting social care or complex packages of care in the community.

Other non-inpatient medical services:

- The respiratory service is supported by respiratory physiologists and lung function testing.
- The gastroenterology service is supported by the endoscopy service. The Endoscopy Unit was purpose built and opened in February 2016. The unit provided 15 sessions each week.
- The Chemotherapy Day Unit consisted of a large bay with reclining chairs and two side rooms for patient treatment. The Endoscopy Service and Chemotherapy Day Unit were managed by the Clinical Support, Cancer and Diagnostics Care Group.
- In-reach medical services include care of the elderly, rheumatology, and Out-Patient and Home Parenteral Infusion Service (OHPIT).

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 13,635 medical admissions from January 2018 to December 2018. Emergency admissions accounted for 7,803 (57.2%), 45 (0.3%) were elective, and the remaining 5,787 (42.4%) were day case.

Admissions for the top three medical specialties were:

- General medicine with 7,119 admissions (52.2% of total admissions)
- Clinical oncology with 3,592 admissions (26.3% of total admissions)
- Gastroenterology with 1,299 admissions (9.5% of total admissions)

(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, however they did not make sure all staff completed all the training modules.

Nursing and medical staff with mandatory training below the target for some of the training modules, meant they may not be fully equipped to undertake their role safely. There were no checks at ward level and senior leadership did not demonstrate oversight from the care group about compliance with individual training modules. There was a focus on overall trust compliance with mandatory training.

Mandatory training completion rates

The trust set a target of 85.0% for completion of mandatory training.

St Mary's Hospital

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for qualified nursing staff in the medicine department at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Blood Borne Virus Training	6	6	100.0%	90.0%	Yes
Load Handling	4	4	100.0%	90.0%	Yes
Fire Safety Part 1 - Theory	135	136	99.3%	85.0%	Yes
Infection Prevention & Control Level 1	134	136	98.5%	85.0%	Yes
Health, Safety and Welfare	131	136	96.3%	85.0%	Yes
People Handling	123	132	93.2%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	120	136	88.2%	85.0%	Yes
Infection Prevention & Control Level 2	111	136	81.6%	85.0%	No
Medicines Management Theory	201	252	79.8%	85.0%	No
Hand Hygiene	103	136	75.7%	85.0%	No
Information Governance	99	136	72.8%	85.0%	No
Adult Resuscitation	96	135	71.1%	85.0%	No
Medicines Management Practical Assessment	73	112	65.2%	85.0%	No
Adult Resuscitation - ILS	51	110	46.4%	85.0%	No

At St Mary's Hospital the 85.0% target was met for seven of the 14 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for medical staff in the medicine department at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety Part 1 - Theory	20	21	95.2%	85.0%	Yes
Health, Safety and Welfare	19	21	90.5%	85.0%	Yes
Infection Prevention & Control Level 1	17	21	81.0%	85.0%	No
Fire Safety Part 2 - Extinguishers	16	21	76.2%	85.0%	No
Infection Prevention & Control Level 2	16	21	76.2%	85.0%	No
Information Governance	15	21	71.4%	85.0%	No
Hand Hygiene	13	21	61.9%	85.0%	No
People Handling	13	21	61.9%	85.0%	No
Adult Resuscitation	11	20	55.0%	85.0%	No
Adult Resuscitation - ILS	1	7	14.3%	85.0%	No
Paediatric Resuscitation	0	1	0%	85.0%	No
Paediatric Resuscitation - PILS	0	1	0%	85.0%	No

At St Mary's Hospital the 85.0% target was met for 2 of the 12 mandatory training modules for which medical staff were eligible.

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

The trust submitted updated additional data regarding mandatory compliance dated 3 April 2019, this provided overall figures for departments and wards. For the medical service overall, including the medical assessment unit, mandatory training compliance ranged from 64% to 100%.

However, the updated information was not divided into the individual training modules. We asked the trust for updated information with regard to resuscitation training for qualified nursing and medical staff.

Nursing staff – adult resuscitation training:

Colwell – 79%

Appley – 81%

Stroke Unit – 68%

For nursing staff for adult immediate life support (ILS):

Colwell – 67%

Appley 55%

Stroke Unit 53%

For medical staff compliance with adult resuscitation:

31%

For medical staff compliance with adult ILS:

28%

We asked the trust about actions taken to address the training gap with adult resuscitation and ILS training. The trust provided information that 18 staff had been booked on to training over the next three months, which would make the medicine team achieved to be almost 86%. The trust told us that a further seven staff needed to be booked on to this mandatory training.

We also requested an update with regard to nursing staff compliance with medicines management practical assessment, which the trust submitted data as 65%. Following our inspection, the trust told us compliance with this mandatory module was currently over 80%. In the coronary care unit (CCU) compliance was over 95%. This data was still a concern as it meant other than CCU, up to 20% of nurses had not had their medicines management practical assessment.

The trust told us that when nurses failed the medicines management practical assessment, the nurses were placed on performance management until compliance had been achieved.

Staff we spoke with told us they were given time to complete their mandatory training. Staff in both the medical assessment unit, coronary care unit and cardiac stepdown ward described how recently they had been given allocated team days to undertake their mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, there were gaps in training compliance for nursing and medical staff providing a lack of assurance that staff had the knowledge to recognise abuse.

Whilst staff we spoke with demonstrated an understanding about safeguarding, the non-compliance with safeguarding training and number of referrals 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. We looked at February to April 2019 quality and leadership meetings, there was reference that adult safeguarding training had improved, but there was not a record of the discussion about where improvement was still required. The minutes also noted that a safeguarding awareness week was planned for week commencing 29 April 2019. Compliance levels with safeguarding training was highlighted as a breach at the last inspection in January 2018.

Safeguarding training completion rates

The trust set a target of 85.0% for completion of safeguarding training.

St Mary's Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for qualified nursing staff in the medicine department at St Mary's Hospital is shown below:

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	135	136	99.3%	85.0%	Yes
Safeguarding Children Level 1	133	136	97.8%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	132	136	97.1%	85.0%	Yes
Safeguarding Children Level 2	100	130	76.9%	85.0%	No
Safeguarding Adults Level 2 Part 1	100	136	73.5%	85.0%	No
Safeguarding Adults Level 2 Part 2	98	136	72.1%	85.0%	No
Preventing Radicalisation Level 3	69	136	50.7%	85.0%	No

At St Mary's Hospital the 85.0% target was met for 3 of the 7 safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for medical staff in the medicine department at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	19	21	90.5%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	17	21	81.0%	85.0%	No
Safeguarding Children Level 1	17	21	81.0%	85.0%	No
Safeguarding Adults Level 2 Part 2	15	21	71.4%	85.0%	No
Safeguarding Children Level 2	13	21	61.9%	85.0%	No
Safeguarding Adults Level 2 Part 1	12	21	57.1%	85.0%	No
Preventing Radicalisation Level 3	7	17	41.2%	85.0%	No

At St Mary's Hospital the 85.0% target was met for only 1 of the 7 safeguarding training modules for which medical staff were eligible.

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

Nursing, allied health professionals (AHPs) and medical staff demonstrated a good understanding about safeguarding vulnerable adults and children in conversation. In two handovers, we observed patients who had needed safeguarding referrals which had been completed. From 1 January 2018 to 31 December 2018 12 safeguarding adult referrals had been made by the medicine care group.

Staff we spoke with could not name the safeguarding lead for adults for the trust. There was a named nurse for safeguarding and the accountable person was the director of nursing. Staff said when support was needed they spoke with senior clinical staff in their ward or department or sought information from the trust intranet site.

Preventing radicalisation level 3 training was at 51% for nurses and 41% for medical staff. PREVENT raises awareness to stop individuals from getting involved or supporting terrorism or extremist activity.

The trust provided updated data following the inspection, with four elements of safeguarding training. The trust reported that overall in medicine for nurses and medical staff compliance at April 2019 to be:

Safeguarding Vulnerable Adults level 1 96%

Safeguarding Vulnerable Adults level 2 part 1 85%

Safeguarding Adults level 2 86%

Safeguarding Children level 1 97%

Cleanliness, infection control and hygiene

The service controlled infection risk well. Equipment and the premises were clean. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Hand sanitisers 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. Medical, nursing and allied health professionals (AHPs) we observed consistently adhered to the trust's bare below elbow policy. This was an improvement from the last inspection. However, staff compliance with the hand hygiene compliance target of 90% was not always met on Appley Ward and Colwell Ward.

Staff on all wards used "I am clean" stickers to identify the date and time equipment, such as commodes and monitoring equipment, was cleaned. Equipment that we checked within the medical service was visibly clean and dust free.

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 and face masks. We saw nursing staff, medical staff, AHPs, and visitors using PPE and disposing of it in accordance with trust procedures.

The staff were using disposable curtains in the medical areas we inspected. These were all visibly clean and had dates on when they were last changed. For example, in endoscopy curtains were last changed 4 January 2019 and on Appley ward 11 April 2019. Staff changed disposable curtains six monthly, or sooner if they were visibly soiled.

From April 2018 to March 2019 trust wide there were eight clostridium difficile (C.difficile) infections trust apportioned that had been reported to Public Health England. This figure was similar to other trusts.

Staff working in the chemotherapy unit used PPE appropriately when they delivered care and treatment to patients and the unit was visibly clean. From December 2018 to May 2019, compliance with hand hygiene audits was 100%.

Infection prevention and control was managed well in the endoscopy 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. However, there was some peeling paint in the second stage recovery where chairs had rubbed against the wall. This was an infection risk as the wall could not be cleaned effectively. Staff had organised this area to be repainted before the end of our inspection.

Hand hygiene audits were submitted to us following our inspection for the six months from December 2018 to May 2019. Appley Ward had met the trust target of 90% compliance for one month, Colwell Ward two months, the Stroke Unit for three months and the coronary care unit for six months. In Endoscopy, since December 2018 when the hand hygiene audit had been 98%, the data for January 2019 to May 2019 had not been uploaded. However, the trust told us there would be paper copies. This meant the care group leads did not have assurance of staff compliance with their hand hygiene on Appley Ward, Colwell Ward, the Stroke Unit and Endoscopy.

Appley Ward:

December 2018 72%

January 2019 75%

February 2019 87%

March 2019 78%

April 2019 68%

May 2019 92%

Colwell Ward:

December 2018 88%

January 2019 82%

February 2019 99%

March 2019 no data uploaded. The trust told us there would be a paper copy.

April 2019 84%

May 2019 91%

Stroke Unit:

December 2018 92%

January 2019 89%

February 2019 No data uploaded. The trust told us there would be a paper copy.

March 2019 100%

April 2019 No data uploaded. The trust told us there would be a paper copy.

May 2019 100%.

Coronary Care Unit:

December 2018 98%

January 2019 100%

February 2019 96%

March 2019 100%

April 2019 95%

May 2019 96%

We reviewed minutes of ward meetings and briefings, and the seniors had reminded staff of the need to following prevention and control of infection measures including following effective hand hygiene practice.

Environment and equipment

The service had suitable premises, but there were gaps in the checking of resuscitation equipment on Appley Ward, the medical assessment unit and the coronary care unit. This meant staff may not be prepared in the event of an emergency.

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, was in date and the defibrillator was in working order.

Records we reviewed did not evidence staff had carried out checks of emergency trolleys according to the trust policy. On Appley Ward, there were no checks signed for on the 5, 31 March and 26 April 2019. Within the medical assessment unit there were 2 trolleys. On one trolley there were gaps; 1, 3 and 6 March; 9 and 17 May 2019. On the second trolley there were gaps 1, 3, 4 and 6 March 2019 and 17 May 2019. Emergency trolleys in all areas of the coronary care unit, (acute, step down and pacing room) all had gaps in the recording of emergency trolley checks. The gaps in recording had continued since the last inspection in January 2018.

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.

Staff told us that new resuscitation trolleys had been purchased by the trust and were on the site. The new resuscitation trolleys were tamper evident and waiting to be commissioned. Staff in the wards and departments we spoke with were not aware of the time frame for the new resuscitation trolleys to be commissioned.

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. We found a piece of equipment in the ambulatory care unit, a BP machine, that required a safety electrical testing. The medical devices coordinator immediately reviewed all of the equipment within same day emergency care (SDEC) and noted that one piece of equipment (BP Machine) required a safety test. This was conducted immediately on 16238 machine at 13:30.

The endoscopy lead told us that following a serious incident and identification of lessons learned, an improvement was made for the right equipment to be available and kept on a trolley known as the difficult airway trolley in the endoscopy department.

Assessing and responding to patient risk

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

The communication of National Early Warning Scores (NEWS2), a tool used to identify people at risk of deteriorating, was not always followed. Risks were not assessed when there was over occupancy of the wards or medical assessment unit. Staff had not always followed prompts on the falls care plan to minimise patients from falling and coming to harm.

Staff used a nationally recognised tool, the National Early Warning Score (NEWS2) to identify patients who were at risk of deteriorating. Staff recording NEWS2 observations was mostly completed correctly and the frequency of observations followed the guidance. However, on the medical assessment unit, we found for one patient had an altered NEWS2 recording and staff had not escalated the patient's condition as per the guidance on the NEWS2 document.

The trust was undertaking a compliance audit to review the recording of NEWS2 observations monthly. We reviewed a sample of audits undertaken of the use of the NEWS2 chart on Colwell, Appley and Compton Ward and compliance was 90% or greater.

Staff had completed three incident reports from January to March 2019 where patients with high NEWS2 scores had not been escalated when patients had deteriorated. One of these incidents had resulted in harm. A member of staff reported the incident which was investigated as a serious incident, to identify opportunities for learning. When we observed a nurse handover in Appley ward the permanent qualified nurse highlighted patients' NEWS2 scores. The nurse discussed the escalation and actions taken for a patient with a NEWS2 score of 4. Of the two agency nurses, one did not refer to their patients' NEWS2 score at all, and the other did for only half of their patients. This meant staff may not have a clear picture of their patients' condition from the handover.

Staff were being told by the bed managers to increase above the full bed capacity known as to 'one up' the beds. From what staff told us this was to prevent 12-hour breaches in the emergency department. We were told that the ward sister identified a patient to be moved to a non-designated bed space. Staff told us these were patients close to discharge and was based on a clinical risk assessment. There was not a formal risk assessment framework to support the recording of this clinical risk assessment. This occurred mainly on the medical assessment unit and Appley Ward. On Colwell Ward 'one upping' had happened occasionally. We did not see this happening, but a nurse in MAU said it had happened the day before our inspection. However, data provided by the trust did not support the frequency of patients being placed in non-designated bed spaces described by four members of staff of at least weekly. Trust data stated that there were nine days in the seven months prior to our inspection when patients had been placed in non-designated bed

spaces. During these nine days the trust told us a total of 19 patients had been cared for in a non-designated bed space.

A member of staff told us if they were asked to 'one up' a bed they would try and progress a discharge if possible or put a patient in the memory room. Four staff we spoke with told us they felt pressure by the bed managers to comply with this practice. We found ward staff were reluctant to talk to us in detail about the use of 'one up' beds. In the medical assessment unit this meant a patient being placed in the centre of a bay. On Appley Ward patients were either placed in the middle of a bay or opposite the nursing station. This meant there was no immediate access to oxygen and suction in the non-designated bed space area. However, there were portable oxygen cylinders located within the ward, and a suction machine on the resuscitation trolley. There were also no curtains to place around the bed, no call bell, light, locker or bedside table. This meant the patient could shout for help, but not use a call bell, and had nowhere to put a drink or their belongings. The placing of beds in a non-designated bed space also effected space for staff to move equipment in and out such as hoists and, in an emergency, resuscitation equipment. At a focus group earlier in the year staff told us they had to be creative in how they gave care and felt this was unsafe practice.

Staff on Colwell ward had introduced a process to reduce the risk of patients falling known as *Baywatch*. 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, where 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.

Senior staff told us that on Appley Ward, due to the nature of patient's needs, it was not always possible to use the system of Baywatch. The sister told us patients at risk of falling were risk assessed, and a one to one request made if required. From January 2018 to December 2018 Colwell Ward had reported 21 incidents with regard to staffing levels and Appley Ward 40. This raised a concern as to whether one to one staffing requests were always filled on Appley Ward.

The Baywatch programme was not directly audited to demonstrate its effectiveness. The care group reviewed all falls through the Ward Performance Review process, to identify any actions recommendations to be taken forward by Wards. A review of the Baywatch programme may also be of value in making improvements in the prevention of patient falls. In the period January 2018 to December 2018 on Cowell ward there had been 61 patient slip/ trip/ falls, on Appley ward there had been a 107 for the same period.

Staff assessed patients for their risk of pressure damage to the skin using the Waterlow pressure ulcer risk assessment tool. Staff then showed us a pressure ulcer and moisture lesion prevention plan. We asked staff what equipment was available to support preventing pressure damage and they were not sure. There was no guidance on the pressure ulcer and moisture lesion prevention plan about what equipment was available. We reviewed a patient's records on Appley Ward and on the 6 May 2019 with a Waterlow risk score calculated, and their sacrum was recorded as red with no breaks. The patient's Waterlow risk score was recalculated on 8 May 2019. The patient's risk of development of a pressure sore increased and an airwave mattress requested. Staff had documented in the patient's records that an airwave mattress was not available, and the patient to be transferred when one available. There was no further update with regard to the mattress until 12 May 2019, when it was recorded at 4.30pm that staff had changed the patient's mattress. We asked the trust if there was a waiting list in place for pressure relieving equipment, and they advised there was not a waiting list for pressure relieving equipment.

Staffing

The service did not always have enough staff nursing and support staff with the right qualifications, skills, training and experience and this did impact on the care given to patients.

The level of nurse staffing had meant that there had been delays to patients care and treatment, and patients feeling at times nurses were rushed when providing care. The induction checklist did not include specific training about the use of NEWS2. An endoscopy clinic had also been cancelled in March 2019 due to an unsafe staff skill mix.

St Mary's Hospital

St Mary's Hospital reported the following whole time equivalent (WTE) nursing staff numbers for the periods below for medicine.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
Chemotherapy	5.6	5.0	112.0%
Gastroenterology Medics	2.5	2.3	108.6%
Parkinson nurse specialist	1.1	1.0	106.0%
Diabetics	3.4	3.4	100.0%
General Medicine Management Team	2.0	2.0	100.0%
Heart Failure	2.8	2.8	100.0%
Respiratory	2.6	2.6	100.0%
Laidlaw Rheumatology	5.7	5.9	96.8%
Stroke Clinical Lead	2.1	2.3	93.0%
Coronary Care	25.8	29.5	87.5%
Colwell Ward	15.1	17.5	86.1%
Endoscopy Unit	14.0	16.9	83.2%
AEC	1.0	1.5	68.5%
The Stroke Unit	15.5	22.7	68.1%
Appley Ward	13.0	19.8	65.7%
MAAU	13.6	28.7	47.2%
Total	**126.7**	**163.8**	**77.3%**

From April 2018 to March 2019, the nursing staffing rate within medicine at St Mary's Hospital was 77.3%.

From April 2018 to March 2019, 3 of the 16 nursing teams listed were over established. However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a vacancy rate of 24.1% for nursing staff in medicine. The trust did not set a target for vacancy.

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

The care group leads undertook regular reviews of staff vacancy, recruitment and establishments. The care group were also involved in the trust wide initiatives with regard to overseas recruitment and apprenticeships. All agency and temporary staff undertook a ward based induction. On Compton Ward long line agency staff had been given additional training.

Turnover rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a turnover rate of 13.4% for nursing staff in medicine. This was higher than the trust target of 5.0%. Care should be taken when interpreting turnover rates due to small numbers of staff in some teams.

A breakdown of turnover rates by ward/team is below.

Ward / team name	Annual turnover rate
Parkinson Nurse Specialist	83.5%
Stroke Clinical Lead	39.0%
Laidlaw Rheumatology	30.8%
MAAU	27.2%
Colwell Ward	22.4%
Gastroenterology	22.2%
Appley Ward	15.3%
The Stroke Unit	11.2%
Endoscopy Unit	9.1%
Compton Ward	8.5%
Chemotherapy	7.8%
Coronary Care	3.8%
Diabetes Centre	0.0%
General Medicines Management Team	0.0%
GM Winter Plan	0.0%

Heart Failure	0.0%
Respiratory Physiology	0.0%

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

The care group were worked to reduce staff turnover. The medicine care group had taken actions in line with the trust wide Recruitment and Retention Strategy 2018 to 2021 to improve staff retention. This included supporting staff with career aspirations. Two Ward Sisters we spoke with were in interim Ward Sister positions and welcomed the challenge and development this had offered them.

Sickness rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a sickness rate of 5.9% for nursing staff in medicine. This was higher than the trust target of 3.5%.

A breakdown of sickness rates by ward/team is below.

Ward / team name	Annual sickness rate
Gastroenterology	19.3%
Appley Ward	10.7%
Colwell Ward	9.8%
Compton Ward	7.7%
The Stroke Unit	6.4%
Endoscopy Unit	5.9%
Laidlaw Rheumatology	5.2%
MAAU	4.4%
Coronary Care	3.8%
Heart Failure	3.6%
Chemotherapy	1.9%
GM Winter Plan	1.2%
Diabetes Centre	1.0%
Stroke Clinical Lead	0.9%
Parkinson Nurse Specialist	0.5%
Respiratory Physiology	0.4%
General Medicines Management Team	0.1%

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

Bank and agency staff usage

St Mary's Hospital

The table below shows the numbers and percentages of nursing hours in medicine at St Mary's Hospital from January to December 2018 that were covered by bank and agency staff or left unfilled.

Of the 311,558 total working hours available for qualified nursing staff, 5.9% were filled by bank staff and 13.3% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 8.0% of the available hours were unable to be filled by either bank or agency staff.

Of the 171,472 total working hours available for non-qualified staff, 28.5% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, 2.1% of the available hours were unable to be filled by either bank or agency staff.

Staff group	January to December 2018						
	Total hours available	Bank usage		Agency usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Qualified staff	311,558	18,425	5.9%	41,453	13.3%	24,987	8.0%
Non-qualified staff	171,472	48,936	28.5%	0	0.0%	3,533	2.1%
All nursing staff	483,030	67,361	13.9%	41,453	8.6%	28,520	5.9%

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

To support consistency of care, the trust had approved continuity agency staff in some areas. This meant the same agency nurse worked on the same ward. We saw that staff did receive an induction prior to working on the wards, which was signed by both a trust nurse and the agency member of staff. The induction check list included training and listed various aspects which included the medicines system, safety checks and documentation in use. The documentation list included bowel charts, catheter care plan and falls care plan. However, the induction checklist did not include information about, and the recording of, patients' physiological observations using NEWS2.

The medical assessment unit (MAU) reported 47% whole time equivalent (WTE) nursing staff numbers from April 2018 to March 2019. This was due to a vacancy of 15 band 5 nurses. The matron explained that 6 of these gaps were covered by the booking of long line agency nurses. We reviewed the nursing rotas for March and April 2019. The unit had not run more than one member of staff short for the whole of the two months, which had occurred on three occasions. During our inspection, the MAU was running with planned numbers.

There had also been a recent uplift in the seniority of nurses in MAU to include more band 6 nurses. We noted in March and April 2019, there were only two shifts when the MAU was managed by a band 5 nurse rather than a band 6 nurse or band 7 nurse.

Alongside the MAU there was one bay dedicated for same day emergency care (SDEC), this is the same as emergency ambulatory care (EAU). Previously EAU had been based in a bay within MAU and had frequently become a bedded inpatient area. SDEC had replaced the EAU. Patients in SDEC were assessed, diagnosed, treated to go home the same day, without being admitted into a hospital bed overnight where ever possible. The lead nurse for SDEC explained in April

2019 there had been 188 patients, 130 patients were discharged. There were 58 patients, who were unable to go home, who were admitted.

There were two dedicated band 7 nurses allocated to SDEC supported by a health care assistant from the MAU. The lead band 7 nurse had undertaken specific training and the second band 7 nurse was on a specific training pathway to support their practice in the SDEC. We asked about holiday and sickness cover and were told this came from MAU. The SDEC unit opened in April 2019, and initially provided a service Monday to Friday.

The week before our inspection the SDEC had started to open seven days a week. We asked how the nurse staffing was planned with the increase in hours and were told this was with staff from MAU. The staff were not clear how the MAU could achieve this support from existing staff levels. The sister on the coronary care unit reported an uplift in band 6 nurses, which meant more senior leadership on the ward and improved organisation of appraisals for staff.

Appley Ward, Colwell Ward and the Stroke Unit were all using agency qualified nurses particularly at night, but staff told us the agency qualified nurses were always on duty with permanent staff. Staff told us that at times their wards did run one member of staff short, or with an extra health care assistant where a ward had not been able to resource with a qualified nurse.

Compton Ward had been opened for winter pressures at 30 beds. At the time of our inspection, outside of winter pressure timeframe, the ward was running with up to 15 beds open. There were 13 patients at the time of our inspection. These patients were all medically fit and awaiting discharge, apart from one who had become medically unwell and was being transferred back to an acute medical ward. The ward sister explained to us the challenges had been the high use of agency and bank staff who were on long term contracts. Three staff we spoke with at the time of our inspection had received induction training before they started work on the ward.

On Compton Ward on 22 May 2019, the second day of our inspection, staffing was at planned numbers in the morning but not in the afternoon due to a shortage of one qualified nurse. However, there was an additional healthcare assistant. We spoke with three patients on the ward at the time of our inspection. A patient we spoke with commented they had had to wait a long time on one occasion for assistance of the commode and two patients felt concerned that staff were rushed when supporting them with personal care and mobility.

The endoscopy lead reported there had been some challenges with nursing staff. This had been due to some planned and unplanned staff absence. Nurses that admitted patients helped in the recovery bays if required. The unit did not use agency staff as it was said they would not have the specialist skills required. The unit did use bank staff which were generally their own staff or staff that had previously been employed at the unit. One clinic in March 2019 had been cancelled due to an unsafe skill mix. The endoscopy lead explained the service was in the process of developing a hybrid administration care assistant role to support endoscopy.

The lead nurse for chemotherapy told us that due to planned sickness, the unit had recently used an agency nurse on a long line placement. The lead explained that due to the speciality they always checked that that nurses coming to the unit had the oncology competencies required.

Staffing meetings were held twice daily to ensure staffing needs were met for the whole hospital. This meeting was attended by the matrons from clinical areas across the hospital. At these meetings staff moves were discussed to provide support to wards that were short staffed and minimise risk to patients. Following the meeting staffing reports were e mailed to Heads of Nursing, Matrons and Ward, Department Sisters and Charge Nurses to give them an overview of staffing position and required actions.

Medical staffing

St Mary's Hospital

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

When we asked medical, nursing and allied health professionals about their main concerns and worries, all staff reported that staffing was a significant concern. 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. When we spoke with the medicine care group leads, locum medical staff would often be in post for a fixed time period, rather than single weeks or days. Cardiology medical staff had been supported by medical staff from other trusts by formal arrangements. These actions helped in reducing the risk to patients.

At the inspection in January 2018, it was identified there was a significant number of medical staff vacancies. From October 2016 to September 2017, the trust reported an overall vacancy rate of 25% for medical/dental staff working within medicine. From January to December 2018, St Mary's Hospital reported a vacancy rate of 37.8% for medical staff in medicine.

Medical hours in medicine at St Mary's Hospital from January to December 2018 that were left unfilled were at 15.8%.

St Mary's Hospital reported the following WTE medical staff numbers for the periods below for medicine.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
MAAU Medics	4.0	3.0	133.3%
Diabetes and Endocrinology Medics	4.0	4.0	100.0%
Respiratory Medics	5.0	5.0	100.0%
Stroke and Rehab Medics	3.9	4.9	79.4%
General Medicine, Elderly Medics	24.0	30.9	77.7%
Rheumatology Medics	2.4	3.4	70.6%
Cardiology Medics	4.0	6.0	66.7%
Gastroenterology Medics	3.3	6.4	51.6%
Chemotherapy	0.0	1.2	0.0%
Total	**50.6**	**64.7**	**78.1%**

From April 2018 to March 2019, the medical staffing rate within medicine at St Mary's Hospital was 78.1%.

From April 2018 to March 2019, 1 of the 9 medical teams listed were over established. However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams.

Medical staff that supported chemotherapy were two haematologists based at the trust. Other medical staff that supported patients were from other trusts, where formal arrangements were in place.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a vacancy rate of 37.8% for medical staff in medicine. The trust did not set a target for vacancy.

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

Turnover rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a turnover rate of 24.4% for medical staff in medicine, this was higher than the trust target of 5.0%.

A breakdown of turnover rates by ward/team is below.

Ward / team name	Annual turnover rate
Stroke & Rehab Medics	89.6%
Gastroenterology	40.4%
Rheumatology Medics	39.2%
Respiratory Medics	27.9%
Diabetes & Endocrinology Medics	25.0%
Cardiology	20.3%
General Medicine Elderly Medics	14.6%
Chemotherapy	0.0%
MAAU Medics	0.0%

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

The medicine care group was monitoring the medical staff turnover rate. They worked closely with the lead for medical staff recruitment in the human resources department to recruit and retain staff.

Sickness rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a sickness rate of 1.7% for medical staff in medicine, this was lower than the trust target of 3.5%.

A breakdown of sickness rates by ward/team is below.

Ward / team name	Annual sickness rate

Chemotherapy	4.5%
MAAU Medics	3.1%
Respiratory Medics	2.8%
Rheumatology Medics	2.5%
Cardiology	2.1%
Stroke & Rehab Medics	1.9%
General Medicine Elderly Medics	1.5%
Diabetes & Endocrinology Medics	0.6%
Gastroenterology	0.6%

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

Bank and locum staff usage

St Mary's Hospital

The table below shows the numbers and percentages of medical hours in medicine at St Mary's Hospital from January to December 2018 that were covered by medical and locum staff or left unfilled.

Of the 71,953 total working hours available, 13.9% were filled by bank staff and 12.7% were covered by locum staff to cover sickness, absence or vacancy. In the same period, 15.8% of the available hours were unable to be filled by either bank or locum staff.

Team name	January to December 2018						
	Total hours available	Bank usage		Locum usage		Not filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
General Medicine	59,231	9,942	16.8%	7,792	13.2%	7,622	12.9%
Respiratory Medicine	6,778	40	0.6%	872	12.9%	2,889	42.6%
Stroke Medicine	5,944	0	0.0%	480	8.1%	879	14.8%
All medical staff	**71,953**	**9,982**	**13.9%**	**9,144**	**12.7%**	**11,391**	**15.8%**

(Source: Routine Provider Information Request (RPIR) – Medical agency locum)

Staffing skill mix

In December 2018, 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 62 whole time equivalent staff working in medicine at Isle of Wight NHS Trust

Middle career^	6%	7%
Registrar group~	24%	29%
Junior*	35%	20%

^ 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 - Medical (01/11/2018 - 30/11/2018)

There was one permanent consultant and four locum consultants working in MAU. The trust said the unit worked on a minimum of 3 consultants. When we reviewed the rota from March to May 2019, there had been 6 occasions, usually a Tuesday or Wednesday, when there had been 2 consultants on duty. Medical staff we spoke with in MAU confirmed that all new patients admitted over the weekend were seen by a MAU consultant from 8am to 4pm. On bank holidays 1 MAU consultant was on site 8am to 4pm to assess and review patients.

Junior doctors expressed concerns about patients transferred to medical wards over the weekend. On a Friday, a medical handover sheet was produced by the MAU medical team. This listed patients' conditions, and how they were being managed and treated. Senior nursing staff in MAU used this medical handover to make decisions about who could be moved from MAU, when they were asked to make space in MAU for new patients. The concern was that the junior medical staff were not informed of these patient transfers as there were no doctor to doctor handovers. Junior medical staff we spoke with advised they had found a list of actions needed for patients within the medical records when they did see these patients, but actions taken were delayed as they were not aware of these patients. This put patients at risk of delayed treatment and care.

For the care of stroke patients, there was one permanent stroke consultant and two locum stroke physicians. This meant there was not always a stroke physician on site or on call, and stroke patients needs would be met by a general medical physician at these times.

The nurse lead for SDEC told us they mostly had medical patients, but sometimes they had surgical patients. When the SDEC service began, there was not any agreed support from surgical staff. The leads for the MAU had been working more recently with surgeons to ensure they had capacity to support the SDEC by adding this to their job plans. At the time of our inspection two surgical patients were seen and treated by surgical staff and discharged. This meant the new job plans and standard operating process in place for SDEC had been effective.

The hospital had a hospital at night handover at 8pm and 8am at the time of our inspection. The medical director owned a risk on the trust wide risk register that stated 'hospital at night is not operating effectively at through an enforced hospital at night scheme'. This was dated 31 January 2019. Hospital at night started in 2005 to address the shortened working week for junior doctors with the European directive. The trust wrote the hospital at night system was not working effectively for reasons that included insufficient advanced practitioner capacity managing the hospital at night and different handover times in place for different teams. An action the trust took

to manage this risk included drafting a hospital at night handbook that detailed the roles and responsibilities of those working at night and weekends. The hospital at night staff handbook first published version for the trust was dated the day before the inspection on 20 May 2019. The trust stated the aim of the document was to ensure the trust provided a safer environment for patients overnight and during periods of reduced staffing such as weekends and bank holidays. It was not possible to evaluate the effectiveness of the handbook due to the first published version being the week of our inspection.

We attended the evening handover on 21 May 2019. There was structure to the meeting which was led by critical care outreach service. However, attendance was low. The trust policy expected 19 attendees at the handover. There were less than 10 staff in the room. The off going medical registrar and surgical team did not attend the meeting. The critical care outreach member of staff who chaired the meeting, discussed the patients they were currently monitoring. However, there was no handover by the medical staff about patients that may be new and need close monitoring. Although staff gave us clinical reasons for staff that had not attended the meeting, this did raise concerns about attendees understanding of their roles and responsibilities, and the importance of communicating important information pertaining to patients.

We attended the morning handover on 22 May 2019 at 8am. This meeting was attended with approximately 19 trust staff that included consultants. This meeting included detail about the current patient flow position in accident emergency, if there were any patients with sepsis and any control of infection issues. One medical concern was handed over by a locum medical registrar, with a request for this patient to be followed up.

We asked the trust for any audits undertaken of attendance at the hospital at night meetings for the last 6 months. They sent audit details for 2 months, March and April 2019. The attendance for March 2019 for incoming staff ranged from 0% for the orthopaedic consultant and surgical ward cover to 100% for the critical care outreach service, with an average of 57%. The oncoming medical registrar with overall responsibility for hospital at night from a clinical perspective attended 90% of the time. The attendance for the outgoing ranged from 0% for the orthopaedic consultant and surgical cover to 83% for the critical care outreach service, with an average of 25%. The outgoing medical registrar attended 66% of the time. April 2019 was similar, except attendance by the oncoming medical registrar with over all clinical responsibility for the hospital had dropped to 80%. The inconsistent attendance meant the effectiveness of hospital at night may be compromised.

Junior medical staff expressed concern re lack of middle grade doctors in medicine with little support on non-serious issues for medical trainees, and ineffective use of consultant time. The medical care group senior team told us that eight medical registrars had been recruited to commence in August 2019.

Although funding for four whole time equivalent (WTE) consultant geriatricians, there was only 0.8 WTE in post. As the hospital had recently started to develop a frailty pathway there was a long term locum full time geriatrician and a full time junior doctor specialising in the care of older people in post.

There were a number of medical patients cared for on non-medical wards (medical outliers) at the hospital. These patients' medical needs were covered by a locum consultant and a junior doctor, but there were no middle grade doctors. A doctor told us that there was not always medical cover for outlier patients and recently they had been pulled over to Luccombe Ward to support patients. Luccombe Ward was a surgical ward, that took medical outliers when required.

The trust was funded for three full time gastroenterology consultants, but there was currently one substantive gastroenterology consultant in post. A locum consultant was in place, with another expected shortly. For this speciality there was an experienced middle grade locum in place. Recruitment was planned to fill roles. If patients needed consultant gastroenterology support and the one in post not available, patients would be transferred to the mainland.

Compton Ward at the time of our inspection was accepting patients who were medically fit for discharge with a discharge date. Patients were still the responsibility of the hospital however, on this ward were not under the care of a named consultant and therefore there was not a medical member of staff directly responsible for patients care on Compton Ward. If nursing staff had concerns they told us they contacted a doctor from the medical team who had been looking after the patient before their transfer to Compton Ward. During our inspection on 22 May 2019 a patient had deteriorated and was waiting for transfer back to Appley Ward. The ward sister told us the patient had been assessed promptly on 22 May 2019, and bed allocated on Appley ward the same day.

A junior doctor reported there were no cardiology registrars, but the cardiology consultants were easily available during working hours. Out of hours they were available for advice by telephone.

We spoke with senior staff in the coronary care unit regarding care of patients with non-invasive ventilation. They explained there could be difficulties contacting a respiratory consultant, but they did have access to a medical registrar and a critical care registrar. Out of hours patients were managed by an on call medical consultant.

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 25 records. This included medical notes, patient risk assessments and care plans. Although records were stored securely and easily available to all staff providing care, there were numerous gaps in the completion of information.

The documentation for acute medicine admissions included the emergency department admission document, the MAU admission and assessment document, nursing assessment and care record booklet, risk assessment document and separate care plans. The documentation gaps meant that risks to patients may not be being assessed and addressed.

For a patient on MAU admitted 20 May 2019, who's records we reviewed at 11.50 am 21 May 2019, the intravenous fluids the patient had received had been recorded. There was no record as to whether the patient was nil by mouth to explain why the fluid column was blank, nor was there a record of any urine output. Of the 13 sections of the risk assessment document, the only section completed was the peripheral venous access device assessment and cannula observation. On another patient records we reviewed more of the assessment document was blank than complete.

On Colwell Ward for a patient admitted with delirium, staff had not completed the dementia screening form or delirium factors form. For another patient their care record of day to day activities had been completed, but no personalised care plan to guide how their needs were to be met.

On Colwell Ward staff had undertaken monthly audits of the completion of risk assessment documentation which from June 2018 to February 2019 ranged from 64% to 100%, which gave an

average of 79%. Senior staff we spoke with were aware of the gaps in completion of documentation and felt having consistent agency staff on the ward would help staff become familiar with trust systems and processes. Appley and Colwell Ward sisters were also leading regular meetings with the team, which included the importance of fully completing patients nursing records.

On Appley Ward for a patient the alcohol and smoking assessment had not been completed, although this information was needed as part of meeting this patient's needs. For the same patient although hourly blood sugars requested, these were not recorded for the first three hours of admission.

For another patient on Appley Ward was admitted with sepsis and possible aspiration pneumonia, there was no sepsis screen, no acute kidney injury assessment, no venous thromboembolism screening or dementia screening completed on admission 6 May 2019. Following further assessment of the patient on 7 May 2019 by medical staff, the medical plan of care did become clear but not the nursing care plan. The nursing care plan included the comment 'the patient is incontinent', however did not say what care would be put in place met to meet their elimination needs. The patient's food and fluid charts were not consistently completed. On 22 May 2019 there were no entries on the food chart. The fluid charts were not totalled.

On Appley Ward staff had undertaken monthly audits of the completion of risk assessment documentation which from June 2018 to February 2019 ranged from 48% to 96%, giving an average of 84%. Senior staff we spoke with were aware of the gaps in completion of documentation, and an action they hoped would help, was to have the same temporary staff to provide familiarity with trust systems and processes and consistency. The sister was also leading regular meetings with the team, which included the importance of fully completing patients nursing records.

On Compton Ward a patient admitted 9 May 2019 had an incomplete moving and handling profile dated 10 May 2019 with no further documented assessment. The trust risk assessment for hospital acquired pneumonia (HAP) care bundle compliance was required 'to be completed twice a day for all patients.' Staff had completed the HAP bundle for this patient on the 11, 13, 14 and 20 May 2019. The non-completion by staff of the HAP bundle may cause staff not to take all actions needed, to prevent patients from developing a hospital acquired pneumonia.

For a further patient there were also gaps in the completion of the HAP bundle, along with the falls risk assessment and nutrition risk assessment. The patient also had no estimated discharge date, although this was on the list of criteria for acceptance to Compton ward listed on the ward standard operating process.

When we reviewed a patient notes in the cardiac stepdown ward there were gaps in the medical and nursing documentation. Staff had not completed the acute kidney injury assessment or reviewed nursing care plans.

We also reviewed four patients medical and nursing records of medical patients' outliers to Whippingham and Luccombe surgical wards. For these patients there were also gaps in the documentation. These included a patient's risk assessments not being updated; another patient's risk assessments being updated but not carried through to the care plan and a patient with incomplete fluid charts.

Our review of care plans across all wards and units, showed there was minimal information to promote individualised care, treatment and support for patients. For one patient on Appley ward, their assessment detailed they needed assistance with eating and drinking however there was no description of the assistance the patient actually needed. The documentation was incomplete for

this as well as other care needs. 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 nursing assessments and care plans did not include patient goals.

Senior staff on Appley and Colwell wards had undertaken audits of care planning within their wards. On Appley ward from June 2018 to February 2019, compliance with completing patients' care planning ranged from 10% to 75%, the average 44%. For the last two months audits we received for January 2019 compliance was 26% and February 2019 compliance 40%. On Colwell ward from June 2018 to February 2019, compliance with completing patients' care planning ranged from 17% to 61%, the average 39%. For the last two months audits we received for January 2019 compliance was 43% and February 2019 compliance 41%. When we reviewed meeting records for these wards, there was no focus on the need to fully complete patient care plans.

We reviewed eight care records of patients who had mental health needs and although staff had completed generic risk assessments, there were no mental health risk assessments completed. There was no mental health care plan in place for patients who had known mental health needs, such as schizophrenia, and no crisis plans present in any of the care notes.

We did find for inpatients records we reviewed they all had a fully completed stool chart, intentional rounding and property checklist.

At the last inspection in January 2018 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.

From April 2018 to October 2018 there were 458 outstanding summaries in general medicine. That represented 16% of total discharges from general medicine. A process had been in place to identify what outstanding elements there are in discharge summaries. We did not receive further data from the trust with the progress that had been made with the outstanding discharge summaries. Following the inspection, the trust told us for the month of May 2019 the number of overdue discharge summaries was 70.

For three patient records we reviewed in endoscopy they were mostly completed. Staff did record patients' physiological observations but did not document the NEWS2 score.

Records not being fully completed, meant staff did not have the complete information they needed before providing care and treatment. This put the patient at risk of actions not being taken to minimise their risk of harm, for example gaps in the completion of the hospital acquired pneumonia (HAP) bundle. Incomplete nursing plans was a concern that patients individual needs would not me met to minimise risk, prevent harm and ensure comfort. Staff were required to complete records in line with professional standards. The Nursing and Midwifery Council (NMC), provide professional guidance for nursing and midwifery staff in England for the completion of clear and accurate records in their Code that became effective in March 2015.

Medicines

The provider had systems in place for the safe storage, administration, prescribing and disposal of medicines. However, some medicines in safe storage areas had not been managed safely.

The trust pharmacy department supplied medicines as stock and dispensed for individual patients. This including aseptically prepared medicines for oncology patients. Medicines were stored securely and within their recommended temperature ranges. However, in several secure ward treatment rooms we observed partly used medicines denaturing kits and a liquid medicine lacked a revised in use expiry date and was available for staff to administer.

The wards and departments had holders in which to place small oxygen cylinders. On Appley Ward and MAU there were some loose small oxygen cylinders. These are a hazard, if they accidentally get knocked over. When we spoke with staff the excess oxygen cylinders were removed.

Staff followed the Trust's policy on administering medicines covertly when appropriate. We saw evidence of this being documented and referred to correctly in one patient's care records. Following an incident in the emergency department where a patient had been administered medical air instead of medical oxygen, all the medical gas ports had been checked and the medical air capped off to reduce the risk of further incidents.

Medicines on the wards were prescribed via on the trust electronic prescribing and medicines administration system (ePMAS), whilst in oncology medicines were prescribed on a dedicated oncology patient administration system (PAS) hosted by the local cancer network. Visiting cancer specialist via the oncology PAS were able to remotely prescribe and review patients pathology results. Generally, patients were seen in face to face clinics for treatment reviews and chemotherapy prescribed for administration within the following 3 working days. Telephone treatment reviews had been introduced for patients receiving courses of oral chemotherapy. Oncology and pharmacy staff worked closely to balance the patients' needs with the logistic challenges of the location and the reconstituted shelf life of the medicines. On transfer of patients from the intensive care unit (ITU) to the medical wards, ITU clinicians were responsible for transferring the relevant medicines prescriptions from paper to the ePMAS prior transfer. Post transfer the receiving medical clinicians undertook medicines reconciliation.

The administration of medicines was recorded via the relevant computer system. Monthly ward reports were generated within pharmacy to monitor missed doses, including specifically antibiotics and medicines to support people living with epilepsy and Parkinson's disease. A daily report of antibiotic prescribing was generated to assist in the planning of the consultant microbiologists ward round.

Pharmacy staff visited the unit on a regular basis, supporting patients and staff to optimise the use of medicines including medicines reconciliation. Over the 6 months to May 2019 the average monthly medicines reconciliation rate was 70% (59% to 78%). The trust did not provide a target for expected compliance with medicines reconciliation.

Prior to discharge with the patients' consent, those with high medicines risks were referred for community pharmacy follow up and received a post discharge telephone call from a member of the pharmacy team to resolve any post discharge medicines related questions.

A recent audit of the on-site pharmacy aseptic unit had identified a lack of staff capacity was leading to the development of a back log of documentation reviews. The pharmacy team had developed an action plan and added the capacity concerns to the risk register. However, this could impact on patient care in the future.

Incidents

Staff did not always recognise incidents. Managers did investigate incidents however there were delays with lessons being learnt and actions taken forward. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The top two serious incidents were sub optimal care of the deteriorating patient and treatment delay. Nursing and medical staff reported to us there were delays with receiving feedback following the submission of incident reports.

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 January to December 2018, the trust reported no incidents that were classified as a never event for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

St Mary's Hospital

In accordance with the Serious Incident Framework 2015, the trust reported 43 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from January to December 2018.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Sub-optimal care of the deteriorating patient meeting SI criteria	17	39.5%
Treatment delay meeting SI criteria	11	25.6%
Medication incident meeting SI criteria	5	11.6%
Slips/trips/falls meeting SI criteria	3	7.0%
Pressure ulcer meeting SI criteria	2	4.7%
Screening issues meeting SI criteria	1	2.3%
Surgical/invasive procedure incident meeting SI criteria	1	2.3%
Medical equipment/ devices/disposables incident meeting SI criteria	1	2.3%
HCAI/Infection control incident meeting SI criteria	1	2.3%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	2.3%

Total	**43**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

Staff undertook root cause analysis investigations however, when we reviewed two root cause analysis (RCA) investigations that were since our last inspection, they did not make it clear whether the actions had been completed. One incident occurred 30 May 2018 on Appley Ward. An action identified was 'ward specific induction to be developed', this action was due to be completed by 30 September 2018. We asked the trust for a sample of completed induction forms, the nurse staff induction form had been amended to be specific for Appley ward. These were signed and dated however, there was no issue date or version number on the template. A concern with the completion of NEWS2 was identified for a patient on Compton ward in April 2018 as the patient's pain score had not been recorded, it was not clear from the RCA what had been put in place in relation to this gap in documentation.

Appley Ward had submitted three incident reports in the period from January to December 2018 regarding challenges to find a bed for patients and on MAU seven incidents were reported. This demonstrated that staff did not always recognise what was an incident. The 'one upping' of beds had occurred more than once a week. The Trust Incident Management Policy published in April 2019 described an incident as 'an event which has the potential to produce unexpected or unwanted effects, or any event that has a consequence or a learning point i.e. an event that causes a loss, injury or near miss to a patient, staff or others'. Staff placing patients in non-designated bed spaces had the potential to cause harm to a patient and at each occurrence a 'near miss'. Although the incidents may not have resulted harm, emergency equipment such as oxygen and suction not being at the bed side and patients not being able to call for help with a call bell, had the potential to lead to patient harm.

Staff working in MAU from January to December 2018, in addition to the seven incidents above, had reported 490 incidents, with the top two being moisture lesion, pressure ulcer on admission (137) and patient slip/ trip/ fall (65). Cardiology had reported 15 incidents in total for the 12 months January to December 2018. There were no themes. Two types of incidents had occurred twice, and these were described as accidental injury to staff and communication failure.

Trust wide there were delays with reporting incidents. The median time taken to report incidents was 48 days externally for the trust compared to 30 day for all trusts from April 2018 to September 2018.

Speaking with staff and information on the wards demonstrated that learning did take place following incidents. For example, in MAU, following a patient who absconded, there was an increase in security access to MAU supported by an intercom and signs advising patients, visitors and relatives how to gain access and exit MAU. The nurse in charge also undertook three safety rounds during a 24 hour period.

The two root cause analysis (RCA) investigation reports we reviewed 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.

Mortality and morbidity within 30 days of an endoscopy was an agenda item at the monthly endoscopy user group meeting. For the quarter January 1 2019 to March 31 2019, seven patients out of 1485 died within 30 days of an endoscopy. The group concluded that none of the deaths were due to the endoscopy.

Mortality and morbidity meetings had taken place in the medical service from April 2018 to March 2019. The meeting minutes evidenced that there had been good medical attendance at these meetings. Staff had identified learning actions that included when the coroner should be notified about a death. Also, an action to ensure that following discussions 'do not attempt resuscitation status forms' were countersigned by a consultant.

Safety thermometer

The service used monitoring results well to improve patient safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety information was displayed outside wards and departments with the safety thermometer results, and also included mandatory training compliance and hand hygiene compliance. Information was displayed outside wards and departments with the safety thermometer results, and also included mandatory training compliance and hand hygiene compliance.

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 1 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 18 new pressure ulcers, 4 falls with harm and 4 new urinary tract infections in patients with a catheter from March 2018 to March 2019 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Isle of Wight NHS Trust

1

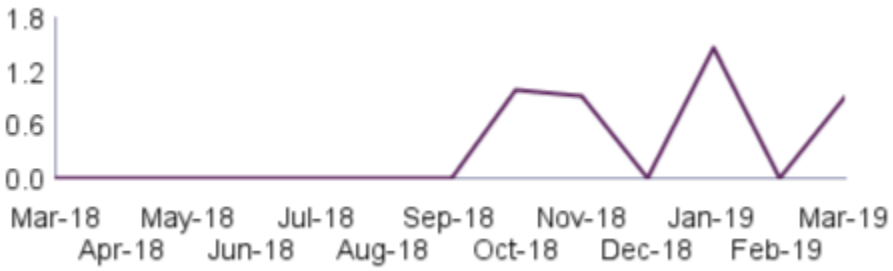
Total Pressure ulcers (18)

2

Total Falls (4)

3

Total CUTIs (4)



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

On Appley Ward, to highlight hand hygiene compliance, a visible hand gel and sign had been placed at the ward entrance.

Is the service effective?

Evidence-based care and treatment

The service did not always provide treatment that reflected 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 always follow the national early warning scores (NEWS2) process and staff did not always complete patient risk assessments or monitoring charts, such as fluid charts.

National audit outcomes below demonstrate where the trust meeting current evidence-based guidance or best practice standards, and where improvements were needed.

In November 2018 the endoscopy service was informed by the Royal College of Physicians Joint Advisory Group (JAG) that it had not been able to demonstrate adherence to the JAG standards on gastro-intestinal endoscopy, and their status was changed to assessed: improvements required. 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. In April 2019 the endoscopy had made the necessary improvements and met all the requirements and their JAG accreditation was renewed until October 2019. This meant the endoscopy unit met the national guidance for delivering an endoscopy service, which included routine auditing of the service provided.

Endoscopy services did not provide local seven day services on site. NICE clinical guidance on 'Acute upper GI bleeding' (CG141 June 2012) recommends offering endoscopy to unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation and endoscopy within 24 hours of admission to all other patients with upper gastrointestinal bleeding as key priorities for implementation. Current arrangement for weekend emergency upper GI bleeds was provided by a local tertiary centre.

At a physician's meeting on 24 April 2019 a consultant highlighted that a patient with a diabetic foot was not assessed as an emergency so did not get transferred when needed to a nearby trust. The trust described in the physicians meeting held on 24 April 2019, how this had resulted in serious harm for this patient. From the information in the meeting record it was not clear in which ward at the trust this incident had happened. The medicine clinical group director stated the trust was seeking more formal partnership with other trusts, and partnership meetings had already been held.

The trust used a nationally recognised sepsis bundle to support identification and treatment of patients with suspected or actual sepsis. The review of patients records demonstrated staff had not always followed the sepsis bundle. There was an action plan to support ongoing and effective use of the sepsis bundle. The service monitored compliance with the sepsis bundle. For inpatient sepsis for eligible screening from April 2018 to March 2019, which involved an audit of 50 sets of patient notes, compliance ranged from 89% to 100%. With regard to the administration of intravenous antibiotics in one hour to all patients who present with severe sepsis, compliance for April 2018 to March 2019 ranged from 89% to 100% compliance. The audit was of 30 sets of patients' records per month where clinical codes indicated sepsis.

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

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health.

Patients had assessments of their nutritional and dietetic needs on admission using a nationally recognised tool. Staff referred patients to dietitians for dietetic support if their assessments indicated the need.

We reviewed the nutrition assessments for two patients with scores greater than three putting them at very high risk. In the medical records we did find guidance provided by the dietitian and speech and language therapist about support needed for these patients with their diet and fluids. However, this was not detailed in the patients nursing care plans.

Staff referred patients identified at risk due to swallowing difficulties to speech and language therapists. Critical care outreach staff carried out swallow assessments for stroke patients when there was no access to speech and language therapists. At the September 2018 stroke operational and governance team meeting, there was a plan to identify new nurses on the stroke ward who required swallow screen training. However, there remained delays for patients who had swallowing problems not related to a stroke. This was the same as the last inspection in January 2018.

We saw staff on the stroke unit and Compton Ward assisted patients at meal times if additional help was required. On Appley Ward there was a sign on the ward stating 'eat well, get well, meals matter'. Audits undertaken by senior staff on Appley Ward showed completion of food charts ranged from 29% to 100%, which gave an average of 49% and completion of fluid charts ranged from 19% to 72%, which gave an average of 48%. On Colwell Ward audit showed completion of food charts ranged from 60% to 91%, which gave an average of 79% and completion of fluid charts ranged from 22% to 45%, which gave an average of 40%. On Appley and Colwell Ward the Ward Sisters at staff briefings and ward meetings had highlighted the need to ensure patients food and fluid charts were fully completed.

Pain relief

Staff usually assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, we did not see a standardised tool in place for people unable to communicate verbally.

Staff used a numerical score to 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. We did not see a standardised tool for patients unable to communicate verbally to monitor the relief provided by pain medicine given based on patients' behaviour.

Patients we had conversations with told us their pain was well controlled, they received pain-relieving medicine when they requested it. Although a root cause analysis investigation we reviewed identified a patient's pain score had not been calculated as part of their assessment.

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

Patient outcomes

Staff monitored the effectiveness of some elements of care and treatment. Staff sometimes used the findings to make improvements, to work towards achieving good outcomes for patients.

Outcomes for stroke patients remained persistently low in three domains. Not all patients were admitted directly to the stroke unit. 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. A stroke pathway was in place for staff to follow, to support both staff working in the stroke unit and on wards outside of the stroke specialist unit.

The stroke consultant nurse had provided education sessions to medical staff and was in the process of updating a standard operating procedure (SOP) for the management of stroke patients. This was to include a formalised escalation plan for when a stroke is identified and no bed available on the stroke unit.

We noted at our last inspection in January 2018 the trust had been slow to respond and develop an action plan to improve dementia care. The trust had now developed an action plan and some actions had been undertaken. The last national audit of dementia identified the trust as an outlier as a delirium policy has not be written. A policy had since been drafted but not yet implemented. However, there was no identified lead to take the policy forward to embed and provide training. Staff told us they had opportunity to attend training about dementia. Data provided by the trust showed training was improved at 76% compared to 2018 training compliance at 40%.

Medical staff completion of the abbreviated mental test screening tool for 65 years and over audit for March 2019 was 80%. This was an increase from national audit of dementia reported in 2017 from 55%. This was important for patients as for patients with a dementia that this test may trigger further assessment of their mental health. Delirium is five times more common in people with a dementia.

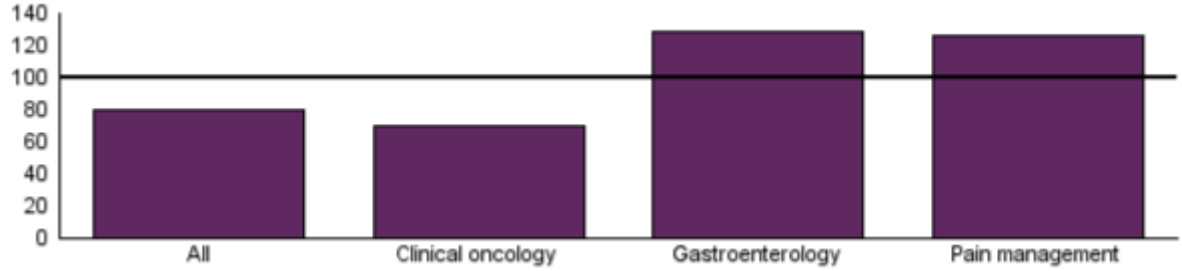
In relation to diabetes care the trust had participated in a Wessex wide diabetic foot care peer review in 2018. The report sets out for the trust areas of good practice and areas in need of development. There was a get it right first time action plan as result produced by the trust.

Relative risk of readmission

St Mary's Hospital

From December 2017 to November 2018, patients at St Mary's Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

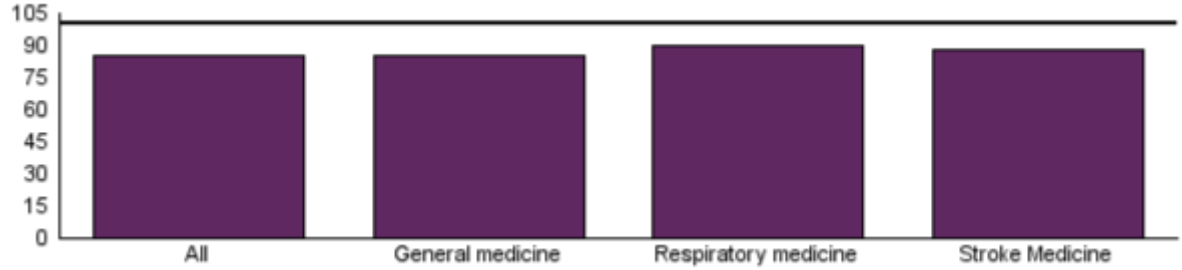
Elective Admissions - St Mary's Hospital



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 represents the opposite. Top three specialties for specific site based on count of activity.

Patients in clinical oncology, gastroenterology and pain management all had a lower than expected risk of readmission for elective admissions.

Non-Elective Admissions - St Mary's Hospital



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 represents the opposite. Top three specialties for specific site based on count of activity.

Patients in general medicine, stroke medicine and respiratory medicine all had a lower than expected risk of readmission for non-elective admissions.

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2017 - 30/11/2018))

Sentinel Stroke National Audit Programme (SSNAP)

St Mary’s Hospital

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 D in the latest audit, October 2018 to December 2018. The hospital has achieved grade D in all the last three audits. The hospital performed worse for its stroke unit, thrombolysis, and speech and language therapy, with all three

domains receiving a grade E in the most recent period. The hospital also performed poorly for multi-disciplinary team working where a grade D was awarded.

Patient centred performance	Dec 17 - Mar 18	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18
Domain 1: Scanning	A	A	B↓	A↑
Domain 2: Stroke unit	D	D	E↓↓	E
Domain 3: Thrombolysis	D	E↓	E	E
Domain 4: Specialist assessments	B	C↓	D↓	B↑↑
Domain 5: Occupational therapy	A	B↓	B	C↓
Domain 6: Physiotherapy	A	B↓	B	C↓
Domain 7: Speech and language therapy	D↓↓	E↓	E	E
Domain 8: Multi-disciplinary team working	C	C	C	D↓
Domain 9: Standards by discharge	B	D↓↓	B↑↑	A↑
Domain 10: Discharge processes	A	A	A	A
Patient-centred total key indicator level	B	C↓	D↓	C↑

Team centred performance	Dec 17 - Mar 18	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18
Domain 1: Scanning	A	A	B↓	A↑
Domain 2: Stroke unit	D	C↑	E↓↓	E
Domain 3: Thrombolysis	D	E↓	E	E
Domain 4: Specialist assessments	B	C↓	D↓	B↑↑
Domain 5: Occupational therapy	A	B↓	B	B
Domain 6: Physiotherapy	A	B↓	B	C↓
Domain 7: Speech and language therapy	D↓↓	E↓	E	E
Domain 8: Multi-disciplinary team working	C	B↑	B	D↓↓
Domain 9: Standards by discharge	B	D↓↓	B↑↑	A↑
Domain 10: Discharge processes	A	A	A	A
Team-centred total key indicator level	B	C↓	C	C

Overall Scores	Dec 17 - Mar 18	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18
SSNAP level	B	D↓↓	D	D
Case ascertainment band	A	B↓	A↑	B↓
Audit compliance band	B	C↓	B↑	B
Combined total key indicator level	B	C↓	D↓	C↑

(Source: Royal College of Physicians London, SSNAP audit)

Stroke patients received thrombolysis treatment in the accident and emergency department and were transferred to the hyper acute stroke unit (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 whist they made transfer arrangements.

Medical staff administered thrombolysis to three patients in the latest data collection period October to December 2018. This represented 4% of the total patient cohort. Of these three patients none of them were thrombolysed within 1 hour. Median time taken from clock start to thrombolysis was 100 minutes, nationally it is 53 minutes. Of all patients admitted between October and December 2018, 100% of the patients eligible for Thrombolysis were thrombolysed. The trust remained an E because according to guidance, they were not thrombolysing enough patients (should be 20%, and of those eligible at least 90%) as well as other factors stated below. The trust was also at an E for the thrombolysis domain when last inspected in January 2018.

The trust saw multidisciplinary team (MDT) working drop from a C to a D for the quarter October to December 2018. MDT working is made up of not only MDT goals being agreed within five days (which the trust were now above the national average for) but is also impacted upon by the occupational therapy (OT), physiotherapy (PT) and speech and language therapy (SLT) assessments. Although the patients are being seen within 72 hours of admission, trusts were also monitored on the median time between the clock start and when they have an assessment. From October to December 2018 the trust had seen the median time to be assessed by an OT increase by more than 10 hours, PT by 7 hours and SLT increase by more than 14 hours on average. This was also bringing down the PT, OT and SLT individual scores meaning OT and PT are now overall as C and SLT remains an E. When the trust inspected in January 2018, the trust for speech and language therapy had been rated at C, so this performance had got worse. The rating for occupational therapy had been the same at C, and for physiotherapy the rating was worse. Physiotherapy was rated B at the last inspection.

The four-hour target for patients' to be admitted to the stroke service had seen a slight increase of 8% the quarter October to December 2018 and the trust had 38% of patients achieving this. Although this was an increase, the trust were still below the national average of 59%. Hospital pressures, staff shortages, delays in assessment and direct admissions to the Medical Assessment Unit (MAU) were all affecting this percentage. The trust was also rated at E when last inspected in January 2018.

The stroke consultant had produced a rolling list of actions dated 24 January 2019 to improve the four hour pathway and decrease thrombolysis start time, to improve patient outcomes. A similar action plan had been put in place at the last inspection in January 2018. This listed nine actions, that included stroke consultants to join stroke bleep team 8am-5pm Monday to Friday in order to speed up diagnosis, thrombolysis door to needle time and transfer to stroke unit. Also, a weekly meeting breach with the medical director. The stroke consultant had also developed an action plan to drive better outcomes for patients, against each of the domains.

The trust provided us with the Sentinel Stroke National Audit Programme (SNAPP) data for January to March 2019. The trust overall SNAPP score had improved from a grade D to a grade B.Standard three thrombolysis had moved from grade E to grade D, standard seven physiotherapy from a grade C to grade B and standard eight speech and language therapy from grade E to grade C. However, the trust's performance for domain two (stroke unit) remained at grade E in the most

recent audit period. Senior staff at the trust told us that significant change would not be seen until August 2019 when data from April to June 2019 available.

Lung Cancer Audit

The table below summarises the trust's performance in the 2017 National Lung Cancer Audit.

Metrics *(Audit measures)*	Trust performance	Comparison to other Trusts	Meets national standard?
Crude proportion of patients seen by a cancer nurse specialist *(Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)*	94.7%	Meets the audit aspirational standard	✓
Case-mix adjusted one-year survival rate *(Adjusted scores take into account the differences in the case-mix of patients treated)*	41.4%	Within expected range	No current standard
Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery *(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen*)	18.6%	Within expected range	✓
Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment *(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen*)	69.7%	Within expected range	✓
Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy *(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)*	60.0%	Within expected range	✗

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

St Mary's Hospital

The table below summarises St Mary's Hospital performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention.

Metrics *(Audit measures)*	Hospital performance	Audit's Rating	Meets national standard?
Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?	No data available	N/A	No data available
Crude proportion of patients who had a vision assessment (if applicable) *(Having a vision assessment is indicative of good practice in falls prevention)*	93.3%	Green	✘
Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) *(Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention*)	50.0%	Amber	✘
Crude proportion of patients assessed for the presence or absence of delirium (if applicable) *(Having an assessment for delirium is indicative of good practice in falls prevention)*	100.0%	Green	✓
Crude proportion of patients with a call bell in reach (if applicable) (*Having a call bell in reach is an important environmental factor that may impact on the risk of falls*)	100.0%	Green	✓

(Source: National Audit of Inpatient Falls)

Staff following the audit had developed an action plan with 12 key actions. When we reviewed the actions included audit of falls documentation, a post falls debrief and the development an Island wide falls and bone health strategy. The action plan included the lead, time scale for action and progress updates. From the falls audits remedial action had been identified that included lying and standing blood pressure monitoring and management of falls.

Chronic Obstructive Pulmonary Disease Audit

St Mary's Hospital

The table below summarises St Mary's Hospital's performance in the 2018 Chronic Obstructive Pulmonary Disease Audit.

Metrics *(Audit measures)*	Hospital performance	Audit's Rating	Meets national standard?
Percentage of patients seen by a member of the respiratory team within 24hrs of admission? *(Specialist input improves processes and outcomes for COPD patients)*	51.1%	Worse than the national aggregate	✘
Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) *(Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)*	100.0%	Better than the national aggregate	✓
Percentage of patients receiving non invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival *(NIV is an evidence-based intervention that halves the mortality if applied early in the admission*)	No data available	n/a	No data available
Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy *(Smoking cessation is one of the few interventions that can alter the trajectory of COPD)*	No data available	n/a	No data available
Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (*Completion of a discharge bundle improves readmission rates and integration of care*)	72.4%	Better than the national aggregate	✓
Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file (*A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt*)	25.6%	Worse than the national aggregate	✘

(Source: Chronic Obstructive Pulmonary Disease Audit)

The service believed the audit had improved care for patients by the identification of the need for earlier review of patients and a consistent approach to care.

Staff following the audit developed an action plan that when we reviewed, detailed six actions to improve patient outcomes. Three key improvement targets were set for 2018, based on a strong evidence base for their effectiveness in improving patient outcomes. These included ensuring that

a spirometry result was available for all patients admitted to hospital with an acute exacerbation. Three care processes were also identified that included ensuring that colleagues within the emergency department, medical assessment unit, respiratory department and trust management work together to determine how many more patients can access respiratory specialist care within 24 hours of arrival (to include weekends).

National Audit of Dementia

St Mary's Hospital

The table below summarises St Mary's Hospital's performance in the 2017 National Audit of Dementia.

Metrics *(Audit measures)*	**Hospital performance**	**Audit's Rating**	**Meets national standard?**
Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good *(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)*	No data available	No data available	No current standard
Percentage of staff responding "always" or "most of the time" to the question "Is your ward/ service able to respond to the needs of people with dementia as they arise?" *(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)*	94.1%	Better	No current standard
Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium *(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary*)	55.1%	Similar	No current standard
Multi-disciplinary team involvement in discussion of discharge *(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)*	96.9%	Better	No current standard

(Source: National Audit of Dementia)

The dementia lead had developed an action plan that detailed 15 actions following the audit. These included to improve compliance in completing abbreviated mental test on admission for people aged 65 years and over, and to ensure referrals were made to the memory service for those who met the criteria for assessment. Staff were undertaking audits twice monthly of the completion of the abbreviated mental test, to be able to feedback results and drive improvement.

Competent staff

There was a gap in the management and support arrangements for staff. Appraisals were below the trust target of 85% for four staff groups.

Medical staff did not always feel clinically supported, and not all essential staff competencies had been undertaken. The General Medical Council (GMC) had placed the trust in enhanced surveillance that followed concerns which included clinical supervision and escalation policies to obtain senior medical support. Medical staff we spoke with told us they remained concerned at the gap of middle grade doctor support, and that some consultants were more approachable than others for supervision and support.

Appraisal rates

St Mary's Hospital

From April 2018 to February 2019, 69.6% of staff within medicine at the trust received an appraisal compared to a trust target of 85.0%.

The breakdown by staff group can be seen in the table below:

Staff group	April 2018 to February 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Allied Health Professionals	8	8	100.0%	85.0%	Yes
Add Prof Scientific and Technic	8	8	100.0%	85.0%	Yes
Estates and Ancillary	5	6	83.3%	85.0%	No
Administrative and Clerical	38	48	79.2%	85.0%	No
Nursing and Midwifery Registered	94	132	71.2%	85.0%	No
Additional Clinical Services	63	99	63.6%	85.0%	No
Medical and Dental	6	18	33.3%	85.0%	No

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

We received updated appraisals information from the trust 22 May 2019 for medical staff in general medicine. 22 of the 23 eligible staff appraisals had been completed from April 2018 to March 2019, which gave an overall percentage of 96%. Across the trust for the period April 2018

to March 2019 for staff grade, associate doctors and speciality doctors 47 of 48 appraisals had been completed. This gave a percentage compliance of 98%.

Nursing staff we spoke with told us the trust were now requesting that all appraisals were completed in the window 1 April to June 30 2019. Wards and departments, we spoke with had plans in place with the aim to meet this target. Senior staff told us the target for completion had increased from 85% to 90%.

The trust had developed a compliance the with adult observational chart policy (AOC) that was marked as effective from 23 October 2017, the policy incorporated the National Early Warning Score (NEWS2). Training requirements for the AOC and NEWS2 included completion of deteriorating patient e learning and completion of deteriorating patient competencies. For the deteriorating patient e learning, compliance average across the medical core service was 80%. For the completion of deteriorating patient competency, compliance was at 32%. We raised a concern with a staff member in the medical assessment unit that the relative of patient who was unwell had not been contacted. This also raised a concern about nursing staff skills in the recognition of the deteriorating patient.

In September 2018 a joint visit took place at the hospital with Health Education England (HEE), the General Medical Council (GMC) and National Health Service England (NHSE). This followed concerns raised as part of the GMC Regional Review of Wessex and information from the GMC National Training Survey undertaken in 2018. Risks were raised with the trust in September 2018. A follow up visit was undertaken 4 March 2019 by the GMC. Two high level risks remained following the March 2019 visit which included concerns about clinical supervision and escalation policies to obtain senior medical support.

We spoke with staff about opportunities to attend training. A junior doctor told us they had attended about 50% of the weekly teaching sessions provided for doctors. The junior doctor told us they were always able to attend, but not encouraged. A consultant told them ‘we cannot stop you from going’.

Staff we spoke to told us that when they started work at the trust they had received an induction. The induction had included e learning. The trust informed us the induction programme had received positive evaluations.

A matron we spoke with explained the matrons had been on leadership courses, and leadership courses were due to commence for band 6 and band 7 staff.

A sister on Appley Ward we spoke with was pleased to be part of a Collaborative Learning in Practice Programme (CLiP). This was a coaching model, where students were encouraged to take the lead in their practice, caring for their own patient group and supporting the learning through identified daily learning outcomes. The student themselves were coached by registered staff with additional mentor support. On Appley Ward, a 4 bedded bay was segregated for the CLiP model. At the time of our inspection 1 programme had taken place with positive feedback from student nurses. The sister explained another programme was due to start.

Staff we spoke with in specialist areas told us about additional training they had done to ensure they were competent. For example, in the chemotherapy unit staff told us about competencies they were working through. In the same day emergency care service, the senior member of staff told us about a history taking course they had undertaken.

Some members of senior staff had developed partnerships with speciality staff working in the mainland to provide supervision and support. This included staff in the pathology department and stroke services.

The trust checked all newly employed nurses and monitored all employed nurses to ensure they maintained registration with the nursing and midwifery council.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked well work together to benefit patients. Mostly all disciplines were represented at board rounds, and coordination with other services worked well.

White board rounds were held on wards daily to ensure plans to meet patients' needs were clear, and any delays in their care pathway were managed. We attended a white board round led by a senior nurse, where thorough plans to ensure patients' needs met effectively were provided by the occupational therapist, physiotherapist and speech and language therapist.

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 contacted a single point of access worker via the hospital switchboard who directed the caller to the most appropriate service for their enquiry. We saw effective interaction between mental health workers and the hospital staff during our inspection. For example, we observed a mental health assessment on a medical ward, where the hospital staff had called for a psychiatrist and an approved mental health practitioner (AMHP) from the local authority to join them to assess the mental health of one patient who was refusing treatment. Staff supported each other to inform the patient of the risks and a plan which might improve their situation. This was an improvement from the last inspection in January 2018.

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.

Staff told us how much patients benefited from the support from the specialist nurses in meeting patients' needs. Specialist nurses included the dementia nurses and palliative care team.
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.

At the MAU board round there were medical and nursing staff and a pharmacist, but no physiotherapy or occupational therapy staff. This was the same as at the last inspection in January 2018.

We spoke with a doctor on a medical round who told us about one of their patients who had been seen by the mental health crisis team, but there had been no record in the medical notes. The mental health crisis team notes could take up to 24 hours to be received, leaving a gap in care and advice for patients.

Seven-day services

Key services were mostly available seven days a week to support timely patient care.

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 and NHS England publishes the results. The latest results on the NHS England website were for March 2018.

There was no endoscopy service at weekends. However, patients that were emergency admissions at the weekend were mostly in receipt of a consultant review and those needing diagnostic services was shown to be achieved most of the time.

Priority clinical standard two requires trusts to ensure all patients admitted as an emergency to be assessed by a consultant with 14 hours of arrival at the hospital. For standard two the weekday results were 72%, but the weekend results were higher at 87%.

Priority clinical standard 5 requires trusts to ensure all inpatients 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 2018 survey results showed 100% performance against this standard Monday to Friday and 87% performance at weekends. However, when we spoke with staff, they did not report any concerns about accessing diagnostic services at weekends. The national stroke audit also indicated no concerns with access to diagnostic services.

Priority clinical standard six 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 2018 survey results showed 88% performance against this standard Monday to Friday and 100 % at weekends.

Priority clinical standard eight requires trusts to ensure all patients with high dependency needs are be 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 2018 survey results showed 98% performance against this standard Monday to Friday and 88% at weekends.

The hospital at night team provided senior clinical leadership cover of the hospital out of hours. The team consisted of junior medical staff and senior nurses. The critical care outreach team was also available seven days a week 24 hours a day to access and provide support for deteriorating patients on the medical wards.

Physiotherapy services, occupational therapists and speech and language therapists were available Monday to Friday. For medical patients, there was an on call physiotherapy service to provide urgent respiratory support. Staff in the medical assessment unit told us their patients would normally be seen within 24 hours of referral.

Pharmacy services were available seven days a week. There was an on call service for when the pharmacy closed.

Health promotion

Staff gave patients practical advice and support to lead healthier lives.

We saw a range of current health promotion leaflets and posters displayed in the medical wards and departments. This was an improvement on the last inspection in January 2018.

Information included for reducing the risk of a further stroke and supporting people to live well. The MAU had a poster display about festival safety, which included advice about not getting over hot, dehydration, sunburn and water safety.

We saw that leaflets and booklets were available and given to patients after treatment and discharge to help them adjust to life following ill health. For example, on the cardiac care ward we saw information leaflets about certain medical conditions, this included recovery and life after cardiac problems. Staff told us the aim of the information was to support patients in adjusting their life style to prevent readmission.

For patients' having endoscopy or chemotherapy treatments they were given information leaflets with advice and guidance about managing their condition to keep well.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always follow national guidance to gain peoples consent. They did not always show an understanding of how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff did not have a good understanding of the requirements under the Mental Capacity Act 2005 when it came to assessing patients. Although staff referred to patients' capacity in their notes, there was no formal documentation of Mental Capacity Act assessments, consent forms or best interest meetings in eight of the medical wards care records we reviewed.

Mental Capacity Act and Deprivation of Liberty training completion

St Mary's Hospital

The trust set a target of 85.0% for completion of Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to January 2019 at St Mary's Hospital for qualified nursing staff in medicine is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	94	134	70.1%	85.0%	No

In medicine the target was not met for the MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to January 2019 at St Mary's Hospital for medical staff in medicine is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	10	17	58.8%	85.0%	No

In medicine the target was not met for the MCA/DOLS training module for which medical staff were eligible.

The trust has reported that the Mental Capacity Act 2005 training module incorporates Deprivation of Liberty Safeguard training.

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

We saw on three occasions that staff had not filled the documentation out correctly. In one patient's care notes, staff had not ticked the consent to access medical notes box. There was no legal information about any decisions to refuse treatment or a lasting power of attorney. An example included for a patient with delirium, staff had not completed the dementia screening form or delirium factors form. In another they had described that a patient had dementia, but staff had not completed part two of the capacity assessment. In another patient's notes, we saw that the patient's family had queried if a formal mental capacity assessment had taken place. Staff had responded with a psychiatrist's opinion rather than completing a mental capacity assessment. At the last inspection in January 2018, we had also found that not all staff fully understood their roles and responsibilities towards the Mental Capacity Act 2005.

However, on the chemotherapy unit and the endoscopy unit discussion with staff and review of records showed staff applied the Mental Capacity Act 2005 to their practises appropriately. Records and discussion with patients showed all patients gave informed consent for their treatment. Staff we spoke with in endoscopy discussed the correct use of consent form 4, which is used for adults who lack capacity to consent for a particular treatment.

The Deprivation of Liberty safeguards (DoLs) application for one patient on a medical ward had expired the day before the inspection. However, when we pointed this out, the nurse in charge immediately requested a seven-day extension for this person.

Staff followed the trust's policy on administering medicines covertly when appropriate. We saw evidence of this being documented and referred to correctly in one patient's care records.

Is the service caring?

Compassionate care

Staff did not always treat patients with compassion and kindness, respect their privacy and dignity, or take account of their individual needs.

Feedback from patients we spoke with, and a focus group with patient highlighted the number of staff on duty to be a concern particularly at weekends and nights, which was impacting on the ability of staff to provide compassionate care that took account of individual needs.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 15.8% which was worse than the England average of 24.0% from January to December 2018.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	
Coronary Care Unit	225	32%	100%	100%	96%		88%		100%	100%	100%	100%	96%	100%	99%
Medical Assessment Unit	198	18%	88%		97%				71%	98%				87%	92%

Key Highest score to lowest score: 100% | 50% | 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Patients told us about the impact the staffing numbers had for their experience of care:

On Compton Ward four patients we spoke with had positive comments alongside concerns about staffing:

‘The nurses seem to care for you. Everybody’s nice, but at the hospital there do not seem to be enough’.

‘Nurses could walk with you, but there are not enough. They say they are too busy’.

‘It’s all rush, rush, rush. Sometimes you have a wash or a shower and sometimes you just have a cat’s lick. Sometimes it is difficult to get my teeth cleaned as of an evening or morning’.

Another patient told us they waited an hour on a commode. “Sitting on the commode I rang my call bell and no one came. That’s happened more than twice”.

On Luccombe Ward, a patient told us ‘The staff have been nice and kind to him, although they are really busy’.

A relative on Appley Ward said to us: ‘We help her during the day, massaging her and feeding her and then there’s no one to do it evenings and weekends, so she gets worse. We spoon feed her. If we go away and come back the food’s on the side, cold.’ Following the inspection, this relative commented that they did feel as if the staffing levels at weekends did improve.

We held a patient focus group with Healthwatch Isle of Wight in summary feedback from the group was mixed with some patients feeling well cared for during their stay and others feeling like the wards were too busy for their needs to be met. Patients told us their own accounts of delays in care and not having clear information to support them and a patient described being unsupported when another patient in the same bay as them had died.

Although we did not see any patients who had been cared for in non-designated bed spaces during our inspection, from what staff told us, these patients were not afforded privacy and dignity as there were no bed curtains. Staff told us when these patients needed a commode or a bed pan, they had to be swapped with other patients. This did not show respect for patients.

However, patients also had positive comments about compassion shown to them by staff;

A patient on Compton Ward – ‘I know all of them. They are all very friendly’.

Two patients in the Medical Assessment Unit (MAU) ‘the staff were very nice and the doctor lovely’ and ‘excellent care from staff’.

In endoscopy the following was fed back by two patients ‘all staff are polite, kind and everything explained clearly. No improvements necessary.’ ‘Best thing was the consideration given by all staff and making a worrying expectation so easy.’

On Colwell Ward ‘I cannot fault the care he is getting and the friendship of the staff.’

The wards had systems in place to maintain patients’ privacy. They used white boards to record information about patients during their stay on wards. We observed in the MAU frosted glass was in place to prevent the white board patient information being seen by visitors. In Appley ward and Colwell Ward patient initials were being used. This was an improvement from the last inspection in January 2018 white boards in the public area of wards detailed the names of patients on the ward.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

We observed examples of emotional support provided for patients on the medical wards. This included actions to ensure patients comfort and ensure patients felt cared about and supported. For example, on Compton Ward ‘The young ones go past the door and they wave. It’s good, it make a difference, because when you are old you are frightened, like when you are young…It makes you feel part of the bigger family.’ We also observed a patient being offered the opportunity to postpone a personal wash to a later time on Colwell Ward, so as they could chat with their wife.

A patient on oncology was feeling unwell with side effects of chemotherapy. Staff were aware and responded calmly and with minimal fuss which the patient appreciated.
In endoscopy, when needed patients were met in a private room to discuss their results. The support of a nurse specialist was sought if required or a message was left for them to contact the patient.

There were several nurse specialists at the hospital to provide emotional support to patients. These included cancer nurse specialist for different tumour sites, Parkinson’s disease nurse specialist and dementia nurse specialists.

A chaplaincy service was available at the hospital to support with meeting patient’s religious needs. At the focus group a positive comment was received from a person who had contacted the chaplaincy service.

Understanding and involvement of patients and those close to them

Staff did not always support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

Patient and those close to them we spoke did not always feel involved in their care and treatment.

Patients on Compton Ward told us about their experience of not knowing their preparations for discharge, long waits for medication and feeling frustrated.

A patient in MAU told us they found the unit chaotic and we were told a relative felt they needed to say with their father in hospital to be their advocate to challenge decisions and knew care pathways.

On Luccombe Ward, a relative commented ‘Dad’s not properly dressed. He’s wearing a hospital gown. So, I don’t know what’s happened. We don’t know what doctor he is under, and whether he will agree with the diagnosis’.

However, a relative on the stroke unit expressed more positively that staff were: ‘Checking her every half an hour. Doing everything; it’s fantastic.’

Also, a relative on Colwell Ward, gave positive feedback that the staff were ‘Good at keeping me informed’.

Is the service responsive?

Service delivery to meet the needs of local people

The service did not fully plan care in a way that met the needs of local people and the communities served. Service delivery lacked pace. However, the service was working with others in the wider system to plan care.

The service was aware of the changes needed to meet the needs of people, however the pace of change had been slow.

At the last inspection in January 2018, the service indicated that the elderly frailty pathway would be fully implemented by 1 August 2018. When we inspected on this occasion the elderly frailty pathway had been recently introduced following the appointment of interim care group director for the medical assessment unit (MAU) and appointment of a transformation director of elderly care in January 2019. There was a long term locum full time geriatrician and a full time junior doctor specialising in the care of older people in post.

Senior staff in another care group within the acute service division, advised us the trust had incorporated the use of the clinical frailty tool in the emergency admission pathway about a year ago. When we spoke with medical and nursing staff working in MAU and on the medical wards, they did not mention the presence of a clinical frailty tool to support the assessment of patients and patient pathways. Senior staff explained there was a meeting planned week commencing 10 June 2019 to decide what the trust priorities were regarding frailty service development, and where oversight and accountability sat for implementing the frailty pathway. This was happening almost two years on from the trust had indicated the frailty pathway would be fully implemented.

At the last inspection in January 2018 the trust had stopped the provision of an ambulatory care emergency service. Since the beginning of April 2019, the service trust had started to provide a similar ambulatory care service, called same day emergency care (SDEC). The SDEC service was consultant led and provided from 9am to 8pm. Through April 2019 the service had been provided five days a week. The week before our inspection the service had moved to seven days week.

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.

The stroke unit had four hyper-acute beds and stroke rehabilitation beds. There had been a recent agreement that one bed in the hyper acute area would be kept to support patients accessing a stroke unit for care within four-hours. The stroke service provided an early discharge team. This enabled patients to return home at an earlier point in their recovery to continue their rehabilitation with support from the stroke therapy team.

The endoscopy unit had two nurse endoscopists who consented and carried out procedures.

The service had five-day access to physiotherapy, occupational therapy services and social worker services.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services. However, further work was needed to embed two initiatives to support people living with a dementia.

The trust had produced a draft dementia quality strategy at April 2019. At the last inspection in January 2018 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. At this inspection we did see some patients with a dementia had a butterfly in place. The dementia lead nurses audited the use of the Butterfly's twice a month at the trust. An audit undertaken in April 2019 showed compliance to be 37% across all adult wards.

A memory room had been created along the corridor leading to Colwell and Appley wards. The memory room, opened in March 2019, had a grammar phone, fake fireplace, old newspapers, books, music and games. The trust was currently advertising for a part-time activities co-ordinator to support more use of the room. Staff showed us fake bus stops that had been created down this corridor. Staff explained the bus stops had been helpful in in helping to reduce distress in people living with a dementia.

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 with patients' relatives, they said they had not seen these documents and had not been asked to contribute to the document. An audit undertaken by the team in April 2019 showed 34% compliance with the 'This is me' document.

On Colwell and Appley Wards there was clear signage of rooms such as toilets and showers and use of colour to help patients find their way. A dementia garden with a bench and plants was accessible to patients on Colwell and Whippingham Wards. We spoke with a volunteer who had been coming to the trust for six years on Monday and Tuesday mornings to sit and talk with patients. A volunteer also told us musical bingo was run by volunteers.

Staff working in the stroke unit supported patients with hearing loops, picture boards, photographs and emoticons to aid communication. We reviewed the care records of one patient with a learning difficulty who had a document in their file about how to support their communication, their diagnosis and support plan and things that were important to them.

Staff had access to telephone translation services for patients whose first language was not English, this included British Sign Language. Staff we spoke with were aware of these services, but they had not needed to contact translation services. We were unable to confirm the usage of translation services, as the trust did not keep a record of the number of translation services accessed. Staff we spoke with in MAU told us there were also some booklets that could be used, for supporting patients with a learning disability.

With regards to single sex accommodation, in the coronary care unit 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 January 2018 to December 2018 showed staff on CCU reported three 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. On Colwell Ward a breach had occurred to prevent and control the spread of infection. There was no indication of what action staff took to protect the privacy and dignity of patients in this situation. 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 16 mixed sex breaches.

Access and flow

Patients could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

In September 2018 a referral to treatment time (RTT) recovery plan was submitted to the trust board that included some key recommendations. This included the use of Compton Ward (winter contingency ward) earlier than planned, to agree funding for weekend working for day cases. Also, to agree to the voluntary transfer of suitable elective patients to a private provider. This was alongside continuity of working with partners to expedite discharges of medically fit patients. Also, the long patient waiting list was reviewed at patient level on a weekly basis to monitor any variation to plan.

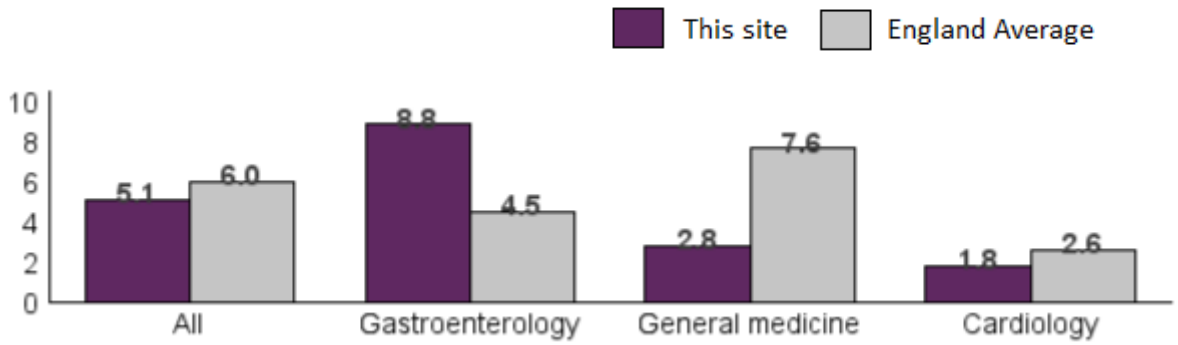
Patients accessed the hospital through planned admissions directly to the relevant wards or departments, via the accident and emergency department, medical assessment unit or straight from outpatients including the X-Ray department. Referrals to same day emergency care (SDEC) went to a medical assessment unit (MAU) consultant from 10am, prior to this, calls were taken by the medical registrar. Staff told us that 80% of calls were from the GP, and 20% from the emergency department.

Average length of stay

St Mary's Hospital

From January to December 2018 the average length of stay for medical elective patients at St Mary's Hospital was 5.1 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 7.3 days, which is higher than England average of 6.2 days.

Elective Average Length of Stay - St Mary's Hospital

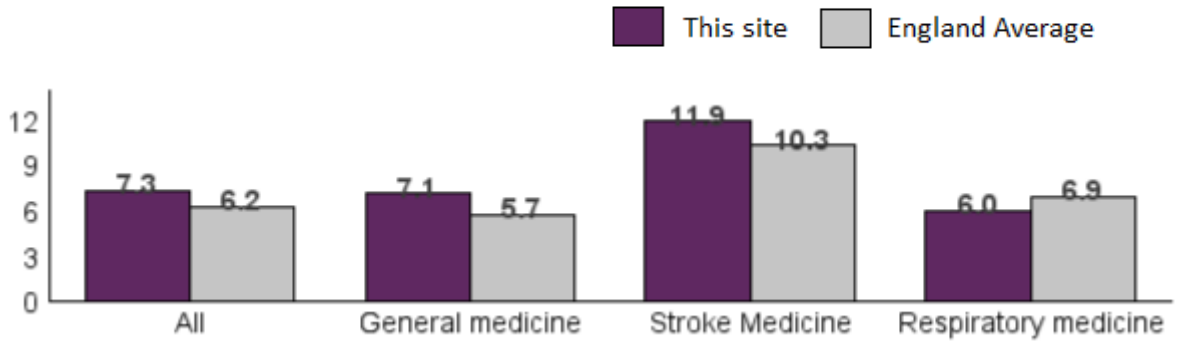


Note: Top three specialties for specific site based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in general medicine is lower than the England average.
- Average length of stay for elective patients in cardiology is lower than the England average.

Non-Elective Average Length of Stay - St Mary's Hospital



Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in stroke medicine is higher than the England average.
- Average length of stay for non-elective patients in respiratory medicine is lower than the England average.

(Source: Hospital Episode Statistics)

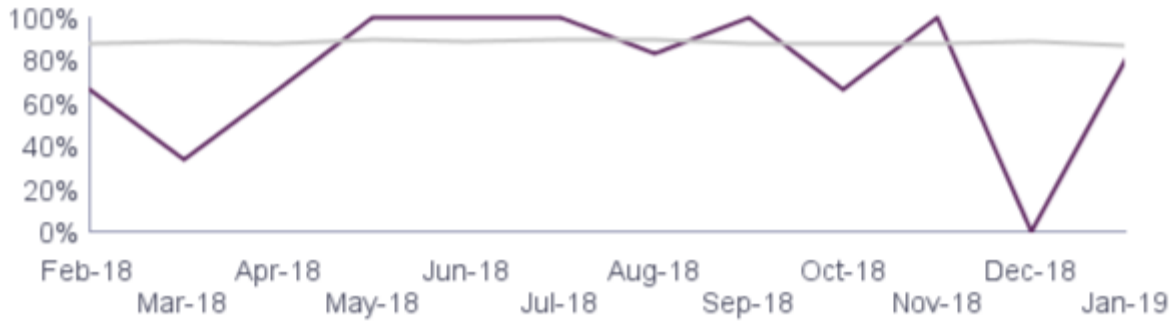
The average length of stay in the medical assessment unit had been 28 hours from April 2018 to April 2019, which was within the trust target of 48 hours.

Referral to treatment (percentage within 18 weeks) - admitted performance

From February 2018 to January 2019 the trust's referral to treatment time (RTT) for admitted pathways for medicine was better than the England average in 5 months and worse than the England average in 6. In December 2018, there was no data available for the trust.

Over the 12 months, the trust's referral to treatment time (RTT) for admitted pathways in medicine ranged from 33.3% (March 2018) to 100.0%.

This was a decrease in the performance at the last inspection in January 2018, where from September 2016 to August 2017, there was had been 3 months below target with the worst at 71%.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Dermatology	100.0%	81.5%

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
General medicine	75.0%	96.8%
Cardiology	73.0%	81.3%
Thoracic medicine	66.7%	94.1%

(Source: NHS England)

We asked about the impact the level of medical outliers was having on surgical patients care. The medical care group leads felt that things were getting better as had not needed to cancel all elective orthopaedic patients this year.

At the time of inspection in May 2019 Compton Ward was still open, suggesting that patients RTT were still below the England average for the above specialties excluding dermatology. When we reviewed the minutes of a monthly physicians meeting held on 24 April 2019 the RTT was stated as 85%. Also, that this figure related to gastroenterology, hepatology, diabetics, cardiology, thoracic and geriatric medicine patients.

The RTT for cancer patients had been underperforming, against the 62 day target for patients to start treatment within 62 days of receipt of urgent referral for suspicion of cancer. From April 2018 to November 2018 compliance had ranged from 66% to 82%. In November 2018 compliance was 71%. Nationally compliance from April 2018 to November 2018, compliance had ranged from 81% to 79%. We met with the lead nurse for cancer who explained the trust were working with NHS Improvement, and weekly monitoring meetings were in place led by the operation manager for the care group. The lead nurse told us that weekend working for some diagnostics had helped. They gave the example at the time of our inspection there were 20 patients waiting for a colonoscopy and there had been 90 patients. However, for other diagnostic delays, for example with urology patients, a solution had not been found. The lead nurse was working to have an inter trust policy to support the diagnostic pathway.

When we asked staff about challenges to their services, all described patient flow. Data from the trust showed that the improvement had been sustained since the inspection in January 2018 regarding the number of patients moving wards.

Patient moving wards per admission

From January to December 2018, 99.1% of individuals did not move wards during their admission, and 0.9% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From January to December 2018, there were 245 patient moving wards at night within medicine. The majority of patient ward moves at night were reported by the medical assessment unit (232 ward moves). This figure was a decrease from the inspection in January 2018, when there had been 958 moves between April and November 2016.

For the medical wards there had been six patients on Appley Ward and zero on Colwell Ward. There had also been seven to Whippingham Ward and three to Luccombe Ward, where there were medical outliers.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

At the previous inspection in January 2018 there were significant numbers of medical patients cared for on non-medical wards (medical outliers). A winter pressures programme implemented at the last inspection had continued, to provide care to these patients in a measured and planned way. This included additional medical staff to provide care and treatment to medical patients on the surgical wards.

At the time of our inspection there were a significant number of medical outliers on two of the surgical wards. The number of medical outliers ranged from 21 to 39 patients each day from 2 February 2019 to 20 April 2019. At the time of our inspection there were 35 medical outliers. The medical care group had kept open Compton Ward to 15 beds for medically fit patients to go to await their 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 clinical pathway and capacity manager and were attended by matrons, ward managers, social workers, housekeeping staff and a representative from the prevention and control of infection team. 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. This was the 8.30am bed meeting, when there were 10 potential breaches, but they had not been verified. On the last day of our inspection

23 May 2019 the acute trust was at operational pressures escalation levels (OPEL) framework level 3. There were 4 OPEL levels. OPEL 3 meant the local health and social care system was experiencing major pressures compromising patient care and continued to increase.

To support effective discharges to care homes we reported at the last inspection in January 2018 that the trust was part of 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 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. For MAU from April 2018 to April 2019 the figure was 12%, the previous year 10%.

From 1 January 2018 to 31 December 2018 the following number of delayed patients were reported:

Appley Ward 309

Colwell Ward 370

Coronary Care unit 9

Coronary Care Ward 93

Compton ward 813

Hyper Acute Stroke Unit none

The Stroke Unit none

The top three most frequent delays were for packages of care where two carers were required four times a day or one to one request for 24 hour care. Secondly patients waiting for a placement in a nursing home or rest home and patients waiting for community rehabilitation.

The trust held stranded and super stranded meetings for patients twice a week at the trust to try and facilitate their discharge. By super stranded the trust meant these patients had been delayed more than 21 days. Each Friday, a third meeting took place which was executive led and held at the council offices. At the meeting we attended at the hospital, there was an operational manager, discharge support staff member and social workers. The patients on the list of delayed transfers of care were between 10 and 72 days delayed. At the trust led meeting we attended there was no allied health professional (AHPs) staff representation at the meeting. There was a plan to re-engage with AHPs, but details of the plan and timescales were not given. There were some actions requiring updates, that could not be answered at the meeting. At the meeting we observed that no deadlines were set for updated to be sought, and who would obtain them.

Staff spoke about challenges relating to the transfer of patients to the mainland. The medicine care group director at the physicians meeting held on 24 April 2019, stated the creation of the transfer team is something for which they would obtain an update for the consultant physicians. At the time of our inspection six patients were waiting for a mainland bed, and eight were waiting to come to the hospital from 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 an 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 patient's ability to access the services they required in a timely manner.

The senior nurse on 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. This was a cause of the regular 'one upping' of beds. The trust confirmed the bed occupancy from April 2018 to April 2019 to be 101% in MAU, from April 2017 to April 2018 the bed occupancy had been 93%. The percentage of 30 day emergency readmissions from MAU had increased to 7% April 2018 to April 2019 compared to 5.5% the previous year.

Learning from complaints and concerns

The trust investigated concerns and complaints. The trust developed lessons learned but these were slow to be embedded in practice. The trust's responses to complaints were not always completed in a timely manner. The trust did not have a target for closing complex complaints, which some of these complaints may have been.

Summary of complaints

St Mary's Hospital

From January to December 2018 the trust received 56 complaints in relation to medicine at St Mary's Hospital. The trust took an average of 41.9 days to investigate and close complaints, and 39.2% were closed within 30 working days. This is not in line with their complaints policy, which states that 75% of complaints should be closed within 30 working days. Some of these complaints may have been complex, but there not a target for closure of complex complaints.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment - General Medicine group	12	21.4%
Communication	11	19.6%
Patient care	8	14.3%
Values and behaviours (staff)	6	10.7%
Privacy, dignity and wellbeing	3	5.4%
Appointments	2	3.6%
Prescribing	2	3.6%
Admissions and discharges excluding delayed discharge due to absence of a care package - see integrated care	2	3.6%
Staff numbers	2	3.6%
Other	2	3.6%
Facilities	2	3.6%

End of life care	1	1.8%
Clinical treatment - Obstetrics & gynaecology	1	1.8%
Restraint	1	1.8%
Integrated care (Including delayed discharge due to absence of a care package)	1	1.8%
Total	**56**	**100.0%**

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

We saw evidence that the trust investigated complaints, however evidence that lessons had been learned were not always promptly embedded in practice. A lesson learned from complaints received in December 2018 was a butterfly symbol was not always used to highlight a patient with a dementia. At that time weekly audits were commenced in MAU to check the butterfly symbol in use when indicated. From our inspection, we were aware the use of the butterfly symbol was not embedded.

Two relatives we had contact with during the inspection period had made formal complaints to the trust. They had also discussed their complaints with a senior nurse. However, one of the relatives, who had expressed concerns about an agency member of staff, was concerned that they had not been listened to when the conversation had not made any difference to the concern they had presented.

The medical service did have 'you said, we did' boards outside their wards or within the entrances. In endoscopy patients had asked for wet wipes in the toilets for patients, these had now been provided. On Colwell ward there was a request for larger dinners and staff now requested snacks for patients if required.

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.

Number of compliments made to the trust

From April 2018 to December 2018 the trust received 1,179 compliments regarding acute services at the trust. Due to the way in which compliments are captured by the trust, it has not been possible to split the number of compliments by team or core service.

The trust has identified a number of key themes from the compliments received across the trust. The trust identified the following themes:

- The main compliment received is with regard to staff behaviour. Staff are described, through individual experiences, to behave in a manner that is kind, patient, friendly, professional, courteous, caring, compassionate, helpful and understanding.
- Specific praise for consultant care
- Treatment with dignity and respect
- Effective and responsive ED
- Excellent care

- Helpful, friendly and efficient Administrators/Receptionists.

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

Is the service well-led?

Leadership

Leaders did not always understand and manage the priorities, issues and risks the service faced. However, they were visible and approachable in the service for patients and staff.

Most of the medical wards (Stroke unit, Compton ward, Appley and Colwell wards) were part of the medicine care group. The medicine care group was led by a clinical director, associate director of operations and a head of nursing and quality. The care group director, associate director of operations and head of nursing and quality had been in post less than 12 months. The Medical Assessment Unit (MAU) was part of the integrated urgent and emergency care group. The Coronary Care Unit and the chemotherapy day unit were part of the clinical support, cancer and diagnostic services care group. Each care group had a similar leadership makeup.

We were not assured that patient flow was given sufficient priority. The care group itself did not provide a plan of how the inconsistency with referral to treatment times was to be addressed in their service. However, when we met with the care group leads the care group director detailed how they were responsible for the inpatient trust processes group to improve patient flow throughout the trust. The associate director of operations discussed at the meeting that discussions about the referral to treatment times in the service were consistent with the trust governance framework. They did not raise a risk for the pressure staff were being put under to 'one up' beds on a regular basis.

Ward sisters did not always prioritise individualised care on their wards, by supporting completion of care plans, when they were aware of audits of the compliance with patient care plans with an average of approximately 40%. Staff had not been given sufficient encouragement to complete the deteriorating patient competency, compliance was 32%.

The medicine clinical care group had two matrons who supported and led the nursing teams. Staff spoke positively about the support and leadership provided by the medicine care group matrons.

Some of the sisters we spoke with were interim or newly appointed so were still establishing themselves. However, staff we spoke with felt supported by the sisters leading their teams. Sisters were also mentioned the difference the increase of band 6 staff particularly in the coronary unit and in MAU to being able to have a senior nurse managing a shift.

Vision and strategy

There was not a detailed vision and strategy for the medicine care group.

We asked the medicine care group leads about their vision and strategy. When we met with the medicine care group leads, they told us there two overarching ambitions were to be a centre of excellence for the elderly, and to work more closely with mental health colleagues. We asked if there was a plan in place with more detail. They suggested we request the 'business operating plan for acute services 2020/ 2021'.

The business operating plan was a generic document for acute services at the hospital, with generic priorities. The expectation was that services would shape how they would make

improvements in their own areas that met the needs of their patients within their area of specialism and expertise. The medicine care group had not considered how they could develop a strategy to fit with the business operating plan.

When we spoke with the MAU clinical leads, they hoped to work more closely with the medical care group with regard to developing the frailty service.

At ward and department level staff were focused on 'getting to good by 2020'. Staff did not mention the ambitions to us to be a centre of excellence for the care of the elderly and work more closely with mental health colleagues.

Culture

Staff did not always feel supported and listened to. The culture did not always appear to be open. Staff had not felt able to challenge the 'one upping' of beds. The service did not seem to always be focussed on the needs of patients receiving care.

Junior doctors did express they did not always feel supported due to gaps in the middle grade of doctors. Within the medical rotation junior doctors expressed concerns with training and support. This was similar to the findings of the GMC visit 4 March 2019. Junior doctors also told us some consultants were said to be more approachable than others.

Staff we spoke with in MAU did not feel they could challenge the bed managers to tell them they were not happy to 'one up' their beds. They spoke with us about the practice when we asked directly, however they did not volunteer the information as a concern or risk or report as an incident. Staff seemed to accept the practice as a normal way of working.

Senior staff we spoke with in MAU, Compton, Appley and Colwell Wards told us they were proud of their teams, and felt well supported. Senior staff and other staff we spoke with said they were aware of the freedom to speak up guardian (FTSUG) role if they had any concerns.

Some staff raised concerns but did not feel listened to by managers and leaders. Some staff felt the chief executive was trying hard to change things and had been supportive.

The consultants felt there had been a significant positive change in the culture since our inspection in January 2018, and provided a letter that listed 10 improvements across the trust. They felt these were focused on the needs of patients that received care. These included an improvement in appraisal compliance for medical staff, and regular and effective safety huddles embedded in wards and departments. However, they also mentioned the implementation of the hospital at night programme and dedicated ambulatory care area. Both these initiatives were slow to have been fully implemented and embedded at the trust in ensuring patients' needs were focussed on.

Governance

The arrangements for governance and performance management did not always operate effectively. Systems and processes did not always ensure a standard agenda in place and actions logs to support consistent good governance, management and accountability.

The medicine care group had set a structure of committees and meetings that supported the governance of the service. This included a leadership meeting that met monthly and reviewed performance, finance, quality and risk. The medicine clinical care group also had a quality, risk and patient safety meeting and a physician's meeting. We reviewed records for three medicine care group 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.

Section 42 refers to safeguarding enquiries that are made by social services. Section 42's, for the three quality meetings from February to April 2019 we reviewed, were not discussed. This meant the service did not know if there had been any section 42's for these three months. Staff at the meeting also did not discuss any compliance concerns there may have been with safeguarding training compliance. We were aware for example that preventing radicalisation level 3 training was at 51% for nurses and 41% for medical staff. In the trust safeguarding policy it was made explicit that the head of nursing for care group was responsible for providing leadership to support safeguarding practice and to support safeguarding enquiries.

Records of the physicians meeting held monthly, showed they identified and reviewed actions. Medical staff always reviewed performance and the financial position of the service at these meetings.

We asked about trust wide senior nurse meetings. The trust informed us the director of nursing held monthly meetings with the ward sisters but these were not minuted. There had not been a meeting in March 2019. The deputy director of nursing also held monthly senior clinical and nursing forums every month. The meeting had an agenda, which was not standard, and this meeting was not minuted. This raised concerns as to how sisters not at that meeting were made aware of discussions at the meeting, and how actions to take forward from the meetings monitored. However, fortnightly and weekly sisters meetings were in place led by Matrons, these meetings were minuted but there was not an action log to monitor actions.

Management of risk, issues and performance

The service did not always identify all risks to the service, so actions could be identified to reduce their impact. Monitoring of performance did take place.

We reviewed the risk register for the medicine care group. This listed 10 risks which included medical cover, delays with discharge summaries and the delayed closure of Compton Ward. The risk register did not capture consequence of patient flow challenges resulting in staff 'one upping' utilising non-designated bed spaces, which may have meant the risk could have been managed better. The register also did not capture the gaps in the completion of resuscitation training by nurses and medical staff, or concerns identified on Colwell and Appley Wards with the completion of parts of the ward documentation.

The coronary care unit risk register had one risk identified which was, the impact on staffing numbers of the need to provide an escort to manage patient transfers. The unit manager had described actions had been described to try and manage the risk, which included the development of a trust wide transfer team. However, the risks with the three resuscitation trolleys not being checked twice daily, which was an ongoing issue, had not been identified as a risk to be managed. Also, the risk of mixed sex breaches was not included as well, in order that actions to address this occurrence could be identified and described.

Risks identified in the MAU risk register were related to medical and nursing staffing, with actions to reduce the risk. The risk presented by the need to use non designated bed spaces regularly had not been identified, on worries expressed during our inspection about the gaps in documentation.

There was no chemotherapy risk register as the service felt there were no risks. When we spoke with senior staff they explained they had recently needed to use agency staff to manage a staffing gap, which was a risk to the provision of the service to patients. The lead also told us they were considering increasing the number of bed spaces so more patients could be treated. This would suggest there was a risk that the service had insufficient capacity to meet patients' needs.

The medicine care group leaders said performance and monitoring of key performance indicators occurred at the monthly leadership meetings. Records of the medicine care group leadership and quality meetings confirmed this occurred. The stroke unit monitored their performance with the use of the Sentinel Stroke National Audit Programme (SSNAP) audit data 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 always have the data in meetings to understand performance, make decisions and improvements.

The governance meetings did not consistently refer to the appraisals that needed to be completed and mandatory training compliance with individual training modules. At the quality risk and patient safety group meeting the overall compliance figure for mandatory training was focussed on. The incorporation of the detailed data with individual training modules would have provided more information of where there were gaps in compliance, for example with resuscitation training. For example, adult resuscitation and immediate life support training compliance ranging from 28% to 79% for nursing and medical staff.

At the ward meetings audit data was not presented to help staff understand gaps in compliance and identify and own actions to make improvements. For example, poor audit results with individual care planning for patients and completion of food and fluid charts in place for patients.

There were arrangements to submit relevant data to national audit programmes. The trust had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements.

The service was using a safer staffing electronic tool, to support safe staffing. The director of nursing produced a monthly report for the trust board of the current position, with actions identified to improve staffing levels.

A bed management system was in place to support patient flow. The trust submitted data electronically to NHS England as were other local trusts, so each could see where support may be needed with patient flow.

Engagement

There was limited engagement with staff and patients to plan and manage services.

Staff did not consistently encourage patients to complete the friends and family test in the medicine care group. From January 2018 to December 2018 the Friends and Family Test response rate for medicine at the trust was 15.8% which was worse than the England average of 24.0% from January to December 2018. When we inspected for the month of April 2019 there had been 30 responses with 97% recommended the hospital. In Colwell the response rate was significantly less at 11, with 82% recommending the ward. Staff did consider changes they could

make as a result of feedback. On Appley Ward, they had a plan to purchase a decibel meter that would alert when the ward became too noisy.

Since the Same Day Emergency Care service had opened on April 1 2019 until May 22 May, there had been 118 response to a trust survey, 'How are we doing?' and 100% of the respondents would recommend the service. During April 2019 there had been 188 patients assessed and managed, we did not have the numbers for May 2019 as at the time of our inspection it was not a complete month.

The patient survey that reported in 2017 noted an area of improvement at the trust was knowing who the person in charge of care was. We noted that in medicine nurses in charge were wearing large red badges, which indicated they were the nurse in charge. Areas of patient experience that had declined were staff discussing additional equipment or home adaptation needs, and length of stay delays. The patient survey results for 2018, were not through at the time of inspection and therefore had not yet been reported on. The patient survey for 2018 was published after our inspection in June 2019.

The dementia service had worked to engage carers as partners in care when appropriate. Staff had embraced the John's campaign which is the right for people to stay with people living with a dementia in hospital. The number of carers signed up to John's campaign in March 2019 was 24 with 16 renewals. During our inspection we did see carers encouraged to be with patients' and support them in daily activities such as eating their meals. The trust on 10 May 2019 held an afternoon tea in the conference room where people living with dementia and their families were invited for an informal chat with staff working at the trust.

Staff were encouraged to complete a pulse survey. Senior staff noted in the April 2019 quality meeting, that the response rate in medicine was low. An action from the meeting was to encourage staff to complete. Trust wide for the acute division in the February 2019 meeting it was noted that results were similar, if not worse, than the last CQC visit. Staff reported as tired and said that they cannot provide safe care, due to staffing. Staff felt that direct management is supportive but not senior management. Staff not recommending the trust as a place to work was in November 2018 38% and January 2019 28%. In the February 2019, there was discussion about the need to develop an action plan in response to the pulse survey findings. We could not determine from the minutes of subsequent quality meetings if this action plan had been completed.

Many staff we spoke with were happy to be working at the trust. On Colwell Ward staff were unhappy with the facilities in the staff room. Staff wanted more storage for their personal teams and comfy chairs. As a result of listening events with staff, senior staff were aware and told us new furniture was currently being purchased. A member of staff commented how they had been supported to develop their skills in endoscopy. However, there were indications of concern with one member of staff saying about one of the medical wards, 'this is a healthy day for staffing', and other staff choosing to do external leaderships to the trust as not assured about the quality of the internal leadership courses. It was also of concern that staff felt they had to use non-designated bed spaces, and felt unable to speak up, to enable staff in leadership positions to review their plans to manage patient flow.

Learning, continuous improvement and innovation

There was a commitment to continually learn and improve services. However, we were not shown examples of innovation or research.

During 2019/20 the medicine care group planned to explore the feasibility of the use of physician associates alongside the programme commencing at Portsmouth University. The plan was to explore alternative options of service delivery utilising physician associates alongside the junior doctor and advanced practitioner workforce.

The consultant body felt there had been an improvement of the quality of investigations that followed a serious incident. They felt this was helped by a member of the quality team being available to provide support.

The consultant body fed back to us in a letter that the clinical commissioning group improvement and assessment frame work data had recently rated the whole islands diabetes service as 'outstanding' based on their two measures for diabetes. This is a whole clinical commission group measure that reflected both primary and secondary care and their integrated work in diabetes care.

A group has been put together, called time to act, to address clinical improvements in all clinical areas within the hospital. Representatives from every area attended this meeting for three hours every three months. Discussions around any points pertinent to clinical practice were discussed, and solutions to problems and issues were identified. The representatives wore a red badge identifying them as 'deteriorations and sepsis champions'.

Surgery

Facts and data about this service

The Surgery, Women's and Children's Health Care Group draws together the surgical and orthopaedic services as well as paediatric and obstetric services. The purpose of the care group is to provide clinical and operational leadership to general surgery, including breast and colorectal; urology; trauma and orthopaedics; ENT; maxillo-facial; ophthalmology; gynaecology; chronic pain; stoma, community and acute paediatrics; obstetrics and midwifery.

Some support services are also included within the care group and include day surgery and main theatres, the pre- assessment and admission unit and anaesthetists.

The wards for the care group include St Helens, Elective Surgery; Whippingham ward, Emergency surgery; Alverstone, Elective Orthopaedic Surgery; Luccombe Ward, trauma and Mottistone Private Ward. All services apart from the Community Paediatric services are provided on the St Mary Hospital site.

(Source: Routine Provider Information Request (RPIR) – Context acute)

The trust had 13,323 surgical admissions from January to December 2018. Emergency admissions accounted for 3,075 (23.1%), 9,110 (68.4%) were day case, and the remaining 1,138 (8.5%) were elective.

(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, however they did not make sure all staff completed it.

Mandatory training completion rates

The trust set a target of 85.0% for completion of mandatory training. Staff told us that previous difficulties accessing the mandatory training in key skills had improved. There was an overall improvement in the completion of mandatory training from our previous inspection.

St Mary's Hospital

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for qualified nursing staff in surgery at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Blood Borne Virus Training	13	13	100.0%	85.0%	Yes
Load Handling	2	2	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	120	120	100.0%	85.0%	Yes
Fire Safety Part 1 - Theory	120	120	100.0%	85.0%	Yes
Health, Safety and Welfare	118	120	98.3%	85.0%	Yes
People Handling	110	118	93.2%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	110	120	91.7%	85.0%	Yes
Hand Hygiene	106	120	88.3%	85.0%	Yes
Infection Prevention & Control Level 2	82	107	76.6%	85.0%	No
Information Governance	89	120	74.2%	85.0%	No
Medicines Management Theory	163	228	71.5%	85.0%	No
Adult Resuscitation	70	119	58.8%	85.0%	No
Medicines Management Practical Assessment	40	103	38.8%	85.0%	No
Adult Resuscitation - ILS	25	67	37.3%	85.0%	No
Paediatric Resuscitation	13	56	23.2%	85.0%	No
Newborn Life Support	2	13	15.4%	85.0%	No
Paediatric Resuscitation - PILS	0	10	0.0%	85.0%	No

In surgery the 85.0% target was met for eight of the 17 mandatory training modules for which qualified nursing staff at St Mary's Hospital were eligible.

There was evidence of improvements from the previous inspection in relation to load and people handling training where nursing staff training completion was above the trust target. However, there was ongoing poor compliance in relation to resuscitation as of the end of January 2019. For example, adult resuscitation training was more than 25% below the target and adult intermediate life support was nearly 50% below target. Paediatric resuscitation was 60% below target and none of the eligible nursing staff had completed paediatric intermediate life support training. However, the service informed us that there was no requirement for ward-based nursing staff to undertake paediatric resuscitation and that registered nurses undertook intermediate life support and healthcare assistant's basic life support training for adults.

The trust provided overall mandatory training figures for the end of the 2018/19 year which showed some overall improvement broken down as per ward or department. These figures showed that overall training compliance for all surgical areas was between 73% (general theatre) and 95% (day surgery ward). At our previous inspection the day surgery ward and Mottistone ward had achieved the trust target for mandatory training. At this inspection, in addition to the day surgery ward and Mottistone, St Helens and Luccombe wards had also achieved the overall target. However, the day surgery unit, general theatre and Whippingham ward continued to be below target. In addition, the trust provided end of year 2019/19 and June 2019 training data specific to resuscitation which showed improvements:

Adult Resuscitation

Specialty	Mar 19	Current (June 2019)
Alverstone Ward	77%	76%
Luccombe Ward	79%	63%
Mottistone Ward	95%	86%
St Helen's Ward	90%	90%
Whippingham Ward	51%	71%
Day Surgery Ward	85%	100%

The service had an action plan in place to continue improvements in this area. There were 32 qualified nursing staff who had yet to complete their adult resuscitation training across the surgical wards. Of these, 24 had been booked onto courses between June and September 2019.

In theatres resuscitation training compliance had improved, although in paediatric resuscitation this was minimal. The service told us that progress had been impacted by staffing difficulties, however there was an action plan in place to address this.

Adult Resuscitation

	Mar 19	Current
Day Surgery Unit	21%	50%
Main Theatres	39%	51%

Paediatric Resuscitation

	Mar 19	Current
Day Surgery Unit	57%	64%
Main Theatres	49%	51%

In the day surgery unit five out of seven staff yet to complete adult resuscitation training had been booked onto a course between June 2019 and October 2019. In main theatres we were told that staffing issues and a high usage of agency staff made it difficult for staff to be released for classroom-based training. We were told that the department was working to identify vacant theatre sessions when the whole theatre team could be released to attend training. This plan was being enacted on a rolling 6-week basis until training was complete.

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for medical staff in surgery at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety Part 1 - Theory	62	65	95.4%	85.0%	Yes
Health, Safety and Welfare	61	65	93.8%	85.0%	Yes
Infection Prevention & Control Level 1	56	65	86.2%	85.0%	Yes
Advanced Paediatric Life Support	14	17	82.4%	85.0%	No
People Handling	52	65	80.0%	85.0%	No
Fire Safety Part 2 - Extinguishers	50	65	76.9%	85.0%	No
Information Governance	47	65	72.3%	85.0%	No
Infection Prevention & Control Level 2	41	65	63.1%	85.0%	No
Adult Resuscitation	40	64	62.5%	85.0%	No
Paediatric Resuscitation	35	59	59.3%	85.0%	No
Hand Hygiene	36	65	55.4%	85.0%	No
Paediatric Resuscitation - PILS	4	31	12.9%	85.0%	No
Adult Resuscitation - ILS	2	33	6.1%	85.0%	No

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

In surgery the 85.0% target was met for three of the 13 mandatory training modules for which medical staff at St Mary's Hospital were eligible. There continued to be low compliance in relation to all areas of resuscitation training for medical staff. In particular, in relation to both child and adult intermediate life support training which were more than 70% below target. Hand hygiene and infection control training for medical staff were also significantly below target. The trust provided overall mandatory training figures for the end of the 2018/19 year which showed some overall improvement broken down as per ward or department. However, compliance continued to be low overall for medical staff with completion rates for junior doctor's within surgery between 43% and 77% across all topics.

The service provided us with up to date resuscitation training figures for medical staff working in surgery.

Adult Resuscitation		
Specialty	Mar 19	Current
ENT Medics	100%	100%

Gynae Medics	100%	100%
Ophthalmology Medics	56%	60%
Oral Surgery Medics	100%	100%
Orthopaedic Medics	55%	63%
Surgical Medics	78%	80%
Urology Medics	60%	80%

Paediatric Resuscitation		
Specialty	Mar 19	Current
ENT Medics	100%	100%
Ophthalmology Medics	67%	77%
Oral Surgery Medics	100%	0%
Orthopaedic Medics	36%	54%
Surgical Medics	50%	44%
Urology Medics	75%	75%

We were told that the action to improve compliance included a monthly review of individual training compliance was shared with all clinical leads and there was a policy in place that study leave expenses were not refunded until individual medical staff were compliant with mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked 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 85.0% for completion of safeguarding training.

St Mary's Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for qualified nursing staff in surgery at St Mary's Hospital is shown below:

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1	119	120	99.2%	85.0%	Yes
Safeguarding Adults Level 1	116	120	96.7%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	111	120	92.5%	85.0%	Yes
Safeguarding Children Level 2	84	106	79.2%	85.0%	No
Safeguarding Adults Level 2 Part 1	92	120	76.7%	85.0%	No
Safeguarding Adults Level 2 Part 2	87	120	72.5%	85.0%	No
Preventing Radicalisation Level 3	68	120	56.7%	85.0%	No

The 85.0% target was met for three of the seven safeguarding training modules for which qualified nursing staff in surgery at St Mary's Hospital were eligible. There was evidence of some improvement in safeguarding children level 2 training (79.2%) from the previous inspection where compliance had been at 63.2%.

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for medical staff in surgery at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1	61	65	93.8%	85.0%	Yes
Safeguarding Adults Level 1	58	65	89.2%	85.0%	Yes
Safeguarding Adults Level 2 Part 2	54	65	83.1%	85.0%	No
Safeguarding Children Level 2	52	65	80.0%	85.0%	No
Preventing Radicalisation Level 1 & 2	51	65	78.5%	85.0%	No
Safeguarding Adults Level 2 Part 1	51	65	78.5%	85.0%	No
Preventing Radicalisation Level 3	33	63	52.4%	85.0%	No

The 85.0% target was met for two of the seven safeguarding training modules for which medical staff in surgery at St Mary's Hospital were eligible. Although under the 85% target, safeguarding children level 2 compliance had improved from 50% at the previous inspection to 80% now.

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

Nursing staff we spoke with were clear about 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 demonstrated a good level of understanding around raising alerts and concerns. Examples shared during inspection included actions taken to escalate concerns about vulnerable adult and risks around different types of potential abuse.

Staff in theatre were trained to child safeguarding level three. They were aware of reporting structures and the type of safeguarding concerns to be mindful of. However, there was no segregation of children from adults in recovery. This meant that staff recovered children post operatively in areas alongside adults. However, we were told that children in recovery were supervised by staff and were not left alone.

The surgical wards had made five DoLS applications in the 12 months from January to December 2018, however of these only one urgent application on Alverstone ward had been approved.

Cleanliness, infection control and hygiene

Standards of hygiene and cleanliness were maintained and there were systems in place to protect people from healthcare associated infection. However, medical staff compliance with hand hygiene training and practice was not consistent and infection rates in some areas of surgery were higher than average.

Data provided by the trust showed that nursing staff had achieved over 85% compliance with infection prevention and control (IPC) and hand hygiene training. However, medical staff compliance with infection control and hand hygiene training was below target at 63% and 55% compliance respectively.

We observed staff following national guidance on infection control. For example, staff with long hair had tied it back and all staff were 'bare below the elbows' at all times to enable effective hand washing and minimise the risk of contamination. We observed nursing staff following NICE QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. However, we also observed medical staff during a ward round not routinely washing their hands immediately before and after every episode of direct contact.

Cleaning staff were aware of the infection control policy and followed cleaning schedules for all ward areas. There was a cleaning supervisor available via bleep for support with any issues.

In theatre the May 2019 hand hygiene audit results were 75%. Senior staff told us that a plan was being devised to address this, although this was not in place at the time of inspection. The trust provided audit results for 2018/19 and up to June 2019. We saw that the 90% trust hand hygiene target had consistently not been met in main theatres. For example, this had only been met once between October 2018 and June 2019. At the time of inspection, we saw that hand hygiene results were displayed on the wards; on Mottistone ward results were 87%, on St Helen's ward results were 95%, Alverstone ward results were 100%, Whippingham results were 94%. Data provided by the trust showed that St Helens, Luccombe and the day surgery ward consistently met the trust target and had results between 90% and 100%. On Alverstone ward there were inconsistencies in the provision of data with only three months of results recorded. On Whippinham ward results were below standard in all bar three out of the 14 months where data was provided.

Elective surgery patients were screened and needed to be MRSA free before being admitted to the Mottistone ward (which was identified as the elective orthopaedic ward at the time of inspection) prior to surgery. MRSA screening was identified as an action in relation to improving infection rates. Data provided by the trust showed that MRSA screening for surgical patients had been low (between eight and 13 patients per month) between April and December 2018. Action taken by the trust included the resumption of MRSA screening for an increased number of elective surgical patients and data showed that between January and the end of March 2019 between 120 and 287 surgical patients were screened each month.

In theatres and on the wards, we observed good infection control practice. In theatres, we observed theatre staff used aseptic techniques and followed appropriate skin antisepsis when undertaking procedural scrub. Staff wore personal protective equipment (PPE) and decontaminated equipment in line with guidance.

Theatre equipment was decontaminated and sterilised between use. Completed cleaning schedules were viewed and staff reported that a theatre deep clean had recently been completed by an external company. There was an annual theatre cleaning schedule in place. 'I am clean' stickers were seen to be placed on equipment once it had been cleaned in both theatres and on the wards. Clinical waste was disposed of in the appropriate clinical waste bags and stored securely for collection. Sharps were disposed of in sharps bins and labelled appropriately. All waste we viewed was stored safely.

The surgical sterilisation unit was compliant with the standards set out in the decontamination of surgical instruments Health Technical Memoranda (HTM 01-01). An external audit of decontamination processes concluded that the trust had effectively implemented, maintained and

improved its quality management system to meet quality objectives and demonstrate regulatory compliance in relation to decontamination. Minor compliance issues had been addressed by the trust.

Surgical infection rates varied across departments. In Ear, Nose and Throat (ENT) surgery and ophthalmology infection rates were 0.0%. In orthopaedics the infection rate was 1% against a mean of 0.7%. This was being reviewed on a regular basis and the Get It Right First Time (GIRFT) team revisited this in March 2019. In urology the infection rate was 5% against a national mean of 1.9%. In general surgery the infection rate was 6.4% against a national mean of 1.9%. In response to the concerns regarding infection rates, some immediate actions had been put in place including the resumption of MRSA screening for some elective patients and the preferential use of single rooms for elective patients. The service had created a detailed action plan and funds had been identified to support prospective surgical site surveillance.

Actions from GIRFT were reviewed at the quality and monthly leadership meetings. We viewed the surgical site infection rate action plan and saw that specific actions had been identified and progress monitored and updated. This included the identification of a matron to lead on SSI coordination, improved monitoring of compliance and competency of aseptic non-touch technique (ANTT) for nurses and healthcare assistants and ring-fenced beds for elective orthopaedic surgery.

Environment and equipment

Appropriate equipment was available, checked and fit for purpose. The environment was not always suitable; however, risk management assessments and plans were in place to mitigate the associated risks.

The trust had made improvements to the environment in theatre. This included replacement floors and walls in two of the theatres. At our previous inspection it was seen that the day surgery unit (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 had been identified but were not adequately mitigated. At the time of this inspection we viewed a risk assessment for the DSU that included detailed daily capacity planning to ensure that admissions were arranged to fit in with the available male and female trolley spaces. Each bay within the unit was allocated male and female with an adjacent bathroom. There was one mixed sex bay although this was reserved for interventions that required a local anaesthetic and where patients remained fully clothed. Longer term plans included the reconfiguration of the unit and this work was expected to start in June 2019.

Staff working in recovery told us that issues with a lack of space sometimes led to a backup of patients in theatres where theatre practitioners would then have to recover patients. We saw that these incidents had been reported, in particular where there was a delay in ward staff collecting patients from recovery.

Ward based equipment was overseen by the engineering department. Equipment such as blood pressure monitors, beds and manual handling aids were seen to have appropriate service stickers in place with clear dates indicating when maintenance and safety checks were due. All clinical equipment we viewed was in date.

Equipment was seen to be in good working order. A ‘star’ system was used for equipment inventory in theatres so that staff were assured that equipment labelled with a star had been

serviced and safety checked. All items of equipment checked in theatre were seen to have been serviced and safety checked.

Resuscitation equipment was visible and accessible. Resuscitation trolleys were kept on all surgical wards and in theatres. Trolleys were not tamper proof at the time of inspection as identified in our previous inspection. However, this issue was identified on the trust risk register and we were told that this was in the process of being addressed with a plan in place to ensure tamper evident seals were applied to each trolley. Trolleys were subject to regular checks and we saw records of these checks. We found that emergency equipment was in good condition and in date.

Random checks of stock consumables such as needles and syringes confirmed that the stock was in good condition and within its expiry date. Store cupboards were seen to be tidy and stocks of consumable equipment were accessible on the wards and in theatres.

Fire equipment was regularly serviced and there were fire wardens on each ward. Annual fire drills were carried out and each ward had a completed fire safety risk assessment.

Children were recovered in the same area of main theatres as adults post operatively. The area was not child friendly.

Assessing and responding to patient risk

Staff monitored and managed risks to patient safety and improvements with evidence of improved processes to help identify the risk of deterioration in patients. Improvements had been made in theatres to patient safety process. However, not all patients showing signs of infection were on the sepsis pathway.

At our previous inspection we found that some staff routinely disregarded safety procedures in theatres. At this inspection we found that the service had worked on an improvement plan to address this issue. For example, theatre standard operating procedures had been reviewed and updated and the use of the World Health Organisations surgical safety checklist (WHO checklist) and the ‘5 steps to safer surgery’ had improved. National safety standards for surgical procedures (NatSSIPS) and local standards for surgical procedures (LocSSIPS) policies were in place, providing additional safety standards to reduce the number of patient safety incidents related to invasive procedures. Staff demonstrated a consistent understanding of safety processes and we observed these in operation within the theatre suite.

Theatre staff told us that the WHO checklist and the ‘5 steps to safer surgery’ were used consistently and that improvements had been made over recent months. Audits were in place, both within observational and record keeping frameworks and we saw evidence of improved audit results. Staff reported that there had been times where safety compliance was as low as 27% and we saw evidence during inspection that this had increased over time from 68% to 99%.

We observed theatre sign-in processes and saw that these were in line with the trust policy and national guidance. Appropriate checks of identity and consent were undertaken. All staff were seen to be engaged with this process including the anaesthetist, anaesthetic practitioner and healthcare assistant. We observed a time out process completed prior to skin preparation by all of the theatre team including the surgeon. The sign out was completed appropriately and the patient handed over to staff in the recovery room. A debrief was completed at the end of the theatre list and audit outcomes recorded. A ‘hot debrief’ was completed if there were specific issues or if an incident occurred.

We saw that guidance on the safer surgery checklist were displayed on the walls in theatre. Audits were completed on paper-based records and the theatre management software and audit outcomes were displayed and shared with staff to ensure continuous improvement. Following feedback as part of the audit the checklist had recently been revised and printed in a different colour to make it easier to identify in the patient record.

Theatre staff followed the Association for Perioperative Practice (AfPP 2016) standards for safe practice. Staff used the 'stop before you block' initiative before an anaesthetist inserted a nerve block to prevent a never event occurring. There were notices visible to remind staff to do this.

Staff told us that because of the improved safety procedures within theatres standard safety practices were now embedded with all staff engaged with the process. Senior staff told us they felt proud of the improvements made in relation to this.

A pre-operative assessment was carried out for each patient prior to admission. Assessments included weight, height, temperature, blood pressure, bloods, electro cardio gram and MRSA screening. Medical staff reviewed the patient records, checked their consent forms and the site of the surgery prior to transfer to theatre.

On the day of surgery, nursing staff undertook an admission assessment where they assessed risks that included falls, pressure ulcers, venous thromboembolism, manual handling and nutrition. Action was taken to review and mitigate the risks during the admission. For example, anti-embolism stockings were provided for patients at risk of venous thromboembolism (VTE). Patient information leaflets were also given to patients on how to reduce the risk of VTE during admission and on discharge home.

The National Early Warning System (NEWS2) had been implemented in December 2018. Training had been provided for nursing staff and support was provided for ward staff from a clinical standards sister. Audits of NEWS2 were routinely carried out and results were shared with staff. On St Helens ward we viewed results of an audit that showed 94% compliance. We saw that NEWS2 was used for all patients. Patients were monitored post-operatively in recovery and on the ward. We saw that NEWS2 scores were routinely recorded for all patients whose records we reviewed.

Safety huddles were observed in theatre and on the wards. Patient safety issues were discussed and action taken to mitigate the risks. Intentional rounding processes were in place on the wards where routine patient safety checks and monitoring were carried out at intervals throughout the shift.

A sepsis care bundle had been introduced across the trust and was in use within the surgical wards. An admission sepsis screen was undertaken, providing prompts for clinical staff to consider the risk of sepsis. The initial sepsis screen would then trigger a six-step screening and action plan for patients with a fever or who were unwell with abnormal observations. While we saw that the admission sepsis screen was routinely carried out, not all patients with a fever or who were unwell had the sepsis six screen completed. For example, on Whippingham ward we reviewed the medical records of one patient with a diagnosis of sceptic arthritis and another who had commenced antibiotics who had not had the sepsis six screen completed.

The critical care outreach team was available seven days a week 24 hours a day to provide support for deteriorating patients on the surgical wards. The team could be contacted by nursing and medical colleagues and also patients or relatives if they were concerned about the treatment and care of patients who were unwell. 'Call for concern' posters were displayed on the wards informing patients and relatives of this.

Staffing

St Mary's Hospital

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, although there was evidence of improvements since the January 2018 inspection. There were ongoing concerns with medical cover out of hours and junior doctors reported some issues with obtaining input from senior colleagues when they needed it.

St Mary's Hospital reported the following WTE nursing staff numbers for April 2018 to March 2019 for surgery.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
Anaesthetics	1.6	1.6	100.0%
Clinical Allergy Unit NHS	2.0	2.0	100.0%
Stoma Nurses	1.8	1.8	100.0%
Alverstone Ward	12.1	12.4	97.4%
Specialist Nurses Surgery	2.6	2.7	97.0%
St Helens Ward	13.9	14.7	94.8%
General Theatre	32.4	36.6	88.4%
Pre-Op Assessment Unit	5.5	6.4	86.3%
Ophthalmic Department	6.1	7.3	83.2%
Day Surgery Ward	8.0	9.8	82.3%
Luccombe Ward	12.1	17.5	68.9%
Whippingham Ward	14.8	22.6	65.4%
Day Surgery Unit	6.4	12.9	49.7%
MFU	0.9	1.9	45.5%
ENT	0.0	0.4	0.0%
Total	**120.1**	**150.5**	**79.8%**

From April 2018 to March 2019, the nursing staffing rate within surgery at St Mary's Hospital was 79.8%.

From April 2018 to March 2019, none of the 15 nursing teams listed were over established. However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a vacancy rate of 25.4% for nursing staff in surgery. The trust did not set a target for vacancy. This was an improvement on the vacancy rate recorded at the time of our last inspection which was 33%.

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

The trust monitored safe staffing levels and used an acuity tool with a safe staffing approach. Ward and theatre huddles included a review of staffing and we saw that safe staffing checklists were in use. On Mottistone ward we were told that the matron would join huddles to provide support for staffing issues.

There was a high vacancy rate in theatres which was identified as the number one risk on the clinical business unit (CBU) risk register. At the time of inspection there were 10.88 whole time equivalent (WTE) vacancies for registered practitioners, with two posts likely to be filled in May and August 2019 and a potential further two posts from overseas recruitment. Senior staff were working with the human resources team to find solutions and there was evidence of some improvements since their previous inspection when there were 15 WTE vacancies for registered practitioners. Shifts were filled by bank and agency staff and the service's ability to maintain establishment staffing levels was on the surgery service risk register. Staff we spoke with in theatres consistently reported that their greatest concern was staffing and that a lack of permanent posts led to increased pressure for the rest of the team. Staff told us that staffing shortages were especially problematic in anaesthetics and that the service had recently introduced a night shift anaesthetic practitioner, which they were happy with, but said it further impacted staffing numbers during the day.

There were varying levels of registered nurse vacancies on the surgical wards. On Whippingham ward there were 7.8 WTE vacancies and on Luccombe ward there were 5.4 WTE vacancies. On St Helens ward there were fewer vacancies, however senior staff told us that this was increasing due to changes such as staff retirements with 4.8 WTE vacancies anticipated. On Alverstone ward registered nurse staffing was close to establishment, however during inspection we were told that their staffing numbers had not increased in line with the move from elective to non-elective surgery. We were told that the proportion of healthcare assistants on shift had increased however.

On one ward we were told by the ward sister that they had recently had a visit from the non-executive director who had provided some assurance about action the trust was taking to improve staffing as some staff were concerned that not enough was being done. As well as recruiting nurses from overseas, the trust ran a nurse apprentice scheme where they were developing care staff on nursing and associate practitioner programmes.

At the time of inspection, the discharge lounge was staffed by two healthcare assistants. We were told that the trust board had made a decision in January 2019 that there should be a registered nurse based in the discharge lounge. The staff we spoke with told us this was so they could support a broader range of patients. Figures provided by the trust showed that between January 2019 and April 2019 there had been 11 shifts where there was no registered nurse on shift in the discharge lounge. Support for the healthcare assistants should a patient be unwell or need nursing input was sought from the bed managers. Staff reported that the bed managers were responsive to their requests for support.

Turnover rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a turnover rate of 8.4% for nursing staff in surgery, this was higher than the trust target of 5.0%. This was a deterioration in turnover rate from our previous inspection when it was 5%.

A breakdown of turnover rates by ward/team is below.

Ward / team name	Annual turnover rate
Day Surgery Unit	18.7%
Pre-Op Assessment Unit	17.6%
Luccombe Ward	15.5%
St Helens Ward	14.8%
General Theatre	10.8%
Alverstone Ward	8.6%
Anaesthetics	0.0%
Clinical Allergy Unit - NHS	0.0%
Day Surgery Ward	0.0%
Ophthalmic Department	0.0%
Specialist Nurses Surgery	0.0%
Whippingham Ward	0.0%

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

Turnover rates were particularly high for staff working in the theatre suites and the pre-operative assessment unit, as well as for staff working on Luccombe, St Helen's and Alverstone wards.

Sickness rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a sickness rate of 5.7% for nursing staff in surgery, this was higher than the trust target of 3.5%.

A breakdown of sickness rates by ward/team is below.

Ward / team name	Annual sickness rate
ENT	16.1%
Day Surgery Ward	10.0%
Alverstone Ward	7.9%
General Theatre	6.6%
St Helens Ward	5.9%
Day Surgery Unit	4.7%
Ophthalmic Department	4.7%
Luccombe Ward	4.6%
Specialist Nurses Surgery	4.6%
Whippingham Ward	3.7%
Pre-Op Assessment Unit	3.3%
Anaesthetics	1.7%
Clinical Allergy Unit - NHS	1.1%

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

Ten of the 13 wards/teams had an above target rate of staff sickness absence.

Bank and agency staff usage

St Mary's Hospital

The table below shows the numbers and percentages of nursing hours in surgery at St Mary's Hospital from January to December 2018 that were covered by bank and agency staff or left unfilled.

Of the 292,194 total working hours available for qualified staff, 5.2% were filled by bank staff and 7.0% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 10.0% of the available hours were unable to be filled by either bank or agency staff.

Of the 145,370 total working hours available for non-qualified staff, 24.6% were filled by bank staff and 0.4% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, 5.6% of the available hours were unable to be filled by either bank or agency staff.

Staff group	January to December 2018						
	Total hours available	Bank usage		Agency usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Qualified staff	292,194	15,092	5.2%	20,597	7.0%	29,320	10.0%
Non-qualified staff	145,370	35,758	24.6%	651	0.4%	8,154	5.6%
All nursing staff	**437,564**	**50,851**	**11.6%**	**21,248**	**4.9%**	**37,473**	**8.6%**

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

Staff reported multiple agency staff used in theatres and on Whippingham ward. We viewed rosters during inspection and saw that for the four weeks leading up to the week of the inspection there were 49 bank or agency shifts covered and two long days and five late shifts unfilled on Whippingham ward. Staff we spoke with told us that staffing had been better since an increase in healthcare assistant hours and that when using agency, they tried to block book nurses to allow for better continuity. On St Helen's ward there had been less use of bank and agency with one shift covered by agency and one shift unfilled over a four-week period, however recent staff changes meant more bank and agency would be used in the coming weeks. On Alverstone ward there were a total of six night shifts and two long days of registered nurse shifts out to bank or agency and five nights and 10 days of health care assistant shifts out to bank or agency.

Ward sisters told us that they helped cover shifts that were unfilled. This included staying into the evening to provide support during the busiest times on a late shift.

Medical staffing

St Mary's Hospital

St Mary's Hospital reported the following WTE medical staff numbers for April 2018 to March 2019 for surgery.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
Urology medics	8.0	7.0	114.3%
Orthopaedic medics	17.5	17.5	100.0%
Surgical medics	18.8	20.0	94.1%
ENT medics	3.0	3.2	93.5%
Oral surgery medics	0.9	1.0	90.0%
Ophthalmology medics	8.4	9.4	89.4%
Anaesthetists	24.1	29.5	81.9%
Total	**80.8**	**87.6**	**92.2%**

From April 2018 to March 2019, the medical staffing rate within surgery at St Mary's Hospital was 92.2%.

From April 2018 to March 2019, one of the seven medical teams listed was over established. However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a vacancy rate of 6.5% for medical staff in surgery. The trust did not set a target for vacancy.

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

Turnover rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a turnover rate of 7.6% for medical staff in surgery, this was higher than the trust target of 5.0%.

A breakdown of turnover rates by ward/team is below.

Ward / team name	Annual turnover rate
Urology Medics	15.8%
Ophthalmology Medics	12.9%
Surgical Medics	12.8%
Anaesthetists	4.4%
ENT Medics	0.0%

Oral Surgery Medics	0.0%
Orthopaedic Medics	0.0%

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

Sickness rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a sickness rate of 1.3% for medical staff in surgery, this was lower than the trust target of 3.5%.

A breakdown of sickness rates by ward/team is below.

Ward / team name	Annual sickness rate
Anaesthetists	1.7%
Orthopaedic Medics	1.6%
Surgical Medics	1.2%
Ophthalmology Medics	0.8%
Urology Medics	0.4%
ENT Medics	0.0%
Oral Surgery Medics	0.0%

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

Bank and locum staff usage

St Mary's Hospital

The table below shows the numbers and percentages of medical hours in surgery at St Mary's Hospital from January to December 2018 that were covered by medical and locum staff or left unfilled.

Of the 131,073 total working hours available, none were filled by bank staff and 1.0% were covered by locum staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 16.8% of the available hours were unable to be filled by either bank or locum staff.

Team name	January to December 2018						
	Total hours available	Bank usage		Locum usage		Not filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Anaesthetics and Pain	61,463	0	0.0%	228	0.4%	12,970	21.1%
Colorectal Surgery	9,336	0	0.0%	348	3.7%	1,567	16.8%
General Surgery	42,233	0	0.0%	24	0.1%	6,012	14.2%
Ophthalmology	18,040	0	0.0%	725	4.0%	1,467	8.1%

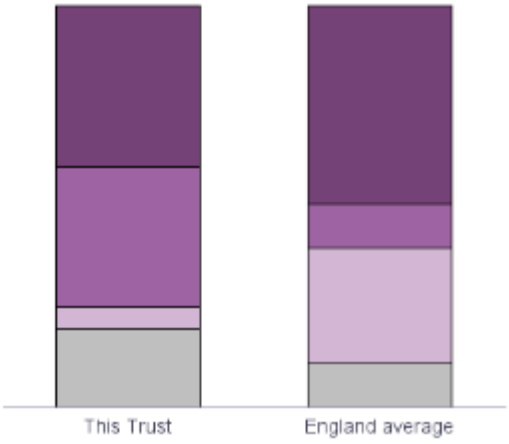
All medical staff	**131,073**	**0**	**0.0%**	**1,325**	**1.0%**	**22,016**	**16.8%**

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Staffing skill mix

In December 2018, 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 whole time equivalent staff working at Isle of Wight NHS Trust



	This Trust	England average
Consultant	40%	49%
Middle career^	35%	11%
Registrar Group~	6%	29%
Junior*	19%	11%

^ Middle Career = At least 3 year 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)

The service recognised they had fewer consultant and registrar grade doctors although they had a higher than average proportion of middle career speciality trainees than foundation year junior doctors to help mitigate this. However, junior doctors we spoke with told us they experienced some difficulties getting the support they needed because of this, particularly when registrars and consultants were in theatres. They also reported mixed experiences in the approachability of senior colleagues. In addition, junior doctors reported issues ranging from being expected to start work earlier than scheduled, regularly finishing late or struggling to take annual leave and complete mandatory training.

Overnight, there was a surgical registrar working until midnight, after which a foundation year two doctor (F2) was the sole on-site doctor covering a range of specialities. The service leads told us they had recently extended the registrar hours until midnight to lessen the burden on junior doctors. A March 2019 Health Education England site visit report stated that the 'trust must address the rota issues that result in F2s being the sole on-site doctor covering a range of specialities. The service leads told us they had put in place arrangements to provide greater support overnight. This included support from the medical registrar for critically ill patients and support from the resident gynaecology registrar. They told us they had also added additional anaesthetist hours over the weekend, with four hours of cover each day. This was actioned in response to serious incidents that had occurred out of hours. In addition, a tablet had been

provided so that orthopaedic registrars could view imaging results from home and provide support remotely. The trust had implemented hospital at night handovers to improve communication, these took place twice a day in the morning and evening. These were handovers between staff working in the day and those working at night. The handovers included a range of surgical speciality doctors as well as doctors from the medical team. In addition, staff working in the critical care outreach team attended and coordinated the meetings.

In September 2018 a joint visit took place at the hospital with Health Education England (HEE), the General Medical Council (GMC) and National Health Service England (NHSE). This followed concerns raised as part of the GMC Regional Review of Wessex and information from the GMC National Training Survey undertaken in 2018. Risks were raised with the trust in September 2018. A follow up visit was undertaken 4 March 2019 by the GMC. High level risks remained for surgery following the March 2019 visit which included concerns about F2s being the sole on-site doctor in surgery covering a range of specialities and clinical supervision concerns around out of hours working.

Patients on surgical wards told us they were seen by a doctor every day. The service operated a pattern of 1 in 6 on call rota for general surgery, with consultants on site during normal working hours and relieved of elective commitments during their on-call sessions.

Surgical leads told us there were arrangements in place to share and develop skills with mainland hospitals. For example, an upper GI consultant surgeon visited the trust on a regular basis and an ear, nose and throat consultant surgeon regularly worked at one of the mainland hospitals.

Records

Records were stored securely and easily available to all staff providing care. There were consistent improvements to the use of and completion of safer surgery checklists in theatres.

Records for surgical patients on the wards included an emergency admission pathway, a risk assessment document, a multidisciplinary discharge planner and nursing needs assessment and care plans. Specific care plans were also used such as tissue viability and catheter care plans. We reviewed 16 patient care and treatment records during inspection.

At the January 2018 inspection it was identified that the WHO safer surgery checklist was not being completed consistently. Staff told us that compliance around that time had been at 27%. We observed consistent practice where the checklists were completed appropriately in theatre with all relevant staff involved. For example, the sign in was completed in the anaesthetic room by all relevant staff including anaesthetics, the anaesthetic practitioner and healthcare assistant. The time out process was completed prior to skin preparation by all the theatre team including the surgeon. Sign out was completed and the handover to staff in recovery was recorded with a debrief completed at end of the theatre list. A ‘hot debrief’ was completed and recorded if any specific issues or incidents occurred. Updated guidance on the safer surgery checklist was displayed within the department alongside audit results.

Audits of the checklists showed consistent improvements. For example, we reviewed a nine-week audit as part of an improvement plan for theatres. At the start of the audit results showed 68% compliance and at the end of the audit this had increased to 99% compliance. We saw evidence that improved compliance had been sustained over time with monthly audit results shared at quality and staff meetings. Monthly observational sample audits were also seen to be completed. Staff felt that the checklist was now embedded into practice.

Patient records were stored securely in lockable trolleys, however on the day surgery ward we viewed theatre lists left on a desk with names visible.

Nursing care records were seen to be in place for patients on surgical wards. These were seen to be legible, dated and signed. We were told that care plans were reviewed on a daily basis, however this was not always clearly recorded. For example, a patient on Whippingham ward had been an in-patient for several weeks and their care plan did not have a record of an update since admission. For example, it was recorded in the care plan that the patient was nil by mouth when this was no longer the case, presenting a risk of confusion if staff unfamiliar with the patient were caring for them. In addition, their pressure ulcer prevention plan had gaps in daily monitoring and recording.

Medicines

The provider had systems in place for the safe storage, administration, prescribing and disposal of medicines. However, there continued to be some gaps in controlled drug recording in theatres.

The trust pharmacy department supplied medicines as stock and dispensed for individual patients. Medicines were stored securely and within their recommended temperature ranges. However, in several secure ward treatment rooms we observed partly used medicines denaturing kits.

Medicines on the wards were prescribed via on the trust electronic prescribing and medicines administration system (ePMAS). On transfer of patients from the intensive care unit (ITU) to the surgical wards, ITU clinicians were responsible for transferring the relevant medicines prescriptions from paper to the ePMAS prior transfer. Post transfer the receiving surgeons undertook medicines reconciliation.

The administration of medicines was recorded via the relevant computer system. Monthly ward reports were generated within pharmacy to monitor missed doses, including specifically antibiotics and medicines to support people living with epilepsy and Parkinson' disease. A daily report of antibiotic prescribing was generated to assisting in the planning of the consultant microbiologists ward round.

Pharmacy staff visited the unit on a regular basis, supporting patients and staff to optimise the use of medicines including medicines reconciliation. Over the six months to May 2019 the average monthly medicines reconciliation rate was 56% (43% to 65%).

Prior to discharge with the patients' consent those with high medicines risks could be referred for community pharmacy follow up and/or receive a post discharge telephone call from a member of the pharmacy team to resolve and post discharge medicines related questions.

At our January 2018 inspection we found that medicines were not always stored securely on the wards. At this inspection medicines were secure and there were systems in place to regularly monitor this.

At our January 2018 inspection we found that controlled drugs in theatres were checked twice daily, however there were gaps in the sign in sheets. At this inspection we found some exceptions to completed records of controlled drug checks. For example, there were four dates in May 2019 where only one check had been recorded. The theatres standard operating procedure for controlled drugs stated that one check was mandatory although two checks were recommended, before and after each theatre session. There were records kept of the supply, administration and disposal of controlled drugs, however there were many instances of only one signature. We

requested audits of the controlled drug checks and these were provided for a limited time period between the 22 May 2019 and the 6 June 2019 as a 'snap shot' of each theatre. These audits did not include the gaps in signatures that we had seen during inspection. In addition, we observed that medicines and fridges were unlocked in the anaesthetic room when theatre was in use. We also observed an incident where anaesthetic medicines including morphine had been drawn up in advance and left unattended in the anaesthetic room. The nurse in charge was informed of this and the medicines were locked away, no further incidents were observed. We saw a theatre huddle record that showed staff were reminded not to draw up controlled drugs in advance of use and that all controlled drugs must be kept locked away.

There were appropriate systems in place to manage the cold chain. Fridges in theatre were checked remotely and visually by staff and temperature escalation processes were displayed.

Ward staff reported that there were sometimes delays in obtaining patients medicines to take home, resulting in delays to discharge. Nurses reported that they now ordered medicines to take home as early as possible and this had resulted in some improvements. We spoke with a patient in the discharge lounge who had been waiting for several hours for their medicines, however, the healthcare assistant spoke to the medical staff and resolved the issue. Action to improve this included trialling 'tablets to take out' (TTO) packs on the wards which were counter checked by a pharmacist. The packs included a one-month supply of pain control medicines and any required post-operative antibiotics. Staff on St Helens ward told us this had helped to improve the discharge process.

Incidents

Staff working in theatres and on the wards recognised and reported incidents. Managers investigated incidents and there was evidence of learning from these. However, medical staff told us there was a reluctance to report incidents, particularly amongst junior doctors due to a belief that issues would not be addressed. Actions from mortality and morbidity meetings were not clearly recorded and some medical staff reported outcomes from incident investigations not being shared. When things went wrong, staff apologised and gave patients honest information and suitable support.

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 January to December 2018, the trust reported no incidents that were classified as a never event for surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

St Mary's Hospital

In accordance with the Serious Incident Framework 2015, the trust reported 24 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from January to December 2018.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Treatment delay meeting SI criteria	5	20.8%
Surgical/invasive procedure incident meeting SI criteria	5	20.8%
Sub-optimal care of the deteriorating patient meeting SI criteria	4	16.7%
Slips/trips/falls meeting SI criteria	2	8.3%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	2	8.3%
Pressure ulcer meeting SI criteria	2	8.3%
Operation/treatment given without valid consent	1	4.2%
Unauthorised absence meeting SI criteria	1	4.2%
HCAI/Infection control incident meeting SI criteria	1	4.2%
Medication incident meeting SI criteria	1	4.2%
Total	**24**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

At the January 2018 inspection it was identified that staff did not consistently identify and report patient safety incidents and there was evidence of reporting fatigue in theatres where staff did not always report incidents as that felt nothing changed as a result. Staff also reported that they did not always receive direct feedback on incidents. At this inspection we consistently heard from staff on the surgical wards that they reported incidents and in theatres we were told there was an improved culture of reporting. However, amongst medical staff we found there continued to be a view that reporting incidents did not always lead to issues being looked into or improvements being made. We were told that doctors were not confident anything would change through the process of reporting and that when incidents were reported outcomes were not always shared.

Staff working in theatre told us that feedback from incidents was provided at weekly staff meetings. We viewed an incident where a patient received an accidental burn and saw that a comprehensive investigation had been carried out. On the wards, feedback from incidents was provided during staff meetings and examples of learning and action were included in the ward quality folder. On St Helens an incident where the patient-controlled analgesia (PCA) dosage was too high was acted on appropriately and the patient was informed and received an apology. Staff were clear about their responsibilities under the duty of candour. On Alverstone ward an incident where a male urinary continence device had been incorrectly fitted led to training for staff in the correct application of the device.

Staff working in theatre told us they routinely reported incidents of staff shortages and on the elective orthopaedic ward incident reports were raised where patients had not been screened for MRSA or where trauma patients were admitted when there were no trauma beds available.

At the January 2018 inspection we found that 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 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 of 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. At this inspection the methods for recording M&M meetings varied across different specialities. For example, urology minutes included details of attendees and where issues had been escalated via the incident reporting system. ENT minutes showed some evidence of feedback and learning points although were not clear about discussions. Orthopaedic minutes were not clear who was involved in discussions. In response to our request for minutes and actions from mortality and morbidity meetings the trust submitted a printout report rather than meeting minutes for general surgery. The report included a section for discussion notes, but it was not clear if this discussion was as part of a meeting or who had been involved. This did not give assurance that the service reviewed, shared learning or monitored action from incidents. The process continued to not be in line with the Royal College of Surgeons guidelines. However, we were told that the outcome of the mortality and obidity meetings was uploaded onto the electronic patient record.

Safety thermometer

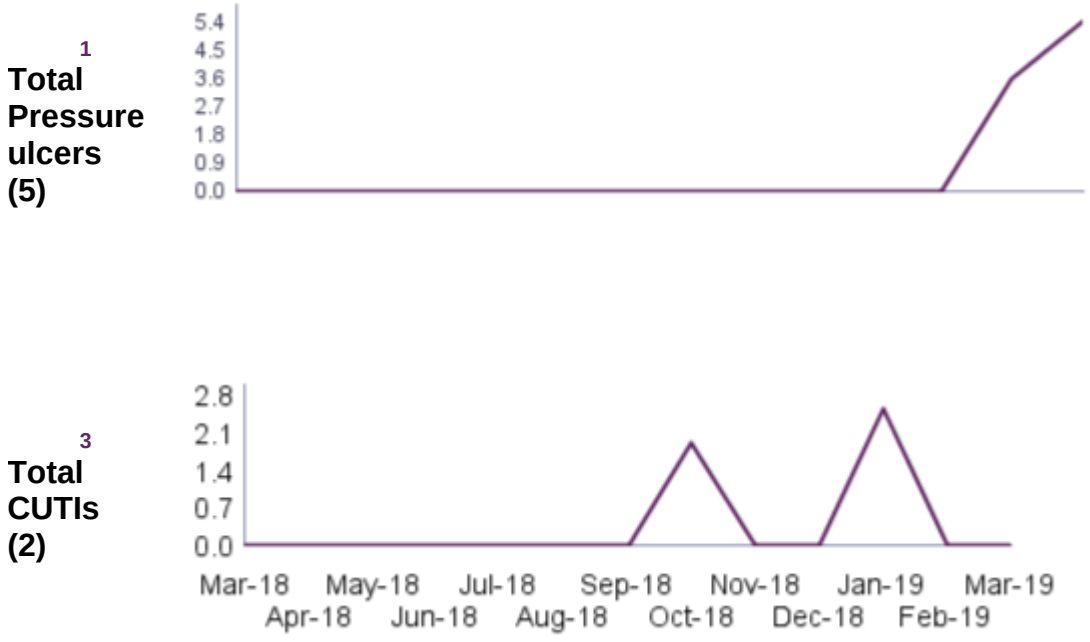
The service monitored patient harms and communicated the results to patients, staff and visitors.

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 five new pressure ulcers, no falls with harm and two new catheter urinary tract infections from March 2018 to March 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Isle of Wight NHS Trust



1 Pressure ulcers levels 2, 3 and 4

2 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

At the January 2018 inspection we found that 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. At this inspection we saw that safety data was clearly recorded on white boards in all ward areas. The data was seen to be updated by the ward sister on a regular basis and staff were aware of trends in their clinical areas.

Competency assessments were seen to be in use on the wards in relation to both the prevention of pressure ulcers and for catheter care. Staff we spoke with told us they had completed the competency assessments as part of an approach to reduce the numbers of CUTIs and pressure ulcers.

Is the service effective?

Evidence-based care and treatment

The service provided some treatment that reflected current evidence-based guidance or best practice standards, however standards around enhanced recovery after surgery and emergency surgery lists were not embedded.

At the January 2018 we found that there were no trust theatre protocols to guide practices and that policies and procedures were not available for reference, including a fasting policy to guide practice on how long patients should fast prior to surgery. At this inspection we saw that a theatre operational policy had been ratified by the trust in October 2018. Local safety standards for invasive procedures (LocSSIPs) had been developed based on the 2015 national safety standards for invasive procedures (NatSSIPs) and staff working in theatres had a good understanding of these.

The trust had implemented the latest version of the National Early Warning Score (NEWS2) tool for monitoring the deteriorating patient. Training and support for the implementation of the score was provided to staff working in surgery by a clinical standards sister.

The service used a nationally recognised sepsis bundle to support identification and treatment of patients with suspected or actual sepsis. An integrated sepsis policy was approved by the trust in March 2019 based on international and national guidance. There was an action plan to support ongoing and effective use of the sepsis bundle and the service monitored compliance. In-patient sepsis eligible screening from April 2018 to March 2019 was audited, involving 50 sets of patient notes, compliance ranged from 89% to 100%. This included 39 surgical patients who required and received intravenous antibiotics and 40 surgical patients who did not require or receive intravenous antibiotics. Overall compliance for patients presenting with severe sepsis and requiring antibiotics within was monitored. Compliance for April 2018 and March 2019 ranged from 89% to 100%. The audit was of 30 sets of patients' records per month where clinical codes indicated sepsis.

At our inspection in January 2018 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. All of the patient records we viewed in this inspection showed that

VTE assessments were carried out for most patients, with the exception of one patient on Whippingham ward.

The trust had a daily planned orthopaedic trauma list. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance advocates the increased availability of emergency (NCEPOD) theatre lists, reduced out-of-hours operating and better access to critical care facilities. At the time of inspection emergency NCEPOD lists were assigned where elective activity had been stood down. 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 based on clinical need. For some emergencies, patients were transferred to the mainland. On inspection we were told that regular general surgery NCEPOD lists had been piloted since April 2019 across three days a week and due to commence across five days a week. However, there were no NCEPOD lists running at the time of inspection and data provided by the service showed a six-week period of emergency surgery that included regular activity outside of the NCEPOD list times we were told about. Access to critical care facilities were limited due to the facilities within the trust. Surgeons reported that limited availability of high dependency beds sometimes led to delays in elective surgery where the peri-operative assessment of the patient indicated that a high dependency bed may be required. In some situations, this led to more patients being treated on the mainland. We saw that delays were reported as incidents and theatre cancellations were audited.

In December 2018 the service rolled out the clinical quality standards and acute strategy, aimed at contributing to the development of care for patients across the trust, including surgical patients. The standards were based on national guidance and we saw evidence of these being implemented on the wards. On both St Helen's and Whippingham wards we saw that each of the 12 standards were being focused on for a month at a time, with individual staff taking a lead and 'championing' the standard. Standards around communication were being focused on in the month of May, with a communication board highlighting elements of good practice and discussion with staff at meetings about ways to improve. We were told that in June 2019 the focus would be on end of life care.

Enhanced Recovery After Surgery (ERAS) treatment programmes is a perioperative care pathway designed to achieve early recovery for patients undergoing major surgery. The programme involved multi-disciplinary input into perioperative care to implement evidence based best practice to improve patient outcomes, reduce complications and reduce hospital length of stay post operatively. The service offered an enhanced recovery programme for patients requiring colorectal surgery with a colorectal surgeon leading the programme. At the time of inspection there was a dedicated clinical nurse specialist focused on ERAS and discussions were underway about having a dedicated healthcare assistant to build more of a team approach. An ERAS programme for joint replacements or revisions had previously been in full operation within the trust, however, this had been discontinued for a time due to elective orthopaedic beds being used for other patients. The programme had 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. At the time of this inspection we were told that the service was in the process of reintroducing the programme and that the hip and knee school had restarted. It was acknowledged that hospital length of stay for patients undergoing joint surgery had increased during the time that the programme had not been running.

Staff used care plans for pressure ulcer and falls management, based on National Institute for Health and Care Excellence (NICE) guidance.

A hydration assessment tool was being piloted on St Helen's ward at the time of inspection. This had been devised based on NICE guidelines CG196 (Acute kidney injury: prevention, detection and management) and CG174 (Intravenous fluid therapy in adults in hospital).

Nutrition and hydration

Staff monitored patients' nutrition and hydration needs and gave them enough food and drink to meet their needs and improve their health.

Patients had assessments of their nutrition and hydration needs on admission and care plans were developed to meet these needs. Housekeeping staff were on the wards to provide support with meal times and providing refreshments. They helped patients to complete menu requests and provided support in accessing special diets. Where needed they supported patients to eat. Stickers were in use alerting to staff to special requirements such as pureed meals.

An audit of fluid balance records by the critical care outreach service showed poor results on in-patient wards. In response to this a new hydration assessment and strict fluid balance chart had been developed and was in the process of being piloted on St Helens ward. The assessment included the identification of red or yellow risk factors such as a NEWS2 score above three (red) or a condition such as diabetes (yellow). Patients identified in the red category were then commenced on a 24-hour strict fluid balance chart and patients in the yellow category commenced on a hydration chart. The hydration chart included symbols for cups of fluid that were scored through once if half a glass was consumed and twice if a full glass was consumed, whereas the strict fluid balance chart required more detailed measurements. Weekly audits were planned during the course of the pilot with aims for regular feedback and adjustments in training and support to ensure that the assessment and records were completed appropriately. The plan was to feedback to the standards quality group at the end of June 2019.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff used a numerical score to measure pain experienced by patients as part of the NEWS2 assessment record. 'Intentional rounding' assessments where nurses assessed patient needs on a regular basis included the assessment of pain. The nursing needs assessment record included a section to assess pain. However, there was no specific pain assessment tools recorded for use as part of this assessment. Nursing staff were aware of pain assessment tools that were available for use with patients who may struggle to communicate and articulate their pain. However, these were not seen to be routinely adopted as part of general assessment procedures.

Patients we spoke with told us their pain was well controlled and they received pain-relieving medicine when they requested it. Patient controlled analgesia (PCA) devices were in use for patients undergoing major surgery, enabling them to control their pain relief as required.

The surgical service had an acute pain nurse specialist who provided outreach support to the wards for complex patients who was supported by a consultant anaesthetist.

Patient outcomes

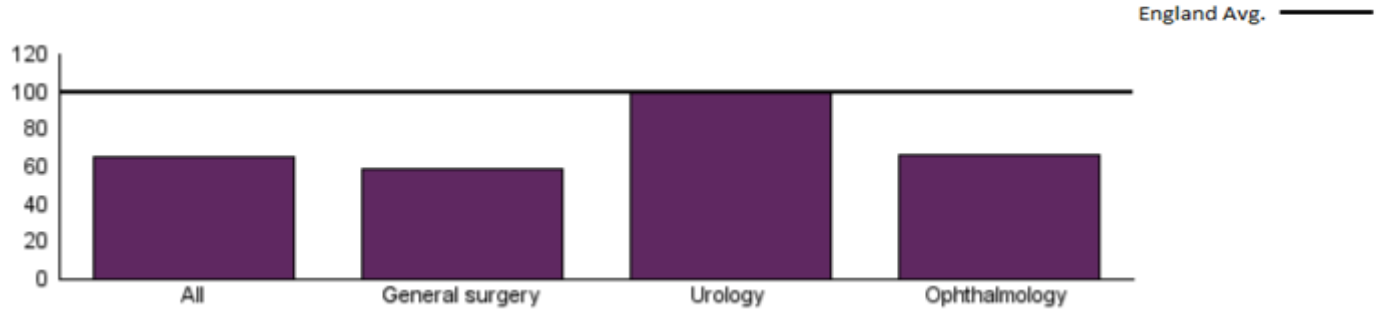
Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and work towards achieving good outcomes for patients. There was evidence of improved patient outcomes.

Relative risk of readmission

St Mary's Hospital

From December 2017 to November 2018, patients at St Mary's Hospital had a lower expected risk of readmission for elective admissions and a lower expected risk of readmission for non-elective admissions when compared to the England average.

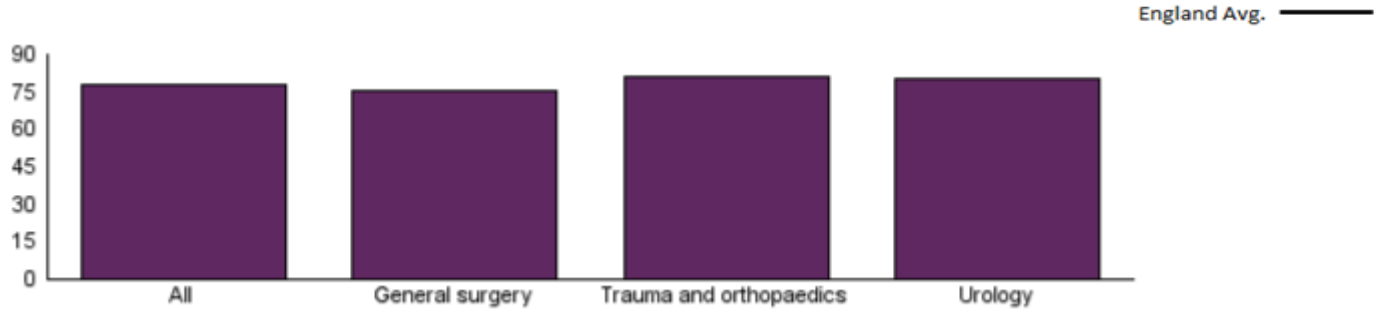
Elective Admissions - St Mary's Hospital



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 represents the opposite. Top three specialties for specific site based on count of activity

- General surgery patients at St Mary's Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at St Mary's Hospital had a similar to expected risk of readmission for elective admissions when compared to the England average. This was an improvement from the previous year when urology expected risk of readmission was higher than the England average.
- Ophthalmology patients at St Mary's Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions - St Mary's Hospital



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 represents the opposite. Top three specialties for specific site based on count of activity

- General surgery patients at St Mary's Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- Trauma and orthopaedics patients at St Mary's Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at St Mary's Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics)

The trust had recently re-implemented the Enhanced Recovery After Surgery (ERAS) programmed in orthopaedics and the programme was in place in general surgery. Physiotherapy staff in general surgery told us the programme helped to improve patient outcomes by providing support pre and postoperatively to support an early discharge. This included supporting patients to be mobile more quickly after surgery and the use of patient-controlled pain relief and the avoidance of the use of catheterisation where possible. Physiotherapy plans were in place for nursing staff to follow and we observed staff supporting patients to mobilise. We requested evidence of audit against the programme to demonstrate the impact on patient outcomes. The service provided us with an undated audit of patients admitted for elective colorectal surgery. The results showed improved length of stay for patients on the programme, for example on the second audit cycle the average length of stay for patients was eight days compared to 10 days for patients not on the programme.

National Hip Fracture Database

St Mary's Hospital

The table below summarises St Mary's Hospital's performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

Metrics *(Audit indicators)*	Hospital performance	Comparison to other Trusts	Meets national standard?
Case ascertainment *(Proportion of eligible cases included in the audit)*	105.2%	Similar	✓
Crude proportion of patients having surgery on the day or day after admission *(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)*	68.1%	Similar	✘
Crude peri-operative medical assessment rate *(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome*)	44.7%	Worse	✘
Crude proportion of patients documented as not developing a pressure ulcer *(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's*	98.8%	Better	✘

admission); this measures an organisation's ability to report 'documented as no pressure ulcer' for a patient			
Crude overall hospital length of stay *(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)*	15.0 days	Better	No current standard
Risk-adjusted 30-day mortality rate *(Adjusted scores take into account the differences in the case-mix of patients treated)*	4.9%	Within expected range	No current standard

(Source: National Hip Fracture Database)

Results showed one area of poor performance in comparison within other NHS trusts; crude perioperative medical assessment rate. Results fell below the National average of 88.7% and at 44.7% was worse than the previous year's results which were 67.7%. There was no orthopaedic geriatrician in post although we were told that elderly patients with hip fractures were reviewed by an elderly care geriatrician. Acutely unwell patients were referred for medical reviews, however we were told that medical reviews for surgical patients were sometimes difficult to establish. We were told there was funding for four whole time equivalent geriatricians, but that recruitment was difficult. At the time of inspection there was one 0.8 WTE in post along with a full-time locum geriatrician. The trust was in the process of developing a frailty pathway and senior staff acknowledged that action to address the geriatrician establishment would need to be part of the pathway.

Bowel Cancer Audit

The table below summarises the trust's performance in the 2018 National Bowel Cancer Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Meets national standard?**
Case ascertainment *(Proportion of eligible cases included in the audit)*	108.3%	Good	Good is over 80%
Risk-adjusted post-operative length of stay >5 days after major resection *(A prolonged length of stay can pose risks to patients)*	51.1%	Better than national aggregate	No current standard
Risk-adjusted 90-day post-operative mortality rate *(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure*)	5.2%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate *(Variation in two-year mortality may reflect,*	15.4%	Within expected range	No current standard

at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)			
Risk-adjusted 30-day unplanned readmission rate *(A potential risk for early/inappropriate discharge is the need for unplanned readmission)*	11.7%	Within expected range	No current standard
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection *(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases, it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)*	50.0%	Within expected range	No current standard

(Source: National Bowel Cancer Audit)

National bowel cancer audit results showed evidence of reduced mortality and unplanned readmission rate. At the January 2018 inspection we saw that the service had developed an action plan in response to this audit. At this inspection we saw evidence of improvement. For example, the risk-adjusted two-year mortality rate had reduced from 29.9% to 15.4%. The risk adjusted 30-day unplanned admission rate had improved from 16% to 11.7%.

National Vascular Registry

The trust did not participate in the most recent National Vascular Registry audit because the trust did not provide vascular services.

(Source: National Vascular Registry)

National Oesophago-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises the trust's performance in the 2018 National Oesophago-gastric Cancer Audit.

Metrics *(Audit measures)*	Trust performance	Comparison to other Trusts	Meets national standard?
Trust-level metrics *(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)*			
Case ascertainment *(Proportion of eligible cases included in the audit)*	>90.0%	Better	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission *(Being diagnosed with cancer in an emergency department is not a good*	9.1%	Better	No current standard

sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)			
Risk adjusted 90-day post-operative mortality rate *(Proportion of patients who die within 90 days of their operation*)	Not eligible	Not eligible	No current standard
Cancer Alliance level metrics *(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.*			
Crude proportion of patients treated with curative intent in the Cancer Alliance *(Proportion of patients receiving treatment intended to cure their cancer)*	42.6%	Significantly higher than the national aggregate	No current standard

(Source: National Oesophago-Gastric Cancer Audit)

In the 2018 Oesophago-Gastric Cancer National Audit (OGCNCA), the trust's case ascertainment was estimated at >90% better than the national average. The trust's results did not show any areas of poor performance compared to other trusts.

The trust was better than other trusts for; age and sex adjusted proportion of patients diagnosed after an emergency admission. The trust scored 9.1%, however this was higher than their 2016 score of 4%.

The trust performed significantly higher than other trusts for the crude proportion of patients treated with curative intent in the Strategic Clinical Network at 42.6%. This was an improvement on the 2016 score of 40.1%.

National Emergency Laparotomy Audit (NELA)

St Mary's Hospital

The table below summarises St Mary's Hospital's performance in the 2017 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard.

Metrics *(Audit measures)*	Hospital performance	Audit's Rating	Meets national standard?
Case ascertainment *(Proportion of eligible cases included in the audit)*	80%	Amber	✘
Crude proportion of cases with pre-operative documentation of risk of death *(Proportion of patients having their risk of*	88%	Green	✓

death assessed and recorded in their notes before undergoing an operation)			
Crude proportion of cases with access to theatres within clinically appropriate time frames *(Proportion of patients who were operated on within recommended times*)	88%	Green	✓
Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre *(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)*	66%	Amber	✘
Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (*Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation*)	95%	Green	✓
Risk-adjusted 30-day mortality rate *(Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)*	10%	Within expected range	No current standard

(Source: National Emergency Laparotomy Audit)

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) for two standards in relation to the proportion of cases with a pre-operative documentation of risk of death and the proportion of high-risk cases with a consultant surgeon and anaesthetist present in theatre. In addition, the trust achieved amber ratings for the crude proportion of cases with access to theatres within clinically appropriate time frames and the crude proportion of highest-risk cases admitted to critical care post-operatively.

The 2018 audit showed improvement with two standards with an amber rating; the proportion of eligible patients included in the audit and the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in theatre. There were no red ratings and three of the standards achieved a green rating for meeting the national standard. Specific action to make improvements included dedicated time post emergency laparotomy to complete the audit, improved risk assessments and working with mainland services and as part of the emergency surgery network.

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises the trust's performance in the 2018 National Ophthalmology Database Audit.

Metrics	Trust	Comparison to	Meets national

(Audit measures)	performance	other Trusts	standard?
Trust-level metrics *(Measures of hospital performance in the treatment of cataracts*			
Case ascertainment *(Proportion of eligible cases included in the audit)*	100.0%	n/a	No current standard
Risk-adjusted posterior capsule rupture rate *(Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.*	0.6%	Better than expected	No current standard
Risk adjusted visual acuity loss *(The most important outcome following cataract surgery is the clarity of vision*)	0.7%	Within expected range	No current standard

(Source: National Ophthalmology Database Audit)

The National Ophthalmology Database audit showed that results were within the expected range or better than expected.

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

The table below summarises St Mary's Hospital's performance in the 2018 National Joint Registry.

	Metrics *(Audit measures)*	Hospital performance	Comparison to other hospitals	Meets national standard?
Trust-level	**Proportion of patients consented to have personal details included *(hips, knees, ankles and elbows)*** *(Patient details help 'track and trace' prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)*	58.3%	Worse	✘
Hospital level: Hips	**Risk-adjusted 5-year revision ratio (for hips excluding tumours and neck of femur fracture)** (*Proportion of patients who need their hip replacement 're-doing')*	1.00	Within expected range	✓
	Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) *(Proportion of patients who die within 90 days of their operation*)	1.00	Within expected range	✓

Hospital level: Knees	**Risk-adjusted 5-year revision ratio (for knees excluding tumours)** (*Proportion of patients who need their knee replacement 're-doing')*	1.00	Within expected range	✓
	Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) *(Proportion of patients who die within 90 days of their operation*)	1.00	Within expected range	✓

(Source: National Joint Registry)

The service was within the expected range for four out of five standards when compared to other hospitals although did not meet the standard in relation to the proportion of patients consented to have personal details included (hips, knees, ankles and elbows).

National Prostate Cancer Audit

The table below summarises the trust's performance in the 2017 National Prostate Cancer Audit.

Metrics *(Audit measures)*	Hospital performance	Comparison to other trusts	Meets national standard?
Men with complete information to determine disease status *(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)*	89.3%	N/A	✘
Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy *(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)*	No data available	No data available	No current standard
Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy *(Complications following surgery may reflect the quality of surgical care*)	No data available	No data available	No current standard
Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy *(External beam radiotherapy uses high-energy beams to destroy cancer*	No data available	No data available	No current standard

cells)			

(Source: National Prostate Cancer Audit)

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

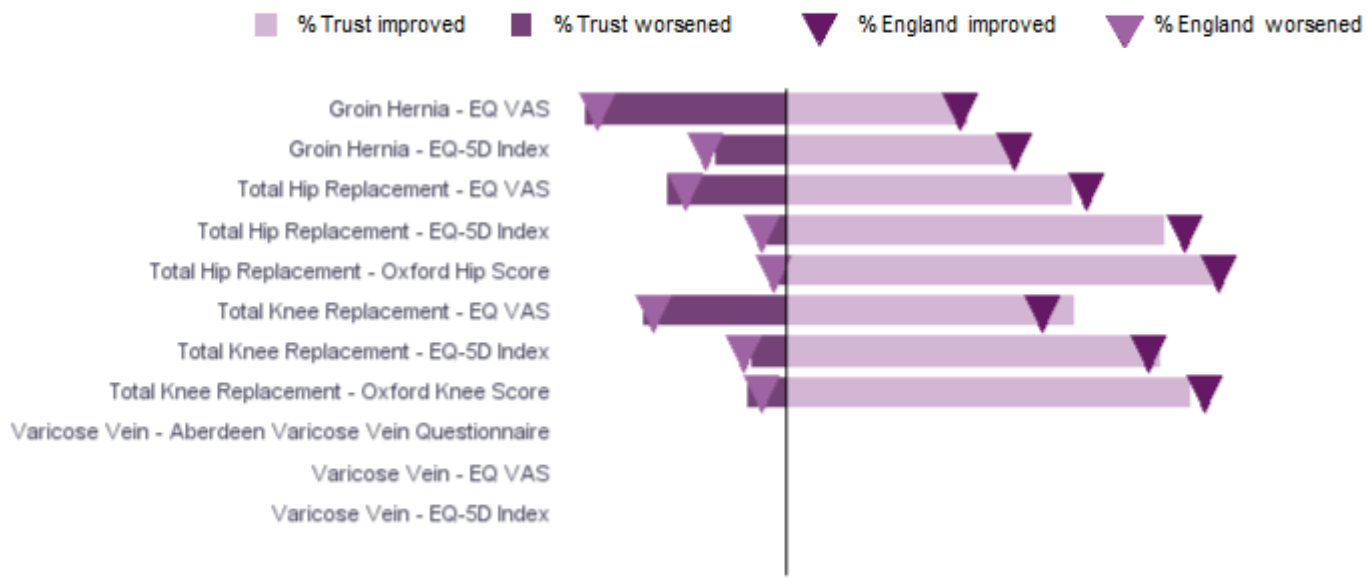
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.



In 2016/17 performance on groin hernias as reported by PROMS was about the same as the England average.

For hip replacements, performance varied depending on the indicator. The trust performed worse than the England average for the EQ-5D index indicator and EQ VAS indicator and performed similar to the England average for the Oxford hip score.

For knee replacements, performance varied depending on the indicator. The trust performed better than the England average for the EQ VAS indicator and the EQ-5D index indicator and performed worse than the England average for the Oxford knee score.

(Source: NHS Digital)

Specialist staff reported receiving patient reported outcome results and attending regular governance meetings where outcomes and quality issues were discussed and learning shared. Staff gave examples of good communication and changes to practice as a result of this information.

As well as the national audits, the service had also carried out local audits in the past year. Audits were seen to be scheduled over the course of the year. These included audits of the surgical safety in theatres, fragility fractures and an audit of the out of hours handover. Examples of audit improvements included the development of a new approach to fluid balance charts with training for staff to support improved practice.

A clinical effectives sub-committee had been developed to improve oversight and ownership at the clinical business unit (CBU) level of clinical effectiveness. Meeting minutes evidenced that audit results were discussed and areas for improvement identified.

Competent staff

There was evidence of improved appraisal completion although appraisals were below the trust target of 85% for five staff groups including nursing and medical staff. Out of hours staff in theatres had not all had their competencies assessed and agency staff working in theatres had only partially completed their inductions.

Appraisal rates

St Mary's Hospital

From April 2018 to February 2019, 72.1% of required staff in surgery received an appraisal compared to the trust target of 85.0%.

The breakdown by staff group can be seen in the table below:

Staff group	April 2018 to February 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Allied Health Professionals	2	2	100.0%	85.0%	Yes
Administrative and Clerical	43	48	89.6%	85.0%	Yes
Estates and Ancillary	5	6	83.3%	85.0%	No
Additional Clinical Services	71	90	78.9%	85.0%	No

Nursing and Midwifery Registered	82	104	78.8%	85.0%	No
Add Prof Scientific and Technic	13	23	56.5%	85.0%	No
Medical and Dental	22	57	38.6%	85.0%	No

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

At 38.6%, the proportion of medical and dental staff who had received an appraisal had worsened since the previous inspection where 75% had previously had an appraisal. However, the trust provided us with updated appraisal completion rates for medical staff up to the end of March 2019. This showed that 100% of medical and dental staff working in the surgical and women & child health service had completed appraisals.

At our January 2018 inspection 65% of nursing and midwifery staff had received an appraisal which was 20% below the trust target. At this inspection 78.8% of nursing and midwifery staff had received an appraisal which was an improvement although remained below the trust target. On the wards senior staff told us they were working towards achieving the appraisal target by the end of June 2019. Wards and departments, we visited had plans in place with the aim to meet this target. For example, on Alverstone ward we were told that sickness had impacted on their ability to complete the appraisals and only 7 out of 20 staff had received an appraisal, although we were told the rest of the team were scheduled in before the end of June.

Staff across the surgical service had completed training in addition to mandatory modules. This included end of life care and responding to the deteriorating patient training. We saw that these modules were monitored by senior staff and that in January 2019 completion rates for end of life care training and deteriorating patient training were between 59% and 100% on the wards and in theatres. ‘Human factors’ training had been provided for surgeons, anaesthetists and theatre staff to improve the culture within the environment. Foundation year doctors told us they received regular training, although did not always have time to complete mandatory training. In addition, some junior doctors report issues with the approachability of senior colleagues and the support/supervision available.

In theatres we saw that competencies were completed based on the post-anaesthetic recovery care qualified practitioner practice document. These competencies covered adults, children and patients with special needs at three levels. We were told that all recovery staff should complete the competencies but, that senior staff were aware that out of hours staff recovered patients who did not have these competencies assessed.

Agency staff working in theatres were given an induction pack to complete. Agency staff were expected to work after a brief tour of the department and there was a reliance on the agency to ensure that staff provided were competent. In the case of long-term agency placements, the agency staff member would undertake the post-anaesthetic recovery care qualitied practitioner competencies in addition to the induction pack. However, two agency staff working in theatres during the inspection had only partially completed the induction packs.

Ward based training and competencies were in place in relation to the administration of medicines, catheter care and pressure ulcer prevention and care. We saw that ward sisters monitored the completion of competencies and we viewed information about this displayed as a reminded for staff on the wards.

Additional training for staff in theatres included paediatric airway training held for the multidisciplinary team and helicopter transfer specialist training. Ward staff had opportunities to

develop link worker skills and different areas, for example in relation to end of life care or infection control.

During the inspection we spoke with a student operating department practitioner and a student nurse on the surgical wards. Both students reported good levels of support from staff and opportunities for learning.

Multidisciplinary working

Staff worked well together as a multidisciplinary team to benefit patients.

At the January 2018 inspection we found that staff in theatres did not always work well together as a team. At this inspection we found that multidisciplinary working in theatres had improved. There was a renewed focus on quality improvement and communication, with staff working together to implement improved practice. Regular meetings and safety briefings took place and staff reported greater consistency and involvement between medical, nursing and allied health professional teams. Staff had attended 'human factors' training to improve team working.

We observed safety briefings and huddles in theatres and saw that all relevant staff were involved including surgeons and anaesthetists. On the wards we observed board rounds and huddles where there was involvement from nursing, medical and allied health professional staff. Hospital navigators were also involved with a focus on identifying patients nearing readiness for discharge and supporting that process. Staff consistently reported improvements in multidisciplinary working.

We saw good evidence of multidisciplinary working across a range of staff groups, including nursing, occupational therapy, physiotherapy, pharmacy, medical staff, the care navigation team, carers lounge staff and senior nursing staff. Twice daily huddles on the wards enabled staff to ensure that pre-assessment, admission and discharge planning took place with a multidisciplinary focus and that information was communicated appropriately and in a timely way.

Hospital at night handovers occurred twice a day during the handover between day and night staff. Attendance included incoming medical and nursing staff, bed managers and the critical care outreach team.

Seven-day services

Key services were not available seven days a week to support timely patient care, however the trust had made some improvements against the priority clinical standards for seven-day services.

The NHS seven-day services programme is a set of 10 clinical standards of which four standards are identified as a priority, to ensure patients admitted to hospital as an emergency receive high quality and consistent care irrespective of whether they attended hospital during the week or at the weekend. The trust carried out regular audits to measure their performance against the priority standards required by NHS England. The latest results on the NHS England website were for March 2018.

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. For standard two, the weekday results were 72%, but the weekend results were higher at 87%. Weekend results showed an improvement since 2017 when the results were 60%.

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 a timescale for reporting on diagnostic tests. The March 2018 survey results showed 100% performance against this standard Monday to Friday and 87% performance 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 2018 survey results showed 88% performance against this standard Monday to Friday and 100 % at weekends. Weekend results showed an improvement since 2017 when the results were 67%.

Priority clinical standard 8 requires trusts to ensure all patients with high dependency needs are be 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 2018 survey results showed 98% performance against this standard Monday to Friday and 88% at weekends.

We spoke with physiotherapy staff on the wards providing support to patients and ward staff around the service's enhanced recovery programmes, they told us that physiotherapy input for patients was not provided on a seven-day basis as allied health professionals worked Monday to Friday. However, physiotherapy for ERAS (Enhanced Recovery After Surgery) orthopaedic patients was provided six days a week with an on call service on Sunday.

Pharmacy services were available seven days a week. There was an on-call service for when the pharmacy closed.

Health promotion

Staff gave patients support and advice to lead healthier lives.

We saw that health promotion materials including leaflets and posters were available in the surgical wards and departments. This included information reducing the risk of a further stroke and supporting people to live well.

We saw that leaflets and booklets were available and given to patients before and after treatment to promote self-care and good health. Discharge leaflets were given to patients prior to them going home. The nursing needs assessment and care plan document included an assessment of alcohol intake. The assessment included a score, with prompts to offer brief advice or onward referral to specialist services. An assessment of smoking habits was also undertaken, and staff were prompted to offer smoking cessation medication or onward referral to stop smoking services based on the patient's wishes.

Enhanced recovery after surgery services were in place for both general surgery and orthopaedics. The programme involved offering additional support and guidance to patients undergoing surgery, with an aim of enhancing their recovery so that they could go home as soon as possible. Guidance included aspects of care aimed at improving mobility, pain control and general health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently show an understanding of how to support patients who lacked capacity to make their own decisions or were experiencing mental health. There were improvements seen in checks of consent for patients undergoing surgery.

Mental Capacity Act and Deprivation of Liberty training completion

St Mary's Hospital

The trust set a target of 85.0% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training modules from April 2018 to January 2019 for qualified nursing staff in surgery at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	92	120	76.7%	85.0%	No

In surgery the target was not met for the MCA/DOLS training module for which qualified nursing staff at St Mary's Hospital were eligible.

A breakdown of compliance for MCA/DOLS training modules from April 2018 to January 2019 for medical staff in surgery at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	44	63	69.8%	85.0%	No

In surgery the target was not met for the MCA/DOLS training module for which medical staff at St Mary's Hospital were eligible.

The trust has reported that the Mental Capacity Act training module incorporated Deprivation of Liberty Safeguard training.

Staff we spoke with had some understanding of how and when to assess whether a patient had the capacity to make decisions about their care, however this was not consistent. Training rates showed improvement since our previous inspection. For example, at the last inspection only 22.2% of nursing staff in surgery had completed Mental Capacity Act training, at this inspection the training rate had improved to 76.7%. This remained lower than the trust target of 85%. On Whippingham ward we saw that while training completion for staff was at 76%, most of those who had not yet completed it had been booked to attend.

Although staff referred to patients' capacity in their notes, there was no formal documentation of Mental Capacity Act assessments or best interest meetings in any of the care records we reviewed. We reviewed the records of a surgical patient on Whippingham ward where a 'do not attempt resuscitation' order was in place, however there was no indication of the patient's mental capacity noted.

We spoke with a member of the learning disability team who told us that they had regular weekly best interest meetings for patients with a learning disability. This involved discussions with the

relevant medical teams about patients with a learning disability where surgery was proposed with plans recorded in patient records on how best to support them.

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. At the previous inspection we found that the final check of consent was not done consistently by anaesthetists within theatres. At this inspection we saw an improvement in checks carried out by anaesthetists.

We saw examples of signed consent for interventions such as catheter insertion.

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, taking account of their individual needs. However, on St Helens ward arrangements for the pre-operative care of patients in the day room meant that staff were not always able to protect their privacy and dignity. Feedback from patients and relatives included that care for patients at night was not of the same standard as during the day. Friends and family test survey completion rates were low, meaning that services were not always aware of patient feedback in order to improve.

Friends and Family test performance

The Friends and Family Test response rate for surgery at Isle of Wight NHS Trust was 13.5% which was worse than the England average of 24.0% from January to December 2018.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	
Day Surgery Unit	261	12%	98%	98%	99%								100%	100%	98%
Luccombe Ward	220	37%	95%	93%	100%				95%	100%	100%	92%	94%	100%	96%
Mottistone Suite	192	33%	80%	100%	97%			98%		95%	100%				97%

Key: Highest score to lowest score — 100% | 50% | 0%

4. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.
5. Sorted by total response.
6. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

The percentage of patients who would recommend the service ranged from 80% to 100% between January 2018 and December 2018. There were consistent gaps in recording and staff reported there had been issues in getting patients to complete the survey. The response rate for surgery at 13.5% had deteriorated since the 2017 survey results when it was 24%.

The trust provided us with results across the service for April 2019 where a total of 59 surveys had been received from patients on surgical wards. Response rates for each ward ranged from nine to

11 completed surveys. Results of patients recommending the service ranged from between 93% and 100%. The overall percentage of patients recommending the surgical service was 98%. May 2019 results showed 70 completed surveys, all through paper responses at the point of discharge. Results varied between 75% and 100% of patients recommending the service. There was no text, electronic, online of phone surveys completed. Friends and family test results were not displayed on the wards.

We spoke with nine patients and relatives on the wards and an additional 20 members of the public at a focus group during the inspection. Feedback from patients we spoke with on the wards was positive, as were 16 of the 17 completed comment cards we received from patients and relatives using the service during and in the lead up to the inspection. Positive comments included that staff were compassionate and caring, kind and attentive. However, feedback from the focus group was mixed with patients highlighting a concern about the number of staff on duty, particularly at night. For example, we heard that the care people received at night was perceived to be worse than during the day, that too many things going on at night impacted on people's sleep and that when wards were short staffed staff could be dismissive. People told us there was a correlation between high use of agency staff and delays in answering call bells at night.

We observed staff interacting with patients in a kind and caring way. They were friendly and approachable and spent time with patients. Staff reported that they were satisfied with the quality of care they were able to give patients although on wards where there were staffing issues this was sometimes more difficult. For example, on Whippingham ward nursing staff told us they would sometimes have to stop in the middle of medicines administration to respond to the needs of patients which they felt was not safe practice.

One patient told us that 'the care and medical attention I have received has been first class. It is clear that the whole team have the patient at the heart of everything they do'. Another on St Helens ward told us that 'nothing was too much, and the care was amazing' and a third 'I have received the very best care on Alverstone ward.' A patient in the pre-assessment clinic reported that staff were caring, helpful and efficient.

A member of the housekeeping team on St Helens ward told us that staff would regularly 'do more' for patients and worked as a team to make them feel comfortable and reassured. For example, we were told that a member of staff had made a birthday card for a patient.

We saw evidence of 'thank you' letters on the wards and comments included that patients had been treated with kindness and supported to feel as comfortable and relaxed as possible during their admission and prior to surgery.

We saw staff worked to maintain their patient's privacy and dignity. Patients in theatres and recovery had their dignity maintained at all times. On St Helens ward we were told that patients would regularly be cared for in the day room prior to surgery as the admissions lounge was not always in use. We were told of an incident the week before inspection where a patient had to receive bowel preparation prior to surgery and because a bed space wasn't free they had to wait in the day room. Staff were concerned for the patient's dignity and privacy and had reported this as an incident, nursing staff advocated for patients who were in this situation. Service leads told us that a working group had been set up to look at issues of bed occupancy which included ways to improve privacy and dignity while patients were waiting for a bed. This included using other departments for patients requiring specific preparation prior to theatre.

Emotional support

Staff provided emotional support to patients to improve their wellbeing and make their admission more comfortable.

We received positive feedback from a patient who had been admitted following a fall, they told us they had felt very anxious and distressed prior to surgery and described the staff member who had supported them at this time as a 'godsend.'

Patients said they found staff to be supportive and reassuring, particular when patients were feeling anxious about surgery. We observed staff to be sensitive to patients' needs and saw that they aimed to treat them holistically in a way that met their emotional as well as physical needs.

A chaplaincy service was available at the hospital to provide support for patients around religious and spiritual needs. The service was designed to provide support for people from multiple faiths and those with none. We received positive feedback from patients about the support they had received from the chaplaincy service.

Understanding and involvement of patients and those close to them

Staff provided support and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Feedback from patients we interviewed was that they had clear plans of care in place and had been involved in their post-operative care and discharge planning. However, family members we spoke with about a patient who had been an inpatient within the surgical service for many weeks told us that the plan of care was unclear, and that ineffective information sharing had impacted on this.

One comment card we received detailed how staff provided a good explanation around interventions and care and how this had helped to reduce the patient's extreme anxiety. A patient on St Helens ward reported that staff had given them a good deal of information which helped to put their mind at rest. They were given time to ask questions and told us that nothing was too much trouble for the staff. Other patients told us that the information provided prior to surgery helped them to understand what to expect from both the surgery and their admission. Patients we spoke with confirmed their treatment had been discussed with them and they felt able and supported to make informed decisions. Patients told us they were signposted to other services for support on discharge.

There was support available to carers in a carers lounge. There was signposting to the lounge in ward areas stating that 'carers are welcome here'. Staff from the carers lounge visited the wards to find out if there were carers who may want to use their services. A member of the carers lounge team attended the huddle on Whippingham ward in order to identify carers who may need support. The ward sister told us that support had been provided to a family of a patient who had been in hospital for several weeks and that carers could visit the lounge to rest. Ward staff reported that the carers lounge was a useful space for carers. This included signposting to other service for ongoing support for carers.

Is the service responsive?

Service delivery to meet the needs of local people

The service provided did not always reflect the needs of the population served. Facilities and premises were not always appropriate for the services delivered, however there were clear plans in place to address this.

During inspection we were told by a number of surgeons that there were some difficulties associated with a lack of high dependency beds for elective patients. This meant that they sometimes had to cancel surgery if an intensive therapy unit (ITU) bed was not available. Where patients had more urgent needs they would be transferred to the mainland. There were arrangements in place with two mainland NHS Trusts to support the services on the island. We were told that discussions had begun around more formal long-term arrangements as part of a strategy for surgery on the island. Expressions of interest had been requested from other trusts and there was a broad plan for 89% of surgery to take place on the island and 11% to take place on the mainland.

There were issues with capacity on the day surgery unit and at our January 2018 inspection we identified that the environment was not suitable due to mixed sex breaches on the day surgery unit ward. During this inspection we found that the service had undertaken a risk assessment in relation to the mixed sex breaches and there were mitigating actions in place to ensure breaches did not occur. In addition, there were longer term plans to refurbish the day surgery unit to increase capacity by 20 – 30% and provide a long-term solution to the risk of mixed sex breaches. We were told that the changes were in the planning phase and that an initial date to begin work in April 2019 had to be moved due to bed capacity issues. The work was planned to take place when there was less pressure on beds and we were told this was likely to be the end of June 2019.

The service had developed an admission lounge next to theatre to relieve the pressure on wards undertaking pre-operative admission processes. However, the lounge was not yet fully utilised due to staffing difficulties.

Meeting people's individual needs

The service took account of patients' individual needs. They had services in place to support patients with a learning disability on their journey through surgery. However, the process to review and update individual care plans for patients on longer term admissions needed to improve.

All patients requiring elective surgery had a pre-operative assessment. Specific needs were identified and referrals to the appropriate teams or specialist nurses were made. This meant that reasonable adjustments were made to facilitate admission. For example, orthopaedic patients requiring hip or knee elective joint surgery were engaged as part of the enhanced recovery programme which meant that there was a clear focus on their rehabilitation needs prior to admission.

There were systems and staff members in place to aid the delivery of care to patients in need of additional support. A national scheme to identify and support patients with dementia or impaired memory had been adopted. Dementia nurses and practitioners were available to support patients and ward staff. A trust wide dementia strategy was in the process of being adopted, providing clear priorities for how the trust and the services were going to meet the needs of patients over the long term.

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.

Patients with learning disabilities were referred to the learning disability liaison team prior to admission. An assessment was carried out by the team and arrangements were in place to introduce patients to the surgical pathway prior to admission to aid familiarisation. For example, patients with a learning disability could be taken through the admissions process, meet staff and shown the equipment that would be used prior to admission. In addition, weekly best interest meetings were held between the learning disability team and anaesthetic and surgical teams as to review the needs of patients.

The service had developed a number of information leaflets for patients. For patients on the enhanced recovery programmes, they had leaflets about the surgery and what to expect. However, we were told that as the enhanced recovery programme in orthopaedics had only recently started up again, these leaflets were due to be updated.

Staff reported that interpretation services were available and could be accessed by phone. They told us that this was an 'over the telephone' service where translation was available in over 100 different languages. British sign language interpreters were also available to support deaf patients, information prior to admission or appointments about accessing the hospital included a request to inform the service of any communication needs or interpretation requirements. Staff knew how to access the service and reported recorded barriers to communication in patient's records so that their communication needs could be anticipated.

There was a memory service nurse liaison team within the hospital. The team provided support to patients and their carers, as well as to the ward staff to ensure that the patient's needs were met during admission. We did not see any patients with dementia at the time of our inspection, however staff reported that the 'hospital passport' was in use. The passport provided a straightforward way of recording information about the individual and their likes and dislikes, background and important events in their lives, supporting the process of the delivery of person-centred care.

At our January 2018 inspection we found that there was some provision for people living with dementia on the surgical wards with a bay on Luccombe ward that had been adapted for people with dementia. At this inspection the arrangements remained the same as the previous year, however, a draft dementia strategy that was due to be adopted by the clinical standards group in June 2019 detailed clear priorities for improving dementia care across the trust. Priorities included the development of 'dementia friendly' areas with secure, safe, comfortable, social and therapeutic environments. We saw that this process of development had begun on the medical wards within the hospital.

Staff reported that they had recently completed dementia training. There were 'fidget boxes' available with items for patients to handle and use to help reduce their agitation. On Whippingham ward, we were given an example of a patient with dementia where staff used their knowledge of the patient's past to help keep them calm on the ward. This included staff purchasing vegetables for the patient to peel as 'meal preparation' as it was an activity that was familiar to them. Staff said they had good support from the memory liaison team, who met with patients and their carers and helped with strategies and guidance. Staff also told us they were able to access one to one support for patients with extreme agitation or where there was additional risk.

Care plans were completed on admission. Standard templates were in use although staff reported they tried to individualise the plans as much as possible. We saw evidence of this, particularly where there was multidisciplinary input. However, we viewed the care plan of one patient who had been an in-patient (across three different wards) for several weeks and saw that their care plan had not been updated. For example, the plan recorded that the patient was 'nil by mouth' when

this had not been the case other than at the very beginning of their admission or prior to surgery. Staff reported that they thought care plans were geared towards shorter admissions and while we were told they were reviewed on a daily basis this was not always clearly recorded.

Access and flow

Patients could not always access the service when they needed it to receive the right care promptly. Patients stayed in hospital longer than average following non-elective surgery and in some specialities for elective surgery. Waiting times from referral to treatment had deteriorated and were significantly below average. Urgent treatment delays led to compromised patient care in some cases.

At the January 2018 inspection we found that the trust had a 'winter plan' in place, in preparation for an expected rise in medical and surgical emergency admissions. The plan was focused on creating adequate capacity to meet the increased demand and using elective surgical and rehabilitation beds to meet the increased emergency need. At this inspection we found that the trust continued to use elective beds to meet the needs of increased emergency admissions. Whippingham ward (emergency surgery) had mostly medical patients on the ward; St Helen's (elective surgery) had a combination of elective and emergency patients (surgery and medical); Mottistone (private ward) was taking elective orthopaedic patients; Luccombe (trauma) had a large proportion of medical patients; and, Alverstone (elective orthopaedic surgery) remained non-elective with efforts to return to elective surgery in the weeks before our inspection lasting only a few weeks.

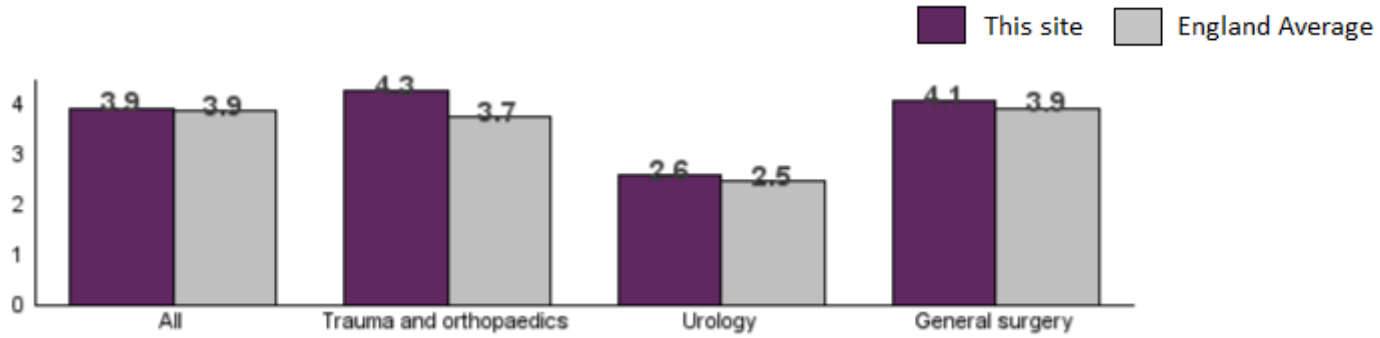
Bed capacity in the Day Surgery Unit (DSU) had been identified as an issue and there were plans in place to expand the unit. In order to do this the service planned on moving patients from Whippingham ward to Compton ward (currently the 'winter pressure' ward) so that the day surgery patients could move to Whippingham ward. Plans for this work had been due to commence at the end of April 2019 but the trust had been unable to due to pressure on beds.

Average length of stay

St Mary's Hospital

From January to December 2018, the average length of stay for patients having elective surgery at St Mary's Hospital was 3.9 days, which is the same as the England average. The average length of stay for patients having non-elective surgery at St Mary's Hospital was 6.5 days, which was higher than the England average of 4.7 days.

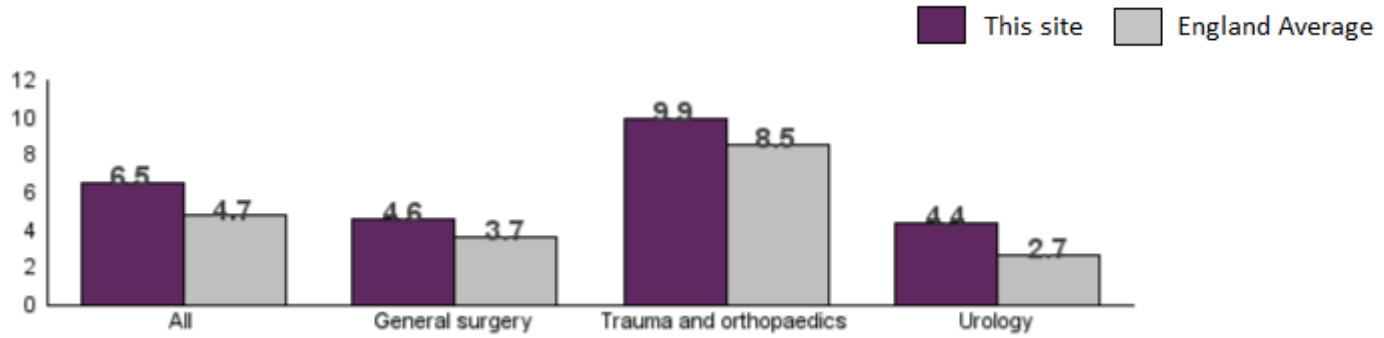
Elective Average Length of Stay - St Mary's Hospital



Note: Top three specialties for specific site based on count of activity.

- The average length of stay for patients having elective trauma and orthopaedic surgery at St Mary's Hospital was 4.3 days which is higher than the average for England which was 3.7 days.
- The average length of stay for patients having elective urology surgery at St Mary's Hospital was 2.6 days which is slightly higher than the average for England which was 2.5 days.
- The average length of stay for patients having elective general surgery at St Mary's Hospital was 4.1 days which is slightly higher than the average for England which was 3.9 days.

Non-Elective Average Length of Stay - St Mary's Hospital



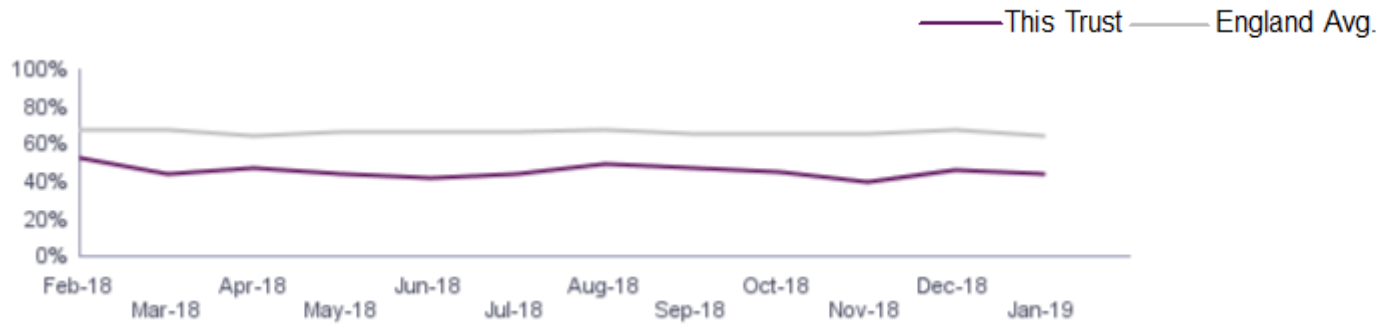
Note: Top three specialties for specific site based on count of activity.

- The average length of stay for patients having non-elective general surgery at St Mary's Hospital was 4.6 days which is higher than the average for England which was 3.7 days.
- The average length of stay for patients having non-elective trauma and orthopaedic surgery at St Mary's Hospital was 9.9 days which is higher than the average for England which was 8.5 days.
- The average length of stay for patients having non-elective urology surgery at St Mary's Hospital was 4.4 days which is higher than the average for England which was 2.7 days.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

In each of the months from February 2018 to January 2019 the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery. This was a deterioration compared with the time of our previous inspection when three specialities were above the England average for RTT rates.

Specialty grouping	Result	England average
Ear, nose & throat (ENT)	69.4%	60.8%

Five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	68.8%	76.1%
General surgery	59.6%	71.9%
Oral surgery	50.5%	57.2%
Trauma & orthopaedics	39.1%	58.8%
Ophthalmology	25.8%	65.5%

Some improvement was seen in ENT surgery when compared with our previous inspection in January 2018 with the ENT RTT rate showing an improvement of 7% in this time. However, all other specialities showed worsening performance. At 39.1% trauma and orthopaedics showed a 25% reduction in performance, at 50.5% oral surgery showed a 26% reduction in performance and at 59.6% general surgery showed a 13% reduction in performance.

We saw that a 2018/19 recovery plan had been developed where the service had agreed to deliver an RTT performance of 89.3% against a target of 92%. However, performance had started to deteriorate after the first quarter due to pressures on elective beds from emergency admissions and unexpected increased activity over the summer period. Staff reported that a significant number of medical outliers (medical patients cared for on non-medical wards) had been cared for on surgical wards. For example, at the time of inspection Whippingham ward was mostly made up of medical patients with only five surgical patients despite being a surgical ward. In turn this meant that St Helens ward which usually took elective surgical patients had a majority of non-elective patients. Staff reported that this impacted on the flow of surgical patients through the hospital.

We asked the service leads if there was a recovery/improvement plan for the current year but were told that improvement was not possible to achieve due to the contract arrangements with the clinical commissioning group (CCG) resulting in higher activity impacting on the timeliness of elective surgery. They told us that the volume of activity demand exceeded planned activity and as such there was an agreement in place with the CCG that RTT performance would be lower.

At our January 2018 inspection we were told that the trust had set up a workstream to improve RTT rates and that milestones had been identified and there was an ambition to achieve 85% theatre utilisation rates from 79.9% in October 2017. At this inspection theatre utilisation rates were at 74% in February 2019 and that this was an improvement compared with 60% utilisation in April 2018. Improvements in theatre utilisation had been as a result of the work of the theatre steering and user groups.

At this inspection we were told that weekly meetings with operational leads and booking teams looked at equitable use of resources and RTT optimisation. This included a review of patients in order of the date of referral and a clinical harm review by clinicians for patients who had a long wait and in order to prioritise. Clinicians described RTTs as a big challenge and told us that patients waiting for elective hip surgery could wait between 40 and 52 weeks.

Referral to treatment times were discussed at speciality departmental meetings where breaches were reviewed, including those where there had been harm to the patient and those where there had been no harm. We saw that this approach was consistent across all specialities.

During inspection we were told of incidents where patients waited for weeks to months for an urgent endoscopic retrograde cholangiopancreatography (ERCP), a technique to diagnose and treat certain biliary or pancreatic problems. We viewed incident reports relating to this and saw that these were being investigated as a cluster. The incidents included patients who became unwell while waiting for urgent treatment where there was a delay of up to five months. One patient had been admitted to the intensive therapy unit, another had two admissions to hospital while waiting for the procedure and a third had three admissions to hospital while waiting for the procedure. The incidents had been reported at the point when treatment was provided, several months after the initial incident. They were continuing to be investigated at the time of our inspection (approximately two months from the date of reporting) and the latest information provided by the trust indicated that a table top review had not resulted in agreement, therefore a whole service review was being carried out with involvement from the executive team.

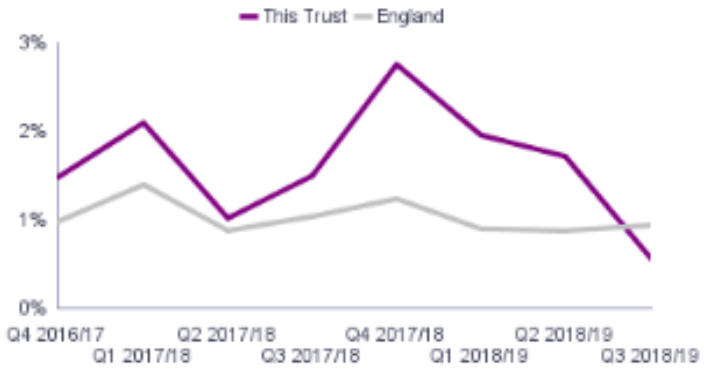
Patients requiring emergency surgery were prioritised based on clinical need. We requested data from the trust on incidents relating to any delays in emergency surgery and were informed of one delay that had been reported as a serious incident.

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 two years, the percentage of cancelled operations at the trust was generally higher than England average, although in the most recent quarter the cancelled operations at the trust as a percentage of elective admissions was lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations. Overall this was a worse picture than at our previous inspection in January 2018, however steady improvements had been made since quarter four 2017/18.

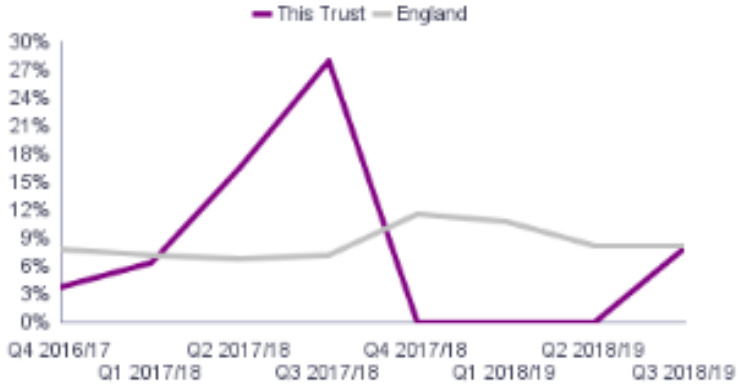
Cancelled Operations as a percentage of elective admissions - Isle of Wight NHS Trust



Over the two years, the percentage of cancelled operations not treated within 28 days fluctuated greatly with the highest percentage reported in Q3 2017/18 (28% not treated within 28 days). Cancelled operations as a percentage of elective admissions only includes short notice

cancellations. In the most recent quarter (Q3 2018/19), 8% of cancelled operations at the trust were not treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Isle of Wight NHS Trust



(Source: NHS England)

The service had implemented weekly theatre capacity meetings attended by a range of staff across the surgical service. A WhatsApp group had also been set up, providing real time information about theatre utilisation and the reasons lists started late or overran. Information about theatre lists was circulated daily and where there were gaps or cancellations these lists were offered to other specialities. For example, we saw evidence that vacant theatre lists had been offered for elective trauma and orthopaedics.

Patient moving wards per admission

From January to December 2018, 99.5% of individuals did not move wards during their admission, and 0.5% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From January to December 2018, there were 12 patients moving wards at night within surgery. The following wards reported instances of patients being moved at night; Whippingham Ward (seven ward moves), Luccombe Ward (three moves) and Alverstone Ward (two ward moves).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Staff reported improvements in the volume of bed moves. For example, on St Helen's ward nursing staff told us that patients used to move wards on a regular basis but that they now generally moved only because of clinical reasons. However, we received feedback from the family of a patient who had been admitted several weeks before and they told us the patient had been moved four times.

On Mottistone ward we were told that the consultant on call was available to discuss the admission of elective patients to the ward when the hospital has reached bed capacity. There was a standard operating protocol to guide staff should beds be requested for non-elective or non-orthopaedic patients.

Discharge planning for patients was undertaken by ward staff in conjunction with the navigation team who supported planning to ensure that further support was in place for the patient including transfer to the discharge lounge and a home help assessment prior to discharge. Patients were reviewed by the multidisciplinary team prior to discharge including physiotherapy, occupational therapy, medical staff and pharmacy. We observed ward huddles using a hand over board and discussions about potential discharge dates and any blocks to this. Staff were aware and mindful of patient flow and an assessment of discharge needs was carried out as part of the admission process. A twice daily bed meeting was carried out where beds were allocated for patients admitted for elective surgery. We also observed discussions in the night time handover about capacity and the number of elective admissions planned alongside of the number of emergency beds required for patients in the accident and emergency department.

Patients who were fit for discharge but were waiting for medicines, transport or for the discharge process to be complete were transferred to the discharge lounge where possible. Feedback from patients about delays in their discharge included mixed experiences in terms of waiting for medicines to take out (TTOs). However, some patients we spoke with as part of a focus group told us they believed there had been improvements in this area. The pharmacy department audited the time it took for TTOs to be dispensed and this was between 1 hour and 29 minutes and 2 hours and 27 minutes in the three months between March and May 2019.

Surgical outliers (surgical patients cared for on a non-surgical ward) were monitored and recorded. Data provided by the trust over a 12-week period between February and April 2019 showed on average there were 1.5 patients per day identified as surgical outliers. Staff reported that this was usually general surgical patients on an orthopaedic ward or the medical admissions unit. Staff did not report any problems with surgical outliers not receiving appropriate medical treatment and care because they were cared for on a non-surgical ward.

A theatre admissions lounge had been developed next door to theatre. The aim was for elective patients to be admitted through the lounge to relieve the pressure on beds that were not yet vacant. Staff reported that there had been issues with staffing the lounge, so patients regularly continued to be admitted through St Helen's ward. At the time of inspection all patients for elective general surgery were admitted through the lounge. However, we were told by ward staff on St Helens that they weren't certain that this would continue in the mid to long term until the staffing issue had been resolved.

We were told there had been incidents of patients being admitted for surgery with no bed allocated and that this had impacted on theatre efficiency but not patient harm. However, staff reported that this had sometimes impacted on patient's privacy and dignity and their ability to provide care. For example, in relation to a patient receiving pre-operative bowel preparation and having to wait in St Helen's day room as a bed was not free. In addition, we viewed an incident from April 2019 where a patient with diabetes, a left sided weakness and breathing difficulties had to wait in the day room. Staff reported they were unable to check the patient's pressure areas, change their position or monitor their diabetes appropriately. We requested data about the proportion of patients prepared for theatre in the theatre admissions lounge and those prepared in the day room of St Helens ward, but this was not provided. We reviewed minutes from theatre admissions meetings but, did not see evidence of discussions about the issues of patients being prepared for theatre in the day room. There was, however discussions about improving staffing within the theatre admissions lounge.

Staff reported that patients not having a bed pre-operatively was a weekly occurrence. Senior staff told us that bed management processes had been developed to enable continual monitoring and

decision making about bed utilisation and theatre lists. They told us that this had been instrumental in a recent reduction in short term cancellations.

Learning from complaints and concerns

The service investigated concerns and complaints. The service identified lessons learned and shared these with staff and there was evidence of improved practice as a result of this. However, the responses to complaints were not always completed in a timely manner.

Summary of complaints

St Mary's Hospital

From January to December 2018 the trust received 91 complaints in relation to surgery at St Mary's Hospital. The trust took an average of 43.4 days to investigate and close complaints, and 30.0% were closed within 30 working days. This was not in line with their complaints policy, which states that 75% of complaints should be closed within 30 working days. We spoke with one patient who told us they had made two complaints about their treatment and care during previous admissions, including post-operative complications. They told us that the response to their complaint had not been within the time frame provided by the trust. However, they also told us they received a phone call informing them of the delay.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Communication	21	23.1%
Clinical treatment - Surgical group	20	22.0%
Values and behaviours (staff)	13	14.3%
Admissions and discharges excluding delayed discharge due to absence of a care package - see integrated care	6	6.6%
Patient care	5	5.5%
Appointments	4	4.4%
Waiting times	4	4.4%
Access to treatment or drugs	4	4.4%
Trust admin / Policies / Procedures including patient record management	2	2.2%
Prescribing	2	2.2%
Facilities	2	2.2%
Post-treatment complications	2	2.2%
Clinical treatment - Accident and emergency	1	1.1%
Clinical treatment - Paediatric group	1	1.1%
Clinical treatment - Anaesthetics	1	1.1%

Delay/failure/inadequate observations incl monitoring	1	1.1%
Privacy, dignity and wellbeing	1	1.1%
Consent	1	1.1%
Total	**91**	**100.0%**

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

Patients we spoke with were aware of how to complain and there was evidence of learning from complaints. For example, a patient on Mottistone ward had complained about the length of time tablets to take out (TTOs) took to be dispensed leading to a prolonged wait in the discharge lounge. Action was taken to include communication with staff at handover and in the communication folder to reduce the risk of future delays. Specific action included that the patient would only go to the discharge lounge once their TTOs had been prescribed.

On Alverstone ward a complaint about a missing piece of jewellery led to a daily audit of patient property checklists to ensure these were better completed and reduce the risk of the incident happening again.

Learning from complaints was discussed team meetings and we saw evidence of information being shared with staff about complaints in the quality folders kept on the wards. There were information boards on all wards and these included a 'you said, we did' section where any themes or issues identified from patient feedback would be shared alongside the action taken as a way of sharing the improvements with patients and staff alike.

Number of compliments made to the trust

From April 2018 to December 2018 the trust received 1,179 compliments regarding acute services at the trust. Due to the way in which compliments are captured by the trust, it has not been possible to split the number of compliments by team or core service.

The trust has identified a number of key themes from the compliments received across the trust. The trust identified the following themes:

- The main compliment received is with regard to staff behaviour. Staff are described, through individual experiences, to behave in a manner that is kind, patient, friendly, professional, courteous, caring, compassionate, helpful and understanding.
- Treatment with dignity and respect
- Effective and responsive ED
- Excellent care
- Helpful, friendly and efficient Administrators/Receptionists.

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

Is the service well-led?

Leadership

Leaders understood the challenges facing the service but there were areas of risk that were not being sufficiently prioritised. Ward leaders were visible and approachable but, some

junior medical staff had concerns about the approachability of their senior colleagues and did not always feel that their concerns were addressed. Interim management posts were evident within the service and staff reported a lack of visibility of some senior care group staff.

The surgical service was part of the Surgery, Women's and Children's (SWCH) care group which sat within the acute services division and was led by a clinical director. The SWCH care group was led by a clinical director, associate director of operations and a head of nursing and quality.

Nursing staff on the wards and staff in theatres reported that ward sisters were visible and supportive, and they felt confident about escalating issues and concerns. Ward managers felt supported by matrons and operational leads, however reported that matrons responsible for the wards were interim and new in post. Nurses reported being aware of who the matrons were but told us that they had not had much contact with them and in some cases reported that they believed the matrons' time was taken up managing beds and the flow of patients through surgery. There was an interim theatres manager in post covering main theatres and the day surgery unit, in addition there was an operations manager responsible for these areas.

Junior medical staff reported that the approachability of middle grade doctors and the support provided was variable. There was also a view amongst some junior medical staff that their concerns and issues were not always looked into or addressed by leaders.

Not all staff on the wards knew who senior care group and trust leaders were.

Vision and strategy

There were acute service, nursing and quality strategies in place and staff were aware of these, however there was no surgery specific strategy in operation.

There was an operational plan in place for acute services but not a specific surgical strategy. We asked the surgical care group leads about their vision and strategy. They told us that this was based on partnership arrangements with mainland services in order to build a strategy together where 89% of surgical activity was on the island and the remaining 11% on the mainland. The leads told us that a call for expressions of interest from mainland providers had been made but as yet there was no clear strategy in place.

The 2020/21 acute services operational plan was in draft form and had identified priorities such as a redesign of the acute services, theatres productivity, and getting beyond 'good'. In addition, there was a trust wide quality improvement strategy based on the 'getting to good' turnaround objectives. These objectives had a patient safety focus and were identified as to; 'empower and motivate team ownership; innovate and challenge, improve our staff value and worth; and, improve care for our patients'.

We viewed the trust wide strategy and saw that values had been identified relating to patient care, team working and improvement. There was acknowledgement that the Isle of Wight had a higher than average proportion of older people and a need to be more 'age friendly'. There was a clear aim to become a centre of excellence for the care of older people. Surgical leads told us that there had been discussions around a frailty pathway and there was a clear desire to deliver this, however detailed plans had yet to be developed and we were told that blocks were apparent, such as staffing issues.

Ward staff were engaged with the nursing and quality strategies but, told us they were concerned about conflicting priorities in relation to service level priorities such as the development of the day

surgery unit and the proposed loss of beds during the refurbishment, at a time when pressure on beds was already high. One member of ward staff told us that clinical directorate meetings involved service leads advocating for their own service and they did not believe there was sufficient leadership oversight to take plans forward.

Culture

There was evidence of an improved culture in theatres and the culture on the wards was centred on the needs of patients. However, junior medical staff did not always feel supported and listened to and there were suggestions that issues, and concerns were not being escalated because of this.

At our January 2018 inspection we found there was a culture within theatres amongst some medical staff where the behaviours were not always positive and there had been a failure to deal with concerns. At this inspection we found that medical and theatre staff had undertaken 'human factors' training to improve communication and behaviours. Staff were encouraged to speak up if they had concerns and we observed posters reminding staff to 'stand up to bullying' and 'say nothing – nothing changes'. Freedom to Speak Up advocates had been identified and there was a structured meeting programme supporting improved communication.

Staff in theatres told us they felt that there were increased levels of respect between colleagues. They spoke of improved engagement between anaesthetists, surgeons and theatre staff and more open communication. One member of staff described a 'family' atmosphere where support was apparent. Staff on the day surgery unit told us that morale had been poor but, was now much improved. Surgical leads told us they felt there had been a significant improvement in the culture within theatres.

Junior doctors told us they did not always feel supported by senior colleagues. They reported mixed experiences in the approachability of senior colleagues. In addition, they reported issues ranging from a lack of senior support for clinical decision making, being expected to start work earlier than scheduled, regularly finishing late or struggling to take annual leave and complete mandatory training. We also heard from some medical staff that they did not receive feedback when raising concerns and were not confident that their concerns would be addressed. This included concerns about clinical competence, a perceived lack of follow up when things went wrong and a fear of possible retribution. We were told that not all medical staff were reporting incidents and concerns because of this.

There was an open, supportive and respectful culture amongst staff on the wards and we observed cooperative and supportive relationships. There was a focus on the needs of patients and we heard examples of where staff had gone out of their way to provide support. We heard there was support for appraisal and career progression and staff consistently told us that ward managers were supportive and focused on staff development needs. For example, on one ward we spoke with a deputy sister who told us they had regular support sessions with the ward sister to increase their confidence in their role.

Governance

The governance arrangements had improved, however minutes from mortality and morbidity meetings were not in line with the Royal College of Surgeons guidelines and there were concerns that issues raised in relation to this were not being followed through effectively.

There was evidence of improvements to the governance of the surgical service. There was a consistent approach to discussing governance matters which was an improvement from the January 2018 inspection. There were theatre steering and user group meetings, clinical lead meetings, quality risk meetings, monthly and weekly leadership meetings and speciality department meetings. The recording of these meetings had improved, and we saw consistency in the recording of quality and risk. For example, issues such as incidents, complaints, patient flow and referral to treatment times were discussed at all levels of the governance structure.

We reviewed minutes or mortality and morbidity meetings and found that while these were taking place on a monthly basis for each speciality which was an improvement from the previous inspection, the methods for recording of the meetings varied across different specialities. Issues included a lack of recording of attendance and action to take forward learning points was not clearly recorded. The process continued to not be in line with the Royal College of Surgeons guidelines.

In theatres there were weekly staff meetings jointly between main theatres and the day surgery unit where incidents, audit outcomes, safety alerts, staffing and the World Health Organisation (WHO) checklist audit results were reviewed.

There were monthly ward meetings and minutes showed that incidents, complaints, staffing and risks were reviewed. However, the minutes from Whippingham ward did not include a list of attendees.

Management of risk, issues and performance

The service had systems in place for monitoring performance and the identification of risks, however not all risks were recorded on the risk register and actions to reduce the impact of risks relating to bed management issues were not managed in a way that clearly mitigated the risks.

The surgical service maintained a risk register and risks were incorporated into the acute services and corporate risk registers. For example, we saw that anaesthetic and theatre staffing issues were incorporated across all risk registers. Specific surgical risks included mixed sex breaches in the day surgery unit, theatre staffing levels and bed capacity issues. However, not all risks were identified on the surgical risk register. For example, the register did not include risks relating to bed management issues and the mix of surgical and medical patients on surgical wards, the mix of elective and non-elective patients on elective wards, the issues relating to the use of the day room on St Helens ward to prepare patients for surgery and deteriorating referral to treatment times. We were told that the bed management issues were held at the trust level on the risk register, not the care group level. However, this did not provide clarity for how the risks were being managed at the care group level.

Routine risk assessments were carried out on the wards, including the assessment of the risk of fire, security, manual handling and control of substances hazardous to health (COSHH). As part of this process there was a prompt to add any identified risks to the risk register.

We were told that risks were considered when planning services, however ward staff reported concerns about bed management and there being insufficient oversight and action to mitigate the risks. These concerns included conflicting priorities that were impacting on the service's ability to properly address the risks. For example, in relation to the mix of emergency and elective patients and the high proportion of medical patients admitted to surgical beds. A risk assessment had been carried out on St Helens ward about the risk of patients being admitted to the day room pre-

operatively where a bed had not yet been allocated. Mitigation included the use of the theatre pre-operative lounge and we saw evidence of discussions about staffing issues relating to the lounge in meeting minutes. Other aspects of risk mitigation had been reviewed regarding patients receiving bowel preparation in other departments where privacy was able to be maintained, although it still occurred.

On Whippingham ward we reviewed a risk assessment of the issues relating to a high proportion of medical outliers and the combined emergency and elective admissions impacting on surgical beds and activities. The risk assessment was in draft form and included risks associated with surgical medical cover being stretched across three wards accommodating emergency surgical patients, a high reliance on agency staff and medical outliers across both Whippingham and Luccombe wards. Specific control measures included twice daily ward huddles to identify specific issues and review patient acuity and medical outliers being cared for by a designated medical team. The level of risk was identified as extreme and the draft version of the assessment was awaiting senior staff sign off. Action to reduce the risk had yet to be completed.

We reviewed a 'Ten-minute check in' record on St Helens ward which was to be completed with the head of nursing and quality or matron. This included a review of hand hygiene results, equipment, training, records completion, incidents, staffing and appraisal rates. However, only two checks had been completed between October 2018 and May 2019. Ward sisters reported regular visits from matrons although told us there were a number of interim arrangements and staff new into post.

There were improvements to the monitoring of performance in theatres. There was a theatre dashboard in operation, where theatre start and finish times were logged and issues of late starts and theatre lists overrunning were recorded. A real time activity dashboard recorded activity against key performance indicators (KPIs) and exception reporting where KPIs were not met. This enabled surgical leads to identify and monitor areas for improvement. We viewed the dashboard and saw that activities such as mixed sex breaches, workforce issues, complaints, incidents and risks were recorded.

The service leads understood the challenges faced by the surgical service and there were clear priorities in relation to increasing capacity to meet demand and the management of patient flow throughout the service. However, there were areas of risk such as referral to treatment times and timely access to some treatments that had not received sufficient priority although we were told that a joint programme of work between the trust and the clinical commissioning group was in place with an aim to reduce waiting times.

Information management

The service used data to understand performance and make decisions about improvements.

There were improvements in the use of information and data. Theatre dashboards provided live information about theatre utilisation which had led to improved performance. Improvements to the recording of governance meetings meant that performance information was reviewed and used to make improvements. This included information about training and appraisal compliance and the management of bed occupancy.

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

and serious incidents), staff data on appraisals and referral to treatment times. These were rated and showed where performance was below the target level.

Performance data was displayed in ward areas on the 'getting to good' boards. This included data about falls, infection control, mandatory training, medicines incidents, length of harm free care and any patient concerns that had been raised and the action taken to address them.

Audit data was used to promote improvements and we saw evidence of standing agenda items relating to this as part of the governance meetings.

The service had implemented a safer staffing tool to support safer staffing on the wards and in theatres. Staff on one ward told us this had led to managers having a better understanding of staffing against patient acuity and meant that staff were less likely than previously to get moved to other wards.

A bed management system included up to date data to support bed management meetings and huddles and better coordination of patient flow.

Junior doctors reported some concerns about limited access to computers and issues with the electronic prescribing system not always being accessible.

Engagement

Staff reported improvements in the way managers and colleagues engaged with them.

This was particularly apparent in theatres where actions to make improvements had led to greater opportunities for communication. For example, meetings were taking place on a weekly basis between main theatres and the day surgery unit. Staff reported feeling listened to and that their views and experiences were valued. A staff survey was underway in theatres at the time of our inspection, however this was in the early stages and results were yet to be available.

Staff on the wards reported experiencing collaborative and positive interactions with direct managers and a service engagement strategy had been re-launched in October 2018 to engage staff about service improvements. The ward sister and deputy on orthopaedics had feedback boxes where anonymous feedback could be left on their roles. The feedback was then used and reflected on with a view to learning and making improvements.

Staff reported that they did not always feel involved in changes within the trust. For example, one specialist nurse told us that changes such as the introduction of the hospital at night handover had not involved discussion with staff that were likely to experience an operational impact. Other staff on the wards reported that senior staff did not always involve them and therefore were not always fully aware of the impact of proposed changes. However, we saw evidence of staff meetings where changes were discussed at ward level.

Learning, continuous improvement and innovation

There was a commitment to continually learn and improve services with evidence of improvements in some areas.

We saw that information about the quality standards strategy on all wards. Ward sisters had worked with staff to introduce the strategy and we saw evidence of this on information boards. Both St Helens and Whippingham wards had information boards about communication and were planning end of life care boards for June 2019. The intention was to have a link staff member on the wards for each of the 12 areas to take a lead on quality improvements. A survey of staff

understanding of the strategy in April 2019 showed that 50% of nurses were aware of the strategy. Nurses we spoke with during inspection had an understanding of this.

The trust participated in external reviews to promote continuous improvement. This included the 'getting it right first time' (GIRFT) programme in orthopaedics, a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. We saw evidence of GIRFT team visits and findings were shared at governance meetings.

We asked staff in theatres what they were most proud of and were told that this was the improved safety processes in theatres. On the wards we saw evidence of quality improvement boards that were managed by the ward sisters. Staff were encouraged to share ideas for improvement. For example, on Mottistone ward this included the development of a discharge lounge checklist to reduce patient delays. Nursing staff told us they felt involved in thinking about initiatives to drive improvements and that their views and ideas were considered.

There was evidence of improved theatre utilisation and new ways of approaching capacity issues. For example, we were told of a new trauma coordinator post where patients waiting semi-urgent procedures were managed at home where appropriate and when there is a space on a trauma list they were called in at short notice. We were told that his prevented blocking of beds while waiting for a space on the theatre list. Theatre utilisation had improved from 60% to 74% with a target of 85%.

Gynaecology

Facts and data about this service

We inspected the 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 looked at all domains.

The gynaecology service forms part of the surgery division at the hospital. We were not able to separate gynaecology specific data from the data provided about the surgical services and therefore some data will be reflective of the whole surgery service.

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. There are six Hysteroscopy clinics a month which each have seven slots and six Colposcopy clinics a month which each have 10 slots.

Routine outpatient gynaecology clinics are held alongside speciality clinics, fertility, fast track and oncology.

All planned and unplanned gynaecological surgery is delivered in main theatre or day surgery.

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 or Whippingham ward.

During the unannounced visit, we visited the following areas/departments:

- Main operating theatres

- Gynaecology outpatient's department
- St Helens and Whippingham wards

During the inspection visit, the inspection team:

- reviewed six sets of patient records
- looked at performance information and data about the trust
- spoke with 18 members of staff at different grades including consultants, doctors, nurses, operating department practitioners (ODPs), theatre and outpatient department managers
- met with most consultants, matrons, director of the surgery division, medical director and the director of nursing.

There were no inpatients until the last day of the inspection. We were able to speak with two patients waiting for surgery. We spoke with three women in the outpatient's clinics.

The Care Quality Commission last inspected gynaecology services in 2018 when gynaecology was inspected as an additional service. Only two domains were inspected, safe which was rated inadequate and well led which was rated as requires improvement.

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, due to work pressures and the level of compliance remained below the trust's target.

The hospital programme of mandatory training and updates for staff included infection prevention and control, health and safety, adult resuscitation and equality and diversity. Training was provided both face-to-face and electronically.

The trust's training system did not update staff when training was required. Training compliance was reliant on the manager regularly and manually accessing an electronic record and staff being released to attend. The record listed each staff member and detailed whether they had or had not completed required training. Senior staff on one ward had begun to leave notes for staff to remind them to update their training.

St Mary's Hospital

Nursing staff

The trust's target of 85% compliance with mandatory training was met in only five of the 11 selected modules for nursing staff. Areas of poor compliance were adult resuscitation, medicines management theory and practical, hand hygiene and information governance. Medicines management was very poor with 0% compliance.

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for nursing staff in gynaecology at St Mary's Hospital is shown below. However, this figure is for nurses working in gynaecology and maternity services, as the trust could not separate the data for these two groups of staff. We were not assured these numbers are correct as there are nurses on two surgical wards where women go as inpatients and nurses cover the clinics:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety Part 1 - Theory	3	3	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	3	3	100.0%	85.0%	Yes
Health, Safety and Welfare	3	3	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	3	3	100.0%	85.0%	Yes
People Handling	3	3	100.0%	85.0%	Yes
Medicines Management Theory	5	6	83.3%	85.0%	No
Adult Resuscitation	2	3	66.7%	85.0%	No
Hand Hygiene	2	3	66.7%	85.0%	No
Information Governance	2	3	66.7%	85.0%	No
Infection Prevention & Control Level 2	2	3	66.7%	85.0%	No
Medicines Management Practical Assessment	0	3	0.0%	85.0%	No

Medical staff

The trust's target of 85% compliance with mandatory training was very poor for the medical staff who had not achieved the target in any of the ten selected training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for medical staff in gynaecology at St Mary's Hospital is shown below. However, this figure is for medical staff working in gynaecology and maternity services, as the trust could not separate the data for these two groups of staff.:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Adult Resuscitation	9	11	81.8%	85.0%	No
Fire Safety Part 1 - Theory	9	11	81.8%	85.0%	No
Fire Safety Part 2 - Extinguishers	9	11	81.8%	85.0%	No
Hand Hygiene	9	11	81.8%	85.0%	No
Health, Safety and Welfare	9	11	81.8%	85.0%	No
Infection Prevention & Control Level 1	9	11	81.8%	85.0%	No
Information Governance	8	11	72.7%	85.0%	No

Infection Prevention & Control Level 2	8	11	72.7%	85.0%	No
Newborn Life Support	8	11	72.7%	85.0%	No
People Handling	7	11	63.6%	85.0%	No

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

Safeguarding

Staff used procedures 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.

Nursing staff understood how to protect patients from abuse and the gynaecology service worked well with the trust safeguarding team and other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

We were not assured that medical staff understood how to protect patients from abuse as they had not all completed the training and the completion was below the trust target for training. Medical staff said they had been busy and short staffed.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, where a woman had been abused staff were able to identify this and knew where support could be found for the woman and themselves.

Safeguarding had 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.

St Mary's Hospital

Nursing Staff

The trust's target of 85% compliance with mandatory training for safeguarding was met in five of the seven selected training modules for nursing staff. Areas of poor compliance were safeguarding children level 2 and preventing radicalisation level 3. All nursing staff records we saw showed staff 100% compliant with level 2 safeguarding training, this included deprivation of liberty safeguards (DoLS) and female genital mutilation (FGM).

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for qualified nursing staff in gynaecology at St Mary's Hospital is shown below. However, this figure is for nursing staff working in gynaecology and maternity services, as the trust could not separate the data for these two groups of staff:

The table below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)

Preventing Radicalisation Level 1 & 2	3	3	100.0%	85.0%	Yes
Safeguarding Adults Level 1	3	3	100.0%	85.0%	Yes
Safeguarding Children Level 1	3	3	100.0%	85.0%	Yes
Safeguarding Adults Level 2 Part 1	3	3	100.0%	85.0%	Yes
Safeguarding Adults Level 2 Part 2	3	3	100.0%	85.0%	Yes
Safeguarding Children Level 2	2	3	66.7%	85.0%	No
Preventing Radicalisation Level 3	2	3	66.7%	85.0%	No

Medical Staff

The trust's target of 85% compliance with mandatory training was poor and only met in two of the eight selected training modules for medical staff. Areas of very poor compliance were safeguarding children level 3 and preventing radicalisation level 3.

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for medical staff in gynaecology at St Mary's Hospital is shown below. However, the trust was unable to separate medical staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of medical staff working across both core services.

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	10	11	90.9%	85.0%	Yes
Safeguarding Children Level 1	10	11	90.9%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	9	11	81.8%	85.0%	No
Safeguarding Adults Level 2 Part 1	9	11	81.8%	85.0%	No
Safeguarding Adults Level 2 Part 2	9	11	81.8%	85.0%	No
Safeguarding Children Level 2	8	11	72.7%	85.0%	No
Preventing Radicalisation Level 3	6	11	54.5%	85.0%	No
Safeguarding Children Level 3	4	11	36.4%	85.0%	No

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

Cleanliness, infection control and hygiene

Staff managed infection risk well and understood the relevant policies. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff followed infection control policies including the use of personal protective equipment (PPE). There was evidence of multi-disciplinary team compliance with dress code and hand hygiene,

there was good practice by staff of using hand gel in clinical rooms and on the wards. This was in line with the National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3).

Data provided by the trust showed that all ward staff groups had achieved 100% compliance with infection prevention and control (IPC) training level 1.

The trust's target of 85% compliance with mandatory training was poor in hand hygiene with only 66.7% of staff completing the training. However, compliance with hand hygiene training and IPC level 1 for medical staff was 81.8%, a rise since the last inspection but still below the trust target of 85%.

Gynaecology outpatients and wards were visibly clean, tidy and well maintained. Bed spaces, consulting rooms, waiting rooms and staff areas were dust free and visibly clean in hard to reach areas including beneath beds. Ward, bed spaces and the gynaecology outpatients' areas were organised and clutter free. Furniture was clean and in good condition, fully wipeable and fully compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment. Staff used an 'I am clean' stickers when equipment had been cleaned after use.

The staff kept clear records and senior staff undertook regular audits to make sure wards and clinics were clean. Ward and outpatient's cleaning were carried out by the trust's housekeeping staff. Staff were assigned to each ward and worked from 8am to 3pm with an on-call team available out of hours to deep clean each room when a patient had left the hospital. Staff completed daily records of the cleaning to monitor how much cleaning was completed according to the cleaning schedule. There were weekly cleaning audits to evidence compliance with the hospital cleaning schedule. Results of the audit of the cleaning schedule were displayed on the main corridor outside of the wards.

Environment and equipment

The layout of the premises did not always keep people safe. The layout of the wards did not meet the needs of women living with dementia as there were no clear lines of sight down the wards.

The maintenance and use of facilities, premises and equipment kept people safe.

Patients could reach call bells and staff responded quickly when called.

The theatre lounge was new, and was clean, bright and spacious, with comfortable chairs, with the use of a television**.** Staff implied that going forward all elective patients will attend the lounge instead of going to the ward. Staff were in the process of agreeing a statement for admission criteria to the theatre lounge. There were plans to improve the environment further to create an even more comfortable space. There was no timescale for this.

The service had suitable facilities to meet the needs of patients' families. There was a clinical room for private discussion, assessment and review.

Staff carried out daily safety checks of specialist equipment with an internal; team carrying out regular servicing.

Staff had enough suitable equipment to help them to safely care for patients. All equipment we checked had been safety checked and a sticker placed on it indicating when the next service was due. One scan machine had not been checked in the required period.

Staff managed waste safely. Staff used bins to dispose of sharp instruments, such as needles. Sharps bins were not filled above the safe level before being replaced. Lids were closed to avoid accidental injuries or spillages.

Resuscitation trollies were checked by staff and daily checklists had been completed. Staff kept store rooms tidy. There were no out of date stock items. There was evidence of cleaning schedules, the sluices were clean. In one area a couple of boxes were stored on the floor, staff moved them on reporting.

Assessing and responding to patient risk

Staff completed risk assessments for each woman although they had not always updated them when they moved wards. In one case the records had not been updated although there had been two ward changes.

Medical staff had not always responded to changing risks for women, missing the opportunity to refer the women for further treatment.

The trust asked staff to use the National Patient Safety Agency guidelines which has five steps to safer surgery, these were the World Health Organisation (WHO) checklists. The (WHO) checklists were not always being followed correctly to ensure patient safety was not compromised.

The trust provided us with checklist audit reports for the period 1 April 2019 to the 12 May 2019. The audits were weekly and covered 694 WHO records. Four were not available in the patient notes and in one case it was incomplete. There were 36 that had not been completed electronically. This meant that in four cases there was no electronic or paper copy of the WHO assessment. The completion of these documents both electronically and on paper for every surgery had been a requirement at the last inspection.

There was a procedure for risk management which was not followed by all staff. Senior staff reviewed the electronic records system daily for individual patient risks and allocated for an urgent investigation if required. However, risks were not always identified or recorded by medical staff on the electronic records system for example, a failure to do a full blood count which was required when a woman had been prescribed a particular medicine that needed bloods to be taken to check it was not damaging them. This risk had not been identified or reported so no further action was taken to prevent reoccurrence.

Risk management meetings took place monthly we attended one on the second day of the inspection. One of the medical attendees at the risk meeting asked if all issues regarding wrong/inappropriate notes needed reporting on the electronic records systems as an issue. Staff told their colleague “Yes they should be.” No action had been suggested or minuted by staff to mitigate these incidents for the future.

Staff carried out intentional rounding 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 records we reviewed.

There were systems to help staff identify and respond to changing risks for women using services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenged. For example, sepsis recognition, diagnosis and early management (NICE Guideline 51). Nursing staff identified and acted upon patients at risk of deterioration.

Nurse staffing

The service had enough nursing staff of all grades to keep patients safe on the wards and in outpatients. Managers accurately calculated and reviewed the number and grade of nurses,

nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. The rotas evidenced this, and staff confirmed to us there were enough staff.

Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. Senior staff told us of nurse vacancies however, they managed to cover the rotas with either overtime, hospital bank staff or agency.

Theatre lounge nursing staff were not engaged in any clinical activity and sat at a desk with no defined duties. If the lounge became busy, then a health support worker was allocated from a ward to support the nurse.

There were no dedicated wards for gynaecology patients, instead they were placed mostly on St Helen's or Whippingham wards. The wards were staffed to meet patients' needs and most staff had had appropriate training. These wards were assigned as elective surgical however, they had medical outliers using the beds, particularly on Whippingham ward.

St Mary's Hospital

St Mary's Hospital reported the following whole time equivalent (WTE) nursing staff numbers for the periods below for gynaecology. Gynaecology inpatients were placed on surgical wards, it was not possible to separate gynaecology staffing numbers. These numbers did not account for that staff that worked in gynaecology outpatients.

The trust was unable to separate nursing staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of nursing staff working across both core services. From April 2018 to March 2019, the nursing staffing rate within gynaecology at St Mary's Hospital was 62.1%.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
Gynaecology	1.8	2.9	62.1%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

St Mary's Hospital

The trust was unable to separate nursing staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of nursing staff working across both core services. From January to December 2018, St Mary's Hospital reported a vacancy rate of 13.8% for nursing staff in gynaecology. The trust did not set a target for vacancy.

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

Turnover rates

St Mary's Hospital

The trust was unable to separate nursing staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of nursing staff working across both core services. From January to December 2018, the trust reported a turnover rate of 39.2% for nursing

staff in maternity and gynaecology services, this was higher than the trust target of 5.0%. The high percentage was attributed to the small scale of the services.

A breakdown of turnover rates by team/area is below.

Ward / team name	Annual turnover rate
Maternity and Gynaecology	39.2%

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

Sickness rates

St Mary's Hospital

The trust was unable to separate nursing staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of nursing staff working across both core services. From January 2018 to December 2018 the trust reported a sickness rate of 0.8% for nursing staff in gynaecology, this was lower than the trust target of 3%. However, the trust was unable to separate nursing staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of nursing staff working across both core services.

A breakdown of sickness rates by team/area is below.

Ward / team name	Annual sickness rate
Gynaecology	0.8%

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

Bank and agency staff usage

St Mary's Hospital

The table below shows the numbers and percentages of nursing hours in gynaecology at St Mary's Hospital from January to December 2018 that were covered by bank and agency staff or left unfilled. However, the trust was unable to separate nursing staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of nursing staff working across both core services.

Of the 5,602 total working hours available, 9.0% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 2.2% of the available hours were unable to be filled by either bank or agency staff.

Of the 1,486 total working hours available, 42.9% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, none of the available hours were unable to be filled by either bank or agency staff.

Staff group	January to December 2018			
	Total hours	Bank usage	Agency usage	Not filled by bank

	available					or agency	
		Hrs	%	Hrs	%	Hrs	%
Qualified staff	5,602	503	9.0%	0	0.0%	126	2.2%
Non-qualified staff	1,486	638	42.9%	0	0.0%	0	0.0%
All nursing staff	7,088	1,141	16.1%	0	0.0%	126	1.8%

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

Medical staffing

The medical staff did not all have the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The data we were sent from the trust shows an over establishment of medical staffing. However, staff said the service did not always have enough medical staff and as a result clinic were occasionally cancelled.

The trust was unable to separate medical staff working in maternity from those working in gynaecology. Therefore, the data below includes medical staff working across both core services.

St Mary's Hospital

The trust was unable to separate medical staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of nursing staff working across both core services. From April 2018 to March 2019, the medical staffing rate within gynaecology at St Mary's Hospital was 107.1%. This was an over establishment.

St Mary's Hospital reported the following WTE medical staff numbers for the periods below for gynaecology.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
Obs Gynaecology Medics	15.0	14.0	107.1%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

St Mary's Hospital

The trust was unable to separate medical staff working in maternity from those working in gynaecology. Therefore, the data below is inclusive of nursing staff working across both core services. From January to December 2018, St Mary's Hospital reported a vacancy rate of 0.0% for medical staff in gynaecology. The trust did not set a target for vacancy.

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

Turnover rates

St Mary's Hospital

From January to December 2018 the trust reported a turnover rate of 22.0% for medical staff in gynaecology, this was higher than the trust target of 5.0%. The trust was unable to separate medical staff working in maternity from those working in gynaecology. Therefore, the data below includes medical staff working across both core services

A breakdown of turnover rates by team/area is below.

Ward / team name	Annual turnover rate
Obs/Gynaecology Medics	22.0%

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

Sickness rates

Sickness rates for medical staff were high and the sickness rates were above the trust target.

St Mary's Hospital

From January to December 2018, the trust reported a sickness rate of 12.4% for medical staff in gynaecology, this was higher than the trust target of 3.5%. The trust was unable to separate medical staff working in maternity from those working in gynaecology. Therefore, the data below includes medical staff working across both core services.

A breakdown of sickness rates by department is below:

Ward / team name	Annual sickness rate
Obs/Gynaecology Medics	12.4%

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

Bank and locum staff usage

The table below shows the numbers and percentages of medical hours in gynaecology at St Mary's Hospital from January to December 2018 that were covered by medical and locum staff or left unfilled. The trust was unable to separate medical staff working in maternity from those working in gynaecology. Therefore, the data below includes medical staff working across both core services.

Of the 29,198 total working hours available, none were filled by bank staff and 5.3% were covered by locum staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 0.5% of the available hours were unable to be filled by either bank or locum staff.

Team name	January to December 2018						
	Total hours available	Bank usage		Locum usage		Not filled by bank or locum	
		Hrs	%	Hrs	%	Hrs	%
Obstetrics and Gynaecology	29,198	0	0.0%	1,537	5.3%	157	0.5%

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Records

Records were clear and easily available to all staff providing care however, they were not always up to date, safely stored or in the correct notes.

At the last inspection in 2018 the service had failed to ensure that medical records displayed the patients name or patient number on each page. At this inspection we saw this had improved.

When patients transferred to a new team, there were no delays in staff accessing their records.

Staff completed risk assessments for each patient. 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. Staff had not always updated the records when women moved wards.

Records were not always safe and securely stored. Secure notes trolleys were being supplied by the trust. We saw a notes trolley delivered to one ward and the staff moved files into it.

The theatre lounge did not have a notes trolley and notes were kept in the reception area. The member of staff in the theatre lounge remained on the reception desk, there was no plan of what would happen to the safety of the records should they be called away in an emergency.

There were three incidents in the month of April to May 2019, relating to both physical and electronic notes. There were another woman's chemotherapy notes in one file, and two others with letters indicating the wrong results for those women in the electronic notes systems. We noted these issues were discussed at the gynaecology risk meeting, no solution was offered to prevent reoccurrence.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. This was an improvement from the inspection in 2018.

There were no medications used or stored in gynaecology outpatient's department. This section refers to St Helens ward only.

On St Helen's Ward, medicines were managed safely, and systems ensured patients received the right medication. Medicines were stored appropriately. Medicine fridges on all wards were locked and monthly audits of fridge temperatures showed temperatures remained within agreed ranges. The lockers for patients' own medicines, were compliant with security.

Pharmacy audited patient medicines on the wards each month. They reviewed the allergy status documentation, medicines reconciliations, and warfarin patients with raised International Normalised Ratios. Staff consistently documented patient allergies.

Medicines and medical devices were checked daily by the nursing team in line with the trust policy. Controlled drug balance checks were undertaken by nursing staff and pharmacy and waste was managed appropriately. This was an improvement since the last inspection.

On St Helens ward and in gynaecology outpatients the resuscitation trolley was checked twice a day by staff in line with trust guidelines.

The emergency drugs on the resuscitation trolleys were stored in tamper-evident containers, as recommended by the Resuscitation Council (UK).

Emergency blood supplies were available and major haemorrhage protocols were in place in theatres. The theatre fluid store was well organised an all items were within date.

Incidents

The service did not manage patient safety incidents well.

Not all staff knew what incidents to report and how to report them. Nursing staff reported serious incidents clearly and in line with trust policy. Medical staff did not report all incidents as they did not know when to report. We were not assured that appropriate risks were always identified and that incidents would not be repeated.

Managers investigated incidents they were aware of and shared lessons learned with the whole team and the wider service. The trust had recognised it had not managed patient safety incidents well. The trust had promoted a new system to encourage the reporting of incidents and to review incidents more promptly, this had been introduced in February 2019. This approach had still not been embedded and not all staff were using the new system and continued to use their own. The trust had identified where staff needed support and guidance in managing incidents by attending these meetings.

Managers ensured that actions from patient safety alerts were implemented and monitored. These were discussed at nursing staff meetings.

During the gynaecology risk meeting we attended on inspection numerous examples of incidents were discussed. Senior staff in attendance at the meeting highlighted to medical staff that all incidents discussed met the criteria for reporting. The senior staff reported to us they had looked at the records following the meeting and had found there were many that had not been reported.

Since the last inspection the trust reported no serious incidents which met the reporting criteria set by NHS England for gynaecology services. However, given that not all incidents had been reported for review we were not assured this was the case.

The service had had no ‘never events’ on any wards. 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. The trust had reported one incident from January to December 2018, that was classified as a never event for gynaecology. Senior managers told us following an investigation this has since been downgraded.

- June 2015 – Retained foreign object post procedure

(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

(SIs) in gynaecology which met the reporting criteria set by NHS England from January to December 2018. The one incident was classified as a surgical/invasive procedure incident meeting SI criterion. This has since been downgraded.

(Source: Strategic Executive Information System (STEIS))

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.

We were given an example of how the trust had met this regulation at the gynaecology risk meeting, where test results indicated cancer, but this had been missed by the medical staff and they had missed the opportunity to refer for fast treatment. A letter had been sent and one medic stated, “Well it is done now they had the operation and biopsy done.”

Safety thermometer

The nursing staff used monitoring systems well on the wards to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer data was displayed on wards for staff and patients to see. For example, 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 previous month (April 2019).

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 harm and their elimination. Data collection took place one day each month and was submitted to NHS Digital within ten days of the suggested data collection date.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient’s subject to the Mental Health Act 1983. Staff told us they protected the rights of patient’s subject to the Mental Health Act and followed the Code of Practice. There were no women detained under the Mental Health Act during the inspection.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

There were forms available and when they were completed in the notes, they were securely bound. However not all the forms were of the same version. This had not been recognised by staff or their managers. This meant the records could have been inaccurate and staff had not followed

through on the trust policy and change of records. Staff amended the records after it was highlighted to them.

There was evidence of risk assessments, consent forms and follow up by most staff. In the records we looked at, the nursing and medical notes were signed, dated and included details of the consultation and what the woman had understood.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Staff advised women when they needed to seek further help and advised what to do if their condition deteriorated. This included staff following the Royal College of Obstetricians and Gynaecologist guidance on termination of pregnancy.

Nutrition and hydration

Staff monitored women and made sure they had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. Due to bed management issues and waiting to ensure a bed was available, women were at risk of being without food for long periods.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. In the records we looked at there was evidence of food and fluid monitoring. However, where staff had not updated care plans when a patient’s needs had changed, the daily food and fluid records did not reflect the care plans.

Staff followed national guidelines to make sure patients fasting before surgery were not without food or fluid for long periods. Staff in the theatre lounge kept women up to date where possible about delays and cancellations in their surgery.

Specialist support from staff such as dieticians and speech and language therapists were available for women where it had been identified by nursing staff. Women were given a choice of food and drink to meet their cultural and religious preferences.

Staff assessed and managed women’s pain relief. The records we saw showed where staff had asked the individual about their pain and had offered pain relief as prescribed. Alternatively, we saw where nursing staff had requested an assessment of the patient by the medical staff.

Patient outcomes

The trust was unable to separate outcomes for women receiving gynaecology care from those receiving general surgery, as gynaecology is an additional service. It was therefore not possible to report on patient outcomes.

From December 2017 to November 2018, patients at St Mary's Hospital had a lower expected risk of readmission for elective admissions and a lower expected risk of readmission for non-elective

admissions when compared to the England average.

Information was not readily available about outcomes for women in this service, although clinical audits of length of stay were carried out. For example, the length of time from the decision to discharge and leaving the ward. In most cases a delay was through availability of discharge medications.

The trust had undertaken audits on delayed discharge home after elective major gynaecological surgeries. They found the majority of patients went home within the standard time frame. They identified areas for improvement: documentation and post-operative pain relief. Their plan of action included:

- Early liaison with anaesthetists and pain control team.
- To improve documentation, all staff informed and advised to document properly.
- Timely review by registrars with access to medicine ordering systems, for prompt prescription of take-home drugs.
- Staff to address social issues before the admission.

Competent staff

The service had not made sure all staff were competent for their roles.

Managers had not always supported medical staff to develop through regular, constructive clinical supervision of their work. Managers told us they had identified poor staff performance and those staff were offered additional support to improve. Given that medical staff had not received regular clinical supervision we could not be assured there were no other staff who needed support.

Managers supported nursing and support staff to develop through yearly, constructive appraisals of their work. However, the trust had not met its target of appraisals for administrative and clerical staff.

Managers supported nursing and support staff to develop through yearly, constructive appraisals of their work. Records showed that appraisals had taken place and development was available for staff.

Managers made sure all nursing staff attended team meetings or had access to full notes when they could not attend. Staff showed us examples of where staff had signed to say they had read meeting records.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us about their induction experience at the trust and it was positive.

Appraisal rates

St Mary's Hospital

From April 2018 to February 2019, 29.6% of staff within gynaecology at the trust received an appraisal compared to a trust target of 85.0%. The trust was unable to separate staff working in maternity from those working in gynaecology. Therefore, the data below includes staff working across both core services.

The breakdown by staff group can be seen in the table below:

Staff group	April 2018 to February 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)

Nursing and Midwifery Registered	3	3	100.0%	85.0%	Yes
Additional Clinical Services	1	1	100.0%	85.0%	Yes
Administrative and Clerical	2	9	22.2%	85.0%	No
Medical and Dental	2	13	15.4%	85.0%	No
Allied Health Professionals	0	1	0.0%	85.0%	No

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

The trust confirmed an improvement on the uptake of appraisals of all medical staff from 38.6 % at the end of February 2019 to 100% at the end of March 2019.

Multidisciplinary working

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, to try and lessen multiple ward moves. Minutes were available for absent staff to read.

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and good outcomes for the women.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, staff working with GP's in the sexual and gynaecological care of younger women.

There was evidence of good multi-disciplinary working across the staff groups in gynaecological

outpatients. For example, nurses and doctors carrying out gynaecology clinks liaised with the maternity staff who were running the maternity day assessment and antenatal clinic at the same time.

Patients could see all the health professionals involved in their care in one -stop clinics at the outpatient department. Staff kept patients informed when they attended clinics.

There was positive staff morale and attitude in gynaecological outpatients. It was a small team working in a calm quiet environment. Staff worked well together, including clerical staff. The morale on the wards was less positive as their work was affected by medical outliers and they were aware that gynaecology surgery was cancelled due to a lack of beds.

Outpatient staff had found a general theme with under 16's requesting a termination was because the young women were running out of contraception. In response the staff were working with the sexual health clinic and GPs on education and planning for the young people.

Seven-day services

Key services were available seven days a week to support timely patient care. For any unexpected complications and issues women had to access the emergency department.

The outpatient clinics operated from Monday to Friday and there was access to emergency/urgent assistance via telephone although women told us they could not always get an answer. Staff were aware there was an issue and it had been raised at senior level for resolution.

Consultants led daily ward rounds on all wards including the weekend. They were also available at weekends via an on-call service.

There was access to diagnostics and pharmacy at 24 hours a day seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. For example, the service supported women to be as fit as possible for surgery and encouraged them to eat the right food, mobilise joints, stop smoking and reduce alcohol intake.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Public health information leaflets were available in outpatients for example smear test, miscarriage association and local supports groups.

The service worked with GP's to improve the rates of cervical screening and to promote colposcopy services to try and reduce the stigma affecting attendance at these clinics. Staff explained this work with enthusiasm as they saw it as a natural development of their service.

There were a variety of information leaflets available in several languages on the wards and in outpatients, although several needed to be updated/reviewed because guidance had changed, women could still access information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff said when needed there were agreed personalised measures that limited patients' liberty.

Ward staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Both nursing and medical staff gained consent from patients for their care and treatment in line with legislation and guidance.

Patient records showed that staff recorded consent from women about the procedure that was to take place. Staff made sure patients consented to treatment based on all the information available.

Staff gave us examples to show they understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

There were policies and systems in place on when and how to use the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Mental Capacity Act and Deprivation of Liberty training completion

St Mary's Hospital

The trust set a target of 85.0% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. Not all nursing staff had completed training on the Mental

Capacity Act and Deprivation of Liberty Safeguards and the percentage was very low in comparison to the trust target. However, the trust was unable to separate staff working in maternity from those working in gynaecology. The data below does not include all staff working across both core services.

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	1	3	33.3%	85.0%	No

The trust set a target of 85% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The target was not met for the MCA/DOLS training module for which medical staff were eligible, and the percentage was very low in comparison to the trust target. The trust was unable to separate staff working in maternity from those working in gynaecology. We were concerned that not all medical staff had completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). This could affect freedom of women attending the service.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to January 2019 at St Mary's Hospital for medical staff in gynaecology is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	5	11	45.5%	85.0%	No

The trust has reported that the Mental Capacity Act training module incorporates Deprivation of Liberty Safeguard training.

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

Is the service caring?

There were no gynaecology patients on the wards, the below information is based on observation of the outpatient's department.

Compassionate care

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Most women we spoke with said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. Staff took the time to interact with women using the service and anyone accompanying them in a respectful and considerate way. The outpatient's clinic was spacious, and privacy and dignity were maintained. It was tidy

and privacy curtains were available and used by staff to protect the privacy and dignity of women.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff gave patients and those close to them help, emotional support and advice when they needed it. Nursing staff offered emotional support and were caring in their manner with the women who attended the clinics.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Counselling and psychological services were offered to women and staff ensured that women knew how to access these through conversation and information leaflets. Nursing and support staff developed relationships with the women they saw and ensured that relevant emotional support was offered during and after termination of all pregnancies (TOP). They supported women in accessing other providers for TOP at specific gestation times. To help with this support an assessment for anxiety and depression was provided and with further support available if the women chose it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The service could demonstrate a clear understanding of gynaecological and urogynaecology procedures and how they impacted on women's lives. The staff were improving the service for women through education, information and working with other agencies such as GP's.

Understanding and involvement of patients and those close to them

Staff made sure patients and those close to them understood their care and treatment on the wards and in outpatients.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make advanced decisions about their care on the wards and in outpatients.

Women we spoke to in the theatre lounge aid that staff had supported them to make informed decisions about their care on the wards and in outpatients.

Staff involved women in giving feedback about the service in the Friends and Family Test survey. The feedback from the Friends and Family Test was mostly positive for the wards and outpatients.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. For example, where needs and choices were not being met for urgent referrals women were seen in the sexual health clinic and extra appointments were made.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff when they attended.

Staff knew and understood the standards for mixed sex accommodation on the wards. Where wards were mixed, staff ensured protocols to protect individual privacy and dignity were met and knew when to report a potential breach.

Facilities and premises were not always appropriate for the services being delivered in the outpatients/clinic area. For example, pregnant women sat alongside women attending for other health needs such as infertility, staff managed this whilst respecting women's privacy and dignity.

The service had systems in place, so staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia. The service had systems to help care for patients in need of additional support or specialist intervention. For example, there were learning disability liaison staff who told us how they worked with women who needed to access gynaecological services, to lessen their anxiety and concerns.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Wards were not designed to meet the needs of patients living with dementia, the wards had poor visual monitoring due to the shape and layout. Staff carried out regular checks in addition to intentional rounding to manage safety.

Staff supported patients living with dementia and learning disabilities by using specific documents and patient passports. We saw these being used and in women's records.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, we saw specialist staff attending wards to support the ward staff and the patient.

The service had information leaflets available in languages spoken by the patients and local community.

The information on display was not always suitable or appropriate for the waiting areas in outpatients. For example, information regarding a miscarriage, or termination were in areas where pregnant women sat. Staff told us they were looking to revise how they displayed information.

Staff had not always made sure women could get help from interpreters or signers when needed. Staff reported one incident where a woman attended a clinic and it had not been noted anywhere English was not her first language. The staff then had to find assistance whilst the woman waited.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were worse than the national average.

From February 2018 to January 2019, the trust's referral to treatment time (RTT) for admitted pathways was worse than the England average for gynaecology. The trust's performance ranged from 25.0% to 67.5% compared to the England average for gynaecology which ranged from 70.3% to 74.4%. We were told of one case where a paper referral went missing, however it was not known it was missing because there was no electronic copy, when it was found it was over a year old.

Managers did not always work to keep the number of cancelled appointments, treatments and operations to a minimum. When women had their appointments, treatments and operations cancelled at the last minute, rearrangements were not within national targets and guidance. For example, the staff in the gynaecology department failed to follow up with a patient at their six months follow up. This meant that women may have further complications or be at risk of a shortened life due to the delay.

Clerical staff commented they were unable to make appointments beyond six weeks. A senior member of staff said, "Patients should be empowered to call if they have not heard at five months for a follow up." "The patient is our backstop." Staff said if patients phone they cannot always get through and patients were not ways recorded on the list for follow up. Senior staff commented there was less capacity in clinics due to the lack of a consultant.

There were plans to expand day surgery to give an additional two spaces on the surgical list as well as better management of single sex recovery which was a challenge at present.

Managers and staff worked to make sure women did not stay longer than they needed to and started discharge planning as early as possible. This was problematic depending on the aftercare required in some cases. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Delayed discharge was often related to support services in the community which were outside of the control of the hospital.

Managers monitored the number of delayed discharges and knew which wards had the highest number. Where possible, they took action to prevent them, for example ordering 'to take home medicines' early where possible.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient moves between wards/services however these moves were made on bed capacity and in one case a patient had moved three times. Bed capacity was a daily issue at the trust. Therefore, the service moved women based on bed need and not always where there was a clear medical reason, or it was in their best interest. Sometime women were moved at wards at night.

Bed capacity was a daily concern affecting the elective surgery list and placed women at risk of not receiving their treatment in a timely manner.

On the last day of the inspection the surgical wards were tasked with finding five beds however, there were no inpatient beds. One surgeon had gone ahead with an operation without ensuring there was a bed. The woman had to remain in theatre recovery due to a lack of bed capacity and

potentially placed them and others at risk as no inpatient beds meant that surgeries were cancelled.

We observed senior staff trying to create bed spaces and there was pressure from the bed management team to find beds, senior staff mentioned ‘one upping’ (putting a bed in space that is essentially not suitable or large enough) to the ward staff, implying a bed space was to be created.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

St Helens and Whippingham wards were assigned to be surgical wards however, medical patients and had been placed on these two surgical wards. Managers worked to find beds daily and this was not based on surgical but medical needs. This affected the number of women who could receive their elective procedure, as they were the first to be cancelled when there was a bed capacity issue.

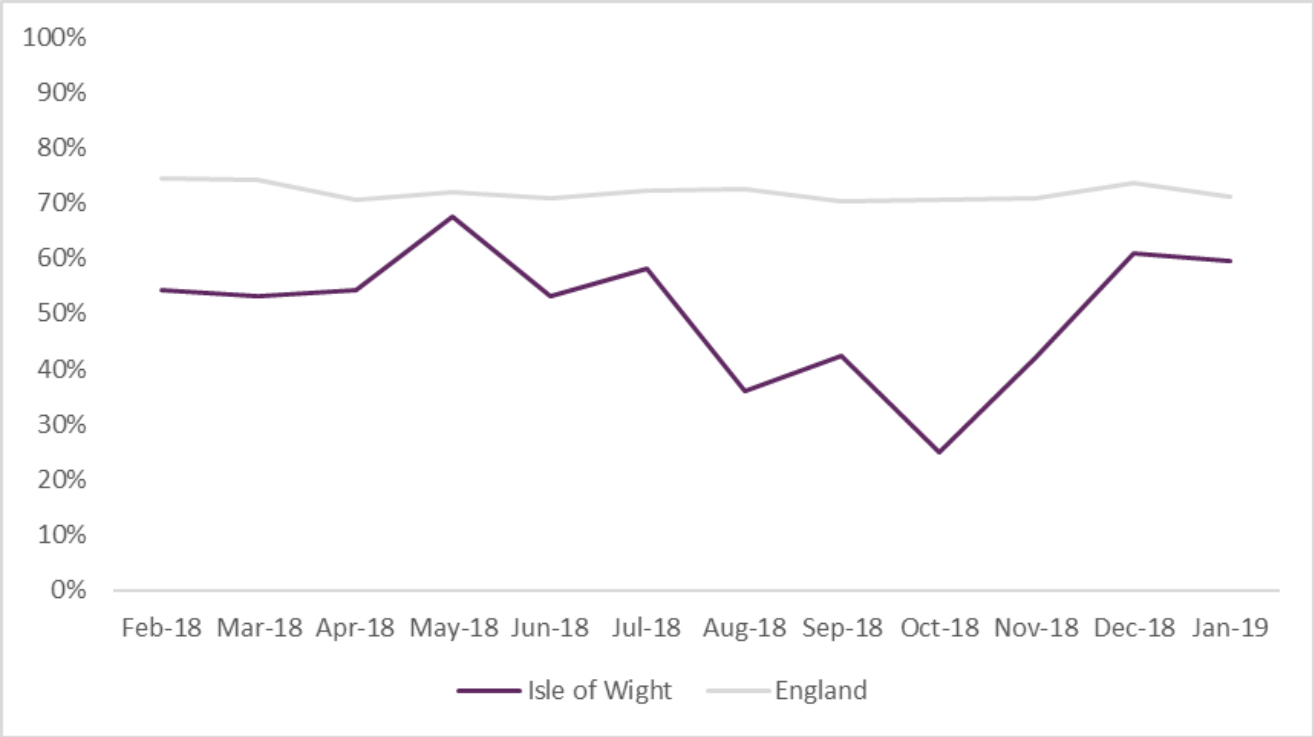
In outpatients staff monitored and took action to minimise missed appointments. There was evidence of a robust telephone service in outpatients to support women on the TOP pathway. There was also a failsafe to follow up on DNA (did not attend), and for women who had not contacted the department to advise of their decision, staff undertook to contact the women concerned. Staff told us of the plans to review the IT systems that could support outpatient’s clinic utilisation with better management of the waiting list and monitoring outcomes.

Staff ensured that patients who did not attend appointments were contacted by phone. Staff in the gynaecology outpatient’s department (OPD) monitored the waiting list based on a 6-4-2 weeks scale so there would be enough time to put women on the appropriate pathway. We saw the local spreadsheet used to manage this.

Referral to treatment (percentage within 18 weeks) – admitted pathways

The trust was below the national average of referral to treatment date. This can be seen on the table below.

Gynaecology Referral to treatment rates (percentage within 18 weeks) for admitted pathways, Isle of Wight NHS Trust



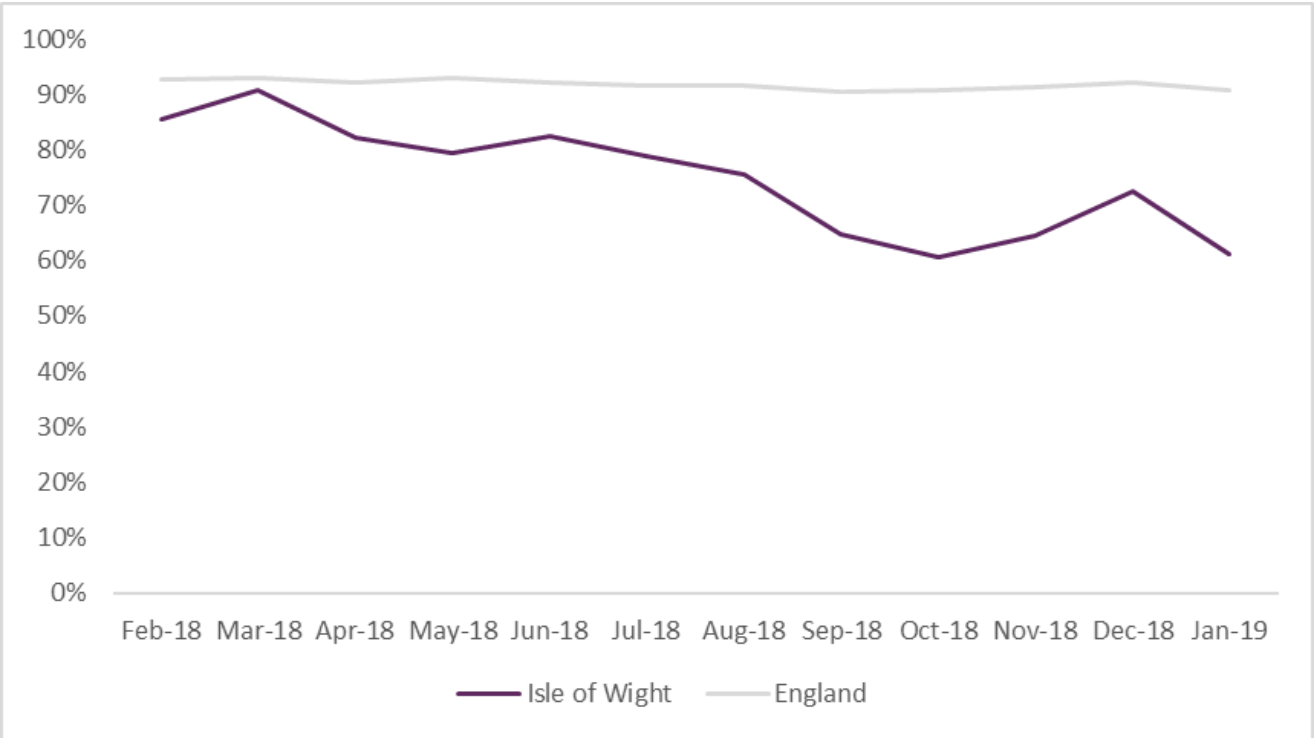
(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From February 2018 to January 2019, the trust's referral to treatment time (RTT) for non-admitted pathways for gynaecology was worse than the England average for gynaecology for the 12 months reported.

The trust's performance ranged from 60.5% to 90.8% compared to the England average for gynaecology which ranged from 90.7% to 92.8%.

Gynaecology Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Isle of Wight NHS Trust



(Source: NHS England)

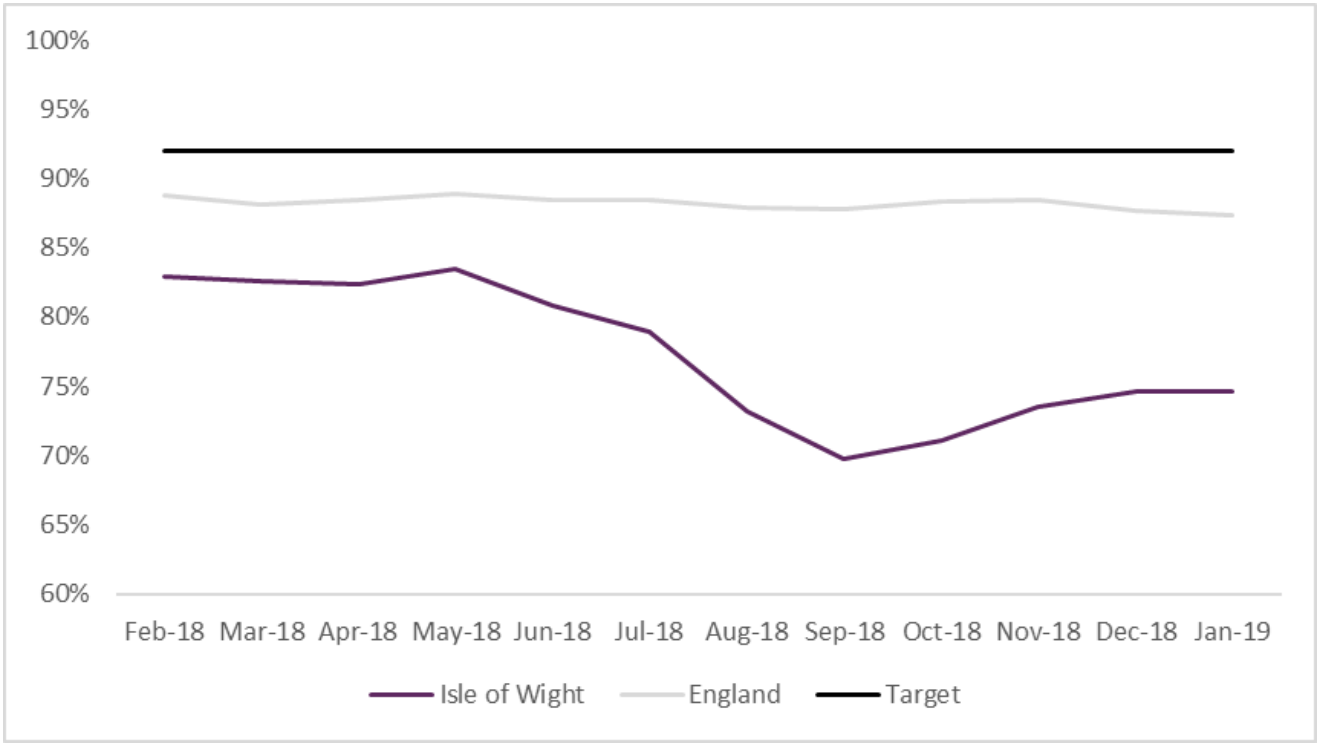
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From February 2018 to January 2019, the trust's referral to treatment time (RTT) for incomplete pathways for gynaecology was worse than the England average for gynaecology for the 12 months reported.

The trust's performance ranged from 69.8% to 83.5% compared to the England average for gynaecology which ranged from 87.4% to 88.9%.

The trust also failed to meet the 92.0% operational standard for incomplete pathways in all 12 months reported.

Gynaecology Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Isle of Wight NHS Trust



(Source: NHS England)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff**.** However, some women told us they were anxious about speaking out about staff attitudes.

The service clearly displayed information in the form of posters and cards about how to raise a concern in patient areas.

Patients, relatives and carers knew how to complain or raise concerns. Women we spoke with were mostly happy, however there was an expression of a poor experience on St Helen's previously due to a delay in discharge and being made to feel like a nuisance with staff talking over them. They expressed anxiety about going there after surgery. Due to the lack of beds this

could not be managed effectively as the women did not know if they would have the surgery or where they would go afterwards.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. However, senior staff had not always shared feedback from complaints and learning with staff and learning to improve the service.

Summary of complaints

St Mary's Hospital

From January to December 2018 the trust received eight complaints in relation to gynaecology at St Mary's Hospital. The trust took an average of 58.8 days to investigate and close complaints, and none were closed within 30 working days. This is not in line with their complaints policy, which states that 75% of complaints should be closed within 30 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment - Obstetrics & gynaecology	2	25.0%
Communication	1	12.5%
Admissions and discharges excluding delayed discharge due to absence of a care package	1	12.5%
Privacy, dignity and wellbeing	1	12.5%
Values and behaviours (staff)	1	12.5%
Access to treatment or drugs	1	12.5%
Clinical treatment - Surgical group	1	12.5%
Total	**8**	**100.0%**

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

Number of compliments made to the trust

From April 2018 to December 2018 the trust received 1,179 compliments regarding acute services at the trust. Due to the way in which compliments are captured by the trust, it has not been possible to split the number of compliments by team or core service.

The trust has identified several key themes from the compliments received across the trust.

- The main compliment received was about staff behaviour. Staff are described, through individual experiences, to behave in a manner that is kind, patient, friendly, professional, courteous, caring, compassionate, helpful and understanding.
- Specific praise for consultant care.

- Treatment with dignity and respect.
- Effective and responsive ED.
- Excellent care.
- Helpful, friendly and efficient Administrators/Receptionists.

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

Is the service well-led?

Leadership

Leaders did not always have the integrity, skills and abilities to run the service.

Medical staff did not have the right skills and abilities to run a service to provide high-quality sustainable care. There was poor communication amongst senior staff and in some cases, staff did not use the methods of reporting and managing the service stipulated by the trust.

Medical staff told us there were no set teaching sessions arranged and no guidelines for procedures on the trust intranet to assist them in learning how to treat women. They said the senior medics undertook most of the work and they did not always feel involved.

Leaders understood but did not always manage the priorities and issues the service faced. For example, cancelling surgeries due to lack of beds, not ensuring the path from diagnosis and decision for treatment was with in national timescales.

Leaders were not always visible and approachable in the service for women and staff. Whilst leaders supported staff to develop their skills and take on more senior roles, all staff we spoke to who had benefited from this development, told us this finished in June 2019.

Vision and strategy

Staff were aware of the vision for what it wanted to achieve in outpatients, there was a strategy to turn it into action, developed with all relevant stakeholders.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff in outpatients, understood and knew how to apply them and monitor progress. This included better access to support, possible expansion of the building and working with others such as GP's to meet the needs of women's sexual health needs.

Vision and strategy on the surgical wards were not clear to all staff. Staff told us there was no clear vision or strategy for the department. Planning was related to bed capacity and was led mostly by the needs of medical patients and emergencies. Surgical beds were lost to patients with medical needs.

The Trust had a mental health strategy "Mental Health and Learning Disability Division Strategy, 2018 – 2021". However, staff were not aware of it. The provider should ensure staff working in the acute sector of the hospital are aware of the Trust's mental health strategy.

Culture

Most staff felt respected, supported and valued. This was dependent on which part of the service they worked. Nursing staff we spoke with were focused on the needs of patients receiving care. Most staff promoted equality and diversity in daily work and nursing staff were provided with opportunities for career development.

The outpatient clinic staff said they were very proud of the service and there was good team work which was patient focused. Staff told us the service was a good environment to work in and all the staff were supportive. Staff were aware of how to raise concerns, the senior nurses in outpatients were autonomous and worked well with the teams. Staff were aware that in their immediate department they could speak up. Staff told us there was previously a bullying culture in the trust but felt this is not an issue within the clinics.

In November 2018 a review of the gynaecological service at the trust had been carried out by the Royal College of Obstetricians & Gynaecologists (RCOG). RCOG found the obstetricians and gynaecologists felt it was acceptable to communicate in a “robust manner rather than a professional manner”. RCOG stated there was a lack of insight about the impact of communicating in such a manner for the recipient of the communication whether a peer or a junior member of staff.

At this inspection staff confirmed there were issues with communication, they also told us it had improved a little since the last CQC inspection.

RCOG found complaints from women also reflected issues with communication which painted a picture of poor communication skills including aggressive and disrespectful attitudes.

Inspectors observed these attitudes at a meeting during the inspection. During the discussion of one case the lead for this surgery stated, “The operation went well” and at the first postoperative clinical round when X complained of pain and feeling unwell, the lead stated at the risk meeting they thought X was “just whinging”.

A patient told us they had been an inpatient previously and were nervous of being admitted to the same ward due to the staff attitudes. We were not assured staff would raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes.

Senior management felt there had been some improvement in the behaviours of the consultants. They also believed there has been some improvement in the nursing culture and it was ‘much better,’ and in the medical culture there was ‘more work to be done’. Staff had attended human factors training which was beginning to have an impact on how staff communicated. Senior management gave us an example of where a health care assistant raised a complaint about a consultant’s behaviour, which was heard and investigated.

Governance

Not all leaders operated effective governance processes, throughout the service and with partner organisations.

Staff told us that since the last CQC inspection there has been a ‘big’ focus on audit safety checklists they said their compliance with these records was increasing.

The review carried out by the Royal College of Obstetricians & Gynaecologists (RCOG), in November 2018 found issues with the governance of the service. RCOG gave two examples, the first showed an inadequate response from the gynaecology team as well as poor communication and professional decision making. The second was a serious surgical complication requiring investigation and an audit of complications post major gynaecological surgery. This information

was not shared with the clinicians. This meant there was no shared learning to mitigate further similar issues.

There were similar concerns about governance and risk management expressed by the RCOG in their report and in the CQC inspection in 2018. The RCOG and CQC were told there had been no ‘never events’ in the last 18 months and serious incidents were recorded on the electronic records system.

At this inspection we found that not all incidents were recorded, therefore there was no scrutiny to prevent reoccurrence and no lessons learned or shared with the teams. There was a lack of governance surrounding adverse events and there was a non-reporting culture. We were not assured that the current governance protected women using the service.

Many staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. This took place at team meetings on the wards and in outpatients amongst nursing and support staff.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They had not always identified and escalated relevant risks and issues and acted to reduce their impact. They did not always have plans to cope with unexpected events.

There was a monthly gynaecology risk meeting chaired by a consultant gynaecologist and obstetrician. We attended the May 2019 meeting. In this meeting all incidents logged on a spreadsheet were discussed. For example, issues with three sets of notes having wrong patient information, the lack of equipment to carry out planned procedures and ‘missed’ diagnoses. These were discussed at the meeting with no decisions made on how to ensure this does not reoccur. The only action in relation to these issues was to share the minutes.

Attendees at the meeting included the theatre manager, the head of midwifery, ward manager and all grades of medical staff. We saw the minutes from the previous meeting in April 2019. In one incident there was a failed piece of surgical equipment and part of the woman’s internal anatomy was perforated when the surgeon inserted the equipment. The detailed description of the incident indicated a surgical process had not been followed and a CT scan had not been reported on. The lesson was “If repeating the process after previous failure its always best to repeat the hysteroscopy.” There was no reference to the failed reporting or lack of best practice. The minutes were shared with staff, but the lack of detail meant lessons could not be learnt.

It was not clear if the spreadsheet containing the details of the incidents was shared with the risk manager or anybody else from the trust’s senior management team for learning to take place. We were advised following the meeting that the trust had implemented a recording system that was not being used at the meeting.

The monthly clinical harm review meetings made an assessment of potential growth and how extra demand was managed or sub contracted if there was no capacity. There was an overview of cancer referrals and potential growth in antenatal and outpatient referrals. This fed into a steering group with the clinical commissioning team and trust to provide an oversight.

There was a process where the gynaecological team and pre-admission team met to review the waiting list. It only worked when there were beds available to be used for inpatients.

The theatre user group was set up to review theatre use and the theatre steering group had a multi-disciplinary team with a focus on actions and to identify gaps to avoid theatre cancellation. One action was to ensure the elective surgery list was not affected by emergency surgeries which was a daily challenge, an action which could not be met.

Information management

Parts of the service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

In the gynaecology service there was no consistent collection, analysis, or management of information to support service improvement. However, the system in gynaecology outpatients identified vulnerable people enabling staff to respond.

The systems to improve the accuracy and timeliness of reporting were not embedded in practice.

Engagement

Not all leaders and staff actively and openly engaged with women, staff, equality groups, the public or local organisations to plan and manage services.

Staff told us they were keen for the department to work harder at getting feedback from staff and women using the service and to work through actions to help listen and maintain a good reputation. There was feedback in the form of comment cards and women fedback to staff verbally.

However, they did collaborate with partner organisations to help improve services for women, for example working with other trusts to ensure that women received specialist treatment when required on the mainland.

Family friendly test (FFT) had been introduced across the service however the staff were unable to separate gynaecology feedback from general surgery feedback. We did not see that women were given the FFT cards. Senior staff analysed the feedback however this was not readily available to all ward staff. Although senior staff told us it was positive.

Learning, continuous improvement and innovation

Not all staff were committed to continually learning and improving services. They did not all have a good understanding of quality improvement methods and the skills to use them. Not all leaders encouraged innovation and participation in research.

There were 20 recommendations made by the RCOG following their visit in November 2018. We spoke with one consultant about the report and the recommendations. One recommendation was to have a nurse practitioner for ambulatory gynaecology, the response was “We do not have enough patients to have a lead nurse”. In a previous reply it was said “We do not have enough registrars we have to cancel clinics”. Another recommendation was to facilitate: incident reporting, analysis and feedback, recording of all incidents and sharing learning when actions were taken. Clinical staff told us they kept a spreadsheet of their surgeries. “You will have to ask colleagues

what they do". The trust told us they were expanding nurse led clinics and interventions into a number of other areas including pessary clinics and urodynamics.

Staff told us they had been upset following the last inspection and the trust being in special measures. They said the trust had made changes that had been required by CQC to meet the regulations, however these were not embedded as not all staff were following new guidelines and systems.

Teamwork was variable depending on the area for example staff in gynaecology outpatients worked well together, it was more difficult for ward staff. This led to a lack of learning, continuous improvement and innovation for the service.

In outpatients, senior nursing staff told us they were in the process of setting up a home medical TOP where women will attend once to collect all medication and take them at home with instruction. The guideline has been agreed and sent for final ratification through the quality and safety guideline group.

End of Life Care

Facts and data about this service

End of life care encompasses all care given to patients nearing the end of their life and following death. Patients received care in any ward across all services within the trust. End of life care 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 end of life care to patients across all clinical areas who have different conditions including cancer, stroke, cardiac and respiratory disease and dementia. The hospital does not have a dedicated ward for end of life care. It provides end of life care to some patients in the community.

Public Health England Fingertips data (2018) revealed the trust had fewer emergency admissions in the last 90 days of life and fewer patients die in hospital when compared to the national average.

The trust had 559 deaths from April 2018 to March 2019.

(Source: Hospital Episode Statistics)

In January 2019, the trust signed a memorandum of understanding with a local hospice on how in partnership the two organisations will deliver end of life care at St Mary's Hospital. A new integrated palliative care and end of life care team (IPET) had been formed under a single leadership structure. To ensure patients received safe, effective and compassionate care at the end of their life, the trust introduced the priorities of care individualised care plan. The team had re-launched a new priorities of care individualised care plan (PoC), appointed an additional palliative care consultant, identified the key performance indicators for end of life care, standardised syringe driver training, successfully bid with the local hospice for end of life care discharge coordinator and launched the End of Life Care Operational Group which included all the key stakeholders.

The service operates with extended hours-Monday to Friday 8am to 8pm. The service provides a resource within the whole trust. It includes face to face patient reviews in acute and mental health services and advisory service to the ambulance and community services during these hours. A local hospice clinical co-ordination hub provides the palliative and end of life care expertise, support and advice out of hours and at weekends.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

This report refers to the inspection of end of life care at St Mary's Hospital. The inspection mainly covered patients whose death was imminent (expected within a few hours or days). It included those approaching the end of life and were likely to die within the next 12 months irrespective of underlying diagnosis. We inspected do not attempt cardio pulmonary resuscitation (DNACPR) forms, drug charts, checklists and nursing care records.

During our inspection we looked at end of life care for adults and visited various wards at St Mary's Hospital where patients received end of life care. We spoke to a representative sample of most teams involved in end of life care: bereavement team, chaplaincy, clinical director for end of life care, cleaners, medical equipment trainer, consultants, clinical nurse specialists, end of life care discharge coordinator, end of life care champions, equipment library technician, healthcare assistants, mortuary staff, operational manager, pharmacist, registered nurses and ward clerk. We observed interactions between the staff and patients and relatives in their 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. However, it had not made sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training.

At the last inspection in January 2018, managers did not make sure everyone completed mandatory training and the trust did not follow the national standard for end of life care training, as end of life care training was not mandatory. The trust set a target of 85% for completion of mandatory training. In end of life care, the trust told us eligible nursing staff met the trust's target with 85% overall compliance rate. End of life training was mandatory for all staff.

Mandatory training completion rates

The trust set a target of 85.0% for completion of mandatory training.

St Mary's Hospital

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for qualified nursing staff in the end of life care department at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety Part 1 - Theory	14	14	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	14	14	100.0%	85.0%	Yes
Hand Hygiene	14	14	100.0%	85.0%	Yes
Health, Safety and Welfare	14	14	100.0%	85.0%	Yes
Load Handling	2	2	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	14	14	100. 0%	85.0%	Yes
People Handling	12	12	100 0%	85.0%	Yes
Infection Prevention & Control Level 2	13	14	92.9%	85.0%	Yes
Information Governance	11	14	78.6%	85.0%	No
Medicines Management Theory	16	28	57.1%	85.0%	No
Adult Resuscitation	7	14	50.0%	85.0%	No
Medicines Management Practical Assessment	0	1	0. 0%	85. 0%	No

At St Mary's Hospital the 85. 0% target was met for eight of the 12 mandatory training modules for which qualified nursing staff were eligible.

Medical staff received but did not keep up to date with their mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for medical staff in the end of life care department at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety Part 1 - Theory	4	5	80.0%	85.0%	No
Health, Safety and Welfare	4	5	80.0%	85.0%	No
Infection Prevention & Control Level 1	4	5	80.0%	85.0%	No
Fire Safety Part 2 - Extinguishers	3	5	60.0%	85.0%	No

Information Governance	3	5	60.0%	85.0%	No
Infection Prevention & Control Level 2	3	5	60.0%	85.0%	No
Adult Resuscitation	2	5	40.0%	85.0%	No
Hand Hygiene	2	5	40.0%	85.0%	No
People Handling	2	5	40.0%	85.0%	No

At St Mary's Hospital the 85.0% target was met for none of the nine mandatory training modules for which medical staff were eligible.

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

Some medical staff did not meet the target as they only became part of the department in January 2019 when they were brought under one single governance structure.

The mandatory training was comprehensive and met the needs of patients and staff.

The trust followed the guidance from NHS England, which included subjects related to enhance patient safety. The trust had implemented the mandatory national standard for end of life care training for all staff. The end of life strategy identified mandatory training on end of life care for all staff. The trust had set a target for compliance at 85% and achieved 82% by the end of May 2019. There were plans for a new e-learning for end of life care to be launched in the summer of 2019.

Managers monitored mandatory training and alerted staff when they needed to update their training.

For example, the integrated palliative and end of life care team (IPET) had received specific training such as the five priorities for end of life care.

The above data highlighted good rate of uptake of end of life training was mandated both by the National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015 across all staff groups, and by the trusts' policy across all clinical staff groups.

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 their training should the need to do so arise.

Nursing staff received training specific for their role on how to recognise and report abuse. The training followed guidance based on the safeguarding policy launched by NHS England Safeguarding team.

Safeguarding training completion rates

The trust set a target of 85.0% for completion of safeguarding training.

St Mary's Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for qualified nursing staff in the end of life care department at St Mary's Hospital is shown below:

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	14	14	100.0%	85.0%	Yes
Safeguarding Adults Level 1	14	14	100.0%	85.0%	Yes
Safeguarding Children Level 1	14	14	100.0%	85.0%	Yes
Safeguarding Adults Level 2 Part 1	13	14	92.9%	85.0%	Yes
Safeguarding Adults Level 2 Part 2	13	14	92.9%	85.0%	Yes
Safeguarding Children Level 2	12	14	85.7%	85.0%	Yes
Preventing Radicalisation Level 3	7	14	50.0%	85.0%	No

At St Mary's Hospital the 85. 0% target was met for six of the seven safeguarding training modules for which qualified nursing staff were eligible. The trust increased the frequency of offering the Preventing Radicalisation Level 3.

Medical staff received training specific for their role on how to recognise and report abuse. The training followed guidance based on the safeguarding policy launched by NHS England Safeguarding team. Some medical staff did not meet the target as they were not part of the department until January 2019, when they were brought under one single governance structure.

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 medical staff in the end of life care department at St Mary's Hospital is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 1	5	5	100.0%	85.0%	Yes
Safeguarding Adults Level 1	4	5	80.0%	85.0%	No
Preventing Radicalisation Level 1 & 2	3	5	60.0%	85.0%	No
Safeguarding Children Level 2	3	5	60.0%	85.0%	No
Safeguarding Adults Level 2 Part 1	2	5	40.0%	85.0%	No
Safeguarding Adults Level 2 Part 2	2	5	40.0%	85.0%	No
Preventing Radicalisation Level 3	2	5	40.0%	85.0%	No

At St Mary's Hospital the 85. 0% target was met for one of the seven safeguarding training modules for which medical staff were eligible.

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

Some medical staff did not meet the training target set.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding training included examples of harassment and discrimination. The policy identified the protected characteristic under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm, and worked with other agencies to protect them. At the last inspection, most staff did not know how to apply safeguarding training. At this inspection, we found staff knew how to apply their knowledge. The training programme provided staff with a checklist including the various agencies the trust worked with and their roles and responsibilities. Staff shared with us an example of joint working with other agencies. Between March 2018 and April 2019, staff reported four safeguarding concerns about patients who received end of life care. Between March 2018 and April 2019, a local nursing home reported one safeguarding alert to the local authority. This related to the care provided by the trust for a patient who received end of life care. 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 this case. The IPET was aware of them and had examined them. The outcome was the incident was used for learning.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a dedicated safeguarding team within the hospital and they regularly met with local authorities. Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making. For example, staff knew the referral process to the safeguarding team. Staff could access the trust's intranet site to make a safeguarding referral and sent the referral form to the trust safeguarding team.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed care to patients at the end of their life and saw they could reach call bells with ease. Patients and relatives told us staff responded quickly when called.

The design of the environment followed national guidance. There were enough spaces available in the mortuary, and refrigeration was suitable for the needs of the service. Staff told us these facilities were usually enough to meet the needs of the hospital and the local population. The mortuary had additional portable storage facilities available during times of high demand, for example, during bank holidays. However, it had not been necessary to use temporary facilities in the last four years.

The mortuary fridges recorded the temperature of the refrigerators daily. Mortuary fridges were locked, and keys were held in secure locations. The fridges were alarmed with alerts directed to the reception staff should the temperature fall outside the normal range.

The setting 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 was visibly clean and uncluttered.

Staff carried out daily safety checks of specialist equipment. The trust used one brand of syringe driver across all wards which reduced the likelihood of confusion or error by staff,

particularly bank or agency staff. A syringe driver is a small, portable, battery powered infusion device which is suitable for patient use in the hospital and at home and is used for delivering measured doses of pain medication. The trust conformed to national safety guidelines on the type and use of syringe driver.

Nursing staff explained the process to report a faulty syringe driver. Syringe drivers were stored and delivered or collected from the equipment library. Staff told us this made sure they were clean, safe to use, serviced and maintained properly. They were kept in the equipment library where they were serviced and maintained. Nurses told us these were available on request without delay. We checked two syringe drivers during the inspection, and both had been serviced and were in working order.

The service had suitable facilities to meet the needs of patients' families. Some wards had gathering spaces and places where families could meet, confer and talk with care staff. Ward staff planned to provide a member of the family a camper bed for an overnight stay if required. The hospital had 12 side room that could be used for patients at the end of their life. Wards had side rooms they allocated to patients at the end of their life. However, if a patient required isolation, then they would prioritised over a patient at the end of their life. Staff provided the family with a recliner chair for overnight or extended stays. The facilities families used had been refurbished with new carpets, fixtures and fittings. This included the viewing area in the mortuary, the bereavement office, the chapel and a separate spiritual space for people of faith and no faith.

The service had enough suitable equipment to help them to safely care for patients. Each ward had enough moving and handling equipment to allow patients to be cared for safely. Staff had access to all other equipment for patients at the end of their lives, including pressure relieving mattresses and air cushions. These were available through the equipment library. Staff told us they could access any equipment both in and out of hours.

Staff disposed of clinical waste safely. Staff had access to clinical waste bags and clinical waste bins. Staff wore appropriate personal protective clothing when dealing with infectious or offensive waste. They washed their hands after handling even if they wore gloves. They followed correct procedure in case of a spillage.

Assessing and responding to patient risk

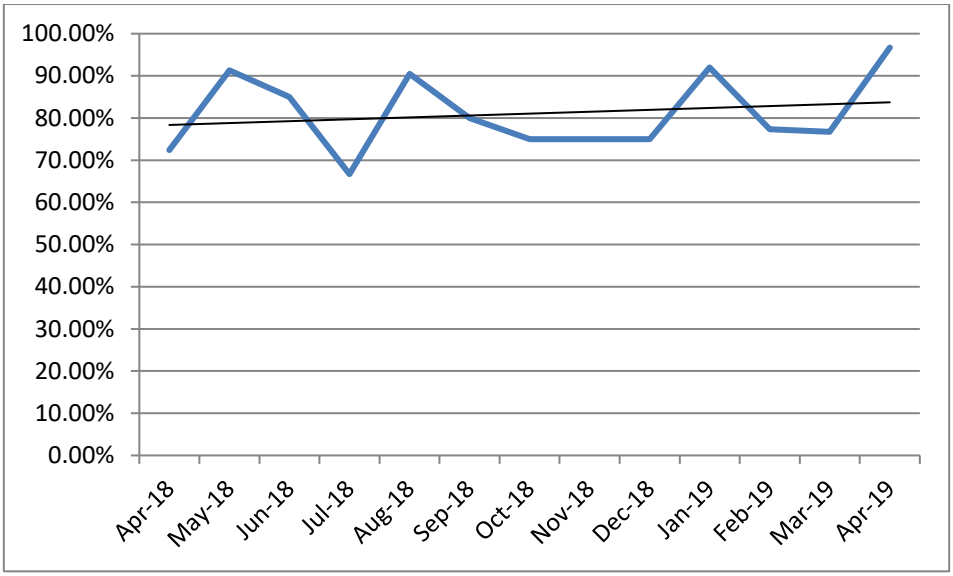
Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life. However, staff did not always identify patients needing end of life care as soon as possible after their admission to the hospital and receive care more suitable to their needs.

Staff used a nationally recognised tool to identify deteriorating patients but did not escalate them appropriately. In April 2019, the trust concluded that the lack of strong clinical leadership between critical and palliative care clinical leaders resulted in patients not receiving care more suitable to their needs. Starting in June 2019, the trust planned to integrate working between critical care outreach staff and the Integrated Palliative and End of Life Care Team (IPET) to provide co-ordinated leadership of the care of all seriously ill patients to ensure that patients received care more suitable to their needs.

The trust had implemented several initiatives to identify deteriorating patients and ensure patients received care more suitable to their needs. The initiatives included introduction of the National Early Warning Score (NEWS2). This is a tool developed by the Royal College of Physicians to

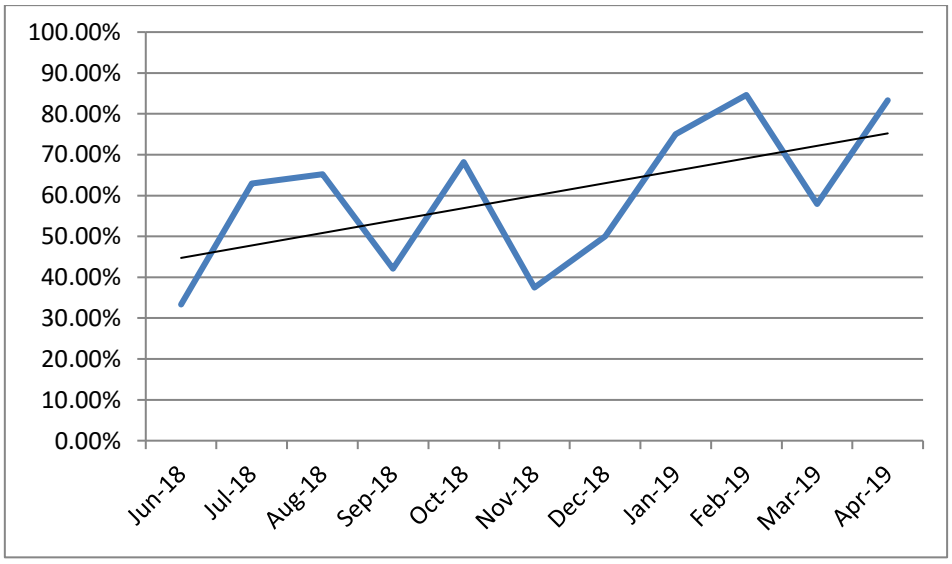
improve the detection and response to clinical deterioration in adult patients. It is a key element of patient safety and improved patient outcomes. The trust introduced a new educational initiative that included online training and medical team training in discussing 'bad' news and treatment escalation preferences. The trust had initiated an island-wide advance care planning system that removed barriers to acting on patients' care preference. This resulted in the increased use of available hospice beds when requested. It improved the speed of transferring patients from hospital to a hospice or their home. Despite all these initiatives, patients at the end of their life were not identified as soon as they should have been and did not receive care more suitable to their needs at the earliest opportunity.

The care notes we checked showed consistently that staff recognised when patients were dying and began recording their care in a priorities of care document. This document ensured patients received safe, effective and compassionate care at the end of their life.

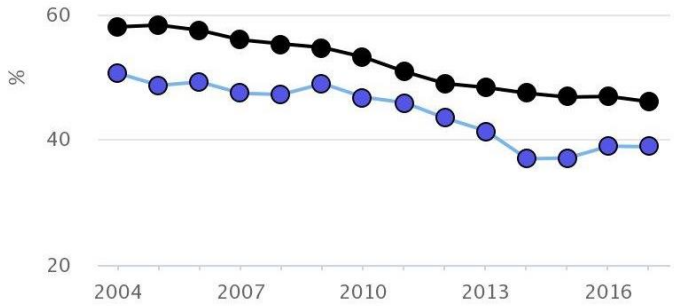


However, data provided by the trust (see above) showed that staff were recognising earlier that patients were dying. An audit of care notes from April 2018 to April 2019 showed increase in the proportion of cases where staff recorded this recognition in the notes.

An audit of care notes from June 2018 to April 2019 showed a steady increase in the proportion of cases where staff recorded that patients were dying more than 24 hours before death. The chart below shows a steady increase in the proportion of patients recognised as dying and receiving end of life care instead of life-saving care.



Some data sources confirmed that staff recognition that patients were dying received care more suitable to their needs: Isle of Wight NHS Trust had a low hospital death rate (38.8% compared to 46.0% England average). The changes in place of death influenced this data rather than that fewer patients were dying)

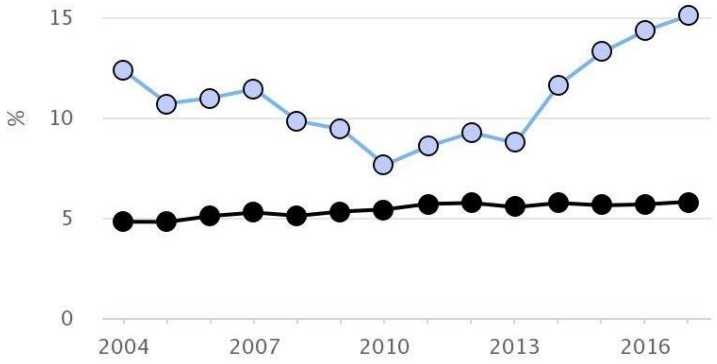


The chart above shows that patients cared for by the trust (blue line) used fewer acute services in the last 90 days of life that the England average (black line), showing that more patients were receiving the end of life care they needed.

The Isle of Wight was in the lowest 20% of trusts in England for:

- three or more emergency hospital admissions during the last 90 days of life
- all admissions to hospital during the last 90 days of life.

The chart below shows there had been a steady rise in the number of people dying in a hospice as their preferred place of death rather than hospital (15.1% compared to 5.8% England average). The blue line shows trust data and the black line data for England.



By bringing together clinicians from critical care (who were often well placed to identify patients with an uncertain or poor prognosis) with clinicians from palliative care, the trust planned to identify patients needing end of life care earlier on in their admission to the hospital.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. The Integrated Palliative and End of Life Care Team carried out risk assessment of patients referred to them. We reviewed records of 20 patients who were at the end of their life and all had risks such as falls, malnutrition and pressure damage assessed and contained details of action taken. For example, in all 20 records, we found the Malnutrition Universal Screening Tool (MUST) used to determine malnutrition risk and the Waterlow tool used to evaluate patients' risk of developing pressure ulcers.

Staff knew about and dealt with any specific risk issues. Staff were aware patients receiving end of life care were most susceptible to pressure ulcers and automatically ensured they were cared for on correctly calibrated pressure-relieving mattresses.

Staff shared key information to keep patients safe when handling over their care to others. Staff used structured communication tools that made it easy for them to remember to share important information. They used SBAR as a tool (Situation, Background, Assessment, Recommendation)

Shifts changes and handover included all necessary key information to keep patients safe. We observed staff handover meetings and saw how staff were kept abreast of the progress of patients who were at the end of their life. For example, patients were identified, and staff were informed of key information to keep them safe. Examples of such information sharing included whether the patient has been started on the end of life care pathway, had been referred to the end of life care team, or could be moved only in exceptional clinical circumstances, or whether there was any family situation the staff needed to know about.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting. patients after death.

All ward areas were clean and had suitable furnishings which were clean and well maintained. Other areas we inspected, such as the chapel and visiting rooms, we visibly clean, tidy and well maintained. We inspected the viewing suite in the mortuary complex. The mortuary fridges were visibly clean, and we saw the mortuary staff followed infection control procedures. 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 procedures, and this included the wearing of gloves, aprons and the use of body bags. The mortuary had enough facilities for hand washing, separate bins for general and clinical waste, and appropriate signs.

The service score for cleanliness was better than the England average. 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 setting in which care is provided, as well as supporting non-clinical services such as cleanliness. In 2018, St Mary's Hospital scored 99.1% for cleanliness, which was above the England average of 98.4%.

Cleaning records were up to date and demonstrated all areas were cleaned regularly. The mortuary complied with all the regular audits they carried out. It completed cleaning schedules for each area and adhered to the hospital's standard precautions policy. Cleaning audits for December 2018, January 2019 and March 2019 reported 97% compliance, which demonstrated standards of cleanliness and hygiene were maintained to a high standard in the mortuary and viewing areas.

Staff followed the infection control principles including the use of personal protective equipment (PPE). The trust had developed policies and procedures which ensured after death, the health and safety of everyone who had come in contact with the deceased person's body was protected. Ward staff we spoke with knew 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. Porters confirmed they had received appropriate training and their supervisors carried regular checks. This ensured they adhered to the trust policies and procedures.

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 needed. Mortuary staff explained the safety precautions and systems to prevent and protect patients and staff from a healthcare-associated infection. Mortuary staff could explain the standard of practice document for the receipt of bodies (suspected infection) and could direct us to the policies necessary for their practice. We saw staff in the mortuary area wearing the correct personal protective equipment (PPE), such as gloves, aprons and over shoe protectors as needed by hospital policy. PPE was accessible throughout the department.

Staffing

The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service did not use any agency or locum staff in end of life care. The service had enough nursing and medical staff to keep patients safe. There was a nominated lead or champion/link worker for end of life care on each ward.

St Mary's Hospital

St Mary's Hospital reported the following whole-time equivalent staff (WTE) nursing staff numbers for the period below for end of life care.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
Cancer CNS	12.9	12.0	107.7%
End of Life Education	2.0	2.0	100.0%
EMH Inpatient Unit	0.0	1.0	0.0%
Total	**14.9**	**15.0**	**99.5%**

From April 2018 to March 2019, the nursing staffing rate within end of life care at St Marys Hospital was 99. 5%.

From April 2018 to March 2019, one of the three nursing teams listed were over established. However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

St Mary's Hospital reported the following WTE medical staff numbers for the period below for end of life care.

Ward / team name	April 2018 to March 2019		
	Actual staff	Planned staff	Staffing rate (%)
EMH Medics	5.0	4.1	124.4%
Cancer Admin Service	0.1	0.1	100.0%
Total	**5.1**	**4.1**	**123.9%**

At the last inspection, the service did not have enough consultants. The staffing levels were below the National Institute of Health and Care Excellence (NICE) guidelines. At this inspection, the service met the staffing levels set by NICE.

From April 2018 to March 2019, the medical staffing rate within end of life care at St Mary's Hospital was 123.9%.

From April 2018 to March 2019, one of the two medical teams listed were over established. However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The service had low vacancy rates for all staff.

Vacancy rates

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a vacancy rate of -3.8% for nursing staff in end of life care. The trust did not set a target for vacancy.

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

From January to December 2018, St Mary's Hospital reported a vacancy rate of 22.8% for medical staff in end of life care. The trust did not set a target for vacancy.

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

The vacancy was primarily due to the lack of a consultant in palliative care medicine. The trust had recently appointed to this role and the individual was going to start in July 2019.

Turnover rates

The service had reducing turnover rates for all staff.

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a turnover rate of 5.6% for nursing staff in end of life care. This was higher than the trust target of 5.0%.

A breakdown of turnover rates by ward/team is below.

Ward / team name	Annual turnover rate
Cancer Clinical Nurse Specialist	6.4%
End of Life Education	0.0%

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

The turnover rate at inspection was 3.5%, lower than the trust target of 5.0%

From January to December 2018, St Mary's Hospital reported a turnover rate of 0.0% for medical staff in end of life care. This was lower than the trust target of 5.0%.

A breakdown of turnover rates by ward/team is below.

Ward / team name	Annual turnover rate
EMH Medics	0.0%

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

Sickness rates

The service had reducing sickness rates for all staff.

St Mary's Hospital

From January to December 2018, St Mary's Hospital reported a sickness rate of 5.9% for nursing staff in end of life care. This was higher than the trust target of 3.5%.

A breakdown of sickness rates by ward/team is below.

Ward / team name	Annual sickness rate
EMH Medics	9.7%
Cancer Clinical Nurse Specialist	6.2%
End of Life Education	0.2%

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

However, the rate of sickness at inspection in May 2019 was the same as the trust target of 3.5%. The service was aware of the previous higher sickness rate than the trust target among staff and attributed it to the time of considerable uncertainty regarding the structure of the end of life care team.

From January to December 2018, St Mary's Hospital reported a sickness rate of 0.0% for medical staff in end of life care. This was lower than the trust target of 3.5%.

A breakdown of sickness rates by ward/team is below.

Ward / team name	Annual sickness rate
EMH Medics	0.0%

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

Bank and agency staff usage

The service had low rates of bank nurses used. It did not use any agency staff to cover sickness, absence or vacancy for all staff.

St Mary's Hospital

The table below shows the numbers and percentages of nursing hours in end of life care at St Mary's Hospital from January to December 2018 were covered by bank and agency staff or left unfilled.

Of the 22,399 total working hours available, 2.7% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, none of the available hours were unable to be filled by either bank or agency staff.

Of the 5,247 total working hours available, none were filled by bank or agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, none of the available hours were left unfilled.

Staff group	January to December 2018						
	Total hours available	Bank usage		Agency usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Qualified staff	22,399	612	2.7%	0	0 0%	0	0.0%
Non-qualified staff	5,247	0	0	0	0.0%	0	0.0%
All nursing staff	27,789	612	1.9%	0	0.0%	0	0.0%

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

From January to December 2018, the trust reported they did not use any bank or medical locum staff to cover sickness, absence or vacancy for medical staff in end of life care.

(Source: Routine Provider Information Request (RPIR) – Medical bank locum tab)

Managers limited their use of bank and requested staff familiar with the service. Managers told us they relied on their own staff as bank when needed because they were familiar with the service.

Managers made sure all bank staff had a full induction and understood the service. Managers used their own staff as bank and as such they were assured they had a full induction and understood the service.

Records

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

Patients notes were detailed. Staff could not access patient records easily. At the last inspection, staff had not kept detailed records of patients' care and treatment. Records were not clear or up-to-date. At this inspection the care records and individual care plans we looked followed the trust policy. In the medical notes of patients approaching the end of their lives, there were clear and detailed descriptions of their conditions and of the reasons behind the decisions to stop active treatment. We reviewed 25 priorities of care individualised care plans (POC) and the quality of information in the notes relating to end of life care, symptom management, discussions with families and patients where appropriate was of acceptable standard. All records had the DNACPR form at the front of the notes. All forms were completed as required by legislation. However, staff could not access records easily as they were not stored in a chronological order. This made the search for information more difficult. For example, discussions with the patient and their families was recorded but could not be found easily.

The service maintained the records within the mortuary. We saw staff completed mortuary records following trust protocol provided an audit trail.

When patients transferred to a new team, there were no delays in staff accessing their records. There was a system for GPs to be informed a patient who they provided care to had been identified as requiring end of life care as this information was included in the care summaries sent to them on discharge. The care summaries included any medication changes. A similar communication was sent with the patient to the care home if appropriate. Medicine changes, those, of older people with complex needs, were communicated promptly to the GP. GPs had direct access to the ward and they could speak to a medical consultant or nurse consultant for advice on the phone.

When patients were discharged home, discharge summaries followed NICE QS15 *Patient experience in adult NHS services*, Statement 12: Patient experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. We inspected 10 discharge summaries and found most of the following were covered: reasons for admission, investigation done and results, changes to medication, destination on discharge, plans for follow up, plans for rehabilitation if appropriate, DNACPR status, pressure risk, weight management.

Records were stored securely. 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. Mortuary records were stored in lockable cabinets.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. At the last inspection, patients did not always receive the right medication at the right dose. At this inspection the trust pharmacy department ensured wards held stocks of medicines prescribed to patients who were at the end of their life. If a ward needed additional stock for a patient out of hours, they could identify and source stock from other wards. Due to a current supply problem with one medicine within the end of life care pathway, the pathway had been amended to include another, other medicines, and interim guidance had been circulated to staff. We spoke to two nurses on separate wards about patients who had been prescribed the medicine on the end of life care pathway. In both cases, the medicine on the end of life care pathway had been prescribed on admission, the patients had improved, and the medicine on the end of life care pathway had been stopped.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicine. The trust had guidance on anticipatory prescribing / just in case medicines at end of life. Staff prescribed anticipatory medicines 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. Patients (where patients were conscious) and carers were given advice about the medicine.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All medicines stored on the wards were in a locked cupboard, medicine trolley or medicine refrigerator. The medicine cupboards complied with the trust policy and was kept locked. Medicines refrigerators were kept in a locked area and used only to store medicine. Staff recorded the temperature at least once each day and took standardised actions when it was not within the range of 2°C and 8°C.

Staff followed current national practice to check patients had the correct medicines. There were clear guidelines for medical staff to follow when writing up antimicrobial and anticipatory medicines for patients including those medicines included within a syringe driver. Medicines were readily available to patients requiring treatment for palliative and end of life care. The guidelines were based on NICE guidance QS61 *Infection prevention and control* and QS121 *Antimicrobial stewardship*. The policy had been ratified in January 2017 and was reviewed in January 2019. There was an Island wide approach to antimicrobial and anticipatory prescribing. The palliative care consultants jointly employed by the trust and the hospice developed guidelines for *Palliative care prescribing*.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were posted on the staff bulletin board and staff were expected to have read and signed them. However, medicine incidents which took place on other wards were not widely shared across the organisation.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. During our previous inspection in 2017, we found most patients on end of life care were quite sleepy. Concerns were identified about the dose administered within a variable dose prescription for one medicine which had resulted in this level of sleepiness. We found doctors prescribed pre-populated medicines, doses and frequency via protocol on the trust electronic prescribing and medicines administration system (ePMAS). At this inspection, pharmacy and end of life staff explained the actions they had taken, changes made and monitoring of prescribing they had undertaken since our previous inspection.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise and record safety incidents, concerns and near misses using the hospital's electronic reporting system (the system to collect and report incidents). There was a specific list box of end of life care on the incident reporting tool and this allowed staff to report these incidents. To prompt clinicians on the types of incidents which could be reported, prompts such as syringe drivers, communication, record keeping, and recognition of the dying were added.

Staff reported all incidents they should report.

At the last inspection, the service did not manage patient safety incidents well, Staff did not recognise incidents and report them. Investigations of incidents were not undertaken, and lessons were not shared across the whole team. At this inspection, the service managed patient safety incidents well. Between April 2018 and March 2019, the trust reported 36 incidents. For 19 of these, there was no harm. Thirteen were considered minor incidents. Three were deemed to be moderate and one resulted in death. The serious incident panel investigated the incident that resulted in death. The panel concluded the death was not avoidable. However, the patient did not receive an appropriate end of life experience because of the lack of clear decision around end of life plan and ceiling of treatment. Lessons have been learnt from this incident and the following four actions had been taken: Education on end of life recognition and management for medical staff working in emergency department and medical assessment unit. They were completed on 31

May 2019. The incident was discussed as part of the junior doctor forum in May 2019. All ward-based staff have been given continuing education on how to access the end of life resources available. The incident was discussed at the trust's educational forum of End of Life Champions in May 2019 and Case in Time to Act in June 2019.

Staff reported serious incidents clearly and in line with the trust policy. The trust followed the NHS England guidance on *Serious Incident Framework Supporting learning to prevent recurrence* (March 2015). Serious incidents were reported to the commissioners and recorded the incident on the NHS serious incident management system. The trust informed other regulatory, statutory, advisory and professional bodies about the incident depending on the nature and circumstances of the incident.

The service had no never events on any wards. From April 2018 and March 2019, the trust reported no incidents which were classified as a never event for end of life care. Never events are serious patient safety incidents which 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.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw evidence the service applied duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014 following three relevant incidents. 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 them with reasonable support. While the IPET, chaplaincy team and mortuary and bereavement team had not reported any incidents which met the requirements for the duty of candour regulation, staff we spoke with knew their responsibilities and principles regarding this. They were aware they would be needed to inform the patient or their relatives of the incident, make an apology and they explained how the hospital should respond to any incidents.

Managers debriefed and supported staff after any serious incident. Staff told us there was considerable support from managers after any serious incident. Staff involved in the investigation process had the opportunity to access professional advice from their relevant professional body or union, staff counselling service and occupational health service. Managers provided staff with information about the stages of the investigation and how they would be expected to contribute to the process. The incident reviewed had a detailed action plan and the lead for the delivery of the action plan.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Families were not involved in these investigations. The trust used root cause analysis to investigate all serious incidents. Root cause analysis is used identify the root causes that resulted in the serious incident and helps prevent the serious incident from happening again. The trust carried out three levels of investigations. These were: (1) small scale investigations for less complicated incidents done by local experts in the same department (2) large scale investigations for complicated incidents done by experts from other departments 3) independent investigations done by experts from other trusts.

We reviewed an incident reported as a death which had been investigated by local experts in the same department. The local experts identified the root causes of the death and the lessons to prevent it from happening again. The trust followed its policy of completion of investigation within 60 working days. The incident took place on 30 January 2019 and was declared a serious incident

on 13 February 2019. The final report was completed on 23 April 2019 and sent to the commissioners on 7 May 2019.

However, there was no documentation to confirm the families had been offered to be involved in the investigation of the death. The trust sent a duty of candour letter to the son of the deceased to notify him that an investigation will be undertaken and they were not invited to participate. As the son did not respond to the duty of candour letter outlining any specific questions of the investigation, the trust considered this to be enough evidence to confirm families had been offered to be involved. We did not consider the family had been formally invited to participate in the investigation as evidence of applying the duty of candour. However, the report was going to be shared with family following the completion of the investigation.

Staff received feedback from investigation of incidents, both internal and external to the service. The IPET and end of life care leads from other specialties reported and discussed end of life care incidents at monthly meetings of End of Life Care Operational group. Staff received feedback from all such incidents. Members of the End of Life Care Operational Group received regular feedback from investigations of incidents external to the service. The group was updated on an investigation of a serious incident in a neighbouring hospital that involved a medicine. The lead doctor in end of life care highlighted the actions that were taken including a training how junior doctors will be supported with written summary and telephone advice regarding the medicine.

Staff met to discuss the feedback and look at improvements to patient care. The End of Life Care Operational Group discussed all the incidents and the learning points. These were then cascaded through the various leads on the wards. An inspection of the minutes of two ward meetings highlighted the incidents and the learning from it. Other wards had learning points placed on information walls for nurses.

There was evidence that changes had been made as a result of feedback. A single piece syringe driver was used throughout the trust. There had been an incident whereby a staff had placed a label on the wrong part of an existing two-piece syringe driver and the label fell off. This incident was discussed with the medical equipment team and at the End of Life Care Operational Group. It was agreed a single piece item would be bought to prevent such incidents.

Managers shared learning with their staff about never events that happened elsewhere. The End of Life Care Operational Group identified learning from never events through the national patient safety alerts issued by NHS Improvement and the national patient safety incident reports (NaPSIR).

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust implemented a newly revised care planning tool called priorities of care individualised care plan (PoC). The PoC was well set and 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 Quality standard (QS)13 *End of life care for adults* and NICE CG140 '*Palliative care for adults: strong opioids for pain relief*.' The plan replaced the *Liverpool Care Pathway*. The implementation of the tool began in 2015 and a revised version was re-launched in April 2017 with another new version re-launched in October 2018.

The latest audit in April 2019 highlighted the trust's compliance with NICE guidance NG31 *Care of dying adults in the last days of life,* which covered the clinical care of adults (those over 18) who were dying during the last 2-3 days of life and the National Framework for end of life care at 60%. Managers collected data for assurance as part of their key performance indicators (KPI).

Managers regularly checked and found most staff followed the guidance outlined in the following two NICE guidance: The NICE Quality standards QS144 *Care of dying adults in the last days of life* covers the clinical care of adults (aged 18 and over) who are dying, during the last 2 to 3 days of life. This guidance describes high-quality care in priority areas for improvement. The NICE Quality standard QS13 *End of life care for adults*. This quality standard covers care for adults (aged 18 and over) who are approaching the end of their life. This includes people who are likely to die within 12 months, people with advanced, progressive, incurable conditions and people with life-threatening acute conditions. It covers support for their families and carers and includes care provided by health and social care staff in all settings, as well as describing high-quality care in priority areas for improvement. Audits undertaken on QS144 and QS13 undertaken in 2018 highlighted the trust's compliance at 70%. The baseline assessment for QS13 states people approaching the end of life were to be offered spiritual and religious support appropriate to their needs and preferences. The End of Life Care Operational Group monitored both the number of end of life care referrals and the number of chaplaincy interventions. The results from January to April 2019 showed 70% of the patients referred to end of life care were seen by the chaplain.

The presence of the priorities of care individualised care plan had increased. The results of the audit between the period August 2018 and March 2019 showed an average of 82% of the records reviewed had the individualised care plan.

Standards of practice for the mortuary were based on national guidelines. Mortuary policies were up to date, evidence based and relevant to the service they provided. Ward staff, mortuary staff, and porters knew of these policies. They could describe the procedures followed and equipment used.

The IPET carried out a baseline assessment to check how each ward implemented the six ambitions for palliative and end of life care. We inspected the results of four wards and found good progress had been made across the trust. Where there were gaps, wards had to submit an action plan which was monitored by the IPET.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Staff in end of life care knew the new (2015) Mental Health Act and the code of practice. For example, they knew the five new guiding principles, and its application to human rights and health inequalities.

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.
Staff made sure patients had enough to eat and drink, including those with specialist

nutrition and hydration needs. Nutrition and hydration were included in the daily assessment in the priorities of care nursing care plan. Medical staff knew the General Medical Council (GMC) guidelines for nutrition and hydration in end of life care. Nurses made referrals to the Dietitian and assessed and supported the patient with their nutrition needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 20 set of notes and found in 16 set of notes, staff had fully and accurately completed fluid and nutrition charts. 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. The other four set of notes missed out recording of information as the patient did not require an assessment

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used Malnutrition Universal Screening Tool (MUST) when they assessed patients at risk of malnutrition. They monitored the daily assessment in the priorities of care nursing plan to identify patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff could made direct referrals to gain expert advice about swallowing. This was available to all patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain. However, there were no suitable assessment tools to support patients who were unable to communicate.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. At the last inspection, 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.

At this inspection, staff monitored patients' pain using an assessment tool in accordance with NICE Quality standards. Our inspection of 20 medical and nursing records showed symptom control for end of life patients had been managed to the relevant NICE Quality standard. The standard defined best practice for the safe and effective prescribing of strong opioids for palliative care. Pain scoring was completed for patients every time their observations were recorded. For five patients on the priorities of care individualised care plan this was a minimum of three times a day and after any interventions, including medicines, were given. However, there were no suitable assessment tools to support patients who were unable to communicate. Staff relied on patients' requesting pain relief or by their non-verbal behaviour. The impact of this would be not all staff would interpret non-verbal consistently in the same way.

Though a recognised pain assessment tool was not in use, nurses reviewed patients' pain and its control regularly. We did not observe any patients in pain during our inspection. Relatives told us staff regularly came to assess patient pain control.

Patients received pain relief soon after requesting it. The IPET responded quickly in supporting staff to ensure there were no delays in responding to a patient's increase in pain as it happened. Patients told us they were asked about their pain at regular intervals and given pain relief where appropriate. All staff were pro-active in managing patient's pain. We reviewed five nursing records for patients in the last days of life and saw where pain assessments were included in the priorities of care individualised care plan (PoC). After giving patients pain relief, staff asked them whether the pain relief had worked.

Staff prescribed, administered and recorded all pain relief accurately. We inspected 20 records and found pain relief was recorded accurately. In all records, we found the right medicine was prescribed and administered accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated all relevant national clinical audits. The service performed well in national clinical outcome audits and managers used the results to improve services further. The End of Life Care Operational Group used the results and identified the need to focus improvement on the following areas:

- Gaining feedback on end of life care
- Ensuring all conversation with patients and those deemed important to the patient recorded.
- Continue to deliver on its current improvement plan.

The trust performed better when compared nationally. There were nine key components identified in the latest 2019 *National Audit of Care at the End of Life (NACEL)*. The trust scored better when compared nationally in six out of nine indicators. These were as follows:

- Recognising the possibility of imminent death
- Communication with the dying person
- Involvement in decision making
- Individual plan of care
- Governance
- Workforce/specialist palliative care

The trust scored worse nationally in the following two areas:

- Communication with families and others
- Needs of families and others.

The trust did not receive a rating on families and others experience of care as the number of families who took part in the survey was quite small.

Managers had an action plan to improve the service further. For example, it monitored the priorities of care individualised care plan (PoC) to ensure staff documented communication with families and others. Business cards with information on how to access the IPET and bedside postcards on services available to patients, relatives and carers were left with families and others. These postcards can be completed while patients and those closest to them were still in hospital. It allowed the staff to address any issues or concerns at the earliest opportunity.

Managers carried out a comprehensive audit programme. Since the formation of the IPET, there was now an improved approach towards audit programmes. The IPET identified nine audit topics and when these would be undertaken. The nine audits included the following:

- Audit of NICE guidance NG31 *Care of dying adult in the last days of life* to be undertaken quarterly.

- Audit of NICE quality standards QS144 and QS13 to be undertaken yearly.
- The trust's the key performance indicators.
- Mortality review to be undertaken quarterly.
- Do not attempt cardiopulmonary resuscitation process compliance audit to be undertaken quarterly.

Since the launch of the IPET in January 2019, between January and April 2019,

- 100% of the referrals were seen within 48 hours.
- 22% of the referrals were seen on the same day.
- 85% of the notes audited had the priorities of care individualised care plan.
- 80% cases preferred place of care was identified.
- 68% cases preferred place of care was met.
- 36.5% of the referrals were cancer related cases.
- 63.5% of the referrals were non-cancer related cases.
- 80% of case load had advance care plan conversations.
- On average seven cases each month were fast tracked.

Managers used information from the audits to improve care and treatment. Managers streamlined access to care and treatment though a single point of contact. Since January 2019, ward staff called one central number or bleep and highlighted their needs. The IPET then decide who best to attend to the referred patient: a team member with an expertise in end of life care or a team member with expertise in specialist palliative care. Prior to the launch of the single point of contact, patients on the wards sometimes waited over 48 hours before seen by the team. Since the launch of the IPET in January 2019, no patient on the ward had waited more than 48 hours before seen by the team. Staff on wards told us the single point of contact had improved care and treatment. The IPET improved care and treatment by improved documentation of the priorities of care document and early escalation of concerns of deteriorating patients. The team undertook an audit of patients who died in hospital. During the reporting period April 2018 to March 2019, the trust reported 559 deaths. A first stage review identified 89 of these patients may have received poor care. Senior clinicians trained in the method of structured judgement reviews (SJR), undertook a second review of those patients. The SJR tool looked at the strengths and weaknesses in the caring process, provided information about what can be learnt when care goes well and to identify points where there had been gaps, problems or difficulty in the care process.

There were engagement meetings or follow-up of audit outliers. The engagement improved compliance to mandatory training. The trust had set a standard of 85% compliance to mandatory training. A monthly audit of mandatory training uptake in March 2019 identified 29 areas had achieved 100% compliance, three areas had achieved between 80% and 85% compliance and 50 areas fell below the needed 85% compliance. All areas were followed-up by the clinical director for end of life care to assess the reason for poor compliance and identify whether any support was needed. The monthly audit in April 2019 identified 37 areas had achieved 100% compliance, 11 areas had achieved between 80% and 85% compliance and 34 areas fell below the needed 85% compliance.

Managers shared and made sure staff understood information from the audits. The results of the audit were shared at the monthly meeting of the End of Life Care Operational Group and cascaded to wards.

Improvement was checked and monitored. Each ward received a visit from the IPET to check and monitor improvements in the care patients who were at the end of life. The assessment was based on the six ambitions identified in *Ambitions for Palliative and End of Life Care*. The IPET identified for each ambition, areas of poor compliance and areas of good patient care. and shared these with the ward. The ward produced an action plan which was the focus of the next monitoring process in 6-12 months.

Competent staff

The service made sure staff were competent for their roles. Managers appraised nursing, allied health professional and administrative and clerical staff work performance and held supervision meetings with them to provide support and development. However, medical staff were not supported to develop through yearly, constructive appraisals of their work. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Staff received end of life care training which covered the identification of people in the last 12 months of their life in the last year. Staff received end of life care up-skilling through an e-learning programme. IPET staff were trained in advance care planning and had regular discussion with patients about care plans. The specialist palliative care service staff provided support and training to generalist staff. The trust had a structured syringe driver training programme to ensure all relevant staff received the same standard training from the same trainer. The training programme was based on competencies identified. On completion, staff needed to carry out competency assessment on their ward under supervision. Only once the supervisor signed these off, were staff allowed to use the syringe driver. All wards had a list of staff who had completed this process. Ward managers considered this list of staff when organising the rotas. At the time of inspection, over 250 staff had been trained.

Managers made sure staff received any specialist training for their role. All members of the IPET had received specialist training for example in supervision, on undertaking fast track for discharges, advance symptom management course and others. The trust identified end of life care 'champions' in each area and developed and built capacity in them through training and development. End of life care champions told us they found the training very useful. Mortuary staff provided training to portering staff on how to transfer the deceased patient.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff said they were encouraged and supported to complete some new training programmes to develop their skills and knowledge. This was done through appraisals.

A breakdown by nursing group is below:

Staff group	April 2018 to February 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Nursing and Midwifery Registered	11	13	84.6%	85.0%	Yes

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

For example, staff discussed with their line manager the importance of understanding the law. As a result, a training session on law had been organised for all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The clinical director for end of life had created an IPET training plan for all members of the IPET. The plan was created through training needs analysis and this identified the gaps in the team knowledge base. As a result, the service had an IPET training plan and there was each member of the team a personal educational plan with deadlines on when these will be complete. One staff was on an academic pathway pursuing a masters in end of life care.

Managers did not support medical staff to develop through yearly, constructive appraisals of their work. From April 2018 to February 2019, 33% of staff within End of Life Care department at the trust received an appraisal compared to a trust target of 85.0%.

A breakdown by staff group can be found below.

Staff group	April 2018 to February 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Medical and Dental	2	6	33.3%	85.0%	No

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

There were enough clinical educators to support staff learning and development.

There were two clinical educators: one for end life care and one for syringe driver and they supported staff learning and development.

Managers gave all new staff a full induction tailored to their role before they started work.

Staff had up to four weeks before they became part of the rota. In these four weeks, staff were not considered as part of the rota for any activity. They received professional based induction.

Managers supported allied health professional staff and administrative and clerical staff to develop through yearly, constructive appraisals of their work. From April 2018 to February 2019, 100% of allied health professional staff and 86. 7% of administrative and clerical staff within end of life care department at the trust received an appraisal compared to a trust target of 85.0%.

A breakdown by staff group can be found below.

Staff group	April 2018 to February 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional Clinical Services	1	1	100.0%	85.0%	Yes
Add Prof Scientific and Technic	1	1	100.0%	85.0%	Yes
Healthcare Scientists	2	2	100.0%	85.0%	Yes
Administrative and Clerical	13	15	86.7%	85.0%	Yes

Managers identified poor staff performance promptly and supported staff to improve. Staff highlighted how staff who did not perform were made fully aware of where their performance did not meet the required standard and managers gave encouragement and support to improve. Staff said how there were open and honest two-way conversations between themselves and their manager. Staff were encouraged to speak up about issues that affected their performance at work.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. They held monthly team meetings on different days of the week (excluding the weekends) to ensure all staff could attend these meetings. Minutes of these meetings were shared with all staff. Staff were asked to sign the minutes to assure the manager they were read.

Multidisciplinary working

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

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

Relevant professionals were involved in the assessment, planning and delivery of patient care. We observed good working relationships between a range of health professionals within the trust. The weekly IPET was attended by doctors, nurses, social workers, allied health professionals (AHP) and members of the chaplaincy. The IPET discussed caseloads at the weekly multidisciplinary meetings. The team discussed diagnostic challenges, management options and any other issues about their current patients. As a result, increased needs were identified and acted upon.

Members of the IPET acted as a point of reference for any ward staff who needed support or advice. They attended meetings for the different specialties to anticipate any patients whom they may need to support. Nursing and medical staff told us there was good communication with the IPET. Ward staff knew how to contact the IPET both within and out of their working hours.

The IPET had a good working relationship with the end of life care discharge co-ordinator and other members of the hospital team and hospice. Between them could arrange rapid discharges to a patient's home or other places such as local hospice.

There was effective communication between the IPET and the critical care outreach. This allowed co-ordinated leadership of all seriously ill patients.

During our inspection we observed occupational therapists, dietitians, speech and language therapists and members of the chaplaincy speaking with patients and their nursing and medical staff. We observed their involvement written in the medical records we reviewed.

Membership of the End of Life Care Steering Group meetings was broad and well attended.

Members of the bereavement team and the mortuary staff appeared to have a good working relationship which allowed them to arrange family visits for viewings and collecting necessary paperwork as distressing as possible. The bereavement team had good relationships with the **hospital's medical staff which meant they could get death certificates signed in good time.**

Seven-day services

Key services were not available seven days a week.

Consultants led daily ward rounds on all wards, except weekends. Patients were reviewed by consultants depending on the care pathway. Manager confirmed the trust did not provide a seven day a week service to support timely care. The IPET provided a Monday to Friday 8am to 8pm face-to-face palliative care service at St Mary's Hospital. One cancer nurse specialist, who 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 arrangement did not meet the recommendation from the NICE guidelines for *End of life care for adults*, which states, "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".

Mortuary services were available 8.30am to 4pm Monday to Friday with on-call cover out of hours. The bereavement service was available to help families with viewing between 9am to 3.30pm. The chaplaincy service provided 24 hour seven days a week on call service.

However, portering staff provided seven days a week, 24 hours a day to transfer the deceased from the wards to the mortuary.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Patients were offered information on how to help themselves with activities of daily living. For example, for bathing and showering, the use of specialised or adaptive equipment to maximise safety. To promote meal preparation, patients were guided how to reorganise their kitchen storage for easier access.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. To promote healthy lifestyles, patients were provided with what they wanted. This included relaxation techniques such as yoga or meditation and sometimes, just a general chat. The chaplains provided opportunities for such general chats that helped patients come to terms with the end of their life. Some patients wanted to know how they would know when death was near. Staff shared with them information on recognising signs when death was near.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards Capacity Act and Deprivation of Liberty Safeguards and achieved the trust's target. Most medical staff had not completed the training and did not achieve the trust's target.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

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.

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.

We reviewed 20 DNACPR forms and found the following:

- 100% of DNACPR records were found immediately at front of notes.
- 100% of the forms had been dated when signed.
- 100% had the identified the level of treatment clearly stated.
- 100% clearly identified the rationale for clinical decisions.
- 20% (4) patients were recorded as having questionable capacity.
- 50% of these (2) patients recorded as having Mental Capacity Assessment (MCA) or best interest decision.

Of the four patients recorded as having questionable capacity, only two had any record of Mental Capacity Assessment /Best Interest decision within their notes.

Doctors carried out all the necessary assessments. We saw evidence in the notes for 20 patients where the doctor who carried out the decision used the two-stage test to identify the patients who did not have capacity.

Eighteen (90%) of the patients' medical records or treatment escalation plan included a summary of communication about DNACPR with either the patient or their relatives.

Mental Capacity Act and Deprivation of Liberty training completion

Staff clearly recorded consent in the patients' records. Staff followed the trust policy on the recording of consent in the patients' records of do not attempt cardio pulmonary resuscitation (DNACPR). The policy stated the DNACPR decision could be made by a doctor ST3 or equal or above, speciality 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. The last audit undertaken by the trust was in January 2019 and all actions emerging from these had been implemented.

We reviewed 20 DNACPR forms and they had all been signed by an appropriate senior clinician within the set time frame. Instances where they were signed by associate specialist, a consultant verified these decisions within 72 hours. No forms were signed by registered nurses.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware the lack of capacity may not be permanent condition. They knew the assessments of capacity should be time and decision specific. They highlighted that one should not decide if someone lacked capacity based upon age, appearance, condition or behaviour alone.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff told us when deciding what was in the best interest of the patient, they needed to consider the past and present wishes and feelings, beliefs and values may have influenced the decision taken by the patient if they had capacity and other factors the patient would like them to consider if they had capacity.

Staff made sure patients consented to treatment based on all the information available. Staff were aware the person who gave consent must be given all the information about what the

treatment involved. This included the benefits and the risks, whether there were reasonable alternative treatments and what will happen if treatment does not go ahead.

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards Capacity Act and Deprivation of Liberty Safeguards achieving the Trust's target. The trust set a target of 85. 0% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. A breakdown of compliance for MCA/DOLS training courses from April 2018 to January 2019 at St Mary's Hospital for qualified nursing staff in end of life care is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	12	14	85.7%	85.0%	Yes

In end of life care the target was met for the MCA/DOLS training module for which qualified nursing staff were eligible.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Managers ensured proper use of Deprivation of Liberty Safeguards. They checked on staff use of this and helped them fill the forms out where necessary.

Most medical staff had not completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards Capacity Act and Deprivation of Liberty Safeguards. They did not achieve the trust's target. The trust set a target of 85. 0% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. A breakdown of compliance for MCA/DOLS training courses from April 2018 to January 2019 at St Mary's Hospital for medical staff in end of life care is shown below:

Training module name	April 2018 to January 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	2	5	40.0%	90.0%	No

The trust reported the Mental Capacity Act training module incorporated Deprivation of Liberty Safeguard training.

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

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff told us how they accessed policy in the intranet and got accurate advice on the MCA and DoLS. They highlighted how they would access the lead person identified for MCA/DoLS who oversaw practice and compliance within the trust.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The trust had a lead person who oversaw practice and compliance within the trust. The trust lead monitored how well the service followed the MCA and recommended changes to practice when necessary.

Staff implemented DoL safeguards in line with approved documentation. Staff had access to Form 1 request for standard authorisation and urgent authorisation, and form 2 request for a further standard authorisation. They had access to guidance for completion of both forms.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff showed discretion when caring for patients. They demonstrated compassion when they interacted with patients at the end of their life and their families. We carried out SOFI which 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. The original framework was designed for use by the Commission for Social Care Inspection (CSCI) in their inspections of services for people with dementia or severe learning disabilities. SOFI 2, the second edition of the tool, reflects the change in the regulatory framework and the wider range of services that CQC regulates compared to CSCI. Its use has been extended to anyone who has difficulties communicating their experience of care.

We observed a member of staff being discreet and responsive when caring for a patient on end of life care. The individual was called by their name. The individual was comfortable the way the member of staff spoke with them. The interaction was at a pace which recognised the importance of helping create a relaxed atmosphere. The member of staff encouraged the individual to try to hold their hand. The individual smiled because the member of staff recognised, supported and took delight in making them smile.

Patients said staff treated them well and with kindness. They offered them a smile which did not show them pity or sympathy. Patients commented on how important it was for them to receive a genuine and warm smile. One patient told us they had asked for a wish from their angel (their nurse). They said they wished for their angel to hold their hand as they passed away.

Staff followed policy to keep patient care and treatment confidential. They did not share the patient's name or the care they received to their work colleagues. They ensured the room was always closed or the curtains pulled when they wanted to talk with the patient.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff knew the various personal, cultural, social and religious needs of patients. The chaplain was aware the needs of a Muslim patient who wanted to be buried in London. The chaplain worked with the family to ensure the relevant paper work was completed in a timely manner to allow for the religious needs of the patient to be met.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. When needed, staff took time to sit with the patient or their relatives and provided them with support. One family member told us how instrumental staff were to them as they gave strength and support to the dying person. They told us: “I just could not have done what I did without the emotional support and advice from staff. I know I still have them to reach out to, if needed.”

The bereavement team provided a compassionate and responsive service to bereaved families and provided further advice as required. It was understood certain religions required their dead were buried as soon as possible after death. In such circumstances, the team tried to ensure all the relevant paperwork was completed as soon as possible so the family could register the death.

The bereavement team kept relatives updated of any delays with releasing the body; for example, where a post mortem was required. They offered practical advice and sign posted relatives to other services as required.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Most staff had received training on breaking bad news. They told us how they had to learn to build resilience as they broke bad news to patient or families. And yet, every time they broke bad news, it felt like it was the first time ever they had done this.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff were empathetic to the people’s care and understood how their wellbeing was affected. Since working on caring for patients on end of life care, some staff realised how the patient and their families were going through a separation and how their role was to ensure the family unit did not fall apart.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff said patients sometime put a strong face to support their families while the families do the same to support the patient. Staff told us in those circumstances, they tried to have each understand the other. One staff commented: “Sometimes we must help each understand the needs of the other. This way they would perhaps be of great solace to each other.”

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff highlighted the importance of understanding before being understood. We observed how staff interacted with someone whom they supported through their personal presence. The family member was intensely emotional, and the staff member listened to them. We observed how staff calmed the family member down.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Families sent in notes of appreciation and thank you cards to staff. We randomly picked five cards/note and each note or card always had one of these words or phrases: “angels,” “outstanding” “friendly” “constantly smiling” “unique” “brought a smile on….”

Staff supported patients to make advanced decisions about their care. Staff helped patients empower themselves to make advanced decisions about their care. This required staff to carefully navigate to ensure as they empowered the patient and the family did not feel disempowered. Staff maintained the delicate balance.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. Patients were positive about their care and treatment. Comments from relatives of the deceased was positive. There were no specific feedback relating to end of life care in the friends and family test survey.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. They worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The trust had employed an end of life care discharge coordinator who organised the discharge of patients from the hospital who were at the end of their life. This often needed to be done quickly if they were to get the patient to their chosen place to die. The hospice discharge coordinator spoked with other staff and could often arrange a rapid discharge within a day and sometimes a few hours. The hospice discharge coordinator involved other allied health professionals such as occupational therapy services who could organise specialist equipment to be set up at the patient's home.

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 allow relatives to spend the maximum amount of time with their relative.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff always ensured patients who received end of life care were cared for on single sex accommodation. Staff knew what actions to take when there was a potential breach.

Facilities and premises were appropriate for the services being delivered. The hospital did not have any designated end of life or palliative care wards or beds; patients were nursed as required across all wards. Patients at risk of infection or those who were infectious were prioritised for side rooms to prevent cross infection with other patients. However, if the ward did not have any patient who required a side room, patients who received end of life care were then allocated side rooms whenever possible and if it was their wish. The multi-faith room provided a place of worship, quiet time and prayer for people of all faiths and none. Prayer mats and religious texts were available for Christians, Jewish, Hindu, Sikh, Buddhist and Muslim religions.

Mortuary viewing facilities were appropriate and allowed relatives privacy. Viewing was usually arranged through the bereavement officer who accompanied relatives to the mortuary. Nurses were responsible for recording the deceased's belongings and handing them over to the bereavement office. The bereavement office arranged for these items given to the relatives. Jewellery and other such items were given to the relatives in decorative bags.

The service had systems to help care for patients in need of additional support or specialist intervention. Patient records showed the IPET was responsive to all palliative care patients and end of life care patients. We received positive feedback about the IPET referral process was positive. Since the merger of the end of life care team and the specialist palliative care team, staff told us the timeliness of the service had greatly improved. The IPET met the needs of patients and

relatives. Staff gave examples of how quickly the hospice discharge coordinator arranged rapid discharge. One staff told us “rapid discharge now meant rapid.”

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service had information leaflets available in languages spoken by the patients and local community. All staff received training in equality and diversity as part of their induction. Staff could access guidance on wards and on the intranet on how to provide care in accordance with peoples’ religious and cultural preferences.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were aware how to access interpreters or signers when needed. We reviewed one record which highlighted how staff accessed a signer for a loved one.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff asked patients whether they had any cultural or religious preferences in food or drink. We reviewed one record where a patient had asked for vegan food. Staff confirmed in the notes the option chosen by the patient and provided details on which vegetarian options on the menu were vegan appropriate. Where the options were not, staff ensured a vegan option was available.

Staff gave additional support to patients who needed it. Staff provided comfort bags to patients for that contained essential basic items for example toothbrush, toothpaste and soap. These were packed in a decorative knitted bag. Patients felt their individual needs were met.

Access and flow

Waiting times from referral to achievement of preferred place of care and death were in line with good practice. Patients could not access the specialist palliative care service when they needed it as it was provided only Monday to Friday. However, there were delays in the transfer of deceased from wards to the mortuary.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Patients identified as requiring palliative care such as symptom control were referred to the IPET by individual consultants or ward staff. The team carried bleeps for urgent referrals. Since the launch of the IPET in January 2019, between January and April 2019, all patients were seen with 48 hours of their referral with 22% of the referrals were seen on the same day. In 80% of the cases preferred place of care was identified and in 68% cases preferred place of care was met. On average seven cases each month were fast tracked. Fast tracked cases were resolved within 24 hours.

As the service was not a seven-day service, patients could not access the specialist palliative care service when they needed it. There was an on-call rota at weekends to support members of the local community, including police and funeral directors, which allowed access to the mortuary at weekends.

However, staff were unable to always transfer the deceased from the wards to the mortuary in a timely manner. Staff said that sometimes it could take up to two hours for the porters to arrive and initiate the transfer of the deceased. The trust did not collect any information on how long wards had to wait for porters to arrive and transfer the deceased to the mortuary. One patient told us they were in hospital recently (February 2019) for a procedure. A patient on the opposite bed died. They told us there was a delay of up to four hours before the deceased was transferred to the mortuary. The trust did not monitor this data.

The trust had in total 20 porters and six porter co-ordinators to cover the service seven days a week, 24 hours a day. Over the past five years, seven porters had left the service and were not replaced. After allowing for annual leave, sick leave and other forms of leave, the daily rota of porters was four to five during the day and two porters and a porter coordinator at night. In April 2019, there were 80 recorded calls for deaths which required transfer from wards to mortuary. Each transfer required two porters. If a call was out of hours and at weekends, three porters could be required. If a call came during the day, 50% of the portering workforce would be needed to undertake a transfer. If a call came at nights and weekends, 100% of the portering workforce would be attending to deaths and transfers from wards to mortuary.

Managers monitored that patient moves between wards/services were kept to a minimum. 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.

Staff did not move patients between wards at night. We reviewed 20 records to assess whether patients were moved between wards at night and we found no patients were moved.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns.
We found leaflets throughout each ward telling patients and relatives about how to access Patient Advice and Liaison Service (PALS) to make a formal complaint. None of the patients or relatives we spoke with felt they had cause to complain.

The service clearly displayed information about how to raise a concern in patient areas.

The IPET left a card with contact details of the team with patients who received end of life care and their relatives. The trust website had a section on how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff showed us the policy on the intranet and knew how to deal with it.

Managers investigated complaints and identified themes. We saw complaints about the service were reviewed at the monthly End of Life Care Operational Group meeting. Emerging themes were discussed and identified, this had included lack of specialist equipment and medicine. There was a follow-up at the following month's meeting on the outcome.

From March 2018 to April 2019, the trust received six complaints from relatives whose loved ones received their end of life care at St Mary's Hospital. The trust generally took an average of 23.3 days to investigate and close complaints with 83% were closed within 30 working days and 17%

within 60 days. This is in line with their complaints policy, which states that 75% of complaints should be closed. There was a delay of closure for one complaint because the complaint became a serious incident. It had to be investigated before providing a response to relatives.

A breakdown of complaints by type is shown below:

- Access to treatment or drugs with two complaints
- End of life care with two complaints
- Communication with two complaints

Number of compliments made to the trust

From April 2018 to December 2018 the trust received 1,179 compliments regarding acute services at the trust. Due to the way in which compliments are captured by the trust, it has not been possible to split the number of compliments by team or core service.

The trust identified the following themes:

- The main compliment received was about staff behaviour. Staff were described, through individual experiences, to behave in a manner that was kind, patient, friendly, professional, courteous, caring, compassionate, helpful and understanding.
- Specific praise for consultant care
- Treatment with dignity and respect
- Effective and responsive emergency department
- Excellent care
- Helpful, friendly and efficient administrators/receptionists.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff acknowledged complaints and ensured patients, if relevant, or their relatives received feedback from managers. The feedback included the offer of a face-to-face meeting with the family and what had been learnt from the complaint including changes that had taken place.

Managers shared feedback from complaints with staff and learning was used to improve the service. The complaints were shared at the monthly End of Life Care Operational Group and the emerging themes were shared with wards.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

At the last inspection, 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 this inspection, we

observed a transformation of the service. Highly capable leaders with integrity, skills and abilities to run the service had been appointed. The trust had appointed a non-executive member to have responsibility for end of life care. This person understood their role and had experience of working as a non-executive member of the board of the hospice.

In August 2018, the trust launched its new '*End of Life Care Strategy 2018-2022*' with a corresponding increase in the total budget for end of life care by just over 370%. From the period April 2017 to March 2018, the total budget for end of life care was £36,443. For the period April 2018 to March 2019, the total budget for end of life care was £135,873.

The executive leadership team appointed a high calibre leader to lead end of life care. They ensured an additional £99,430 for the delivery of end of life care. Together with their team, local and national experts, they began the task of re-energising end of life care at the hospital. This highly motivated and compassionate new team of clinical nurse specialist, nurses, doctors, chaplains, volunteers, managerial and administrative and clerical staff carried out a review of the previous CQC inspection in January 2018 and identified the key issues and priorities the service faced. They energised wards and departments to deliver high quality patient centred end of life care. Each ward and department had an end of life care champion who could be from any grade if they were passionate about the care patients at the end of their life received. These champions took responsibility for communicating changes in practice from the leadership and fed back issues from their area.

The leaders built on the existing infrastructure co-created by the hospital palliative care team and the end of life care nurse facilitator. The new team identified how they will become a 'good' service. They remained visible and approachable in the service for patients and staff.

By January 2019, the trust had signed a memorandum of understanding with a local hospice on how in partnership the two organisations will deliver end of life care at St Mary's Hospital. A new integrated palliative care and end of life care team (IPET) had been formed under a single leadership structure. The team had re-launched a new priorities of care individualised care plan (PoC), appointed an additional palliative care consultant, identified the key performance indicators for end of life care, standardised syringe driver training, successfully bid with the local hospice for end of life care discharge coordinator and launched the End of Life Care Operational Group which included most of the key stakeholders.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust is on a journey of "Getting to good by 2020" and their *End of Life Care Strategy 2018-2022*, which they developed with all relevant stakeholders, shaped the direction of travel and provided focus along the way. The *Quality Strategy* identified end of life care as a core improvement area. The trust used the national work presented in the *Ambitions for Palliative and End of Life Care* to set about its vision and strategy for end of life care for the trust. The trust had a clear vision for end of life care. It was for patients to experience high quality end of life care and the workforce was critical in the realisation of this vision. To energise the workforce, the trust linked its vision to the six ambitions defined in the national work presented in the *Ambitions for Palliative and End of Life Care.* There are six ambitions and each ambition had a corresponding

strategy and a workable plan to turn the ambition into action and a delivery date by which this would be achieved. For example, there were four identified strategies to deliver the first ambition where each person was treated as an individual. For the six ambitions, there were 28 corresponding strategies each with a workable plan and a delivery date for completion. The leadership team of the IPET monitored progress on the plan and reported it to the monthly End of Life Care Operational Group meeting.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they enjoyed and took great pride in caring for patients who were at the end of their life. They said the trust leadership team ensured greater integration of end of life care within the organisation and within the new *Quality Strategy*. The IPET team and those delivering end of life care on the wards felt respected, supported and valued. Trust leaders welcomed their ideas and suggestions. The culture in the delivery of end of life care focussed on the needs of patients receiving care and their loved ones. Staff working in the IPET had opportunities for career development. For example, each ward had an end of life care champion and all staff on the wards were encouraged to apply for the role. Staff told us the open culture encouraged them to raise concerns without fear. Staff shared examples of how the IPET addressed concerns they had raised.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were governance processes with all stakeholders to support the delivery of the strategy. The governance structure of end of life care had changed since the previous CQC inspection in January 2018. There was now a direct reporting to the trust management board as required. End of life care had a clear governance framework, which ensured responsibilities for end of life care could be identified from the members on the trust board through to key members of staff. Members of the Integrated Palliative care and End of life care Team (IPET) knew the chief nurse, a member of the trust board had overall responsibility for end of life care. There were effective structures and systems of accountability to support the delivery of the strategy. The End of Life Care Operational Group had an oversight of end of life care in the trust. The trust formalised the ward to board meeting structure to ensure there was a clear governance process. The trust developed a structure so end of life reported into operational forums and linked to trust board. The formal minutes of the monthly End of Life Care Operational Group fed into the trust Quality committee which met monthly. There were reports from the End of Life Care Operational Group to trust board on a quarterly basis. The End of life Care Operational Group collected activity and performance data for end of life care within the trust. The End of Life Care Operational Group established a formal link with the mortality group to share lessons learnt from death.

All staff were aware of what was their role and who were they accountable to in the delivery of care to patients at the end of their life**.** Staff at all levels were clear about their roles and

accountabilities. For example, all staff in IPET had an up to date job description. The end of life care champions had a job description and a contract in place for the time they were expected to work on their ward on end of life care. The local governance arrangements were clear about the role of the 'senior responsible clinician' in end of life care. The clinical director had an overall responsibility of end of life care with a clear job plan.

The trust had defined measures of success for end of life care. The IPET identified and collected data on key performance indicators for end of life care. These KPIs were presented to the End of Life Care Operational Group for monitoring. These indicators were recommended to and agreed by the trust Quality Committee, a sub-committee of the trust board.

Staff at every level of the organisation had regular opportunities to meet, discuss and learn from these measures of success. Every week, the IPET discussed the results of the KPIs for end of life care. The End of Life Care Operational Group reviewed progress on the performance indicators and reported every quarter to the trust Quality committee, a sub-committee of the trust board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, not all risks identified were on the risk register. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. We noted at the last CQC inspection in January 2018 there was no dedicated risk register for end of life or palliative care. One had since been introduced and was discussed at each End of Life Care Operational Group. Patient safety incidents were collected by the electronic incident reporting system and from across all divisions. They were discussed and any learning from end of life care incidents was identified.

The following were the three current risks on the register in April 2019:

- Non-compliance with best practice guidelines for end of life care across the trust.
- Timely access and availability of syringe driver.
- Access to the information systems to allowed staff from the emergency department and the medical assessment unit to view records of patients in the community.

For each of the above risks, there were action plan in place to lessen them. At the May 2019 meeting of the End of Life Care Operational Group, the risk register was reviewed. A recent audit in April 2019 confirmed the trust met the best practice guidelines for end of life care across the trust. A recommendation was made to the trust quality committee to remove this risk from the risk register.

The service acknowledged key services were not available seven days a week. They had a preliminary discussion with the CCG and the outcome was pending. They planned to place this item on the risk register after the completion of these discussions.

There was effective board oversight of performance regarding antimicrobial prescribing. Action had been taken to remove certain medicines from the formulary.

The mortuary had an action card which outlined actions to take in the event of a major disaster such as mass loss of life and incidents that involved the release of chemical, biological or radioactive materials.

Staff contributed to decision-making and worked with the end of life care discharge coordinator who organised the discharge of patients at the end of their life to their preferred place of care. This often needed to be done quickly if they were to get the patient to their chosen place to die.

However, the delays in the transfer of deceased from wards to the mortuary was not on the risk register.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. The service did not collect any data on timeliness of transfer of the deceased from the wards to the mortuary.

The service identified and collected monthly key performance indicators (KPI) for the service. These were as follows: (1) Evidence of recognition; (2) Priorities of care identified and met ,(3) Rationale for why priorities of care were not met, (4) Communication with the dying person, (5) Communication with those deemed important, (6) Complaints, (7) Concerns ,(8) Incidents related to end of life care and, (9) Uptake of end of life care mandatory training. Staff could access the data they needed as they part of the monthly End of Life Care Operational Group meeting. The service had integrated and secure information systems. Data or notifications were submitted to the CQC in a timely manner. However, the service did not collect any data on the timeliness of transfer of the deceased from the wards to the mortuary.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders and staff included patients, staff, the public and local organisations to plan and manage the service. The trust had identified end of life care champions to embed good end of life practice. They had a job description for this role. They received protected time for undertaking the delivery of this work at the ward level. The service held a staff and public event on end of life care in January 2019 where over 100 people attended. They collaborated with the local hospice and jointly provided the service of end of life care discharge coordinator.

The trust carried out a bereavement survey of relatives and friends. The results were reported on a time frame basis and there were actions to be undertaken because of the survey.

The service was part of the national end of life care network and the clinical director was a core member of this national network team. It was part of the Island wide end of life care strategic group. The service worked with two mothers of patients who had since passed away and worked with them as critical friends. The mothers reviewed the end of life care strategy, the key performance indicators and other relevant documentation and provided valuable feedback to the service. We spoke with one mother who told us had their loved ones been in the care of the end of

life care team in May 2019, the time of this inspection, they would have had a different and improved experience.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had made substantial improvements to end of life care services since we last inspected. Most of the hospital 'must do' actions which related to end of life care had now been fully implemented. For example, there was an executive framework which monitored the quality, risk, and performance issues within end of life care. We found there was monitoring of the rapid discharge system. All patients nearing the end of life care 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. Importantly, leaders encouraged innovation.

The joint venture between the trust and the hospice was one-such innovation which had now been implemented. It had begun to develop improved ways of working. The senior leaders who came up with this innovation had concluded 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. Their perseverance was acknowledged and valued as other issues that have emerged as this innovation was being implemented, such as the early identification of the dying patient, had now become the pivot of the trust's quality strategy.

The trust had developed end of life care performance measurements were part of the service and the organisation's dashboards. These were regularly presented to the trust board. A dashboard is a document providing summary information about the performance of a service.

Community health services

Community health services for adults

Facts and data about this service

The Community Nursing Service provides general and specialist nursing care to adults with nursing needs who are unable to attend their GP Surgery, or where care would be more appropriately provided at home. The Isle of Wight NHS Trust community services are divided into three localities and three teams, West and Central, North East and South Wight.

The service includes, nurses, pharmacy, allied health professionals, advanced clinical practitioners and a variety of community clinics and a continence service. The service is delivered 8am to 8pm seven days a week, with out of hours emergency care 8pm to 8am provided by the ambulance service (community practitioners).

The service includes a Crisis Response Team (CRT) and the Rapid Assessment Community Response Team (RACR). These multidisciplinary teams consist of nurse practitioners and nurses,

occupational therapists, physiotherapists, assistant practitioners, social workers and care support workers. The teams have access to equipment and social service care packages seven days a week and are fully integrated with the emergency services, pharmacy, and the single point of access teams SPARRCS.

Adult speech and language therapy are based at St Mary's Hospital and provide an island-wide service to adults with acquired or developmental disorders of speech, language, communication or swallowing. This includes individuals with learning disabilities. The service is delivered in a range of acute and community settings covering the whole range of the patient journey.

The physiotherapy service, based at St Mary's Hospital, provide an island-wide service to adults in a range of acute and community settings and inputs into a number of specialist multi-disciplinary teams (MDTS) such as rehabilitation, early stroke discharge and amputee rehabilitation. They combine their knowledge, skills and approach to improve a broad range of physical problems associated with different 'systems' of the body. They treat issues associated to neuromuscular, musculoskeletal, cardiovascular and respiratory systems conditions. The professional lead provides clinical leadership to all physiotherapists employed by the organisation.

Podiatry services are based at St Mary's Hospital with the service delivered in a number of community and primary care settings. Specialist clinics include, a shoe clinic in conjunction with orthotics, diabetic screening in GP surgeries, nail surgery, ulcer clinic with a consultant diabetologist, musculoskeletal podiatry, podiatry clinic in conjunction with NHS spinal triage service multi professional triage team (MPTT), lower limb triage team, and treatment of diabetic ulcers.

Dietetics, based at St Mary's Hospital, provide an Island-wide service to residents of all ages, assessing, diagnosing and treating diet and nutrition problems. The team provide input in a range of acute and community settings, direct and indirectly to provide specialist advice and practical guidance to enable people to make appropriate lifestyle and food choices.

Occupational Therapy, based at St Mary's Hospital, work with people of all ages to carry out activities they need or want to complete. Occupational Therapists (OTs) work with individuals to find alternative ways to do these activities and to empower people to live life their way. Acute OTs are based in the main hospital site alongside other acute therapists.

Technology Enabled Care (TEC) is a fast-evolving service run by the community services but provides support across all the organisation’s divisions. The team work with different departments to research and implement systems to help improve their services and deliver better care to patients. The TEC team support the provision of Telehealth on the island and have recently supported the implementation of tele-swallowing clinics in conjunction with speech and language teams.

The service has 50 commissioned rehabilitation beds (CRB) in three nursing homes. These beds are for patients who have been assessed for rehabilitation, but not in an acute setting. These beds are therefore aimed at filling the gap between primary and secondary care and reduce pressure on beds in the acute trust.

During the inspection we visited the team at one of the CRB nursing homes, the crisis team and the RACR team, we spent time in clinics which included the dietetic, podiatry and the spinal and lower limb multi professional triage team (MPTT). We visited the district nursing teams for all three localities and spoke with 50 staff members across all modalities. This included, advanced clinical practitioners, physiotherapists and occupational therapists, rehabilitation assistants, nurses of all bands, a pharmacist, consultants, podiatrists, administrative staff, students and members of the dietetic team. We held focus groups for the physiotherapist, TEC staff and

occupational therapy leads and spoke with members of the senior leadership team.

Is the service safe?

Mandatory training

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

Mandatory Training completion

Trust wide

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for qualified nursing staff in community services for adults is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	81	81	100.0%	85.0%	Yes
Load Handling	3	3	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	81	81	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	77	81	95.1%	85.0%	Yes
Health, Safety and Welfare	77	81	95.1%	85.0%	Yes
Hand Hygiene	68	79	86.1%	85.0%	Yes
People Handling	66	78	84.6%	85.0%	No
Medicines Management Theory	126	152	82.9%	85.0%	No
Infection Prevention & Control Level 2	63	78	80.8%	85.0%	No
Information Governance	62	81	76.5%	85.0%	No
Adult Resuscitation	53	78	67.9%	85.0%	No
Adult Resuscitation - Non-Clinical	2	3	66.7%	85.0%	No
Medicines Management Practical Assessment	39	73	53.4%	85.0%	No
Adult Resuscitation - ILS	0	4	0.0%	85.0%	No

In community services for adults the 85% target was met for six of the 14 mandatory training modules for which qualified nursing staff were eligible. The trust target was almost met for the people handling module (completion rate of 84.6%).

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for qualified allied health professionals in community services for adults is shown below:

Training module name	April 2018 to January 2019

	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	47	48	97.9%	85.0%	Yes
Health, Safety and Welfare	47	48	97.9%	85.0%	Yes
Infection Prevention & Control Level 1	47	48	97.9%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	43	48	89.6%	85.0%	Yes
Hand Hygiene	43	48	89.6%	85.0%	Yes
People Handling	42	47	89.4%	85.0%	Yes
Infection Prevention & Control Level 2	42	48	87.5%	85.0%	Yes
Information Governance	41	48	85.4%	85.0%	Yes
Adult Resuscitation	34	48	70.8%	85.0%	No
Paediatric Resuscitation	1	4	25.0%	85.0%	No

In community services for adults the 85% target was met for eight of the 10 mandatory training modules for which qualified allied health professionals were eligible.

(Source: Universal Routine Provider Information Request (RPIR))

Training was provided for all staff to ensure they were competent to perform their roles. There was a designated list of mandatory training, which covered safety systems, processes and practices. Staff we spoke with were positive about the provider's commitment to their training, the quality and the support they were provided with to complete this and how this had improved since our last inspection.

Staff accessed training via an electronic system which provided some flexibility to staff on when and where this was completed.

The locality team leads monitored their teams mandatory training. All teams told us they had improved their mandatory training compliance and had worked hard to achieve or nearly achieve the trust target. Staff at the North East locality told us their lead would have focus weeks if a topic showed a low compliance rate. This was reflected in the most recent compliance data which was 94% at the time of our inspection. Central and West district nurses were 76% in April 2019, this had improved at the time of our inspection to 84% and South Wight compliance at the time of our inspection was 81.4% these fell just below the trust target of 85%.

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.

Safeguarding Training completion

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

Trust wide

A breakdown of compliance for safeguarding training courses April 2018 to January 2019 for qualified nursing staff in community services for adults is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Adults Lev 1	80	81	98.8%	85.0%	Yes
Safeguarding Children Lev 1	80	81	98.8%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	75	81	92.6%	85.0%	Yes
Safeguarding Adults Lev 2 Part 2	66	75	88.0%	85.0%	Yes
Safeguarding Adults Lev 2 Part 1	63	75	84.0%	85.0%	No
Safeguarding Children Lev 2	59	78	75.6%	85.0%	No
Preventing Radicalisation Level 3	38	78	48.7%	85.0%	No

In community services for adults the 85.0% target was met for four of the seven safeguarding training modules for which qualified nursing staff were eligible. The trust target was almost met for the safeguarding adults' level two (part 1) module (completion rate of 84.0%).

A breakdown of compliance for safeguarding training courses April 2018 to January 2019 for qualified allied health professionals in community services for adults is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children Lev 3	4	4	100.0%	85.0%	Yes
Safeguarding Children Lev 1	46	48	95.8%	85.0%	Yes
Safeguarding Adults Lev 1	45	48	93.8%	85.0%	Yes
Safeguarding Children Lev 2	44	48	91.7%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	43	48	89.6%	85.0%	Yes
Safeguarding Adults Lev 2 Part 1	43	48	89.6%	85.0%	Yes
Safeguarding Adults Lev 2 Part 2	42	48	87.5%	85.0%	Yes
Preventing Radicalisation Level 3	36	48	75.0%	85.0%	No

In community services for adults the 85.0% target was met for seven of the eight safeguarding training modules for which qualified allied health professionals were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

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.

From January to December 2018, the trust made 1,098 safeguarding referrals. Of these, there were 27 referrals in community services that concerned adults, although the trust was unable to separate these by core service.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Staff were aware of the systems to make sure their patients were safe. The provider's policy on safeguarding was accessed via the computer system. The organisation had appointed safeguarding leads and staff were able to obtain advice and support if they were unsure about a referral. All the locality bases had information displayed about safeguarding and child protection awareness.

Staff were able to give us examples of when they had to make a safeguarding referral. For example, a podiatrist and nurse podiatrist told us they had raised a safeguarding for a patient who had attended their clinic. They talked through the process, who they had contacted at the trust and reasons for their concerns. Staff in the amputee rehabilitation clinic, told us what they would do and had done when they have been concerned for a patient's mental health.

Staff were aware of Prevent and this formed part of the mandatory training element. Prevent is part of the Government's counter-terrorism strategy *"the only long-term solution to the threat we face from terrorism. Prevent focuses on all forms of terrorism and operates in a pre-criminal space, providing support and re-direction to vulnerable individuals at risk of being groomed in to terrorist activity before any crimes are committed."*

A meeting which included the fire service, social workers and police was held monthly for those people living in the community who were identified as vulnerable.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean. However, some of the audit results showed poor practice and improvements in audit submission was required.

Staff received infection prevention and control (IPC) training as part of their mandatory training. IPC level 1 mandatory training had been completed by 100% of qualified nursing staff in the community services. Hand hygiene had been completed by 86.1% and IPC level 2 by 80.8% (slightly under the trust 85% target) in the time frame of April 2018 to January 2019. For the qualified allied health professionals in community services for adults 97.9% had completed level 1, 87.5% had completed level 2 and 89.6% had completed their hand hygiene mandatory training.

Each locality community nursing teams and the clinics monitored infection prevention and control (IPC) monthly and this was added into the electronic system and reported monthly to the IPC

committee. In November 2018 nine community clinics submitted their hand hygiene data, only two areas were compliant. The IPCC reviewed the challenges to good practice and identified actions for underperforming areas. For those clinic areas who were not compliant staff were expected to read the policy and mentoring for new staff was identified. For those areas that were non-complaint they were re-audited. For example, the South Wight area had achieved 80% in November 2018, this was below the target of 90%. The service was re-audited in January 2019 and scored 100%.
We reviewed the infection prevention and control audit for the West and Central nursing teams from June 2018 to March 2019 and found only six out of the 10 months had recorded data. Whilst data for the six months was above 90%, showing a good compliance with infection control practices, with four months of missing data there was no assurance monitoring of staff practices was embedded into the teams.
Community staff carried protective clothing such as gloves and aprons and observed 'bare below the elbows' to ensure effective handwashing. Staff also had hand-sanitising gel to prevent the risks of cross infection. We were told that supplies were kept stocked up and that protective equipment was always available. We observed community nurses working in patients' own homes, and saw they washed their hands when able and used personal protective equipment including hand sanitising gel, gloves and aprons. We observed good aseptic techniques and all equipment was cleaned or disposed of after use.

In the podiatry clinics we observed good infection control practices and use of personal protective equipment (PPE) such as aprons, gloves and masks. After each patient, PPE was changed, hands washed, stations cleaned down and floors swept. Each cubicle had a trolley where the podiatrist equipment was placed, and a specific tray was used for their sterile equipment. We observed how the trays were cleaned between patients.

Although some clinic areas were old and not originally designed for this purpose all the clinic areas we visited were visibly clean and tidy. Curtains were clean and in date and daily cleaning task lists were completed by staff in every clinic we visited. Handwashing facilities were visibly clean and accessible.

In our previous inspection, Laidlaw Day Hospital kitchen was found un-fit for purpose as it had failed a local infection, prevention and control audit and health and safety inspection. The trust had acted on this and when we visited we saw a new kitchen had been fitted and the areas were visibly clean and tidy.

However, the temperature at the podiatry clinic at North East location was hot and previous infection control visit had removed fans due to the potential of blowing particles around the room. Staff said it was uncomfortable to work and no other solutions had been offered by the IPC teams.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.
Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

We looked at the arrangements for disposal at the localities and clinics we visited and saw there were appropriate arrangements in place that were monitored and effective. For example, there were correct disposal bins in place for the different types of waste created. These were regularly collected and emptied, and guidance was displayed for staff which colour, and bin was correct for each waste stream.

In the podiatry clinics each cubicle had a box attached to the wall for the storing of used scalpel blades. Once there were 100 blades deposited each box was sealed, removed and collected by the trust's clinical waste disposal team. In the clinics there was a system for clean/dirty equipment packs. Sterile podiatry equipment packs were stored in the clean box. Each individual pack had a code and this code was recorded in the patients notes. Any problems with equipment could therefore be tracked back to the patient and the podiatrist that used the equipment. Once the equipment had been used it was placed in the dirty box. Once the dirty box was full it would be closed, tagged and collected by the trust's waste disposal team and the equipment taken to be decontaminated and re-packaged. Clean and dirty equipment boxes were tagged with different coloured tags which meant staff knew which box clean equipment was and which was dirty. This stopped staff from using non-sterile equipment on patients.

The trust had a planned annual preventative maintenance schedule to ensure that medical electronic equipment was regularly serviced and tested. We checked ten pieces of equipment all of which had an in-date service and safety test. This included, syringe driver, scales, nebuliser and irrigators.

Community staff had their own 'observation boxes' of necessary equipment to ensure they could undertake patient observations when on visits. These included blood pressure machines, urinalysis dip sticks, pulse oximeters and thermometers with disposable ear covers. All the equipment we saw had an in-date service and PAT test and were cleaned by staff after every patient use.

Clinics had the use of resuscitation trolleys and bags for both adults and children. The trolleys were not tamper evident, which meant there was a risk of equipment or medicines being removed. This was mitigated by daily checks being completed. We saw that the resuscitation trolleys in the Laidlaw and the North Wing clinics were checked daily by staff when the clinics were open. All checks had been fully completed for the month thus far and those days the clinics were closed were identified.

During our previous inspection in 2018, community nursing staff said 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. During this inspection staff told us they had access to bladder scanners via the continence teams.

Staff accessed equipment such as frames, beds and commodes by ordering through the Integrated Community Equipment Service (ICES). This service was provided seven days a week, with an out of hours service until 8pm. Referrals were made by band 6, 7 and 8 staff in the community teams via a referral form and for those patients who required bed rails a bed rail assessment had to be completed. All requests for equipment had to be sent with a timeframe and these were:

- Routine seven working days.
- Urgent 48hrs/ two working days.
- Priority 24hrs/ one working day (if required same day request needed to be in ICES by 12midday).

Staff we spoke with told us there were rarely any issues when ordering equipment and it would arrive int time frame requested.

In some areas of the trust, buildings were old and tired. The trust was aware of these areas and completed audits on environmental integrity and facilities and in November 2018, East Cowes

scored 67% and the Arthur Webster Clinic 33%. Action plans for those non-compliant were completed and staff worked with estates to try and improve those challenging areas.

In our previous inspection we found variation in the organisation of storage within the community nursing hubs, when other stock that was in date was stored with out of date clinical items, which meant there was a risk of them being used. However, on this inspection we saw storage was well organised, in the West and Central and North East locality hubs. The district nurses made up dressing's bags for their patients with all that would be required during that specific visits. These were clearly labelled with the patients details and segregated in the store rooms.

In the North and East locality base there was a large store cupboard where consumables, patient dressing bags and needles were kept. The door to the room said it should always be shut, however it was open. Whilst patients could not access this area, staff from other areas of the surgery could.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

There was a safe 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 from the community hub 111 service who allocated the patients to the correct locality until 8.30pm. The out of hours cover was through the 111 services that provided a paramedic or specialist practitioner. Community senior managers were on-call out of hours for any issues the teams faced, this was for evenings and weekends.

The community nurses used an electronic system for their care records and since our last inspection had received further training in its use. Staff we spoke with said it was a good system and streamlined all their care assessments and allowed them to access information from the GPs. All patient risk assessments such as the malnutritional universal screening tool, (MUST), falls and pressure sore assessments were completed on the system and accessible to staff on their laptops. Staff said now the service had upgraded to 4G, access to information had improved.

When a new patient required assessment and review, the band 6 triage nurse sent all the appropriate risk assessments to the nurses out in the community. This meant all risks could be assessed and urgent actions implemented at the time of the visit.

There were many patients in the community who were living with diabetes and required insulin injections. To ensure that all staff knew who the most vulnerable patients across their localities were, a red, amber or green (RAG) rating system was used. Patients were rated in order of their vulnerability and their care needs. This meant if staff were unavailable, for example, due to sickness, other staff members would easily know who was the most vulnerable in each of the locality teams.

A new diabetes care plan was due to be launched and staff were about to receive new diabetes in-house training. The new care plans were more intuitive and followed the clinical standards. Each plan could be personalised, and the care plan tracked where injections had been given to make sure that certain areas were not being overused, which had potential to reduce the efficacy of the insulin.

The community nursing staff had recently started using the National Escalation Warning System 2 (NEWS2) for the prevention of deterioration of patients. NEWS2 is the latest version of the

National Early Warning Score which is a system to standardise the assessment and response to acute illness. This method of assessment identified actions or escalation depending on the patients' observation score. This was a paper recording sheet, which was filed in a folder at the patient's home. This enabled those services, such as the ambulance service who were not on the electronic system, access to clinical observations. NEWS2 scores were the same as used in the acute trust. This meant there was standardisation between the community teams and acute teams in the hospital, with all staff understanding the patient's status if an acute admission was necessary. In all the records we reviewed staff had totalled and scored their patients correctly. Although we did not see any patients that required escalation, staff talked us through what they would do in this event. The NEWS2 escalation plan included a Situation, Background, Assessment, Recommendation and Decision (SBARD) tool, a nationally recognised tool to guide staff in handing over succinct and specific information when patients condition deteriorated.

Staff were aware of the link to identify SEPSIS by abnormal observations. Staff had laminated prompts of what to do if their patients 'were not themselves today' and to look for the soft signs of sepsis and escalate.

Staff told us they used a scaled down version of care plans for short term patients who required short term interventions. This included the Malnutrition Universal Screening Tool (MUST) and a tool to estimate the risk of pressure sore development. This meant that those short-term patients who may have required one or two visits were still risks assessed.

The community teams we visited had a safe and effective method of handover. The Rapid Assessment Community Response Team (RACR) team held morning diary meetings to review their daily workload. During this meeting any issues, workload, information or incidents would be shared across the team. Staff told us this improved productivity and communication. The district nursing teams had daily handover at 2pm after all their morning visits. During the inspection we attended four handovers with the district nurse teams across the localities and saw risks, incidents, alerts and caseload planning were discussed. One new member of the team told us this was the best time to share information and learning as everyone got the chance to speak.

We attended a visit with the RACR team to a patient who had recently fallen. We observed how the multidisciplinary team worked together to improve the safety of the patient's home, encourage exercises to improve strength and balance and complete a mobility assessment. We saw how one member of the team assessed the entrance to the patient's home and identified access to the house was not safe. Photographs were taken so a stair rail would be discussed with the equipment teams. The band 4 staff member took this photo rather than wait for another assessment so that the issue could be addressed quickly.

For those patients who required frequent visits by an unqualified staff member, every third visit the patient would receive a secondary check by a trained member of staff. This would support the health care support worker and ensure the teams had oversight of the care of their patients.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
Managers regularly reviewed and adjusted staffing levels and skill mix.

Staffing featured as a high risk on the corporate and divisional risk registers, as it was an ongoing concern. The difficulties in recruitment and maintaining staff was a major concern as a large amount of the workforce was due to retire over the coming years. The trust had worked hard to

maintain its staff and recognised the importance of career development. Recruitment events on the mainland had been successful and, in some areas, where staffing had been problematic would be fully recruited in the coming months. Staff told us when necessary they would work across the localities to fill vacancies which were unfilled by bank staff

West and Central and North-East locality teams used a neighbourhood team approach to safely deliver their services. Each neighbourhood team was overseen by a band 6 team member who would manage the caseloads in their area, complete appraisals and be the point of contact for that team. Most staff told us they preferred this and said it provided better continuity of care for their patients. Patients told us that they liked getting to know a small team of nurses and the patients notes kept in their homes contained the names of all the neighbourhood team nurses. However, not all teams worked to the same model. Whilst the South Wight locality had neighbourhood teams headed up by a band 6 who was the point of contact for that team and was responsible for appraisals, on a day-to day basis the locality had a band 6 team member looking after the caseload for the whole locality. Team members were also more likely to work across the whole patch meaning patients potentially could see a larger pool of staff. This locality felt with one nurse in charge of caseloads it gave them a better oversight of what was happening across the whole locality.

The district nursing teams used an electronic roster system to help them roster their shifts. During our inspection the staffing establishment was being reviewed and updated and the rosters did not always clearly reflect the number of staff required for the shifts. We were told this was in the process of changing and a paper print out was used to track the allocation of bank staff and sickness. This would then be uploaded/ captured retrospectively to ensure all the details were checked correctly recorded and sent to payroll. Staff told us there had been no issues with this process, and felt it was safe, however looked forward to the establishment review being completed and reflected correctly in their rosters.

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.

Caseloads

Caseloads were monitored and reported monthly as part of the local quality indicators, discussed at local level and reported up to the board. Trends showed district nurse caseloads increased significantly since the last financial year. The three localities had active caseloads in December 2018 for:

- 2018-2019-South Wight, 376 (343 in 2017-2018)
- 2018-2019-North East, 450 (372 in 2017-2018)
- 2018-2019-West and Central 536 (475 in 2017-2018)

We were told there were 170 patients who required insulin administered across the three localities. Staff told us the rise in patients requiring diabetic medication had risen year upon year. However, staff and managers we spoke with said their caseloads were generally manageable. This was due to the response of the localities in changing their shift patterns, re-evaluating the patients requiring insulin and allocating their workloads responsively. The team had been given ownership by the divisional lead to change working patterns, the team leader could offer longer day working to the team. This worked well for the team as they could see their diabetic patients at both the beginning and end of the day. Staff could say which shift times they would like to work.

Planned v Actual Establishment

Details of staffing levels within community services for adults by staff group as at April 2018 to March 2019 are below.

Community adults total

Staff group	Actual staff WTE	Planned staff WTE	Staffing rate (%)
NHS Infrastructure Support	27.6	29.3	94.3%
Support to Doctors and Nursing Staff	28.6	31.1	92.0%
Qualified Nursing and Health Visiting Staff	68.0	74.1	91.7%
Allied Health Professionals	33.0	38.0	86.8%
Total	**157.3**	**172.6**	**91.1%**

Qualified nursing staff

Details of nursing staff levels within community services for adults by team as at April 2018 to March 2019 are below.

Team name	Actual staff WTE	Planned staff WTE	Staffing rate (%)
District Nursing Management	3.0	2.0	150.0%
North East Wight District Nurses	20.5	20.3	101.0%
Continence Service	3.0	3.1	97.4%
Stroke Community Team	3.6	4.0	90.0%
West and Central Wight District Nurses	17.3	19.4	89.0%
South Wight District Nurses	17.0	19.5	87.2%
OHPAT (outpatient and home parenteral antimicrobial treatment)	3.6	4.2	86.5%
District Nurses Training	0.0	1.7	0.0%
Total	**68.0**	**74.1**	**91.7%**

Qualified allied health professionals

Details of staffing levels for qualified allied professionals within community services for adults by team as at April 2018 to March 2019 are below.

Team name	Actual staff WTE	Planned staff WTE	Staffing rate (%)
OT Acute	8.0	8.0	100.0%
Podiatry	14.5	16.5	88.0%
Stroke Community Team	2.0	2.0	100.0%
Speech & Language Therapy	2.7	3.5	76.6%

OT General	5.0	8.0	62.5%
Total	**32.2**	**38.0**	**86.8%**

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

From January to December 2018, the trust reported an overall vacancy rate of 11.8% in community health services for adults. The trust did not set a target for vacancy. Across the trust overall vacancy rates for nursing staff were 20.8% and for allied health professionals were 10.5%. Negative vacancy rates have been reported for some staff groups and the trust have stated that this is due to an over establishment of staff in these groups.

A breakdown of vacancy rates by staff group in community services for adults at trust level is below:

Staff group	Total % vacancies overall (excluding seconded staff)
NHS infrastructure support	68.0%
Support to ST&T staff	21.8%
Qualified nursing & health visiting staff (Qualified nurses)	20.8%
Qualified Allied Health Professionals (Qualified AHPs)	10.5%
Support to doctors and nursing staff	-6.1%
Public Health & Community Health Services	-57.2%
Support to ambulance service staff	-69.3%
All staff	**11.8%**

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

Turnover

From January to December 2018, the trust reported an overall turnover rate of 13.1% in community health services for adults. This was higher than the trust's target of 5.0%. Across the trust overall turnover rates for nursing staff were 10.2% and for allied health professionals were 18.9%.

A breakdown of turnover rates by staff group in community services for adults at trust level and by team is below:

Community adults total

Staff group	Total % of staff leavers in the last 12 months
Qualified Allied Health Professionals (Qualified AHPs)	18.3%

Support to Scientific, Therapeutic and Technical Staff	17.6%
Support to Doctors and Nursing Staff	16.0%
Qualified nursing midwifery staff (qualified nurses)	10.2%
NHS Infrastructure Support	9.1%
Students	0.0%
All staff	**13.5%**

Nursing staff by team

Team name	**Total % of staff leavers in the last 12 months**
West & Central Wight District Nurses	15.5%
North East Wight District Nurses	14.2%
South Wight District Nurses	10.9%
Continence Service	0.0%
District Nursing Management	0.0%
DN Community Matrons	0.0%
OHPAT	0.0%
Stroke Community Team	0.0%
All staff	**10.2%**

Allied health professionals by team

Team name	**Total % of staff leavers in the last 12 months**
OT Section 75	32.2%
Podiatry	21.4%
Occupational Therapy	19.3%
OT Acute	16.4%
Speech Therapy	0.0%
Stroke Community Team	0.0%
SPARRCS	**0.0%**
All staff	**18.3%**

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

The occupational therapy (OT) teams told us they had increased frustrations with managing to recruit band 5s to post. After looking at exit interviews it was established that some leavers had felt there was a perceived lack of support. To address this issue the OT band five staff were overseen by an OT lead.

Sickness

From January to December 2018, the trust reported an overall sickness rate of 5.2% in community health services for adults. This was higher than the trust's target of 3.5%. Across the trust overall sickness rates for nursing staff were 7.0% and for allied health professionals were 3.6%.

A breakdown of sickness rates by staff group in community services for adults at trust level and by team between is below:

Community adults total

Staff group	Total % permanent staff sickness overall
Qualified Nursing and Health Visiting Staff	7.0%
Support to Doctors and Nursing Staff	5.4%
NHS Infrastructure Support	3.9%
Qualified Allied Health Professionals	3.6%
Students	0.0%
All staff	**5.2%**

Nursing staff by team

Team name	Total % permanent staff sickness overall
West & Central Wight District Nurses	11.3%
Continence Service	11.2%
DN Community Matrons	7.9%
North East Wight District Nurses	7.5%
South Wight District Nurses	3.7%
District Nursing Management	2.7%
Stroke Community Team	2.3%
OHPAT	2.2%
District Nurse Training	0.0%
All staff	**7.0%**

Allied health professionals by team

Team name	Total % permanent staff sickness overall
Occupational Therapy	5.1%
OT Section 75	3.9%
Podiatry	3.3%
OT Acute	2.4%
Speech Therapy	2.3%
Stroke Community Team	1.9%
SPARRCS	0.9%
All staff	**3.6%**

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

We disused sickness rates for district nurses and were told some of the themes were around personal and work stress. Senior staff told us they were supported by the trusts human recourses department to actively manage their sickness and support those members of staff back to work in the most and this would reduce some of the stress staff had felt about their workload.

Nursing – Bank and Agency Qualified nurses

From January to December 2018, of the 121,949 total working hours available, 4.8% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 8.1% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
North East Wight District Nurses	38,936	283	0.7%	0	0.0%	3,101	8.0%
OHPAT	8,134	329	4.0%	0	0.0%	725	8.9%
South Wight District Nurses	37,199	3,870	10.4%	0	0.0%	581	1.6%
West & Central Wight District Nurses	37,681	1,393	3.7%	0	0.0%	5,444	14.4%
Total	**121,949**	**5,874**	**4.8%**	**0**	**0.0%**	**9,852**	**8.1%**

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

Nursing - Bank and Agency Non-Qualified nurses

From January to December 2018, of the 31,599 total working hours available, 2.8% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 11.0% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
North East Wight District Nurses	8,740	50	0.6%	0	0.0%	0	0.0%
OHPAT	1,818	40	2.2%	0	0.0%	1,145	63.0%
South Wight District Nurses	11,552	180	1.6%	0	0.0%	2,346	20.3%
West & Central Wight District Nurses	9,488	629	6.6%	0	0.0%	0	0.0%
Total	**31,599**	**899**	**2.8%**	**0**	**0.0%**	**3,491**	**11.0%**

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

Medical locums

From January to December 2018, the trust reported that they did not use any bank or medical locum staff to cover sickness, absence or vacancy for medical staff in community services for adults.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

Suspensions and supervisions

During the reporting period from January to December 2018, community services for adults reported that there were no cases where staff have been either suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Quality of records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care however in some clinic areas records were not always stored securely.

The district nurses accessed the electronic system which enabled them to complete risk assessments and care plans at the point of care, however not all services were on the same system, such as the ambulance service. Because of this reason, a reduced set of paper notes were kept in the patient's home. This included a consent form to be signed by the patients and a list of injectable medicines given by the nurses such as insulin, and syringe drivers. These were returned to the bases and scanned on to the system once the care episode was completed. These sets of notes also contained information about the service and the team in the neighbourhood, this meant that patients knew the name of one of the team who would be visiting them.

There were 11 different recording and IT systems across the whole of the community services. The trust was aware of the risks involved with the multiple systems and worked hard to maintain safety. The electronic system which was used by the community nurses and GPs was not embedded across all the community services and solutions were being considered for clinics and the RACR teams to be in line with the electronic systems.

Teams could audit their documentation compliance on the electronic system and we reviewed West and Centrals community nursing teams audit which showed a consistent increase in compliance from June 2018 which was 69% to February 2019 which was 92%.

The localities had 4G which meant staff on the hub computers could see the team's caseloads and when they have been completed, the team could upload photos detailing, wounds, pressure ulcers and rashes that could be looked at back at the hub by other staff if help or advise was required.

Rehabilitation Records in the nursing homes were all paper based. We reviewed two sets of notes and saw they were well written with up to date risk assessments and care plans tailored to the individual. However, staff told us they had no access to computers in the homes and had to leave the site and go to a local hub to access internal systems to incident report, staff said this was inconvenient and potentially may reduce the number of incidents that would get reported.

Paper records in clinics were not always stored safely. In the Arthur Webster Podiatry Clinic all the patient records for the day's clinic were kept in the same room as the patients. There was a

computer in the same area which staff used to review x-rays and other patient information, this was not private and the patient in the end cubicle would be able to see personal information. We asked about security of notes and although staff agreed it was not ideal, the room always had a member of staff present.

In the multi professional triage team (MPTT) clinic at St Marys notes were often left for collection by porters in an unlocked room after the clinic had closed for the day. Whilst the clinic was locked by a pin code pad, other members of staff had access to this area.

Medicines

Whilst the provider had systems in place for the safe storage, administration, prescribing and disposal of medicines, we were not fully assured of the completeness of the medicines administration record.

Nursing staff produced a medicines administration record (MAR) for each dose of each medicine administered by the team. A second nurse within the team would review the information transcribed onto the MAR and where the information had been obtained from. We reviewed three patients records stored at the service base. In the three records there were 31 opportunities for an allergy to be recorded this had only been completed 16 out of 31 times. On two occasions, for two patients the medicine dose had been changed without a review of the transcription by a second nurse. The third patient had their dose described as “U” rather than “units”. Therefore we were not assured that the nurses always had access to accurate and timely information to aid the administration of medicines.

We found out of date medication stored in an administration cupboard in the MPTT clinic. The box of injections contained a mixed batch with one tray having an expiry date of 2016. We identified this to staff who told us this medicine was no longer used and removed the medicines for return to pharmacy.

The community nursing teams did not routinely store medicines in their locality service base; and no longer kept medicines in their cars. Medicines kept at the hubs were limited to a small stock of emergency medicines and were all in locked cupboards. We checked the cupboards at all three locations hubs and all medicines were within their expiry dates. Medication was obtained from the trust pharmacy department. Patient’s own medicines were stored at their homes.

The community nursing teams audited their medication compliance monthly on the electronic system one and we reviewed West and Centrals community nursing audit which showed a consistent score of 100% from June 2018 to February 2019.

Safety performance

Safety Thermometer

The service used monitoring results to improve safety. Staff collected safety information and shared it with staff.

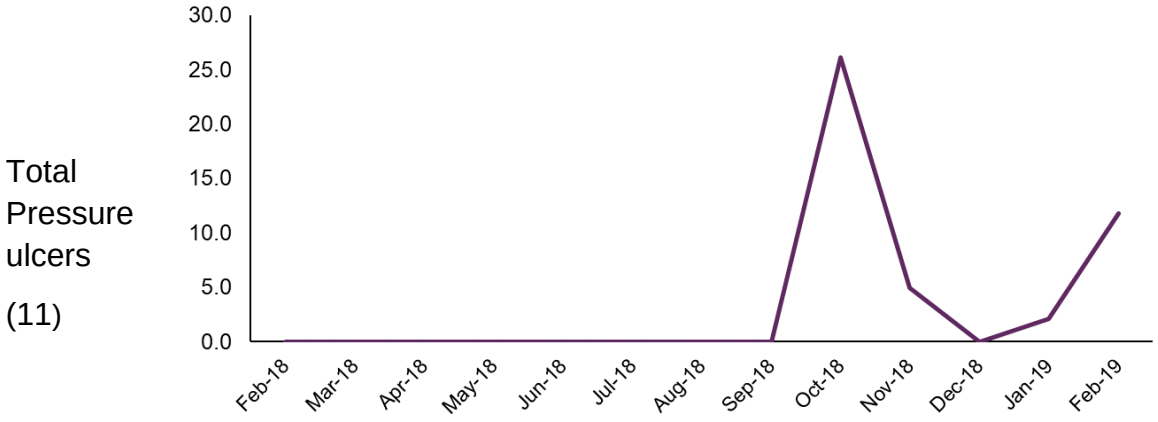
The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.

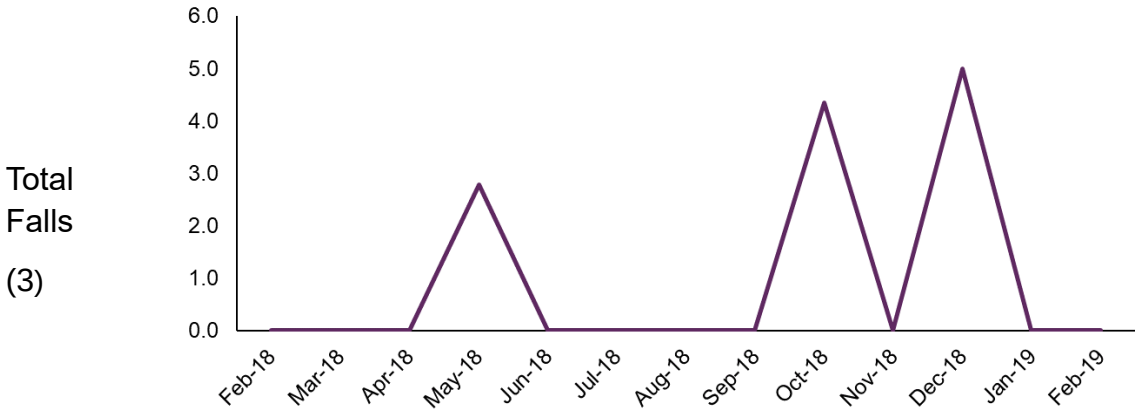
Data collection takes place one day each month – a suggested date for data collection is given but services can change this. Data must be submitted within 10 days of suggested data collection date.

Community Settings

Data from the Patient Safety Thermometer showed that the trust reported 11 new pressure ulcers, three falls with harm and no new catheter urinary tract infections from February 2018 to February 2019 within community settings.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Isle of Wight NHS Trust – Community settings.





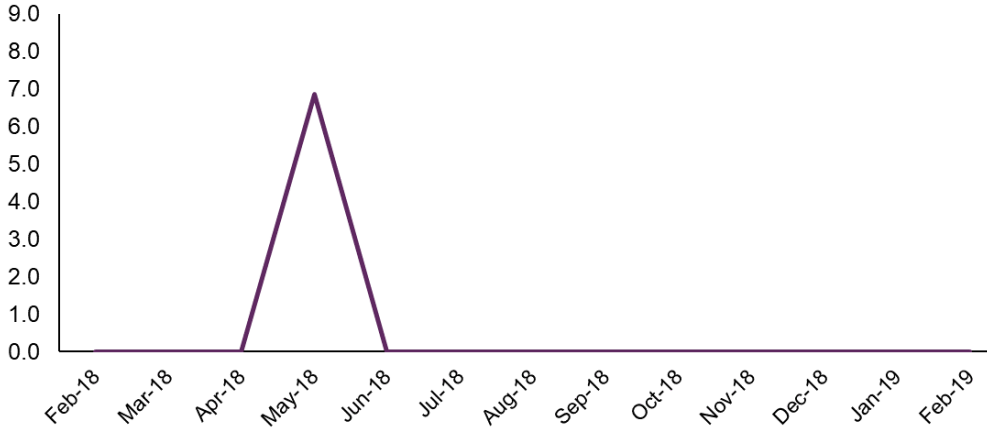
There was a high prevalence of pressure ulcers reported by the trust in October 2018 for care delivered in community settings. There was also an elevated prevalence rate for pressure ulcers in February 2019.

Own home Settings

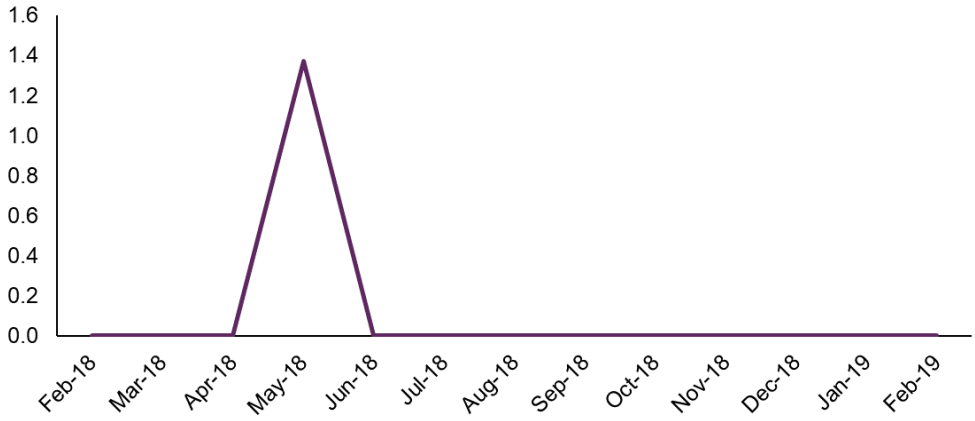
Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, one fall with harm and no new catheter urinary tract infections from February 2018 to February 2019 within own home settings.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Isle of Wight NHS Trust – Own home settings.

Total Pressure ulcers (5)



Total Falls (1)



The five new pressure ulcers and the one fall (with harm) reported by the trust was reported in May 2018. No other harms were reported in any other month from February 2018 to February 2019 for care delivered in own home settings. *(Source: NHS Safety Thermometer)*

We asked if there had been any investigations in to the spike in pressure ulcers during October 2018 and February 2019. The trust told us as part of their *Getting to Good. Our Improvement Journey* that a deep dive had been carried out into the increase of pressure ulcers. The same report had reported quality managers had provided bespoke one to one session for team leaders/service leads on electronic incident reporting and management and serious incident management. However, from the information sent to us it was not clear if any themes had been identified.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

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 January to December 2018, the trust reported no incidents that were classified as a never event in community services for adults. *(Source: Strategic Executive Information System (STEIS))*

Serious Incidents

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 eight serious incidents (SIs) in community services for adults, which met the reporting criteria, set by NHS England between, January to December 2018. Of these, the most common type of incident reported was pressure ulcer meeting SI criteria (75.0% of all incidents).

Incident Type	Number of Incidents	Percentage of total incidents
Pressure ulcer meeting SI criteria	6	75.0%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	12.5%
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	12.5%
Total	8	100.0%

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From January to December 2018, trust staff within community services for adults reported eight serious incidents. Of these, none involved the unexpected death of a patient.

The most common type of serious incident was pressure ulcer meeting SI criteria.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us confidence in the validity of the data.

There was a positive culture around incident reporting which helped promote learning and service improvement for patients. Staff were encouraged to report incidents using the provider's electronic recording system. All the staff we spoke with confident in using this system. Staff told us they received feedback from within their community teams when they reported incidents and were told what actions were taken. However, some staff felt that incidents reported in relation to poor discharges from the main hospital were not feedback and assurances that improvements had been made were not provided. We asked the management teams about these sorts of issues and were told that a working group had been set up to try and improve communications, trouble shoot these sorts of issues.

Staff told us learning from incidents was shared across the service with reported incidents being discussed at team meetings and fed up to the quality, patient safety and risk meeting. We reviewed the team meeting minutes for all three localities, the Central and West and South Wight minutes included incidents as part of a standardised agenda, however the North East minutes did not include the number of incidents reported but included incidents as part of the general recorded discussions. This meant that not all areas assessed the number and themes of incidents on a regular basis.

We asked for the minutes from the quality, patient safety and risk meeting and received the action and decision log. This identified and tracked allocated actions and decisions around incidents such as pressure ulcers and falls.

The community teams shared investigations and learning about serious incidents across all three localities. Serious incidents were investigated by trained staff across the trust who had completed a two day root cause analysis course, lessons learned were identified and actions planned. Each investigating lead would visit all the locality bases and educate staff on the lessons learned. The results were then summarised on one sheet of paper and then displayed at the bases. We saw a 'Lessons Learned' poster from an ungradable pressure injury and the minutes from the investigation interactive session. The displayed information on a page explained the event, notable practice, learning and key messages and the improvements made alongside the assurance process. Many of the staff told us they liked this method of learning and felt it was an effective way to share key messages.

One serious incident investigation into lower leg ulcers identified a knowledge gap across all localities. This resulted in a training package that all staff were to attend/complete. Staff told us it was a great way to learn and they hoped to use this model for learning and training staff on other areas that district nursing teams were involved in.

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 two prevention of future death reports sent to the trust. None of these related to this core service.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff delivered care that took account of national guidance such as National Institute for Health and Care Excellence (NICE) guidelines and quality standards. For example, the community teams had achieved an Amber rating for their work to maintain the standards of the British Association for

cardiovascular Prevention and Rehabilitation (BACPR). The updated BACPR Standards & Core Components were published in 2017 and are the gold standard for delivery in the UK.

The service was part of the Wessex Diabetes Footcare review which aimed to reduce the number of amputations among people living with diabetes in Wessex. This was a key aim of the Wessex Cardiovascular Clinical Network (CVD CN). The Wessex Foot Care standards were jointly developed and agreed by local stakeholders including clinicians and commissioners, with the Specialist Clinical Network facilitating the process. They set out the care that people with diabetes should expect based on NICE guidance foot care for people with diabetes (NG19).

The use of innovative approaches to care and treatment in line with the latest best practice was actively encouraged. New evidence-based techniques and technologies were being used to support the delivery of high-quality care. For example, teleswallowing, this enabled a virtual swallowing assessment and potential treatment of patients in their home setting rather than in hospital and had been introduced across the island to reduce acute admissions due to swallowing impairment. The service told us they had reduced admissions for this sort of complaint by 20% over the last year.

Most community staff had access to NICE guidelines, trust policies and procedures, working protocols and the trust intranet via their laptops. We saw the service regularly reviewed and updated their policies to ensure they were in date and in line with the latest guidance. Relevant and current evidence-based guidance, best practice and legislation was used to develop how the services, care and treatment was delivered. The community bases also displayed up to date information on notice boards relating to for example the recognition of Sepsis.

The service used an integrated working model to deliver effective care and rehabilitation by accessing 50 residential care home beds to achieve community rehabilitation. We visited one of these homes and saw how those patients who were going through rehabilitation had a clear care plan which was up to date and personalised with outcome goals in line with relevant good-practice guidance.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

During our last inspection the community localities audited their assessments of their patient's nutritional status using the malnourishment universal screening tool (MUST) quarterly, this had now increased to monthly. We reviewed West and Central audit data and saw this had improved month after month. The latest data showed a 69% compliance. We visited the community dietetic service who told us how they were increasing education for all staff on correctly using the MUST and referring on when appropriate.

Community patients could access the support of community dietitians. The community teams or hospital staff could refer them dependent on their MUST score or if they had other indicators such as a pressure ulcer. The dietetics service was now fully recruited and waiting lists were six weeks and on target.

During our visit to the dietetic clinic we observed how well staff interacted with their patients. Information was shared using pictorial references and time was given for patients and their carers to ask questions. It was clear that the patient's and their carers left with more understanding about

their conditions, what they could or could not eat and what to avoid, observational sheets and a plan for their next meeting.

We visited podiatrist clinics and saw how education on nutrition and hydration was an important feature. We observed clinicians asking patients how much water they drink, as this could affect their foot health and skin integrity. In one clinic we observed clinicians consistently offering patients water throughout their clinic.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Community nursing teams assessed their patient's pain via a numeric scale, this was done on initial patient assessment visits and consequent visits. We witnessed community nurses assess patient pain and saw safe management of the medicines in the patient's home. On two occasions whilst visiting patients in the community we saw the effective use of electronic systems, to request a GP review a patient's pain medications.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and overall achieved good outcomes for patients.

The service monitored local patient outcomes and undertook a range of audits to promote best practice. Information was collected and available to the various teams. The provider used an electronic performance management system, which produced performance and dashboards for some of the individual community team and specialised services. Caseloads, infection control, documentation, medication, uniform, falls and MUST were monitored monthly. The community nurses had recently updated their NEWS recording to NEWS2 and compliance against this was being monitored. The South Wight team told us last year only 30% of NEWS were being recorded this had now improved to over 80%. We reviewed the audit data for the three localities although the latest figures for April 2019 were still below the 85% target it showed a consistent improvement in compliance since May 2018:

South Wight - 84% (amber - requires improvement)

West and Central - 86% (amber - requires improvement)

Northeast - 79% (red - poor)

The Community Division told us they did not collect data related to Sepsis as this was recorded by the ambulance service against the pre-hospital sepsis programme and in the emergency department on admission.

Crisis response

The crisis response team audited if visits were achieved within four hours of referral over the periods of April 2018 to March 2019. Out of 617 referrals 338 were seen within 4 hours.

Infection control

There were monthly reports to the Infection Prevention and Control Committee (IPCC). This committee had overall surveillance on all localities infection rates, outbreaks, environmental audits, training, hand hygiene compliance and IPCC risks on the risk register. The division had reported:

Clostridium difficile infection - 0

Meticillin-resistant Staphylococcus aureus bacteraemia - 0

Methicillin-susceptible Staphylococcus aureus bacteremia -0

Escherichia coli bacteraemia - 0

Staff told us should there be any outbreaks then the locality teams would work with IPPC to develop any bespoke audits/ action plans that may be beneficial.

Wessex Diabetes Footcare review

The service was part of the Wessex Diabetes Footcare review which aimed to reduce the number of amputations among people living with diabetes in Wessex. The implementation of the standards across Wessex aimed to reduce variation in care and improve outcomes for people living with diabetes related foot complications. To achieve this, the objective was to:

- Raise awareness of the National Institute for Health and Care Excellence (NICE) National Guidelines (NG19) with the Clinical Commissioning Groups (CCG)
- Encourage the CCGs to review the foot care pathways they have commissioned across primary, community and secondary care sectors
- Remind them to undertake any remedial action to ensure the pathways were NICE compliant.

We were provided with the service action plan for the Wessex Diabetes Footcare review which showed out of 10 actions eight were progressing to time, one was complete, and one was causing concern.

Diapedia Audit

The community services monitored their performance against 13 recommendations for those people living with diabetes. This included information and surveillance of the National Diabetes Core Audit. Out of the 12 recommendations 10 had been completed and two were progressing to time.

British National Certification Programme for Cardiovascular Rehabilitation (BACPR)/ National Audit of Cardiac Rehabilitation (NACR)

Community services were part of the BACPR/NACR. The updated BACPR Standards & Core Components were published in 2017 and were the gold standard for delivery of cardiac rehabilitation in the UK. The community teams achieved an amber rating for their work to maintain the standards of the British Association for cardiovascular Prevention and Rehabilitation (BACPR).

The National Audit of Cardiac Rehabilitation (NACR) aimed to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live. The NACR was discussed at the cardiac rehabilitation team meeting which identified that the proportion of patients completing cardiac rehabilitation was 51% and the Isle of Wight were currently at 45%.

Commissioning for Quality and Innovation (CQUIN)

As part of the commissioning for quality and innovation (CQUIN) framework, the commissioners encourage services to continually improve how care was delivered. At the time of this inspection, the provider was working towards these and monitoring their progress. We asked the service to provide us with information of their CQUINs and if they were achieving their outcomes.

CQUIN 8C- A rolling two-year CQUIN that worked across local health systems to improve discharges for patients from all areas of an acute hospital to community settings including NHS Commissioned Care Home beds. The desired outcomes would be improvement in patient outcomes, improvement in patient flow and reduction in delayed discharges. The information provided showed that many milestones were being completed in their agreed time frames.

CQUIN 9- Preventing ill health by risky behaviours – alcohol & tobacco. This aimed to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a 'radical upgrade in prevention' and to 'incentivise and support healthier behaviour'. The CQUIN targets in quarter three (year two) were on target.

CQUIN 10- Improving Wound Assessment. Some areas were below target, however there was a continued improvement.

CQUIN 11- Aimed to support the embedding of personalised care and support planning for people with long term conditions such as chronic pain. The service told us that all elements of this CQUIN had been achieved, however waiting times to see the chronic pain team were 25- 30 weeks.

PROM (performance outcome measures)

The physiotherapy teams were collecting Patient Reported Outcome Measures (PROMS) data to audit outcomes for patients. PROMS assessed the quality of care delivered to NHS patients from the patient perspective. PROM data was collected by the physiotherapy teams and included, muscoskeletal outpatient physiotherapy, amputee rehabilitation and rehabilitation physiotherapy. We were not provided with any further information or results. However, the physiotherapy service took part in the NHS Benchmarking Network 2017.

The service told us they did not use the Royal College of Speech and Language Therapy Outcome Measures (TOMs), however we were told that it was a priority to implement new Outcome Measures in 2019. Members of the community rehabilitation team had attended national workshops in an attempt to roll TOMs out locally.

Audits – changes to working practices

The trust has participated in no clinical audits in relation to this core service as part of their Clinical Audit Programme, however the service had undergone considerable change to working practices. *(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)*

Competent staff

The service had made improvements to ensure staff were competent for their roles. Whilst managers appraised staff's work performance and held supervision meetings with them to provide support and development they had yet to devise mechanisms for monitoring supervision levels across the division. Appraisal rates remined below the trust target.

Clinical Supervision

In our previous 2018 report it had been identified, for some staff, formal clinical supervision did not happen. During our recent inspection the trust told us, community nursing, monthly group clinical supervision sessions were offered and facilitated by the Community Practice Educator in each locality. Sessions were offered for staff in Bands 2-4, another group for Band 5 and 6 and another for Band 7 and above. Individual supervisors were also available if individuals chose to have supervision on a one to one basis as peer supervision. The Clinical Practice Educator kept a log of all sessions and individual attendance.

The trust has commented that "Whilst we are clear that at service level clinical supervision is taking place and has oversight at service manager level, we have yet to devise mechanisms for monitoring supervision levels across the division. This is something we will be working on as we have identified this as an assurance gap".

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)

Appraisal rates

From April 2018 to February 2019, 79.8% of permanent staff within the community services for adult's core service had received an appraisal compared to the trust target of 85.0%.

A breakdown by staff group and by team is shown below:

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Additional Clinical Services	27	31	87.1%	85.0%	Yes
Nursing and Midwifery Registered	63	79	79.7%	85.0%	No
Allied Health Professionals	26	35	74.3%	85.0%	No
Administrative and Clerical	22	30	73.3%	85.0%	No
All staff	**138**	**173**	**79.8%**	**85.0%**	**No**

Nursing staff by team

Team name	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Continence Service	4	4	100.0%	85.0%	Yes
OHPAT	4	4	100.0%	85.0%	Yes
Stroke Community Team	4	4	100.0%	85.0%	Yes
South Wight District Nurses	18	22	81.8%	85.0%	No
West & Central Wight District Nurses	14	18	77.8%	85.0%	No
North East Wight District Nurses	17	24	70.8%	85.0%	No
District Nursing Management	2	3	66.7%	85.0%	No
All staff	**63**	**79**	**79.7%**	**85.0%**	**No**

Allied health professionals by team

Team name	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Speech Therapy	2	2	100.0%	85.0%	Yes
Stroke Community Team	2	2	100.0%	85.0%	Yes
Podiatry	13	17	76.5%	85.0%	No
Occupational Therapy	3	4	75.0%	85.0%	No
OT Acute	6	8	75.0%	85.0%	No
SPARRCS	0	2	0.0%	85.0%	No
All staff	**26**	**35**	**74.3%**	**85.0%**	**No**

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

However, all staff we spoke with during our inspection told us they had received an appraisal. We spoke with one member of staff who had started within the year and had received an effective appraisal which had identified learning to further improve their competence and skills.

New staff had both a trust and local induction. New starters in the community nursing team were supernumerary for two/three weeks, to allow them time to settle in and learn new policies and procedures. New starters told us their induction was effective. We spoke with one new starter who told us they had been given time to complete all mandatory training, received specialist training in end of life, catheter care and paperwork.

Staff were positive about the availability and quality of in-house training, though some staff shortages had restricted some opportunities. Recent training in lower leg care had been completed and update diabetes training was about to be delivered.

Community nursing teams had 'link nurses' who attended meetings for certain specialities. This included, for example, tissue viability as a specialty. Information from these meetings was shared by the link nurses with the rest of their teams at their meetings.

Staff from the dietetics department were now able to offer training in Malnutritional Universal Screening Tool (MUST) scoring to community and hospital staff. Staff were shown how and when to refer to the dietetics department. A nutrition and hydration week had been held to increase the profile and importance of the dietetic department.

There were four advanced clinical practitioners (ACPs) across the whole of the service. Each ACP had a different speciality and could be accessed by all the locality teams to provide support and specialist training. One ACP told us they attended the Wessex sepsis network every quarter ensuring standards were being maintained in community services.

There were development opportunities for staff. Staff we spoke with said the trust supported people to progress when this was possible through internal training and promotions. Staff told us the service had Band 6 development days and the trust had pathways to help nurses progress from a Band 5 to 6 and 7. Apprenticeship schemes had been developed since our last inspection to upskill existing band therapy assistants to band 3 and Band 4. Assistant practitioners (band 4 healthcare assistants with additional training) were able to take on additional tasks once training, and competencies had been completed. The trust told us there had been 196 applications for the 15 places available for Registered Nurse Degree Apprenticeship programme (Sept 19 cohort).

Students we spoke to across the service told us the trust had a positive learning environment. One third year podiatrist student said, "it was a great place to train" and "help and advice was always available to them". They told us permanent staff would let them observe interesting cases and be include them include them in the resulting discussions.

We had positive feedback from patients and their relatives about the competency and approach of all the health professional providing care and treatment. Comments included "If I'm not sure about anything I ask, and they always take the time to explain everything to me" and "I have total confidence in the nurses as they know what they are doing."

The smaller neighbourhood teams had set days where the district nurses would visit residential homes to build on relationships, offer advice and support, and be a port of call for any concerns. The nursing teams also worked alongside the care/residential homes to reduce the development of pressure ulcers. They provided them all with pressure relieving advice in the form of a booklet and asked the nurses in the home to sign up to a pathway to identify any concerns or changes in a patient's condition which may lead to a compromise in skin integrity. This information ensured that residential home assistants were competent to recognise and treat ulcers.

Since our last inspection in 2018 the service had developed competency folders for each member of staff. These folders contained different categories which staff were required to be competent in, such as risk assessment, tissue viability, chronic disease management- medicine management, and professional communication & teamwork and administration for example use of systems. Whilst these were well laid out compressive booklets, we could not see if there were different levels of competencies and what level of competence had been achieved as all staff seemed to have the same framework, regardless of grade. There were no dates to say when the training had taken place or on what date they were classed as competent or when this expired. In addition,

there was no list of approved assessors for the various competencies and it was not clear who could sign individuals as competent.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff within teams and across different services were committed to working collaboratively and developing ways of working that delivered effective and high-quality care. Staff from different teams and specialist services were positive about their colleagues and the joined up working they were involved in delivering. Meetings had recently started between the director of nursing, matrons from the acute hospital wards and community team leaders to look at joined up working between acute and community teams particularly around the discharge processes.

Care coordination for patients with both routine and complex needs worked well. All staff, including those in different teams and services, could be involved in assessing, planning and delivering patient care and treatment. Staff spoke positively about the cooperation and communication with different colleagues and how information was shared to benefit patient care support and treatment.

There was a new integrated palliative and end of life team, that had come into operation since the last inspection in 2018. Staff said the community service now had a voice within this team. Advanced clinical practitioners (ACPs) had attended meetings about the roll out of the new service. Numbers for the new team were displayed on the general notice board and there was a brochure titled End of Life Care Strategy 2018-2022 explaining the service.

The recent change in the locality structures and the implementation of neighbourhood teams across the three localities enabled staff to develop stronger relationships with the GP surgeries. In the West and Central team Band 6 team leaders based themselves at GP surgeries during their day to day work. In the Sandown Surgery meetings to discuss patients they have in common were regularly held.

The previous rehabilitation beds in St Marys were closed and were recommissioned within nursing homes as part of the service redesign. There were 50 rehabilitation beds in three nursing homes. The single point of access, referral, review and coordination service (SPARRCS) managed patient referrals from the acute services. The community teams at the homes held a weekly multidisciplinary meeting to review patient’s goals, new patient admissions and discharge plans. attendance from the therapists and advanced practitioner nurses. We visited one of these homes and spoke with physiotherapist, pharmacists, occupational therapists and care assistants and saw how well established the MDT had become.

We visited the amputee clinic at the Laidlaw Hospital and saw an effective example of multidisciplinary (MDT) working. The clinic was commissioned via NHS England specialist commissioning group and run by physiotherapists, occupational therapists, nurses, councillors, and orthotic and prosthetic department clinicians. Senior staff also worked closely with GP surgeries as a frontline member of staff, for triaging, offering advice and referring to the clinic. The clinic held an MDT meeting once a week with the whole team, this meant all the team knew about their patients who were in the community, community rehabilitation beds or had been admitted to hospital.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Patient information was displayed in the clinics we visited, for example leaflets in the podiatry clinics on wider fit shoes, choosing footwear sock and hosiery for swollen feet, advice about footwear and falls prevention, and pressure areas care. We saw many patient information booklets throughout the clinics provided by charities relating to specific health complaints. These were available in different languages if required.

We observed how clinic and district nursing staff took time with their patients and advised them on their health care. For example, advising patients to increase their fluid intake now the weather was warmer and podiatry staff giving advice on which nail files to buy, where to get them and how to look after their toe nails in between visits.

The prosthetic centre at the Laidlaw hospital had a newsletter which included information on exercise classes and general health tips. For example, how to look after your health during the hotter days.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Consent to care and treatment was sought in line with legislation and guidance. Staff were aware of the need to ask for consent and for this to be appropriately recorded. Staff we spoke with understood the relevant consent and decision-making requirements of the Mental Capacity Act 2005. The consent process was integral to the new electronic system, a mental capacity tab had been added to the district nurse documentation on the electronic system. This linked to guidance on the five core principles of the Act and staff could access this should they have any concerns around a patient's capacity.

Staff gave examples of what they would do if they had doubts about a patient's capacity. This included reviewing the patient with other professionals in the community and accessing links at the main hospital, speaking with a patient's family members to understand personal wishes, and talking with the patient's GP. If a patient was assessed as not having capacity, staff would act in the best interests of that patient with any care and treatment decisions.

Patients were expected to take part in the planning of their care and there was a care planning mutual agreement for them to sign (if able). This ensured that staff discussed the care and planned interventions with their patients.

In the previous inspection (2018) we saw extremely low training compliance (8.9%) for the Mental Capacity Act 2005 (MCA). At this inspection compliance had improved, from April 2018 to January 2019 the trust reported, staff within the community health services for adults, compliance was 77.2%. Whilst this figure was still below the trust target of 85% it was an improvement.

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 85.0% for completion of Mental Capacity Act / deprivation of liberty standards training.

From April 2018 to January 2019 the trust reported that Mental Capacity Act (MCA) training had been completed by 77.2% of staff within community health services for adults.

A breakdown of compliance for MCA/DOLS courses from April 2018 to January 2019 for nursing and midwifery staff in community services for adults is shown below:

Training module name	Number of staff trained	Number of eligible staff	Completion (%)	Target (%)	Target met (Yes/No)
Mental Capacity Act	60	81	74.1%	85.0%	No

The trust did not meet the target for the MCA/DOLS course relevant for nursing and midwifery staff.
A breakdown of compliance for MCA/DOLS courses from April 2018 to January 2019 for allied health professionals in community services for adults is shown below:

Training module name	Number of staff trained	Number of eligible staff	Completion (%)	Target (%)	Target met (Yes/No)
Mental Capacity Act	38	48	79.2%	85.0%	No

The trust did not meet the target for the MCA/DOLS course relevant to allied health professionals.

The trust has reported that the Mental Capacity Act training module incorporates Deprivation of Liberty Safeguard training.

(Source: Universal Routine Provider Information Request - P38 Training)

Deprivation of Liberty Safeguards

From January to December 2018, the trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority relating to community services for adults.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff took the time to interact with patients and their families in a respectful and considerate manner. Feedback we received from patients about the compassionate approach from the community staff was positive. We received positive comments about community staff working in all the various settings and different teams.

We observed numerous interactions with patients in clinics that showed staff did not just focus on the task but considered the whole of the patients' wellbeing. Staff had an excellent rapport with their patients some of which had been visiting the clinics for a long time. We observed how the

podiatrist considered the health of their patients by asking about changes in medications, any slip trips or falls, decline in the diabetes status and saw how staff encouraged and advised their patients on other matters not related to their visit. One patient said to the clinic staff “Thank you for keeping me mobile and able to care for myself”

We spoke with patients in the Laidlaw amputee clinic who were overwhelmingly positive about the care they had received. One patient told us they had given up on trying to walk, but through recent consultation with the councillor and support from the team he was now healthier and fitter and was being supported with walking again.

Staff worked hard to maintain their patient’s privacy and dignity, in the clinics this was often a challenge due to the design of the buildings. In the multi professional triage team (MPTT) clinic, the main office was directly next to the waiting room and personal information could be over heard by those sat in the waiting areas.

In the Arthur Webster podiatrist clinic there were three cubicles and we could overhear all the conversations being held. People working in the clinic recognised this was an issue especially if staff had to raise their voice if a patient had poor hearing. However, the patient’s we spoke with did not mind the lack of privacy and staff told us they had received no complaints. In addition, staff told us they liked working in the same room as it was great for shared learning and for help if a second opinion was required. Staff also said they felt safer as they were not lone working and if a patient should become ill, help was at hand.

We visited the multi professional triage team (MPTT) clinic and saw how the environment did not always allow for patient confidentiality. The waiting room was directly next to the administrator’s office who checked patient’s personal details. We could overhear all the questions asked from the waiting room and staff told us some patients reported they uncomfortable during this initial checking in phase.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff recognised and supported the broader emotional wellbeing of patients and their families. Patients who had received treatment from the specialist therapy teams told us how they were empowered and supported to maintain as much independence as possible. We attended an exercise class for strength and balance, this class was a 12-week programme in three phases, sitting down, up and moving and more active movements. Patients could move through all three phases or just say in one depending on their needs. Staff told us this not only gave the benefits of increased fitness and rehabilitation but also increased sociability and emotional support within the groups.

We saw many comments that patients had sent in to the clinics and the district nurse teams, for example *“I cannot fault your treatment, I was highly impressed with your behaviour and attitude. I feel as if I have made new friends*”.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients and their relatives gave consistently positive feedback and one relative told us *'they always acknowledge me too'*

The community nurse teams had blue folders which were kept in patient homes. These folders had a care planning agreement form which asked patients to sign that they, *'take an active part in the planning of my care, taking into account my own goals and preferences'*. This meant patients were encouraged to be involved with all aspects of their care.

We saw several comments forwarded on from the palliative care team to named community nurses. These compliments were from relatives who were grateful of the support they had received whilst their loved one was at the end of their life.

The district nursing service asked for Friends and Family Feedback, initially the forms were addressed to a central location, but they got lost. Therefore, the service now had envelopes addressed to the locality. Results were discussed at the operational meetings. Friends and Family data for March 2019 showed 88% patients and relatives would recommend the Community nursing services and 100% would recommend the rehabilitation and therapy services.

Is the service responsive?

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

At the time of our last inspection significant changes were taking place in some community services. For example, the decommissioning of inpatient rehabilitation beds and recommissioning them in established nursing homes. The service now provided community rehabilitation across 50 commissioned beds in three nursing homes, these were fully established. Each home had a registered nurse, health acre assistants, physiotherapists, occupational therapists assigned to the community rehabilitation team and funded by the CCG and employed by the acute trust. In April 2019, a dedicated community pharmacist was employed who provided pharmacy services across all three locations. Virtual ward rounds were held weekly with a GP who was linked to each home. A silver phone for out of hours cover for emergencies was staffed by the consultants in accident and emergency at the local hospital.

Further changes since our last inspection had received positive feedback from the patients and staff we spoke to. As previously discussed the three localities were divided into neighbourhood teams, this enabled staff to deliver insulin injections in a timely manner within a reasonable distance, plan their workload within a smaller team and get to know the patients within their neighbourhood. Staff told us that the new neighbourhood teams within each locality worked well. Patients reported to staff that they felt a team approach allowed for more consistency. This had been a real challenge to the teams and some areas were quicker to implement the changes than others. This showed that the services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care.

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.

Clinics were flexible to the needs of their patients. For example, there was a drop-in catheter clinic at Sandown Surgery. Patients with catheter could ‘drop-in’ to the clinic to get assistant/help/treatment. This was popular with catheterised patients as it meant they did not have to wait at home for the community nurse to arrive.

Staff could access translation services when required. Three team members in the northeast locality were attending a sign language course during their free time to help communicate with the patients who sign in their locality. The Integrated community nursing service leaflet gave advice if English was not a patients first language information was available in Polish, Russian, Turkish, Bulgarian, Czech and Bengali.

Meeting the needs of people in vulnerable circumstances

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service had four advanced clinical practitioners (ACPs) who all had different specialities, but all worked under the remit of admission avoidance. ACPs were working with residential/nursing homes to manage their patients in the community and spot the signs of a deterioration, thus reducing GP visits and ultimately avoid an admission to hospital. The ACPs provided education and support for patients with long term complex conditions to stay in their own homes. For example, one patient who was on a ventilator to maintain/assist their breathing was able to return home and be cared for by the community teams.

The service offered Rapid Response Community Response Team (RACR) which provided a multidisciplinary rapid response and intervention services for those vulnerable patients within St Marys Hospital Accident and Emergency Department (A&E), the Medical Assessment and Admissions Unit (MAU) and GPs. The service provided short term care and support for up to seven days a week 08.30-16.30 to enable the patient to return home or stay in their home and therefore avoid an inpatient admission. This short-term interventional crisis service had recently expanded in response to pressures on beds in the acute trust. Traditionally referrals had been via GP and accident and emergency, but now therapists could make referrals if they were concerned about a patient’s frailty. The service had an operational framework which was being re written to reflect the expanded service.

Once a referral was received by the RACR an assessment was completed by the multi-disciplinary team. There was a strict referral criterion which staff had access to and an in-date operational policy. The service was located in the community hub alongside the hospitals NHS111 service, ambulance service and the technology care team. During our inspection we attended a patient assessment which was completed by a senior nurse, a physiotherapist and a health care assistant in the patient’s home, and a community rehabilitation visit with a senior physiotherapist and a band 4 rehabilitation assistant again in the patient’s home. These patients would have been admitted to hospital if it was not for these services. Staff completed a holistic assessment, which was thorough and included family members.

Access to the right care at the right time

People could not always access the service when they needed it and did not always receive the right care in a timely way.

Accessibility

The largest ethnic minority group within the trust catchment area was Asian British with 1% of the population.

	Ethnic minority group	Percentage of catchment population
First largest	Asian British	1%
Second largest	Black/African/Caribbean/Black British	less than 1%
Third largest	Other ethnic group	less than 1%
Fourth largest	White gypsy traveller	less than 1%

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Referrals

The trust had identified services in the table below as measured on 'referral to initial assessment' and 'assessment to treatment'.

From January to December 2018, the trust met the referral to assessment target in nine of the targets listed. The only team to not meet the local target for days from referral to initial assessment was the speech and language therapy (adults) team and the pain team. Most patients were waiting 6 weeks for assessment, but many were waiting much less.

Name of hospital site or location	Name of in-patient ward or unit	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
		National / Local Target	Actual (median)	National / Local Target	Actual (median)	
St Marys	Dietetics - Adults	42	25	See comments	See comments	Community Services commence at the time of initial assessment, so the figures are applicable for both of these sections. Most are locally agreed
St Marys	Home Oxygen Service	-	9	See comments	See comments	
St Marys	Multiple Sclerosis Nurse Specialist	126	35	See comments	See comments	
St Marys	Orthotics - Adults	56	42	See comments	See comments	

St Marys	Osteoporosis Nurse Specialist	126	54	See comments	See comments	with the CCG in the Service Level Agreements.
St Marys	Parkinson's Disease Nurse Specialist	126	70	See comments	See comments	
St Marys	Physio - POGP	42	20	See comments	See comments	
St Marys	Physio - Specialist Practitioner	42	15	See comments	See comments	
St Marys	Podiatry - Adults	112	57	See comments	See comments	
St Marys	Speech and Language - Adults	84	90	See comments	See comments	
St Marys	MPTT	84	53	See comments	See comments	

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

The adult speech and language therapy team had introduced assistants to help manage caseloads and decrease waiting lists. However, this had not improved waiting times as wait times were 13 weeks (91 days) at the time of this inspection.

At the time of our inspection, the multi professional triage team (MPTT) clinic waiting time was eight weeks for spinal appointments and ten weeks for lower limb appointments, Saturday clinics were being held to try and reduce the lists.

During last year the wait for continence assessment was up to 20 weeks for some individuals. Several influencing factors had been identified such as long-term sickness/fragmented caseload management and leadership across localities. An action plan was put in place which included, single leadership, sickness and absence management and caseload reviews and waiting lists had reduced to 10-12 weeks.

The podiatrist clinics were reviewing how they ran their lists in order of acuity. Patients were assessed and rated according to risk, mild/moderate/high. High risk patients should be seen every six weeks but at the time of our inspection we were told by podiatry staff this had started to drop to 10-12 weeks due to demands on the service.

The chronic pain team was a multidisciplinary team which held clinics in a community location in Ryde Health and Wellbeing Centre. The team consisted of doctors, nurses, physiotherapists and clinical psychologists. The current waiting list for a chronic pain multi-disciplinary assessment was 25-30 weeks and the current waiting list for chronic pain physiotherapy assessment was seven to eight months. The service told us they were aware of these waiting lists and said they were trialling an ‘opt in’ appointment scheme.

The Single Point of Access, Referral, Review and Coordination (SPARRCS) teams triaged referrals to the multidisciplinary Crisis Response Team (CRT) and the Rapid Assessment Community Response Service (RACR) who worked alongside each other. Referrals were screened and prioritised within 30 minutes and allocated into the appropriate part of the service.

The CRT provided short term interventions up to 72 hours, seven days a week to prevent people being admitted to hospital or residential/nursing care and aimed to reach patients within four hours of referral. From April 2018 to March 2019 only 55% of patients were seen in 4 hours.

The RACR assessed patients who were in Accident and Emergency, the Medical Assessment Unit or in their own home with the aim to get them home or avoid an inpatient admission and offer support until onward referrals were in place. Expected interventional time frames were:

72 hours for nursing staff

7-10 days for AHP staff

5-7 days for HCA staff

We did not receive any audits to monitor if these time frames were achieved.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, however not all complaints were closed in-line with the trust timeframes**.**

Complaints

From January to December 2018 the trust received 17 complaints in relation to community services for adults at the trust. The trust took an average of 33.2 days to investigate and close complaints, and 47.1% were closed within 30 working days. This was not in line with their complaints policy, which stated that 75% of complaints should be closed within 30 working days.

To have oversight of complaints and where the services were with answering them, the trust had a weekly Flash Report which identified the number of new complaints received, total number of open complaints and the total which were overdue. The report for the 26 April 2019 showed that the community services had two complaints open, one of which was overdue by three days.

We asked to see the minutes of the Community Senior Management Team (SMT) and the Quality and Performance (Q&P) meetings and were told meetings were recorded with an action and decision log and not as a narrative. The SMT action log did not discuss complaints or compliments and the Q&P action log only mentioned work that was being completed around graphs and statistics, no themes were discussed. The trust produced a yearly report on all complaints, concerns and compliments and this report showed analysis of themes, however this was yearly and from the evidence provided we could not be assured that discussions were held regularly around themes of complaint.

A summary of complaints within community services for adults by subject is below:

Subject	Number of complaints	Percentage of total
Appointments	5	29.4%
Values and behaviours (Staff)	4	23.5%

Patient care	2	11.8%
Communication	2	11.8%
End of life care	2	11.8%
Waiting times	1	5.9%
Facilities	1	5.9%
Total	17	100.0%

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Compliments

From April 2018 to December 2018, the trust received 139 compliments regarding community services at the trust. The trusts electronic reporting system was used to capture these, and compliments could be split per area.

The trust identified a number of key themes from the compliments received across the trust:

- Staff behaviour. Staff were described, through individual experiences, to behave in a manner that was kind, patient, friendly, professional, courteous, caring, compassionate, helpful and understanding.
- Specific praise for consultant care.
- Treatment with dignity and respect
- Effective and responsive ED.
- Excellent care.
- Helpful, friendly and efficient Administrators/Receptionists.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Since our last inspection the community division had split from the Ambulance, Urgent Care and Community (AUCC) clinical business unit to become its own division. Alongside this divisional change there was a change to the leadership.

The community division was split into three localities, all the leads and senior staff for each locality now reported to one professional lead rather than community matrons. The professional lead reported to the head of Nursing and Quality, who in turn reported to the deputy director of out of hospital services and then the director of nursing, midwifery and allied health services. This was the same for allied health professionals whose locality leads reported up to locality managers and

then up to the deputy director of out of hospital services and then the director of nursing, midwifery and allied health services.

In our previous report, 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. However, during our recent inspection, we were told that there had been a definite improvement. For the majority of staff we spoke with, the structural changes had made a significant difference, and this was their preferred model of management. Teams spoke highly of the new deputy director of out of hospital services and the director of nursing, midwifery and allied health professionals and community services, telling us that senior leads were approachable, friendly, and visible.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. District nursing staff told us the teams were given more ownership and more of a voice to manage their own workloads. For example, each year there had been an increase in the number of patients who required insulin in the community. Teams worked with senior leads to review staffing times and changed shifts to make this increase in workload sustainable. Senior teams also encouraged innovation and teams were able to upskill their workforce to share the load of the increased demands.

Staff said their senior leaders were visible and approachable. The head of out of hospital services went *back to the floor* twice a month. These were diarised visits to the localities where team meetings, clinics and visits with the community nurses were attended.

Overall, most staff were happy with the changes the division had undergone over the year. However, there were still some instances where staff felt the correct managerial approach had not been taken and some areas remained unsettled with the changes and how this impacted on patient care and outcomes. When we spoke with senior leads about this we were told that staff were being further supported to understand the changes to their areas and support was being offered to demonstrate patient care was not compromised.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision '*working with our island partners and others, we will be national leaders in the delivery of safe, high quality and compassionate integrated care, putting those who use our services at the centre of all we do'.* The community vision was *'to ensure that no person is admitted to an acute setting unless this is unavoidable'.*

The community division had seen extensive changes over the last year, alongside new senior leads and structural changes and was in the process of developing a patient and staff engagement strategy. The developing strategy was to strive to ensure patients were seen at the right time in the right place by the right team to reduce acute admissions and to retain patient's maximum independence. The developing strategy was therefore aligned to local plans in the wider health and social care economy, and we could see services were planned to meet the needs of this and the local population.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We found there was a positive and motivated culture within the community division which was an improvement since our last inspection. All staff we spoke with said the culture had improved over the last 12 months and morale had increased.

Most of the staff told us they felt valued and respected and were appreciated for the role they performed. Staff were positive about the organisation and felt excited about the future development of the community services.

Staff told us that good practice was celebrated by submitting a positive incident form which was an official method of celebrating good work.

The various teams expressed pride at the quality of service delivered and the care and treatment patients were afforded. The culture of the organisation was centred on the needs and experiences of patients who used services. The culture encouraged candour, openness and honesty.

There was a strong emphasis on promoting staff safety particularly in the varied practical lone-working arrangements.

Senior staff told us that there had been support from the executive teams, particularly in realising the benefits of Telecare. They told us that the team listened to the clinicians prior to implementing changes to ensure services were introduced safely.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework supported the delivery of strategy and good quality care. Since our previous inspection in 2018, there had been improvements to rationalise the governance processes for the community division. This had improved and the governance framework ensured that responsibilities were clear, and quality, performance and risks were understood and managed. Staff were clear about their roles and understood what they were accountable for.

There were various ways that teams received important information, the RACR teams had diary reviews daily and would cascade important information here. The district nursing teams had daily handovers where important messages would be shared. Official team meetings were held monthly and minutes would be documented, those staff who did not attend were sent the electronic minutes of the meeting.

Team meetings fed into the operational meetings, which were held weekly across all of the specialities. These then fed into the quality and performance committee (Q&PC) meeting. We reviewed the district nursing operational meeting minutes which had a standardised agenda and covered 10-week plan updates, recruitment incidents complaints and compliments and an overview of the community nursing dashboards. An action tracker and activity log were used to track all actions, and these were red, amber and green (RAG) rated and updated. This was broken

down into specific tabs and included mortality, serious incidents, quality and risk register actions. Meetings were well attended with either no or minimal apologies.

During our previous inspection records of meetings were disorganised, informal. This had improved and every month there was a Q&PC meeting for Band 8a and above which included quality updates, financial performance, initiatives and the divisional strategy. This then fed into the divisional board meeting in the afternoon. During the Q&PC meeting all services were expected to bring an update and present their performance data which was tracked in a tool and RAG rated and allowed for internal benchmarking. We reviewed the action and decision log and saw how attendees were tracked and recorded as present or absent. However, whilst there was an action tracker and decision log there were no minutes. We were told that narrative would be added to this when required. We reviewed this log and saw that all actions were allocated with time frames and completion dates.

All areas had 10-week plans to plan, implement and track improvements to their areas. These had proven to be very popular with staff who told us they felt that if something was put on the plan then it would be achieved. These 10-week plans were tracked across operational meetings and updates were brought to the Q&PC meeting

The staff in the nursing homes who were commissioned by the CCG to deliver rehabilitation services in the community followed the same governance pathway. Staff told us that the local weekly multidisciplinary meetings attended by the occupational therapists, physiotherapist, the newly appointed pharmacist, health care support workers and often a representative from the home fed into the monthly quality and performance meetings.

There was a systematic programme of clinical and internal audit to monitor quality to identify where action should be taken. Since our last inspection the use of the new electronic system allowed each locality to audit performance. This dashboard was then discussed at the operational meeting and issues fed up to Q&PC meeting.

The community division had a small pharmacy team and at the time of our inspection was under development. The service had one recently employed part time community pharmacist and the support of a community technician to help with medicines reconciliation, governance, safety and training/education. Plans for an audit tool were being developed with the input of the lead pharmacist, community division and community pharmacy support. Following on from this would be the implementation of governance meetings.

We reviewed policies which were kept on line and these were in date, had a review date and were version controlled.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However, the community risk register was not up to date as some risks were over their due date and not all high-level risks were escalated to the corporate risk register.

The trust had a corporate risk register and community services had a divisional risk register. The Corporate Risk Register managed high-level (above 15) risks which faced the organisation from a strategic, clinical and business risk perspective. In February 2019 there were two risks above the score of 15 for the community which were escalated up to the corporate register, these were workforce demand and an increase in the requirements in insulin administration. However, when

we reviewed the risk register for the community division there were four risks above 15 which included diabetes, workforce, the orthotics and prosthetic department and noncompliance with falls national targets. The risks entered on the divisional register were comprehensive, with well documented updates and mitigations, however there was a risk that corporate level may not have oversight of all the high divisional risks.

The community risk register held numerous risks and there was alignment between the recorded risks and what staff said was on their 'worry list'. For example, the district nursing teams had told us the increase in patients requiring insulin had a huge impact on the ability to deliver a safe service. This was scored as a high risk on the register, and mitigating actions were documented, we knew from speaking with the teams that these were in place, such as change in shift patterns and upskilling in staff. The due date had not been reviewed and showed this risk as overdue. There were also risks that had been closed ten months earlier which were still entered on the risk register making the document large and unwieldly.

The professional lead accessed the divisional risk registers and discussed risk at their operational and quality district nurse meeting. Staff below this level such as the band 7 staff did not have access to the risk registers so did not know how to review them. They told us that risk was discussed at their senior management team meetings with their leads and this was reflected in how the risks matched what was on their divisional risk register.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

During our last inspection the community nursing teams had transferred some of its paper records on to the electronic system. At this inspection those staff using the electronic system said it worked well and was now embedded. There remained areas that had paper records and other IT systems and the trust told us part of their forward to plan to was to implement this across other areas.

The community division informed patents that their records were kept electronically and, in the folders, kept in the patients' homes there was a care planning agreement for the patient to sign to say this had been explained to them.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The provider used the national NHS Friends and Family Test questionnaires. We saw that the leaflets were distributed to patients and that information was displayed in waiting areas in some of the clinics we visited**.**

The trust board invited patients and carers to share their stories. In the latest board report from May 2019 a wife who cared for her husband living with dementia came and shared her story, to help improve local services.

The board reports discuss that senior teams in the trust listened to what staff said in the 2018 NHS National Staff Survey and in response had developed plans to improve staff experience and engagement. Staff told us that the senior teams were using survey tools to get the views of the staff and to measure the improvements made, a monthly 'pulse survey ' was used to monitor improvements and provide feedback to divisions and departments.

It was recognised by leads that staff could be struggling with some of the changes that had happened since our last inspection. Therefore, a nurse summit had been arranged where staff could speak open and honestly about their views on the changes. Staff appreciated senior managers had arranging a forum in a safe environment to talk about the issues.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The Tele-health team had recognised the value of assistive technology in patient care and admission avoidance. The team had developed a tele-swallowing assessment. This had been introduced across the island and had reduced admissions due to swallowing impairments, this also reduced the speech and language teams travelling commitments.

We saw how staff were working hard to improve their services. A recent quality improvement project completed by an advanced clinical practitioner (ACP) *'What is the impact of introducing an Advanced Clinical Practitioner (ACP) role in residential care setting?*' had been presented at a conference in London.

The ACPs looked across the whole of Wessex for innovation and improvements and were part of the Wessex Community of Safety and Improvement Practice (CSIP). This group aimed to learn and share from each other and *'speed up the adoption of good practices*. Regional events, an annual conference and an online platform facilitated this group.

Accreditations

NHS Trusts can 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 trust reported no accreditations/awards specific to community services for adults.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

Community health services for children, young people and families

Facts and data about this service

The 0-19 public health service is delivered across three localities and operates out of seven bases. The team works on an integrated model.

The Isle of Wight 0-5 Health Visiting Service comprises of a multi-skilled team of Health Visitors, Community Staff Nurses, Community Nursery Nurses and Administrators.

The 5-19 School Nursing Service continue the work identified within the healthy child programme performing health checks and offer support to children and their families throughout the school year as part of the Healthy Child Programme 5-19 programme. This team comprises of a multi-skilled workforce of School Nurses, Community Staff Nurses, Community Nursery Nurses/Senior support workers and support workers. These professional teams are led by Specialist Community Public Health Nurses, who have the specialist qualifications acquired as part of extensive public health training.

The trust is also commissioned to undertake the National Child Measurement Programme (NCMP) for children in reception and year 6 and Human Papilloma Virus (HPV) vaccine for year 8 girls. The team has recently started the delivery of the Diphtheria/Tetanus/Polio leaver's booster and meningococcal ACWY immunisation to year 9 children across the Isle of Wight.

The Children's Speech and Language Therapists, Physiotherapists and Occupational Therapists are co-located in the Children's Therapy building, on site at St Mary's Hospital. The services are accessed via a joint referral form and are provided in a range of community, educational and home settings. *(Source: CHS Routine Provider Information Request (RPIR) CHS Context)*

During this inspection, we inspected:

- The 0 -19 service (health visiting and school nursing).
- The children's safeguarding and looked after children team (LAC).
- The sexual health service.
- The children's speech and language therapy service (SALT).
- The children's occupational therapy service.
- The children's physiotherapy service.
- Two specialist schools for children with learning and physical disabilities.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. During our inspection we spoke with 55 members of staff including school nurses, health visitors, physiotherapists, speech and language therapists, sexual health staff, occupational therapists, the safeguarding team and administrative staff. We reviewed 20 sets of patient records including paper records, electronic records and parent held records. We spoke with 10 children, young people and parents and observed 10 consultations. We observed interactions between children, parents and staff, considered the environment and reviewed a range of documents both before and after the inspection.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory Training completion

The trust set a target of 85.0% for completion of mandatory training.

Trust wide

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for qualified nursing staff in community health services for children, young people and families is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Health, Safety and Welfare	39	39	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	39	39	100.0%	85.0%	Yes
Fire Safety Part 1 - Theory	38	39	97.4%	85.0%	Yes
Hand Hygiene	36	39	92.3%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	35	39	89.7%	85.0%	Yes
Information Governance	35	39	89.7%	85.0%	Yes
Adult Resuscitation	34	39	87.2%	85.0%	Yes
Paediatric Resuscitation	31	36	86.1%	85.0%	Yes
Load Handling	27	36	75.0%	85.0%	No
People Handling	2	3	66.7%	85.0%	No
Infection Prevention & Control Level 2	24	39	61.5%	85.0%	No
Medicines Management Practical Assessment	0	1	0.0%	85.0%	No
Medicines Management Theory	0	2	0.0%	85.0%	No

In community health services for children, young people and families the 85.0% target was met for eight of the 13 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to January 2019 for qualified allied health professionals in community health services for children, young people and families is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	8	8	100.0%	85.0%	Yes
Health, Safety and Welfare	8	8	100.0%	85.0%	Yes
Information Governance	8	8	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	8	8	100.0%	85.0%	Yes
Adult Resuscitation	7	8	87.5%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	7	8	87.5%	85.0%	Yes
Infection Prevention & Control Level 2	7	8	87.5%	85.0%	Yes
Paediatric Resuscitation	6	7	85.7%	85.0%	Yes
Load Handling	5	8	62.5%	85.0%	No
Hand Hygiene	3	8	37.5%	85.0%	No

In community health services for children, young people and families the 85.0% target was met for eight of the 10 mandatory training modules for which qualified allied health professionals were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

We saw evidence that by the end of 2018/2019 all teams within the community CYP service had achieved 85% compliance, or above, with mandatory training.

Staff 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 during supervision meetings with managers. This assured the trust staff fulfilled the trust's requirement for mandatory training.

Staff monitored their mandatory 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.

All staff we spoke with reported they were up to date with their mandatory training and reported that access to training was good.

Staff reported a structured induction programme that included all mandatory training topics listed above. Staff who returned from maternity leave or long-term sickness were allocated protected time to complete the mandatory training.

All health visiting staff and school nursing staff we spoke with had received sepsis training and shared sepsis awareness education with families they worked with. Sepsis recognition was embedded within the infant resuscitation mandatory training which all staff across the service were mandated to attend.

Safeguarding

Staff understood how to protect children and young people 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**.**

Safeguarding Training completion

The trust set a target of 85.0% for completion of safeguarding training.

Trust wide

A breakdown of compliance for safeguarding training courses from April 2018 to January 2019 for qualified nursing staff in community health services for children, young people and families is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children Lev 1	38	38	100.0%	85.0%	Yes
Safeguarding Children Lev 2	35	35	100.0%	85.0%	Yes
Safeguarding Children Lev 3	37	37	100.0%	85.0%	Yes
Safeguarding Adults Lev 2 Part 1	36	37	97.3%	85.0%	Yes
Safeguarding Adults Lev 2 Part 2	36	37	97.3%	85.0%	Yes
Safeguarding Adults Lev 1	37	39	94.9%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	32	39	82.1%	85.0%	No
Preventing Radicalisation Level 3	25	38	65.8%	85.0%	No

In community health services for children, young people and families the 85.0% target was met for six of the eight safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding courses from April 2018 to January 2019 for qualified allied health professionals in community health services for children, young people and families is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	8	8	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	8	8	100.0%	85.0%	Yes
Safeguarding Children Lev 1	8	8	100.0%	85.0%	Yes
Safeguarding Adults Lev 2 Part 1	8	8	100.0%	85.0%	Yes
Preventing Radicalisation Level 3	8	8	100.0%	85.0%	Yes

Safeguarding Children Lev 2	7	8	87.5%	85.0%	Yes
Safeguarding Adults Lev 2 Part 2	7	8	87.5%	85.0%	Yes

In community health services for children, young people and families the 85.0% target was met for all seven safeguarding training modules for which qualified allied health professionals were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

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.

From January to December 2018, the trust made 1,098 safeguarding referrals. Of these, there were 182 child safeguarding referrals were made that related to community health services for children, young people and families. Most referrals made in community health services for children, young people and families were made by health visitors (161 referrals).

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Children on a child protection plan, under the care of the local authority or required additional support were clearly flagged on the electronic records system most services used, which mitigated the risk of staff being unaware of concerns around the family. However, the physiotherapy, speech and language and occupational health services electronic appointment system did not have the function to flag vulnerable children, therefore they had to rely on the referrers offering this information.

There was a safeguarding children's team who oversaw the safeguarding children agenda in all services. The children's safeguarding team included a specialist band 8 nurse, a named midwife for safeguarding, two band 7 nurses and a full-time administrator.

The Looked after Children team (LAC) consisted of a specialist band 7 nurse, supported by a band 6 nurse and a full-time administrator. The team were currently in consultation with the trust leadership team to provide an additional 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.

The Trusts' current children's safeguarding policy did not refer to the current guidance, however this had been recognised and the children's safeguarding lead had reviewed and amended the he children's safeguarding policy and the training and supervision policy to ensure it was reflective of current guidance. This revised policy was due for ratification in July 2019.

Staff we spoke with were familiar with the trust's safeguarding policy and how to access it. They were aware of the procedure to follow if they had safeguarding concerns and could identify the safeguarding lead. Safeguarding policies and procedures were clear and staff we spoke with

showed a comprehensive understanding of safeguarding issues for example, female genital mutilation and child sexual exploitation.

The safeguarding team across the Children, Young People and their Families services (CYP) provided peer support and supervision as required. The team were available Monday to Friday and staff told us they valued the support and guidance provided. This ensured support and supervision was available as part of staff development. The children's safeguarding team received supervision from within the team and externally from the local authority.

The National Health visiting service specification 2014/2015 states that Health visitors (HVs) must receive a minimum of three-monthly safeguarding supervisions of their work with their most vulnerable babies and children. These should include children on child protection plans, those who are 'looked after' and not in residential care and those for whom the health visitor had a high level of concern. Health visitors and school nursing teams received safeguarding supervision four times a year, and more frequently if requested, and staff in other services on request.

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 various staff groups require. 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. All staff we spoke with had the appropriate level of children's safeguarding training.

Embedded within the level two children safeguarding courses was 'The Think Family approach'. The think family approach is a needs led approach and provides support that is 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.

We saw all assessments across the community CYP service contained safeguarding check boxes. Staff referred any disclosures to the multi-agency safeguarding hub (MASH) staffed by the local authority and contacted the children's safeguarding team.
Services such as the looked after children's team and sexual health included child sexual exploitation specific assessments within their initial assessment proformas. All staff we spoke with were aware of child sexual exploitation and had received training on this topic.

Staff reported radicalisation training was new and had replaced the 'Prevent' training, and not all staff had completed it as it was a rolling programme. The data presented above reflected this, and the compliance for level three training was 65.8%.Radicalisation training educated staff on the risk of vulnerable people being exploited and drawn into terrorism.

The sexual health service had a chaperone policy where staff must offer all children and young people 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 recorded the offer in their notes

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children and young people, themselves and others from infection. Staff kept equipment and their work area visibly clean.

In comparison with the last inspection in November 2018 we found all areas of the community CYP service to be visibly clean and well maintained.

Hand hygiene results for January 2019 to February 2019 were 85% for the community division. The 0-19 service achieved 100% hand hygiene compliance in April and May 2019 and sexual health service achieved 100% compliance in March and 93.3% in April and May 2019. This provided assurance teams across the service were following and monitoring hand hygiene procedures.

We observed almost all staff across the service adhered to infection control procedures such as being bare below the elbow, having long hair tied up and using the appropriate personal protective equipment. We observed two members of staff not being bare below the elbow and not using alcohol gel between patients. However, this was an improvement on findings from the inspection in 2018.

All clinics had washable toys, and most were able to provide us with a cleaning schedule. The therapies clinic had strict guidelines on when, how often and what to wash the toys with. We observed staff had completed all cleaning schedules and were up to date, however the sexual health service was unable to show us cleaning schedules for their toys.

Health visitors used cleansing wipes, and clean paper sheets on scales when they weighed babies. Staff cleaned their hands with hand sanitiser gels and equipment between patients. We saw health visitors and school nurses had provision of personal protective equipment such as gloves to take to schools and home visits.

In sexual health, gloves and sanitizer wipes were available in each clinic. Clinic rooms had disposable curtains, which staff changed every six months and we saw were marked with the date of installation and were up to date.

During an immunisation clinic we observed the school nurses disposed of items with bodily fluids and sharps safely.

Infection prevention and control standard operating procedures and policies were current and accessible on the hospital intranet.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept children and young people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients. However, some services did not ensure the resuscitation trolley or grab bag was checked daily.

We observed that staff in the sexual health clinic had not carried out daily checks when the clinic was open to ensure the resuscitation trolley was complete and in good working order. Across the months of March, April and May 2019 staff had not checked the trolley eight times. We raised this with senior staff who immediately set up electronic diary reminders for staff to check it was completed. Within the therapies building, staff had not checked the resuscitation grab bag 16 times over the period of January to April 2019. May 2019 was up to date. This issue was also highlighted in the 2018 inspection. This did not assure us the equipment and medication in both the resuscitation trolley and grab bag was in date and in good working order.

Health visitor clinics were held in various locations which were not owned by the trust, for example children's centres and GP health centres. However, staff ensured there were adequate facilities for children and families such as age appropriate toys, parking and disabled access.

Staff across the service risk assessed all areas where CYP were seen for hazards before each session. This ensured the environment the clinics were held in was safe for children and young people.

Not all areas of the service were child friendly, for example the school nurses said they sometimes administered immunisations to children in the vaccine storage room which was not a child friendly environment. We observed one of the rooms where physiotherapy took place was also very clinical with bare white walls and old furniture and not child friendly.

Staff labelled sharps boxes across the service correctly and we did not observe any boxes to be overflowing.

Waste management was in line with national standards and the trust's policy.

The reception area in sexual health services was a large open-plan room and patients could be overheard when speaking with the reception staff. We raised this issue at the time of inspection and the service lead advised they would investigate reorganising the chairs in the waiting room, so they were further away from the reception area.

The treatment rooms across the sexual health clinic were all set up and stocked in the same way to ensure staff knew where equipment was in each room.

Across the sites, we saw clinic scales were routinely calibrated to maintain accuracy and other clinical equipment such as blood pressure machines were serviced yearly with stickers detailing the date of the next service. Therefore, the service could be assured their equipment was in full working order.

Staff were provided with mobile phones and laptops. Most staff were able to access desktop computers at their offices. However, some staff reported connectivity issues, in and outside of the office, but most staff reported an improvement in connectivity since the last inspection in 2018. Staff told us there was enough office space to work comfortably. However, the SALT team told us there was lack of laptop availability with only four to work on between 10 staff.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks.

The Healthy Child Programme (HCP) and National Child Measurement Programme (NCMP) include assessment stages and tools to identify and respond to children, young people and families (CYP) 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 looked after children's (LAC) team.

The 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. The trust had also used the assessment framework for the assessment of health needs in families. This had the stated aim of providing an effective programme of health visiting contacts at the earliest opportunity to aid improvements in CYP's health outcomes. The midwifery service commenced the assessment which flowed through to the health visiting team.

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.

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). All five sets of notes we reviewed had a completed SERAF.

The therapies team used a front sheet which detailed safeguarding concerns and social concerns. However, four out of the five records we reviewed in the physiotherapy team either had a tick or nothing written in these boxes. This did not assure us the physiotherapy team were assessing for safeguarding risks or concerns.

The service distributed complex cases across the health visiting workforce, to enable staff to manage the additional support needs more effectively.

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. Health visitors told us they discussed the signs of sepsis with parents at the antenatal or new birth visit.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Planned v Actual Establishment

Details of staffing levels within community health services for children, young people and families by staff group as at April 2018 to March 2019 are below.

Community health services for children, young people and families total

Staff group	Actual staff WTE	Planned staff WTE	Staffing rate (%)
NHS Infrastructure Support	9.6	9.6	100.0%
Support to Doctors and Nursing Staff	11.1	11.4	97.8%
Qualified Nursing and Health Visiting Staff	35.5	38.6	91.8%
Allied Health Professionals	9.8	12.1	81.7%
Total	66.0	71.6	92.2%

Qualified nursing staff

Details of nursing staff levels within community health services for children, young people and families by team as at April 2018 to March 2019 are below.

Team	Actual staff WTE	Planned staff WTE	Staffing rate (%)
St George's School Nurse	1.1	1.1	100.0%
0-19 Service (HV and SN)	34.4	37.5	91.6%
Total	35.5	38.6	91.8%

Allied health professionals

Details of staffing levels for allied professionals within community health services for children, young people and families by team as at April 2018 to March 2019 are below.

Team	Actual staff WTE	Planned staff WTE	Staffing rate (%)
OT Paeds	4.7	5.7	82.5%
Speech & Language Therapy Paediatrics	5.1	6.4	80.9%
Total	9.8	12.1	81.7%

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

From January to December 2018, the trust reported an overall vacancy rate of 6.5% in community health services for children, young people and families. The trust has not set a target for vacancy. Across the trust overall vacancy rates for nursing staff were 4.5%; for medical staff were 9.1% and for allied health professionals were 42.4%. A negative vacancy rate has been reported for the support to ST&T staff group and the trust have stated that this is due to an over establishment of staff.

A breakdown of vacancy rates by staff group in community health services for children, young people and families at trust level and by staff group is below:

Staff group	Total % vacancies overall (excluding seconded staff)
Qualified Allied Health Professionals (Qualified AHPs)	42.4%
Medical & Dental staff - Hospital	9.1%
Qualified nursing & health visiting staff (Qualified nurses)	4.5%
Support to doctors and nursing staff	3.7%

Support to ST&T staff	-4.5%
All staff	6.5%

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

The vacancy rate on 8 April 2019 for the 0-19 service were 5.64 whole time equivalent (WTE). Occupational therapies had no vacancies and sexual health had a 0.39 WTE vacancy with a 0.7 vacancy for doctors. SALT had a vacancy of 0.68 WTE. The trust had not broken down the physiotherapy vacancy figures into paediatric and adult services.

The sexual health team employed three consultants on a part time basis. The nursing team consisted of one clinical service manager, a nurse consultant, a band 7 clinical lead, four band 6 nurses and three band 3 clinical/administration roles. The service had recently reached a full complement of staff.

The community practitioners and health visitor's association recommend that each health visitor should hold a caseload of up to 300 families or 400 children. We saw that caseloads of health visitors met these recommendations in all areas although where there were long-term sickness absences or maternity leave, caseloads were higher. However, the service was effectively covering vacancies with bank staff.

Staff in the health visiting team reported they reviewed all caseloads weekly during 'allocation meetings' to ensure caseloads were balanced for each member of staff. Staff we spoke with reported this worked well. All teams across the Isle of Wight held their allocation meetings at the same time on the same day. This helped to highlight any capacity issues within the teams.

The health visiting team were recruiting to one band 7 post, as the band 8 was covering this role as well as their band 8 role. All staff we spoke with were aware of this vacancy. Staff had high confidence that the service aimed to fill vacancies, which was different from what we found in the 2018 inspection.

In the looked after children's team there was a band 7 and a band 6 nurse in post. However, the nurses still had above the national average children and young people on their caseload. During the 2018 inspection the team reported they were creating a band 6 post. At the time of inspection, the team were still in discussions with the trust regarding the need for additional staff.

The therapies team were almost at full complement of staff. The physiotherapists were a few hours short, Speech and language team (SALT) had no vacancies and the occupational health team (OT) had recently created a band 7 post to assist with the autism waiting list using band four money. There was currently a vacancy for a band 5 OT assistant. The data above appeared to include the whole of the therapies service including adult services.

Turnover

From January to December 2018, the trust reported an overall turnover rate of 8.2% in community health services for children, young people and families. This was higher than the trust's target of 5.0%. Across the trust overall turnover rates for nursing staff were 12.0% and for allied health professionals were 0.0%.

A breakdown of turnover rates by staff group in community health services for children, young people and families at trust level and by staff group is below:

Community health services for children, young people and families total

Staff group	Total % of staff leavers in the last 12 months
Qualified Nursing and Health Visiting Staff	12.4%
Support to Doctors and Nursing Staff	5.4%
NHS Infrastructure Support	0.0%
Qualified Allied Health Professionals (Qualified AHPs)	0.0%
Qualified nursing midwifery staff (qualified nurses)	0.0%
All staff	8.2%

Nursing staff by team

Team name	Total % of staff leavers in the last 12 months
0-19 Service (HV & SN)	12.4%
St. George's School Nurse	0.0%
All staff	12.0%

Allied health professionals by team

Team name	Total % of staff leavers in the last 12 months
OT Paeds	0.0%
Speech & Language Therapy Paediatrics	0.0%
All staff	0.0%

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

Sickness

From January to December 2018, the trust reported an overall sickness rate of 3.8% in community health services for children, young people and families. This was higher than the trust's target of 3.5%. Across the trust overall sickness rates for nursing staff were 5.2% and for allied health professionals were 1.1%.

A breakdown of sickness rates by staff group in community health services for children, young people and families at trust level and by staff group is below:

Community health services for children, young people and families total

Staff group	Total % permanent staff sickness overall
Qualified Nursing and Health Visiting Staff	5.2%
Support to Doctors and Nursing Staff	2.6%
NHS Infrastructure Support	1.2%
Qualified Allied Health Professionals	1.1%
All staff	3.8%

Nursing staff by team

Team name	Total % permanent staff sickness overall
0-19 Service (HV & SN)	5.3%
St. George's School Nurse	0.5%
All staff	5.2%

Allied health professionals by team

Team name	Total % permanent staff sickness overall
OT Paeds	1.3%
Speech & Language Therapy Paediatrics	1.1%
All staff	1.1%

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

The lead for school nursing regularly audited sickness to review for any reoccurring themes to try and support staff with an aim to reduce sickness.

Nursing – Bank and Agency Qualified nurses

From January to December 2018, of the 76,222 total working hours available, 2.7% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 6.8% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
0-19 Service (HV & SN)	76,222	2,033	2.7 %	0	0.0%	5,203	6.8%

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

The health visiting team regularly used bank health visitors to cover the universal workload to enable the substantive health visitors to complete quality improvement projects.

Nursing - Bank and Agency Non-Qualified nurses

From January to December 2018, of the 16,841 total working hours available, none were filled by bank or agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, 6.0% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
0-19 Service (HV & SN)	16,841	0	0.0 %	0	0.0%	1,002	6.0%

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

Medical locums

From January to December 2018, the trust reported that they did not use any bank or medical locum staff to cover sickness, absence or vacancy for medical staff in community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

Suspensions and supervisions

During the reporting period from January to December 2018, community health services for children, young people and families reported that there were no cases where staff have been either suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Quality of records

Staff kept detailed records of children and young people's care and treatment. In general, records were clear, up-to-date, stored securely but not all records were accessible by all staff providing care.

Recording of patient events had improved since the last inspection in 2018. Health visiting staff, school nurses, and the safeguarding team all had full access to one shared electronic record keeping system. These teams all had a shared a record. The occupational therapy team had read only access, this meant they were able to read the history. Physiotherapy and Speech and language therapy had no access to the electronic system and relied on information from the referrer, staff told us referrals included enough information for them to be able to treat the individual. The clinical service leads told us staff accessed x-rays via an electronic image recording system.

All therapy services used paper-based records. However, these detailed records were not linked with the child or young person's electronic records. Health visitors would only receive notification if their referral was accepted and a discharge letter. The GP would also receive a copy of the discharge letter.

Administration staff within health visiting scanned hard copy letters, for example from GPs, and the family health assessments into the system. This enabled users of the system to review people's medical history and interventions from health and social care agencies.

Previously at the 2018 inspection, school nurses recorded all information from clinics etc on paper records and stored them in multiple ways. During this inspection we observed school nurses used the electronic notes system to record all details of contacts with children and their families.

The LAC team effectively completed records. They showed the child or young person's health plans, treatments and results along with any interventions or conversations with the local authority.

The sexual health service had read only access to the electronic system with two staff members able to input onto the system. This was a vast improvement from the 2018 inspection where staff would rely on the safeguarding team to update records with their concerns. Staff reported they were pleased with the progress of the electronic system.

We observed records stored securely and access to electronic records was password protected with permissions required for staff to access records relating to their professional discipline. Staff secured paper records in locked cupboards or offices.

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. They clearly demonstrated the chronology of significant events, consent forms and vaccination history.

Health visitors recorded in the parent held child health record (PHCHR) or 'red book'. Staff encouraged parents to bring their PHCHR to every clinic appointment.

The 0-19 and sexual health team included records review as part of their clinical supervision. All staff we spoke with reported this practice was beneficial for their records management and helped ensure they clearly identified clients' needs.

The health visiting team completed a record keeping audit in 2018 which showed gaps in the way individuals recorded visits. It was clear there was no framework for recording antenatal visits which was now in development and the audit ensured staff documented all notes contemporaneously.

However, when reviewing records and when we asked staff, they were unsure of the standard approach to recording the visits on the electronic records. 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. We had highlighted these issues at the 2018 inspection.

Most staff used the symptoms, observations, advice and plan (SOAP) approach when recording their visits, however most staff we spoke with were unsure if there was a standard approach to recording notes on the electronic system.

We observed administration staff checked vaccination forms for a signature, date and the dose and batch number of the vaccine at a vaccination clinic in a school. This ensured an audit trail was in place.

Medicines

Whilst the provider had systems in place for the safe storage, administration, prescribing and disposal of medicines, we were not fully assured the trust had full oversight of medicines administered at the specialist schools, and the health visitor's safe storage of prescription pads.

The sexual health service stored medicines in a pharmacy room and in locked cupboards in the individual rooms. We reviewed the sexual health fridge temperatures, and staff checked temperatures daily and temperatures had not gone above the recommended temperature. This was an improvement from the 2018 inspection. This meant medicines such as immunisations had been stored at the correct temperature consistently. We also noted the above for the school nursing team.

The school nurses at both specialist schools received medicines management training from the local council and were involved in training the school staff in medicine administration. In the last year there were no reported medicine errors in either school. The school nurses had professional oversight of the medicines held at the school. A small stock of emergency medicines was obtained from the trust pharmacy department.

The school nurses had developed healthcare plans for each child based on specialist advice and discussions with parents or guardians. These plans detailed the use of medicines in an emergency and when to call for an ambulance. Asthmatic care plans also included the facility to use an emergency inhaler and spacer held by the school if the child's own inhaler was not available and an appropriate register had been developed as per the Department of Health's guidance. Once completed these plans were agreed between the parents, school and school nurse, with the minimum of an annual review.

Within the specialist schools we found all medicines in locked cupboards and teaching staff administered children's regular medication. School staff received yearly training from the school nurse and local authority in medicine administration. However, one of the school nurses did not have an audit trail of their stock medication administered to pupils and staff.

We observed the treatment room in a specialist school was very hot and did not have temperature monitoring. The school held medicines in this room, and there was a risk the high temperatures could affect the efficacy of the medicines.

The school nurses had new fridges where their immunisations were stored. However, we saw the key to the fridges were not kept in a secure place. We raised this concern during the inspection and the keys were immediately moved to be stored in a secure key safe.

School nurses monitored the temperature of the vaccines every 30 minutes once they were removed from the base fridge. This ensured vaccines were stored within a recommended temperature range to ensure they maintained their efficacy.

One school we visited required some medicine to be kept in the fridge. There was an appropriate medicine fridge which staff checked daily Monday to Friday. During school holidays staff emptied and switched off the fridge. Staff recorded this on the fridge temperature recording log.

At both specialist schools the nurses 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. The nurse then checked this against a consultant or GP letter. This was an improvement from the last inspection in 2018.

Processes were in place for the administration of a single dose of a pain relief medicine by the school nurses. However, we lacked assurance that this process had been risk assessed by the trust. Therefore, we were not assured the trust had an oversight of this process.

Nursing staff who were not prescribers administered medicine under Patient Group Directions (PGD). (A patient group direction allows some registered health professionals (such as school nurses) to give specified medicines (such as immunisations) to a predefined group of patients without them having to see a doctor).

To enable school nurses to administer immunisations, school nurses' names were on a printed list of a group PGD's, but on one of the PGD's, the list did not have their signature or date of signing which did not follow best practice.

The sexual health nurses were able to administer medication using the PGD and one member of staff was a nurse prescriber, and another was working towards this qualification. All PGD's we reviewed were in date, and detailed staff's signatures and date of signing. 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 medicine. We observed these in patient's medical records filled out correctly.

An anaphylaxis kit was laid out ready at schools for nurses to use in the case of a reaction to the immunisations. (Nurses waited at school for 20 minutes post immunisation in case a child had a reaction).

Some health visitors were non-medical prescribers and completed updates concerning non-medical prescribing on a yearly basis. The trusts medicine management policy version 6.1 stated prescription pads are controlled stationary and should always be securely stored. The policy further states the pad should be signed over to the prescriber and they then take full responsibility until the pad is returned and signed back in for storage. However, not all health visitors were returning their prescription pads back to the base after each clinic and had variable means of storage.

We observed staff stored oxygen appropriately, and cylinders were within expiry dates, in the sexual health clinics, therapies department and the specialist schools. This was an improvement from the inspection in 2018.

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

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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 January to December 2018, the trust reported no incidents that were classified as a never event community health services for children, young people and families.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

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 one serious incident (SIs) in community health services for children, young people and families, which met the reporting criteria set by NHS England between January and December 2018. The incident was classified as a medication incident meeting SI criteria.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us confidence in the validity of the data.

(Source: Strategic Executive Information System (STEIS))

The serious incident detailed above was about a health visitor who did not have the non-medical prescribing qualification documented on the nursing and midwifery register even though she has completed all training. A full root cause analysis was completed, and no harm occurred because of the serious incident.

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 two prevention of future death reports sent to the trust. None of these related to this core service.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

The serious incident listed above regarded a member of staff who was a non-medical prescriber and had prescribed over a hundred prescriptions without being listed on the non-medical prescribers register. A root cause analysis showed it was an error within the registration recording system, and the practitioner was able to prescribe, and no harm had been caused.

The trust provided us with a list of reported incidents and near misses for the period of April 2018 March 2019:

Health Visitors – 45 incidents reported – of which 15 were reported as near misses.

School Nurses – 20 Incidents reported – of which 8 were reported as near misses.

Paediatric SLT – 2 incidents reported – of which 0 were reported as near misses.

Paediatric physiotherapy – 2 incidents reported – of which 0 were reported as near misses.

Paediatric OT – 10 incidents reported – of which 7 were reported as near misses.

Staff reported incidents electronically using a specific recognised system. All staff we spoke with told us the reporting system was straightforward to use and their managers encouraged them to report incidents.

Managers were confident there was an effective reporting culture within their teams. They referred to incidents that had taken place in their own teams or in other teams and outlined any learning and changes in practice. For example, a school nurse reported an incident where a child had not been put on the electronic notes system. The feedback from the incident included the action taken to reduce the risk of a similar incident occurring.

Staff reported following an incident where a GP incorrectly documented a child's growth on an adult growth chart, the service now liaised closely with the GP's to ensure they used the correct growth charts.

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.

The therapies team were able to detail an incident where a letter had been sent to the wrong social worker. Feedback to the incident report was given and changes to the administration processes were made.

Following a serious case review in 2018 the 0-19 team attended refresher training on domestic violence.

The trust had introduced a "Leaning to Improve" bulletin, however all staff we spoke with regarding learning from incidents did not mention this bulletin. We were not assured the trust had a system wide method of sharing learning from incidents.

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 demonstrated knowledge of the Duty of Candour, to be open and transparent with people including when things go wrong with their care and treatment.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of children and young people in their care. However, not all staff followed the correct national guidance when giving information to parents and carers regarding bottle feeding.

The policies and procedures used by children, young people and families (CYP) services were developed around national guidelines. Policies were available on the trust intranet system and staff knew how to access them.

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.

However, we observed two staff did not provide up to date guidance provided by the NHS with regards to bottle feeding. This did not assure us all staff were keeping up to date with national guidance.

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 and the questions covered five domains of child development, communication, gross motor skills, fine motor skills, problem solving and personal social development. Health visitors were able to identify follow up actions for any concerns identified.

The service was currently developing a 48-month development review based on the ASQ-3 questionnaires prior to the children starting school. This was all part of the services school readiness project.

The school nursing service specification enabled children and young people to make healthy lifestyle choices and improve their social and emotional wellbeing. To achieve this aim, school nurses delivered health promotion and immunisation services, based on the Department of Health guidance publications.

The National Child Measurement Programme (NCMP) 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. This provided an opportunity for staff to engage with children and families about healthy lifestyles.

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. Since the 2018 inspection the service had reviewed and amended the pathway to ensure complete oversight of decisions made from the band 6 staff. We also saw evidence of clear pathways for concerns regarding children's ability to hear or see when tested in reception.

The sexual health team followed guidance and service standards from other professional bodies including Faculty of Sexual and Reproductive Health (FSRH) and British Association for sexual Health and HIV (BASHH).

The Sexual health service delivered in line with the National Screening Programme Standards and other guidance, asymptomatic screening programmes for the management of sexually transmitted infections.

The speech and language therapy (SALT) team used evidence-based practice when assisting young children to develop their speech. The team used a research focused programme of care when assisting with children and young people's speech development.

The occupational therapy service and physiotherapy were delivering training on the new National Institute of Clinical Excellence (NICE) guidance for early intervention around cerebral palsy. For example, the physiotherapy team had held meetings with the radiology team regarding the requirements for all children with cerebral palsy to have early hip screening.

The 0-19 service 10-week improvement plan identified a need for the standardisation of antenatal and birth visits and were developing standards of practice linked to national drivers. However, these were still under development and there were no clear protocols or guidance within the health visiting service on how staff should carry out a new birth visit in the home. For example, staff told us a 'hands off' approach to assessing the baby should be maintained whilst the leadership team were producing a standard, however during one visit we observed the health visitor to do a full 'hands on' assessment of the baby and another we saw used the 'hands off' approach.

The looked after children (LAC) policy? described the delivery of the service based on the statutory guidance including 'Promoting the Health and Wellbeing of Looked After Children'.

Care plans we reviewed in the specialist schools demonstrated the school nurses created clear personalised care plans which were up to date and in line with relevant good practice guidance and set out clear goals for each child and had been developed with their parents. However, the care plans were stored electronically and did not include the signature of the parents which is not following best practice.

Nutrition and hydration

We observed within all health visitor clinics health visitors and nursery nurses gave advice regarding various methods of feeding for babies including breast and bottle feeding along with weaning advice.

We observed five health visitor clinics or interactions and observed health visitors gave clear, evidence-based information to expectant mothers about breastfeeding, feeding regimes and weaning in each appointment.

We observed school nursing staff gave advice and education on healthy eating and drinking to children and young people.

Health visitors told us breast feeding support groups were in place and there were breastfeeding peer support groups in the community. Health visitors were able to refer mothers to specialists such as dieticians and the speech and language therapy teams for advice about breastfeeding and dietary concerns.

Following identification of children who were under or over weight from the NCMP School nurses were able to make timely referrals to dieticians and paediatricians and were able to provide healthy eating education within schools.

Pain Relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools.

Care plans we observed in the specialist schools included appropriate pain assessment and management plans for example if a child was in pain other options such as encouraging the child to have a drink, get fresh air, lie down before administering the pain relief. 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

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

Audits – changes to working practices

The trust has participated in one clinical audit in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
Child health clinical outcome review programme (NCEPOD) Chronic Neurodisability	Emergency department, paediatrics, community	-	-

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

Across the service there was a clear approach to monitoring, auditing and benchmarking the quality of most of the services and the outcomes for children and young people receiving care and treatment.

For example, the sexual health team contributed to national audits such as the British Association for Sexual Health and HIV (BASHH) – national HIV partner notification and the times to appointment, test results and treatment. They had contributed to the British HIV Association (BHIVA) national audit of Monitoring and assessment of older adults with HIV and Wessex BASHH.

Because of audit, the service had revisited the documentation to ensure effective data collection and staff were working with the pathology lab to improve test results and consider alternatives, such as point of care testing, for quicker results.

The service did not have accreditation with the UNICEF breast-feeding due to a lack of funding and capacity to pursue accreditation. The trust submitted data to Public Health England in relation to the number of babies fully or partially breastfed at six to eight weeks after birth. Data provided by the trust showed the breast-feeding rates at 6-8 weeks was 47.2% which was better than the England average of 42.7% However breast-feeding initiation was 66.4% against the England average of 74.5%.

The health visiting service performed better than the England average for completing screening visits in line with the healthy child programme. From 2017-2018 the service saw 97.7% of babies born within 14 days for a new birth visit (NBV) compared to the England average of 87.7%. The service completed 96.6% of babies six to eight week check by the time they were eight weeks old compared to an England average of 84.3%. The health visiting team completed 95.2% of babies' 12 months' reviews by the age of 12 months and 91.1% of two to two-and-a-half-year-old reviews in the same period. This was significantly better than the England average of 82.6% and 75.7%

respectively. This information also enabled the service to monitor contacts with mothers and babies and assess their emotional welfare (of mothers), growth and development.

Results for the Human papilloma virus (HPV) immunisations for 2017 – 2018 were 89% against the England average of 86.9%. This was a positive start for this newly commissioned service.

The 0-19 service was developing a school readiness programme with the aim of improving outcomes for children who may not be ready for school before they reach the school environment which would be over and above the HCP recommended contacts.

Due to the reduction of special educational needs provision across the Isle of Wight the school nurse team intended to audit the impact of the referral criteria as they believed it was set too high and this resulted in families disengaging from the service and creating poorer outcomes for children. The team hoped the school readiness pilot would reduce disengagement.

The 0-19 service liaised with the midwifery team with regards to antenatal visits and as part of their 10-week improvement plan it further identified two improvement pathways. Firstly, a business case had been written for the electronic records element and a timeframe was agreed for implementation. Secondly, there was an agreement for sharing and checking information with the midwifery team. It was agreed the health visitor team would receive information earlier and attend face to face meeting with midwives at 24 weeks to ensure information about pregnant women was accurate.

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. LAC 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.

The LAC team quality assured the review health assessments using the Royal College of Paediatric and Child Health audit tool for quality of review health assessments. This meant the quality of the reports were based on approved methodology.

The SALT team had undergone Elklan training (which is training to enable SALT to train education staff in preschools and reception year in speech and language techniques) and audited its effectiveness.

The SALT staff audited the progress of their children using the Therapy Outcome Measure (TOMS) outcome which enabled the service to identify clinical outcomes for age groups as well as specific conditions or presentations. For example, the service planned to audit all children in reception year who had interventions for speech sound production at the end of the academic year, to evidence its effectiveness.

The OT team did not have a clinical audit plan in place as their focus was to reduce the waiting times for children.

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 development.

Clinical Supervision

The trust provided the following information about their clinical supervision process:

For community nursing, monthly group clinical supervision sessions are offered and facilitated by the Community Practice Educator in each locality; sessions are offered for staff in Bands 2-4, another group for Band 5/6 and another for Band 7 and above; individual supervisors are also available if individuals choose to have supervision on a one to one basis as is peer supervision. The Clinical Practice Educator keeps a log of all sessions and attendance is also recorded on MAPS.

For community services, each profession has a clinical supervision schedule to meet the needs of staff, patients and the service. Often this is a combination of group supervision, planned individual supervision sessions and ad hoc support. Supervision tends to be recorded on spreadsheets, or proformas held on the departmental drives, with actions and learning discussed at departmental meetings; recorded in those minutes. Individual supervisees will hold more detailed notes for their own development.
The trust has commented that “Whilst we are clear that at service level clinical supervision is taking place and has oversight at service manager level, we have yet to devise mechanisms for monitoring supervision levels across the division. This is something we will be working on as we have identified this as an assurance gap”.

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)

Staff in the 0-19 service told us they received clinical supervision every three months, this included the nurses who worked in specialist schools. Band 7 staff facilitated band 6 nursing staff supervision who in turn facilitated band 3 and 4 staff supervision sessions.

The therapy teams reported they had regular clinical supervision and found these sessions to be beneficial with improving the quality of their work as well as their wellbeing. Many sessions were impromptu showing cohesive support within the teams.

Appraisal rates

From April 2018 to February 2019, 80.5% of permanent non-medical staff within the community health services for children, young people and families core service had received an appraisal compared to the trust target of 85.0%.

A breakdown by staff group and by team is shown below:

Community health services for children, young people and families total

Staff group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Additional Clinical Services	18	19	94.7%	85.0%	Yes
Nursing and Midwifery Registered	32	39	82.1%	85.0%	No
Allied Health Professionals	7	11	63.6%	85.0%	No

Administrative and Clerical	5	8	62.5%	85.0%	No
All staff	**62**	**77**	**80.5%**	**85.0%**	**No**

Nursing staff by team

Team name	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
St. George's School Nurse	2	2	100.0%	85.0%	Yes
0-19 Service (HV & SN)	30	37	81.1%	85.0%	No
All staff	**32**	**39**	**82.1%**	**85.0%**	**No**

Allied health professionals by team

Team name	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Speech & Language Therapy Paediatrics	5	7	71.4%	85.0%	No
OT Paeds	2	4	50.0%	85.0%	No
All staff	**7**	**11**	**63.6%**	**85.0%**	**No**

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

All staff we spoke with reported they had either had their appraisal for 2018/2019 or it was booked. We saw evidence by the end of 2018/2019 all teams within the community CYP service had achieved an appraisal rate of 85% or above which met the trust's target. The above figures do not show the appraisal rates for a completed year.

All staff across the service were encouraged to undertake professional development and received annual appraisals, which were reported to be beneficial to their professional development.

Nurses in specialist 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 were both their line manager.

All health visitors received tier 1 sexual health training from the sexual health team which enabled them to share contraceptive advice amongst other topics with new mothers.

All school nurses and health visitors received training on immunisations and planned to introduce the training programmes from the NHS England's website.

We saw competency workbooks for school nursing for band 3 and 6. These included induction check lists and the competencies required to be achieved for the role.

At the inspection in November 2018 there were no competencies for band 4 and band 5 staff in school nursing. During this inspection we noted the competencies were still in development and awaited approval from the 0-19 lead, division lead and human resources.

The trust supported staff to attend outside training and conferences to improve their skills. For example, the LAC nurses had received refugee training following an increase of unaccompanied refugee minors coming onto the Isle of Wight and two health visitors visited a health visiting team in London to learn about a new methodology of visiting.

The paediatric occupational therapy and speech and language therapy team had separate and joint 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 school nursing and health visiting service had reintroduced practice development meetings where they discussed current issues, improvements and new ways of working. These meetings would often include a speaker from an outside agency. The meetings had been placed on hold and recently reinstated following staff feedback.

All 0-19 staff had received mentorship training enabling them to mentor student school nurses and health visitors as well as student nurses and the school nurse team completed yearly education audits for all mentors across the team to determine learning needs.

There were three community practice teachers within the 0-19 team who enabled the service to support practitioners undergoing the specialist community public health nursing, and students undergoing the post graduate diploma course.

The health visiting service used a volunteer in one area to help welcome families in to the healthy child clinic. Volunteers received their employment checks and training from St Mary's hospital.

The trust offered access to NHS leadership programmes to promote staff development.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit children and young people. They supported each other to provide good care and communicated effectively with other agencies.

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.

The Sexual health service met with the health visiting service and provided staff with postcards which advertised the sexual health service as a tool to introduce the topic of post-natal contraception at the new birth visit.

The sexual health team attended schools to do health promotion around sex and contraceptive education. We observed one drop in session where the team attended a college setting. This resulted in a few of the young people attending the under 18 drop in clinic that same day.

The sexual health team attended regular quarterly meetings with the safeguarding and LAC team to ensure their safeguarding processes remained current and fit for purpose, they also worked alongside many of the other voluntary agencies and charities on the Isle of Wight to promote and advertise the clinic.

The school readiness pilot intended to include speech and language therapists, occupational therapist and physiotherapists to carry out joint care planning.

The 0 -19 team attended monthly multidisciplinary meetings which were attended by paediatricians, social care, therapies and external agencies. This enabled the service to work with other agencies to provide joined up care across the Isle of Wight for children and young people.

The health visiting team met monthly with community midwives for formal handovers of women in their antenatal stage of pregnancy. This ensured the midwifery team passed on any concerns and the health visiting team saw all pregnant women for antenatal contacts.

The therapies team recently introduced workshops for special educational needs coordinators in schools (SENCO) in self-care and sensory needs. These were to provide guidance to SENCO staff who supported children who had been waiting a long time for autistic assessments.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

Health visitors provided healthy child clinics and the school nurses promoted healthy eating.

In the health visiting service, we observed all clinics and consultation rooms displayed health promotion material. This assured us health promotion messages were spread widely across the Isle of Wight.

We observed health visitors discussed immunisations with all parents who attended the healthy baby clinics, and at antenatal and post-natal visits.

The health visiting service promoted breast feeding and included promotional information in the antenatal, new birth and post-natal visits.

Sexual health staff worked with several schools to ensure young people had access to sexual health education, this included specialist 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 college for one week after they had delivered the session, so children and young people could leave questions anonymously.

In sexual health many health promotion messages were on display to the public including HIV information, contraception and unplanned pregnancy.

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.

The school nursing staff used the immunisation sessions to give young people information about their services and informal health advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children and young people to make informed decisions about their care and treatment. They knew how to support children and young people who lacked capacity to make their own decisions.

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 85.0% for completion of Mental Capacity Act / deprivation of liberty standards training.

From April 2018 to January 2019 the trust reported that Mental Capacity Act (MCA) training had been completed by 78.1% of staff within community health services for children, young people and families.

A breakdown of compliance for MCA/DOLS courses from April 2018 to January 2019 for nursing and midwifery staff in community health services for children, young people and families is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Mental Capacity Act	31	39	79.5%	85.0%	No

The trust did not meet the target for the MCA/DOLS courses relevant to nursing and midwifery staff.

A breakdown of compliance for MCA/DOLS courses from April 2018 to January 2019 for allied health professionals in community health services for children, young people and families is shown below:

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Mental Capacity Act	5	8	62.5%	85.0%	No

The trust did not meet the target for the MCA/DOLS course relevant to allied health professionals.

The trust has reported that the Mental Capacity Act training module incorporates Deprivation of Liberty Safeguard training.

(Source: Universal Routine Provider Information Request - P38 Training)

Deprivation of Liberty Safeguards

From January to December 2018, the trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority relating to community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

Staff across the service demonstrated a good knowledge of Fraser guidance. Professionals use Fraser guidance to determine if young people under the age of 16 can receive contraceptive advice or treatment without parental knowledge or consent.

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 five records, and all had consent documented.

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.

The sexual health clinic advised if there were any concerns regarding a person's ability to consent staff would refer to the safeguarding team and the learning disability team for further assessment.

School nurses had a clear process for managing parental consent for the audiology and vision screening, national child measurement programme and immunisations. Staff sent parents information about the programme, a questionnaire and consent form. If parents did not return the consent form the service 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 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.

We observed school nursing staff gain consent from young people before administering immunisations. They gave young people time to consider their decisions and respected their views to decline the injection.

Staff in the specialist schools ensured parents signed consent forms for the administration of paracetamol.

Staff in all services 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.

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Parents and carers, we spoke with were positive about the individual care and attention staff paid to their children and young people across the services.

All the feedback we received from children, young people and their families throughout the inspection was extremely positive. Feedback included:

"So kind and thoughtful and informative. Lovely lot of staff. Thank you for taking care of me"

"I am very happy with the care and the outcome for my child".

"It was faultless, amazing service provided for us as a family. Thank you".

“So grateful to have so many professionals looking after my child’s needs. The session got the very best out of my child, he really enjoyed himself”.

We observed staff engaging with children and their families across the service. We saw compassionate and caring interactions and staff were skilled in talking and caring for children and young people and their families. We observed the school nurses skilfully and effectively distracting children during their immunisations.

In most observations staff respected and promoted the privacy and dignity of children and their families. For example, staff asked parents if we could observe staff while with them. The health visiting teams also had access to additional rooms, within the areas where they held clinics, which staff could use if parents wanted conversations or care to take place in private.

During our inspection we saw children and families of different ethnicities were consistently treated with dignity and respect by staff. Staff respected the adolescent’s viewpoint and respected their need for privacy as well as an acknowledgement of their growing independence and maturity.

All staff we observed introduced themselves to the children and families and took the time to interact with children and those close to them in a respectful and considerate manner. On each occasion, staff addressed babies, children and those close to them by their preferred names and showed interest in what was being discussed. We observed all staff speaking in an age appropriate way.

Staff in the looked after children’s, school nursing teams and sexual health team focused on young people as individuals and with dignity and respect when discussing choices for their futures. Children and young people were involved in agreeing their care plans, which included health plans.

We heard about examples of where, the looked after children team (LAC) had supported children and young people at specific times. For example, the LAC nurse gave an example of when they would travel extensive distances to remain in touch with a young adult leaving care to provide the familiar support they required.

School nurses did not have privacy screens for immunisation sessions in schools and reported they rely on the schools to provide these. We observed one session where there was not a screen available for anyone who may have been feeling faint.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood Children, young people and their families personal, cultural and religious needs.

We observed interactions between staff and patients or children in a range of situations, including at children’s health clinics, schools and contraception clinics. Care and support provided was in a non-judgemental way and we observed staff talk through people’s options in a clear and open way.

We observed staff responding to both the child and family’s emotional needs in a positive and reassuring way. 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.

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. Staff encouraged children and young people 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.

For each child the LAC team work with an emotional wellbeing assessment is completed alongside the physical wellbeing assessment.

We observed school nurses being kind and reassuring, resulting in anxious children awaiting their immunisations feeling more at ease.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

School nurses explained the immunisations given in school in a clear, friendly and age-appropriate way to school children. Health visitors talked to parents in language they could understand and explained, for example, the effects of weaning too early, in a simple and relatable way.

Staff took time to explain treatment or care plans and involved children and young people in any decisions that were needed and used appropriate language and approaches.

The trust had an informative website, which explained their services for children, young people and their families. The website included information about clinics, and information leaflets.

Allocation of practitioners for safeguarding reviews and LAC assessments, where possible, considered if the practitioner had met the family before. This ensured continuity and consistency of approach for both the family and team.

Staff across all services clearly placed the child, young person and their family at the centre of their work. We spoke with many children, young people and parents across the service who all praised the care they received. We also observed 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 discuss a variety of information with expectant mothers. This included explaining the benefits and risks of breastfeeding, immunisations 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.

We observed a clinic 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?

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local children, young people and their families and the communities served. It also worked with others in the wider system and local organisations to plan care.

All children and young people's services were aligned to the national programmes such as the Healthy Child Programme and the National Child Measurement Programme, with set key performance indicators to monitor progress. At a local level, these had been adapted to meet local need. The health visiting service planned for five universal visits which 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. The team were working jointly with the school nursing team to pilot a school readiness project where children would be seen again to assess development before their fourth birthday. This would help to address any development issues before they attended school. Health visitors also scheduled additional visits if required to meet the child and family's needs.

The 0-19 service had developed a community profile for each locality which identified the needs of the local populations for example, areas with high deprivation which may need more intervention from the team. As a result, staff's caseloads had been redistributed to reflect the need.

The 0-19 service were developing a duty line which would be a single point of contact for families to contact the health visiting and school nurse service. The service was hoping the duty line would be implemented by September 2019. Currently the health visitors gave families the office number to contact the health visiting team and ran a message book system. This was the case in the 2018 inspection.

Due to the uptake of immunisations in children under five years old being below the England average across the Isle of Wight, health visitors underwent immunisation training to ensure the information they shared with families was factual and up to date, and with a view to increasing the uptake.

The health visitor service provided infant resuscitation sessions run by a band 4 nursery nurse in two areas of the Isle of Wight. This ensured parents and expectant parents, had equitable access to this training.

School nurses and the sexual health team provided drop in clinics at every secondary school, college and all primary schools (school nurses) to ensure young people were able to access their service. Two schools were disengaging with the service and we observed the sexual health team were working hard to engage them.

The 0-19 service had set up social media to improve their access for children and young people and used a twitter account to advertise the school nurse service. Staff reported they felt this had raised the profile of the service across the Isle of Wight.

Joint clinics between paediatricians, nurses and therapists were held at specialist schools. Joint therapy clinics meant parents and their children did not have to attend multiple appointments and miss school, which parents said was beneficial to their family life and wellbeing.

Clinics to support the healthy child programme were set up in suitable and accessible locations to meet people's needs. The service held clinics in children's centres, GP surgeries for example, with a range of additional facilities available for children and families including cafés, play areas and rooms for confidential conversations. Some clinics ran all day which parents appreciated due to their accessibility.

The main hospital provided sexual health clinics, with drop in clinics available in various locations across the Isle of Wight. All young people we spoke with reported it was easy to access this service.

The sexual health clinic was welcoming of all patients they saw and developed a trans gender friendly clinic environment. For example, the toilets were gender neutral and the notes were filed in

the same coloured folders, replacing the colour coded folders previously used for males and females.

Following feedback from schools and colleges the sexual health changed the format of their teaching sessions for young people to offer a more informal drop in chat rather than formal teaching.

All services were able to use telephone translation services, and some staff at the hospital were able to provide face to face translation. However, this could cause issues as the translator was unable to see what the therapists was doing or requested the child to do; such as for physiotherapy. Staff did not identify this as an issue as they reported translation services were rarely required.

Meeting the needs of people in vulnerable circumstances

The service was inclusive and took account of children, young people and their family's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

School nurses within the specialist needs school offered immunisations, EpiPen training, infection control, care planning and public health issues.

The occupational therapy team had recently re-triaged all patients on the initial appointment waiting list and had apologised to all children and parents for the wait. This ensured the service had risk assessed all children on the waiting list and signposted the most vulnerable children for resources and workshops whilst they waited for their initial appointment.

The speech and language team ran a 'sparkle group' for children with additional needs jointly with the family centre. The occupational health team also offered workshops for any children on the waiting list.

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.

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.

The physiotherapy team had identified children with mobility issues were not very active. They liaised with the local leisure centre and were organising a day where children of differing mobility could sample different sports.

There were two school nurses specifically for children and young people not in education, employment or training (NEET), home educated children or children missing from education which had been identified as being particularly vulnerable. This ensured these children were captured for immunisations, health promotion and general development assessments.

We saw an example of where the sexual health under 18's team attended a sixth form college to run a drop-in session. The team identified a young person as requiring an appointment at the hospital to discuss issues further and the young person attended that afternoon. This demonstrated the ability of the service to identify and capture the trust of vulnerable young people.

The LAC team had developed a new service leaflet for care leavers which included how to register with a GP, dental health, sexual health, healthy eating and emotional health amongst other topics. They had also developed a general leaflet to explain the role of the LAC team which had decreased the amount of LAC children not being brought to their health assessments due to an increased understanding around the benefits of the review health assessments.

Access to the right care at the right time

Most children and young people and their families could access the service when they needed it and received the right care in a timely way.

Accessibility

The largest ethnic minority group within the trust catchment area is Asian British with 1% of the population. The next largest ethnic minority groups within the trust catchment area are Black/African/Caribbean/Black British, white gypsy traveller and 'other ethnic group' all with less than 1% of the population.

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Referrals – In RPIR

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

From January to December 2018, the trust met the assessment to treatment target in four of the targets listed. The only team to not meet the local target for days from assessment to treatment was orthotics (children).

The trust has stated that community services collect their figures at the time of initial assessment therefore no figures for referral to initial assessment have been reported.

Name of hospital site or location	Name of in-patient ward or unit	Days from assessment to treatment		Comments, clarification
		National / Local Target	Actual (median)	
St Marys	Dietetics - Children	84	34	Most of the targets are locally agreed with the CCG in the Service Level Agreements.
St Marys	Occupational Therapy - Children	-	126	
St Marys	Orthotics - Children	14	21	
St Marys	Physio - Children	42	24	
St Marys	Podiatry - Children	112	27	
St Marys	Speech and Language - Children	84	42	

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

Following a completion of a 10-week improvement programme the occupational therapy (OT) team had reduced the waiting time for appointments for children with autism from 12 months to eight months which was just above the national target of 38 weeks. The service had reduced the waiting time for children with physical conditions down to eight weeks. The improvement programme enabled staff to find smarter ways of working as well as feeling less pressured and stressed because they held more manageable caseloads.

To improve timely access to OT for children, children on the waiting list were re-triaged to establish need, and the service had developed workshops targeting self-care with families. The service was in discussion with the clinical commission group to plan service delivery in response to the new autistic spectrum diagnostic service provision. In March 2019 there were five children on the waiting list that had been waiting longer than the 18-week target for an appointment.

The sexual health service met their key performance indicator (KPI) target of seeing 56 males aged 15 years to 24 years tested for chlamydia per month, 3 months out of 12 from May 2018 to April 2019. They met their KPI target for a minimum of 139 females aged between 15 years to 24 years tested for chlamydia per month, five months out of 12 from May 2018 to April 2019. In response to the KPI results the service was trialling a point of access test and home testing kits to improve performance.

Patients made appointments over the telephone for the sexual health clinic. There was no online booking facility for the clinic. Staff told us if a patient requested an appointment for screening for sexually transmitted infections and did not have symptoms staff directed them 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.

Patients received a text with details of their clinic appointment and a text reminder the day prior to appointment once they had booked a sexual health appointment.

The sexual health service held a dedicated drop in clinic for young people under the age of 25 once a week in the hospital and once a week in the community. 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.

Staff in the sexual health department received training and had access to microscopy equipment which allowed staff to analyse swabs immediately, diagnose infections and dispense appropriate treatment.

Speech and language therapists offered drop in sessions across the Isle of Wight. This meant immediate advice was offered to parents/carers while waiting for a referral.

To reduce the number of children and young people who did not attend for appointments the occupational therapy service also sent a copy of the appointment letters to schools. Parents we spoke with reported they were happy with this approach as it alerted the school to what interventions the child was having.

The occupational therapy service was completing a scoping exercise with regards to providing assessment clinics within children’s centres with a view to bringing care closer to the homes of children, young people and their families.

Staff followed the trust's 'Was not brought' policy if appointments were missed. For example, the physiotherapy service described if the child was not known to be vulnerable they would offer two further appointments and alert the referrer of a failure to attend the appointment. If the child was on a child protection plan or there were concerns the physiotherapist would alert the referrer immediately that they were not brought to the appointment.

The LAC team used text messaging to communicate with children and young people. Staff recorded all text messages 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.

During the November 2018 inspection the trust reported a waiting time of eight weeks for LAC children to receive their initial assessment. National guidelines recommend IHAs are completed within 20 days of notifications. The service lead told us this was due to previously not having a dedicated named doctor for safeguarding. The LAC service had resolved this issue by employing a named doctor for safeguarding, and the service felt positive the backlog of IHA's would be cleared over the next month. However, the trust was unable to provide us with the current waiting time for LAC children receiving their IHA.

However, the trust did report 84% of all review health assessments had been completed against a national target of 85%.

School nurses had recently taken over administering immunisations to school leavers from GP's. Previously there was a 30% uptake rate, and since the school nurse team has taken on the contract the uptake rate had increased to 80%. This new service had also helped the school nurse team build links with the secondary schools.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff**.** The service included patients in the investigation of their complaint.

Complaints

From January to December 2018 the trust received three complaints in relation to community services for adults at the trust. The trust took an average of 34.7 days to investigate and close complaints, and 66.7% were closed within 30 working days. This is not in line with their complaints policy, which states that 75% of complaints should be closed within 30 working days.

A summary of complaints within community health services for children, young people and families by subject is below:

Subject	Number of complaints	Percentage of total
Communication	2	66.7%
End of life care	1	33.3%
Total	3	100.0%

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Compliments

From April 2018 to December 2018 the trust received 107 compliments regarding community services at the trust. Due to the way in which compliments are captured by the trust, it has not been possible to split the number of compliments by team or core service.

The trust has identified a number of key themes from the compliments received across the trust.

The trust identified the following themes:

- The main compliment received is regarding staff behaviour. Staff are described, through individual experiences, to behave in a manner that is kind, patient, friendly, professional, courteous, caring, compassionate, helpful and understanding, to list but a few. This illustrates a strong correlation between compliments and staff attitudes.
- Specific praise for consultant care
- Treatment with dignity and respect
- Effective and responsive ED
- Excellent care
- Helpful, friendly and efficient Administrators/Receptionists.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

The service developed a learning from events approach to learning from complaints and had a lessons learned framework in place. Managers monitored all complaints and reported via the Quality and Performance Committee.

All staff we spoke with across the service said the sharing of and learning from complaints and compliments was through their team meetings and on an individual basis if required. We saw evidence of these discussions within the team meeting records.

Across the service we saw complaint leaflets and information on how to complain was on show. Most services we visited had information for children and families on how to complain or share a compliment. We saw evidence of feedback methods appropriate for young children in the therapies department where they could draw a picture of their feedback.

All children and families we spoke with had no reason to make a complaint and were very happy with the service provided.

All staff we spoke with were unable to provide learning from specific complaints as they reported it was rare any of the services received complaints. The overall service lead also reported it was very rare to have a complaint for the community children's and young people's service.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for children, young people and families and staff. They supported staff to develop their skills and take on more senior roles.

Community services for children and young people were part of the community division. The community division leadership team comprised a director of nursing, a deputy director, deputy director of nursing, head of nursing and quality, business managers and locality leads.

The community division was relatively new and all staff we spoke with felt that it contained more appropriate services than the previous clinical business unit and felt the community division now had a louder voice within the trust than before.

Measurements of success of the new division included a 50% reduction in vacancies for the division, 10% improvement in staff survey results in key improvement areas and effective financial management where the division was operating within their financial allocation in 2019/20.

All service leads had attended or were due to attend the middle managers leadership programme. There were joint development sessions for team and service leads and topics covered included financial management, appraisals, giving staff feedback, how to effectively support staff, raising concerns around clinical practice and the awareness of need to report harassment, bullying and abuse.

Discussions with the senior management teams across the service, demonstrated leaders who were patient focused and committed to improving services.

Most staff reported they were aware of the trust leadership team and had opportunities to meet the executive team. The executive team visited teams on a regular basis and most staff told us they valued this opportunity. 0-19 staff told us they had raised concerns about the information technology systems and had been listened to, which was an improvement on the 2018 inspection findings, where staff felt their concerns were not listened to.

All staff reported local leadership was very supportive and had an open-door policy. They appreciated that changes were required to improve the quality of service for the children, young people and their families.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The community divisional strategy 2019 – 2022 had recently been developed and had been reviewed by staff, been through the Quality and Performance committee, divisional board and had been ratified by the executive management team.

The trusts paediatric priorities were:

- Ensure every child has the best start in life.
- Ensure that health services are high quality, affordable, clinically safe and deliver a positive experience of care.
- All health services and partners will work together to deliver care coordinated around the child, young person and family.

The strategic goals of the trust and the organisational aims were to achieve a ‘good’ rating by 2020, aiming for outstanding, which staff we spoke with were aware of.

Every service lead was accountable for their service plans and we saw evidence these were improving and used more efficiently. If areas of the plan were not completed they were overseen and updated and reviewed monthly. The team populated the plan and kept it simple and achievable and at the end of the 10 weeks asked the question ‘So What?’ alongside implementing a quality impact assessment.

The community division had their first yearly business plan which was being finalised at the time of inspection.

The community division strategy had a ‘plan on a page’ which fed into the quality strategy and was linked to the trust visions. The strategy was linked to the sustainability and transformation plans for the Isle of Wight, ensuring the community plan was sustainable for the next five years.

The trusts vision was ‘Working with our island partners, and others, we will be national leaders in the delivery of safe, high quality and compassionate integrated care; putting those who use our services at the centre of all we do.’

The trusts values included Compassionate, Improving, Team working and Valued with the golden thread of CARE running through everything they do. Most staff we spoke with were unable to list the values or the vision.

Culture

Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where children, young people, their families and staff could raise concerns without fear.

The 0-19 team reported a culture change in the respect the service had become more proactive than reactive in past years. For example, schools that were already involved in the school readiness pilot welcomed the new approach and told other schools about its benefits.

Most staff across the service felt proud to work within the children and young people’s service and positive about the impact the service had on the health of the children, young people and their families. Most of the staff we spoke with felt it was a good service to work in and there were opportunities for development.

Staff within the 0-19 service reported the leadership team to be very responsive and invested in staff wellbeing. For example, with the increase in immunisations given, staff reported the boxes were very heavy to transport to schools and raised an incident report. Subsequently managers provided a bag on wheels and a pool car to transport the immunisations.

Many staff we spoke with felt able to suggest innovative ideas and local leadership supported teams to take ideas forward. This was a huge change from the 2018 inspection where staff described the culture as ‘hierarchical’.

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 and we observed the same.

Since the 2018 inspection, where staff in the specialist schools did not have links with the school nursing team on a regular basis, the specialist school nurses had regular meetings with the school nursing team and received training and regular supervision.

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. Most staff reported they were aware of the whistle blowing policy and the role of the freedom to speak up guardian.

Staff worked collaboratively and supported each other in their roles. For example, the school nurse and health visiting team were working more closely to develop a school readiness programme and the therapies team were working collaboratively to provide a more multidisciplinary approach for children with multiple needs.

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

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a trust governance structure of meetings, which escalated to the executive director and board level. The locality clinical leads attended the divisional monthly quality meeting and performance meeting which fed into the divisional board meeting. Information from the divisional board then went to the trust leadership committee and onwards to the trust board by way of an escalation report and a performance report.

Each week the team leaders held meetings with senior leaders as an update of the trust's and divisions status and a chance to escalate any concerns with staffing, complaints or incidents for example. It was also an opportunity to share information back downwards to their individual teams.

The community division engaged with service leads and the clinical effectiveness team to clarify which national audits they were participating in and which local audits were completed. They had developed a governance process to log, monitor and report on the local audits.

Most staff were familiar with the governance arrangements, how performance was monitored and areas for improvement. For example, we saw performance targets for each area discussed in team meetings.

In all services, there were regular team meetings. We observed a physiotherapy team meeting and staff were involved in improvements and asked for ideas.

There were clear lines of accountability for arrangements for safeguarding children and support for children who were looked after.

Services had consistent, systematic audit programmes to monitor the quality of care and identify areas of improvement. For example, all teams across the service followed a records peer review process to identify any gaps in their recording. The speech and language and physiotherapy team completed audits to measure the progress of each child following their interventions. This was a vast improvement following the November 2018 inspection where there was no robust systematic approach to monitoring and improving the quality of the children, young people and families service.

The trust had recently formed a children's board and a mental health and wellbeing board for children. The community CYP leads attended both boards and felt it has given the community children and young people's service more a voice within children's services.

Management of risk, issues and performance

Most areas of the leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce

their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The community division risk register was discussed and ratified at the monthly quality and performance meeting. The teams reviewed incident reports, actions taken, and mitigations agreed alongside dates for completion and updated the reports. The business manager reviewed this monthly and updated and chased actions. At the time of the inspection, the community division held 23 risks, with three scored at 15 or over. One of these related to the IT systems. We saw evidence staff were aware of their services risks, which indicated information was shared appropriately.

The service leads across the community met with the director of nursing monthly to discuss risks to ensure the risk titles accurately articulated the risk position, the current scores were a true reflection of the likelihood and consequence of the risk, the mitigating actions would deliver a reduced or target risk score and they were adequately reviewed as well as consideration of any missing risks.

There were rolling 10-week improvement programmes, which were monitored. Within each team, staff were aware of their own team's objectives and the wider service objectives.

Individual teams undertook monitoring of outstanding objectives in their own service meetings, with regular reporting and oversight by the quality and performance committee which were reported to the community divisional board.

Standard meeting agendas were being introduced. We saw the sexual health and physiotherapy services had standard agendas for team meetings. However, this did not include an agenda item to promote discussion regarding the risk register or learning from incidents.

Information management

The service collected reliable data and analysed it, and staff could consistently find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The community performance dashboard detailed the key performance indicators (KPI) across the services. It showed a trend diagram and whether the services were improving, worsening or staying the same against their KPI's, however, the dashboards did not detail incidents, complaints or staffing levels which were discussed separately during team meetings.

Each service was required to provide a monthly quality report which was tracked using a specific tool and red, amber or green (RAG) rated, which included mandatory training, appraisals, risk register review, innovations, and patient experience feedback. This structure allowed for internal benchmarking and enabled regular oversight and escalation of performance, quality and workforce issues and staff reported effective information sharing.

The trust had many electronic patient record keeping systems which staff had identified in the 2014, 2016 and 2018 inspections as a cause of concern. Teams across the children and young people's service used either paper only or one of the electronic systems to record patient assessments, care plans and outcomes. This increased the risk of inaccuracy of records. This risk had been recorded on the community divisions risk register and mitigations and improvements of the information technology systems were evident. This was an improvement from the 2018 inspection.

Staff across the 0-19 service reported the need for an upgrade to a smart mobile phone to enable them to access internet pages to help with health promotion with families during home visits. Service leads advised us a business case was being made for new smart phones, that would also act as lone working devices, with the ability to track through the phone where an individual practitioner was.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for children and young people.

The school nurse service captured the children's voice by using a children's focus group where they asked for feedback about how they would want information communicated to them. They held four a year, one per term. The service also used social media to engage with the wider community, however the service lead was unsure of how secure the page was. This meant that service users had the opportunity to help design or improve the service and this was an improvement on the 2018 inspection findings.

The SALT team used a 10-week programme called 'Isle Attend', designed to help develop children's attention, communication and independence skills and increase the confidence of practitioners in supporting children who were demonstrating delays. The team had set up social media to provide an ongoing link with those who had been part of the training to support engagement.

The 0-19 team engaged widely with the community by attending school assemblies for reception and year 6 to prepare children for the NCMP, assemblies for Year 8/9 for immunisations and working with all school heads to build on the school readiness work., They also engaged with parents through clinic consultations and feeding survey consultations. They also consulted with children to develop transition pathways.

Following an incident where a GP used an incorrect form to plot a child's height and weight the school nurses ran an engagement and training programme to promote a more collaborative approach to working, which GP's have fed back they are more confident in liaising with the school nursing team and have an increased awareness of their role.

The service used the Membership Engagement Services (MES) feedback forms to obtain feedback from children, young people and their families. Many of the services reported that initial feedback rates were low and did not provide us with any survey results.

All services had feedback cards available for patients to leave feedback and health visitors were encouraged to ask families who gave verbal feedback to record it in writing, so it could be shared across the teams.

The health visiting service had developed a 'you said, we did' poster to display in healthy child clinics across the Isle of Wight, to demonstrate actions taken in response to feedback.

Due to low engagement of staff with the staff survey, a Staff Engagement Strategy was approved at the April Divisional Board identifying key areas for improvement:

- Equality & Diversity
- Health & Well Being
- Immediate Managers

- Morale
- Quality of Appraisals
- Safe Environment

The team leads discussed staff engagement and feedback at the weekly team leads meeting with the senior team and the implementation of the Staff Engagement Strategy action plan will be monitored at Divisional Board. As part of the Staff Engagement Strategy, the division will set up a staff committee to support and influence how the trust addresses the key areas for improvement.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Accreditations

NHS Trusts can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made whether 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 to continue to be accredited.

The trust reported no accreditations/awards specific to community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

A community nursery nurse developed a ‘poo bag’ which was a set of resources to help children use the toilet regularly. The nursery nurse presented the resource to the executive board after winning some money from the trust’s dragon’s den initiative to fund the resource.

The trust encouraged and support innovation and improvement and across the service, teams had regular away days where discussion around learning, improvement and innovation for their service happened. This was a new introduction following the 2018 inspection and staff reported they found the days a valuable learning experience as well as an opportunity to bond with their colleagues.

The 0-19 service were developing a pilot in conjunction with the therapies team for school readiness in a response to the identification that more children were arriving in reception year at primary school with increasing developmental needs. The pilot was in the early stages and outcomes for children were still in the measurement stage.

The occupational health team had recently recruited an autistic spectrum disorder specialist and were developing a triage and assessment process to ensure all children currently on the waiting list were offered interventions while they awaited their initial appointment.

The physiotherapy team has improved transition for children with learning difficulties moving to adult services, by including the learning disability physiotherapist in their team meetings. This had improved communication and awareness of the numbers of children transitioning.

Mental health services

Acute wards for adults of working age and psychiatric intensive care units

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
St Mary's Hospital	Osborne	16	Mixed
St Mary's Hospital	Seagrove	6	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Safety of the ward layout

Staff on both wards completed regular checks of the environment to make sure it was safe. A security nurse was allocated each shift who took responsibility for completing the environment safety checklist. Both wards had good lines of sight and where necessary there were convex mirrors in place to improve visibility to parts of the wards.

Staff had completed a ligature risk assessment on both wards which identified and mitigated the risks posed by ligature anchor points. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

The dignity and confidentiality of patients on Osbourne ward was compromised due to the layout of the wards. Staff, patients and visitors accessing Seagrove ward had to do so through Osbourne ward. There was another entrance (which was a fire escape) to Seagrove ward which staff often used but for safety and security reasons, in its current state, it was not safe for patients and visitors to use as a routine entrance. Staff told us they were not happy with walking through Osbourne ward to access Seagrove ward but patients did not have an issue with it.

Staff on both wards carried personal alarms to summon assistance in an emergency. Staff told us that emergency responses from other wards was good.

Same sex accommodation breaches

Over the 12 month period from 1 January 2018 to 31 December 2018 there were no same sex accommodation breaches within this service.

The number of same sex accommodation breaches reported in this inspection was the same as the zero reported at the time of the last inspection.

All bedrooms on both wards had en-suite facilities. On Seagrove ward, four bedrooms had wet rooms and two bedrooms had bathrooms. On Osbourne ward, all 16 beds had wet rooms and there was a communal bathroom that patients could use if that was their preference. Both wards had allocated bedrooms to the patients of the same gender in different sections of the ward. Therefore, staff on both wards were able to ensure there were no same sex breaches.

Ligature risks

All had a ligature risk assessment in the last 12 months.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Osborne Ward	All high risks mitigated or removed	No	The ligature assessment is a live document regularly monitored and updated by the ward managers. A full review is undertaken annually (last in Feb 2019).
Seagrove Ward	All high risks mitigated or removed	No	The ligature assessment is a live document regularly monitored and updated by the ward managers. A full review is undertaken annually (last in Feb 2019).

Maintenance, cleanliness and infection control

Both wards were clean and tidy. However, there was limited stimulation in terms of pictures on the walls which were relatively bare. On Osbourne ward, there were cracks in some of the walls and the backs were missing from a number of chairs in the communal area, we were told that these were being replaced. Both televisions on Osbourne ward had recently been damaged and new ones were on order, so there was no television in either the male or female lounge. There was a remaining television in the activities room.

Staff on both wards adhered to infection control procedures. There were handwashing basins for staff and patients and wall mounted alcohol gels. The alcohol gels on Osbourne ward had been emptied due to current risk issues involving a patient and so staff carried hand gels on their person which were attached to their clothing or in their pockets.

Patient-Led Assessments of the Care Environment (PLACE)

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

The site which delivers MH - Acute wards for adults of working age and psychiatric intensive care units within the Isle of Wight NHS Trust were compared to other sites of the same type and the scores they received for ‘cleanliness’ and ‘condition, appearance, and maintenance’ were found to be about the same as the England average.

Seclusion room (if present)

At our last inspection in January 2018, we found that the seclusion room on Seagrove ward was not fit for purpose because patients that used the seclusion room had to use the toilet facilities on the main ward. At this inspection, we found that the trust had installed a toilet and washing facilities for patients using the seclusion suite on Seagrove ward. The seclusion suite allowed clear observation and two-way communication between staff and the patient. There was a clock on the wall that patients could see. There was no seclusion room on Osborne ward and if a patient from Osbourne ward required the use of the seclusion suite, staff would formally transfer the patient to Seagrove ward.

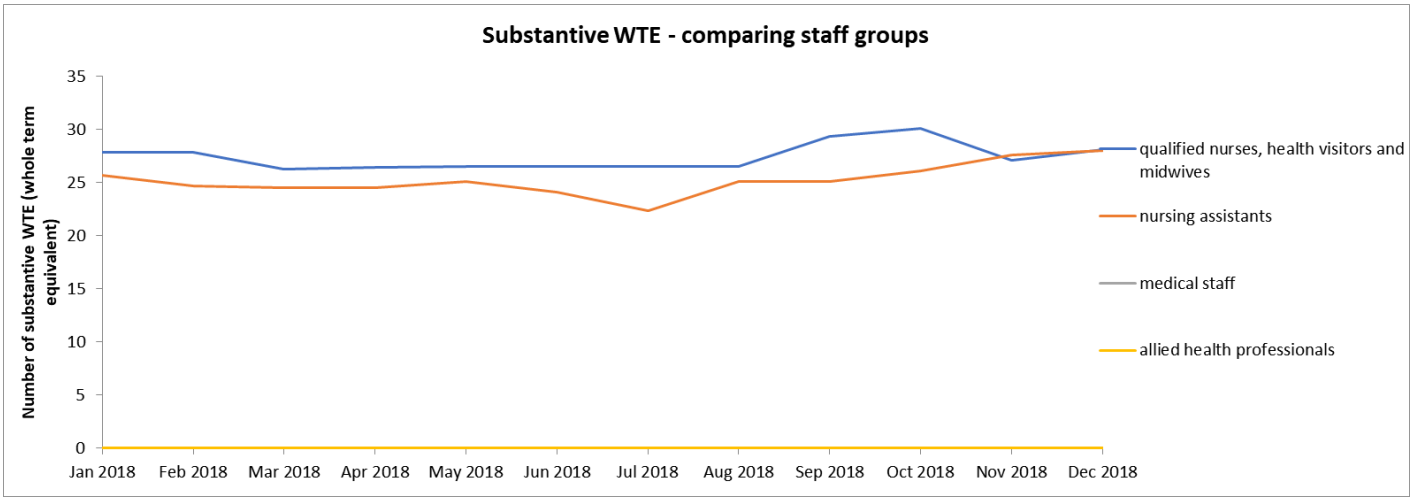
Clinic room and equipment

Staff on both wards ensured that the clinic rooms contained all of the necessary equipment. Equipment was checked, cleaned and calibrated on a regular basis. Staff kept records of fridge temperatures on Osbourne ward. Both wards were temporarily using the fridge on Osbourne ward to store certain medicines that required refrigeration because the fridge on Seagrove ward had been condemned and a new one was on order. As the wards were next door to each other, this did not cause a delay in patients receiving medicines. However, neither clinic room had a room thermometer in it and so staff had not ensured that medicines were stored at the correct temperature. We raised this with both wards’ managers and the pharmacist at the time of inspection and were informed that temperatures in the clinic room would be monitored going forward.

At our last inspection in January 2018, we found that the resuscitation bag on Osbourne ward was disorganised. Staff were using two different lists to check its contents; neither of which were accurate. During this inspection we found that staff on both wards accurately checked the resuscitation bags and the contents were correct.

Safe staffing

The below chart shows the breakdown of staff in post WTE in this core service from 1 January 2018 to 31 December 2018.

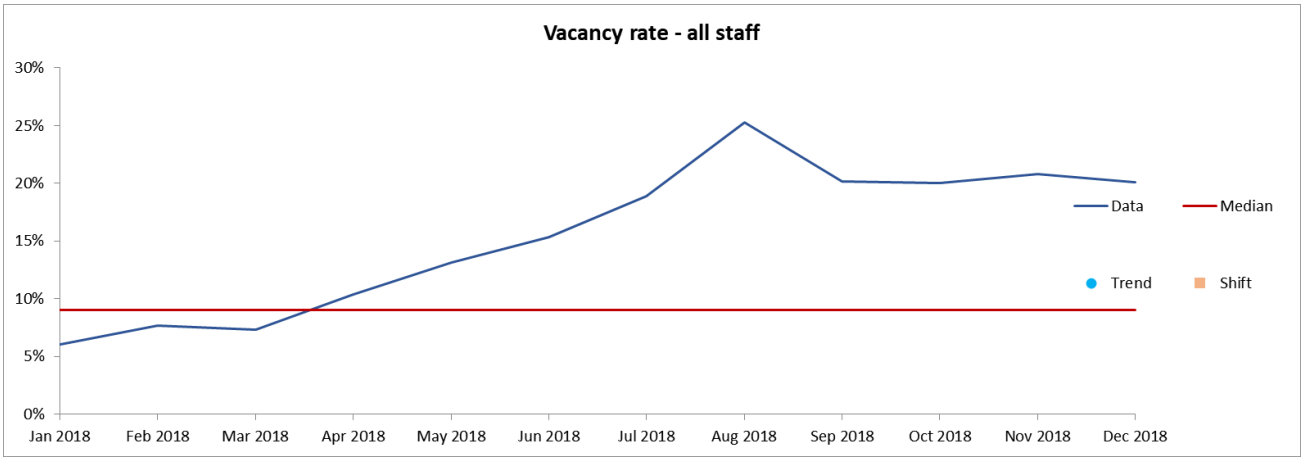


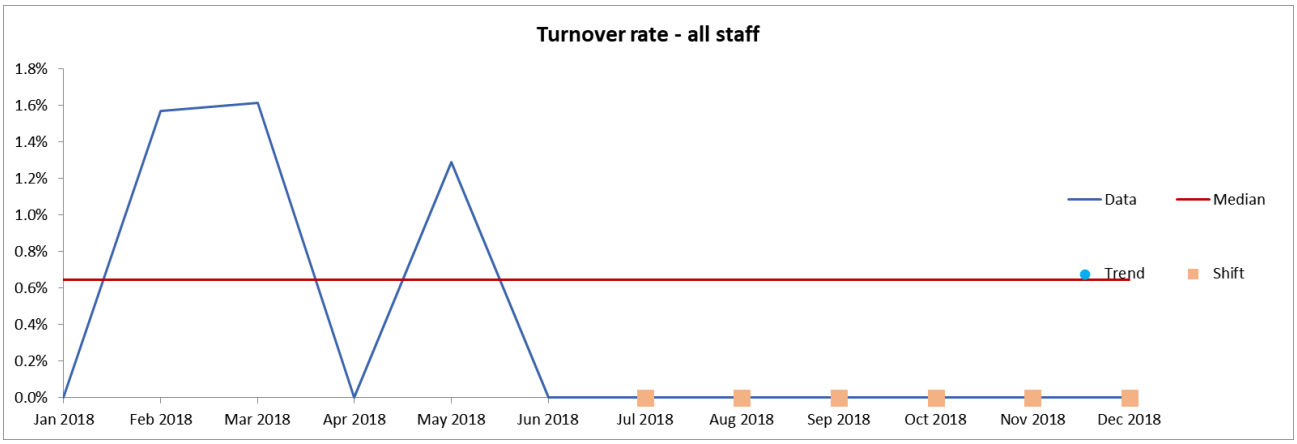
Staff and patients told us there were sufficient numbers of staff on each shift. The number of nurses and healthcare assistants calculated as necessary by the trust, matched the number on each shift. Both ward managers told us they could adjust staffing levels if necessary and had the authority to do so. A qualified nurse was present in communal areas of the ward at all times.

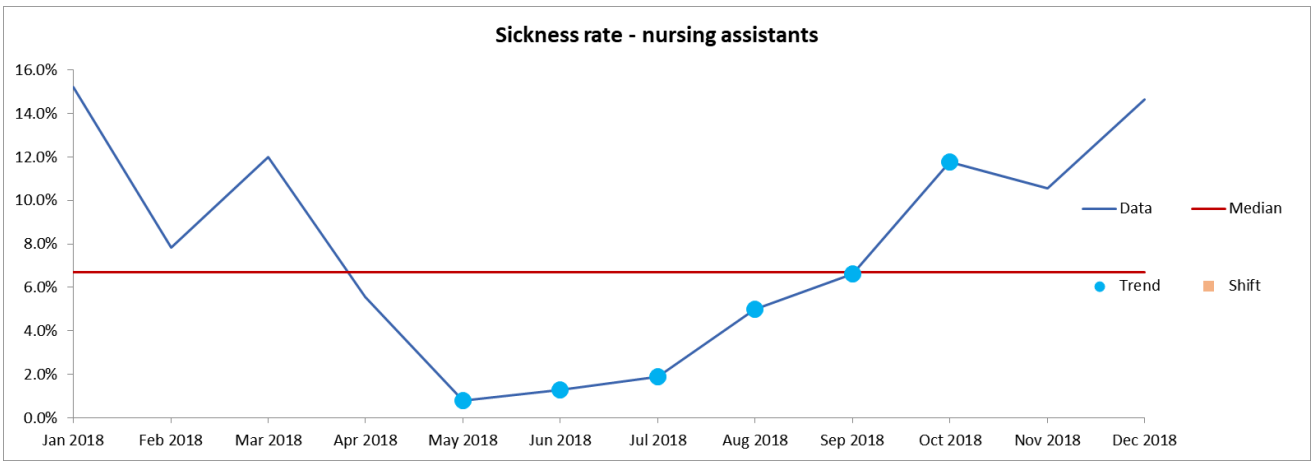
Both wards shared the same medical staff during usual working hours. This consisted of a locum psychiatrist and a substantive consultant psychiatrist, two senior house officers and a nurse consultant. Out-of-hours there was an on-call consultant psychiatrist and senior house officer available for staff to contact.

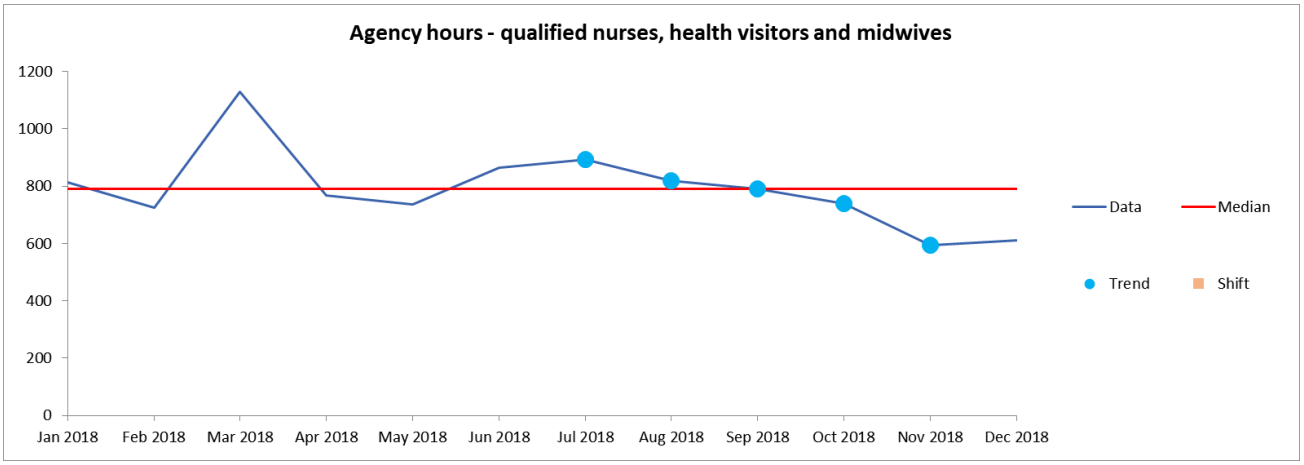
Annual staffing metrics

	Core service annual staffing metrics (1 January 2018 – 31 December 2018)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	63.2	15%	4%	6.9%			
Qualified nurses	27.7	17%	4%	5.7%	132 (<1%)	9487 (15%)	2715 (4%)
Nursing assistants	34.9	14%	4%	7.9%	11244 (20%)	0 (0%)	0 (0%)









Wherever possible the agency staff that worked on the ward were regular staff to ensure consistency of care. The ward used agency staff to cover sickness and to cover vacancies on the ward.

Mandatory training

Training data summary

The compliance for mandatory and statutory training courses at 8 January 2019 was 80%. Of the training courses listed 13 failed to achieve the trust target and of those, six failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training.

The provider reports a rolling month on month training completion rate.

The training compliance reported for this core service during this inspection was higher than the 76% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults Lev 1	71	70	99%	✓	↑
Fire Safety Part 1 - Theory	71	69	97%	✓	↑
Health, Safety and Welfare	71	68	96%	✓	↑
Preventing Radicalisation Level 1 & 2	71	68	96%	✓	↑
Safeguarding Children Lev 1	71	68	96%	✓	↑
Infection Prevention & Control Level 1	71	67	94%	✓	
Load Handling	10	9	90%	✓	↑
Adult Resuscitation - Non-Clinical	10	9	90%	✓	↑
Safeguarding Adults Lev 2 Part 1	71	61	86%	✓	
Safeguarding Adults Lev 2 Part 2	71	60	85%	✓	
People Handling	61	49	80%	✗	↓
Safeguarding Children Lev 2	57	45	79%	✗	↓
Fire Safety Part 2 - Extinguishers	71	56	79%	✗	↑
Mental Capacity Act	71	55	77%	✗	↑
Mental Health Act	30	23	77%	✗	↑
Information Governance	71	54	76%	✗	↓
Infection Prevention & Control Level 2	61	41	67%	✗	
Preventing Radicalisation Level 3	59	35	59%	✗	

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Hand Hygiene	61	36	59%	✗	↓
Safeguarding Children Lev 3	31	18	58%	✗	↓
Adult Resuscitation	61	31	51%	✗	↑
Adult Resuscitation - ILS	29	13	45%	✗	
Total	**1251**	**1005**	**80%**	✗	↑

Managers on both wards told us that there were various reasons that the training completion rates were below the trust target of 85%. On both wards there had been a number of new starters which had affected the training completion rates. Additionally, training attendance was sometimes cancelled by staff due to staffing levels on the ward. Lastly, in some circumstances, staff had attempted to book themselves onto training courses but they were unavailable. Managers also told us that whilst training completion for ILS was only 45% and for adult resuscitation it was 51%, some staff had completed one or the other but not both.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed a risk assessment for every patient on admission, these were regularly reviewed and updated accordingly by the patient's primary nurse. Out of the nine patients' risk assessments we reviewed across both wards, all nine had a risk assessment completed on admission.

Management of patient risk

Staff on Osbourne ward did not update the risk assessment directly following an incident. Instead, risk assessments were only updated on the day of ward review which meant there were a number of days where patients' new risks were not accurately reflected in assessments. We reviewed five risk records on Seagrove ward and seven risk records on Osbourne ward. Staff had updated all five records following incidents on Seagrove ward but only one record out of seven had been updated directly following an incident on Osbourne ward. Staff on Seagrove ward had completed corresponding care plans following incidents but staff on Osbourne ward had not.

Staff assessed the level of observation required for each patient. Patients were observed hourly as a minimum to ensure their safety. Staff could increase patients' observation levels depending upon risk assessment.

Staff had not given appropriate consideration to reviewing blanket restrictions. There was no policy in place to review or reduce blanket restrictions and it was not formally discussed as an agenda item at staff meetings or governance meetings. On Seagrove ward, the patients could only access the garden if they asked staff to unlock it for them and they had to be supervised at all times due to ligature risks in the garden. The female lounge was kept locked and patients could only use this following risk assessment or under supervision due to existing cables behind the television. The contraband list on Seagrove ward was out-of-date and had not been reviewed. There were items

on the list which patients were permitted to have. The list was in the patients' welcome pack and also on the office window so patients may not have been sure about what they could and could not have in their bedrooms. On Osbourne ward there were no wardrobes because staff felt the previous ones posed a ligature risk, this meant that patients had very limited space to put their belongings away in either a bedside table, a chest of drawers or their own baggage.

The trust did not operate a smoke free policy. On Osbourne ward, patients could smoke freely in the garden which was unlocked from 6am until 12pm. On Seagrove ward, patients could smoke 15 minutes past the hour between 6am until 12pm. Staff told us that if a patient was particularly distressed during the night they would allow the patient to use the garden to have a cigarette. Staff offered nicotine replacement therapy to those patients that wanted it.

Informal patients could leave the wards at any time. There was signage on the ward doors to advise patients of this. Informal patients were also informed of their rights on admission.

Use of restrictive interventions

Restrictive Interventions

This service had 97 incidences of restraint (34 different service users) and 85 incidences of seclusion between 1 January 2018 and 31 December 2018.

The below table focuses on the last 12 months' worth of data: 1 January 2018 to 31 December 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Osborne Ward	15	29	17	6	9
Seagrove Ward	70	68	17	8	13
Core service total	**85**	**97**	**34**	**14 (14%)**	**22 (23%)**

Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need.

Staff did not undertake post rapid tranquilisation physical observations as frequently as recommended by the National Institute of Health and Care Excellence (NICE) on either ward. Records showed and staff told us that they did not monitor patients' vital signs as often as they should have done and managers were due to put staff through competencies in this area. We addressed this issue with managers following our inspection and staff completed an audit on the number of rapid tranquilisation episodes there had been on Seagrove and Osbourne ward between 29 January 2018 to January 2019; there had been a total of 12 episodes of rapid tranquilisation on Seagrove ward and six episodes on Osbourne ward. Whilst there had been some monitoring of vital signs staff had not completed them as frequently as they should have done. We were given assurances by managers that an action plan was being put together and both wards were going to ensure that improvements were made and regularly reviewed.

Restraint

There were 14 incidences of prone restraint (face down), which accounted for 14% of the restraint incidents. Over the 12 months, incidences of restraint ranged from zero to 18. The number of incidences (97) had increased from the previous 12-month period (79).

Staff on both wards were unable to provide details about why prone restraint was used as opposed to supine (face up). The electronic incident reporting forms did not capture the rationale for prone restraint or the length of time a patient was in prone restraint. Managers on both wards confirmed they would make an action plan about how to capture this information in the future to evidence that prone restraint is only used as a last resort and for the least amount of time necessary.

Staff on Seagrove ward had begun working on a quality improvement project to reduce restrictive interventions including restraint, seclusion and rapid tranquilisation. Data showed that staff had been closely monitoring each of these restrictive interventions and were sharing their findings with staff and patients. Staff had analysed the data and found that incidents on the ward usually occurred in the late afternoon and so an additional member of staff had been added to the late shift. Initially there was a reduction in restrictive interventions, however, this had not been sustained due to the increased acuity on the ward at the time of our inspection.

There were 22 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from zero to six per month between 1 January 2018 to 31 December 2018.
The number of incidences (22) had increased from the previous 12-month period (15).

There have been zero instances of mechanical restraint reported by the trust over the reporting period.

However, on site we found that one patient had been mechanically restrained on one occasion. Staff had clearly documented the rationale for this in the patient's records. Staff had been trained to use leg straps in certain circumstances and the trust had a policy on the use of mechanical restraint. The number of restraint incidences reported during this inspection was higher than the 33 reported at the time of the last inspection (1 October 2016 to 30 September 2017).

Seclusion

There have been 85 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from zero to 19. The number of incidences (85) had increased from the previous 12-month period (70).

We discussed the increase in seclusion rates with staff but they were unsure why there had been an increase in the use of seclusion. Staff informed us that the last few months had been very busy and there had been an increase in the acuity of patients.

Staff had kept accurate seclusion records. Staff checked patients' physical observations daily and ensured food and fluids were monitored sufficiently.

Segregation

There have been zero instances of long-term segregation over the 12-month reporting period. The number of incidences (zero) had decreased from the previous 12-month period (one).

However, during our inspection, we found that there was a patient in long term segregation. The long-term segregation had occurred after the 12-month reporting period. Records demonstrated that the consultant psychiatrist reviewed the patient every day to ensure the segregation was still appropriate and necessary.

Safeguarding

Staff on both wards knew how to recognise abuse and could give examples of how to protect patients from abuse. Staff made safeguarding referrals to the trust safeguarding team who then raised the alert with the local authority. Records showed that staff made appropriate safeguarding referrals and there was good evidence of professionals liaising internally and externally to keep patients safe.

Children could visit patients off the ward. All child visits were supervised by staff in a designated room off the ward.

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.

This trust made 149 Mental Health and learning disability service safeguarding referrals, however they have not provided a core service breakdown. Between 1 January 2018 and 31 December 2018, 73 safeguarding referrals concerned adults and 76 children.

Serious case reviews

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 January 2018 and 31 December 2018) that relate to this service.

Staff access to essential information

Staff on both wards found the electronic record system time consuming and found it difficult to find the documentation they needed. When patients moved between wards, care plans and risk assessments seemed to become archived and staff would need to recreate them rather than review the current plan of care, which took additional time. Staff also told us that they would print off care plans for patients to sign and then would have to reupload them to the system and felt that a portable device that patients could sign would provide a much more efficient way of working.

Medicines management

The provider had systems in place for the safe storage, administration, prescribing and disposal of medicines. However, the service lacked a process for the management of high dose antipsychotic medicines prescribing.

The trust pharmacy department supplied medicines as stock and dispensed for individual patients. Medicines were stored securely and within their recommended temperature ranges. Medicines were prescribed for patients in line with the doses recorded within their mental health act records. However, where patients were prescribed high dose antipsychotic medicines, the trust lacked a policy to minimise the associated risks. Therefore, we were not assured that medicines were managed safely within this service.

Pharmacy staff visited the unit on a regular basis, supporting patients and staff to optimise the use of medicines including medicines reconciliation.

Track record on safety

Serious case reviews

Serious incidents requiring investigation

Between 1 January 2018 and 31 December 2018 there were seven serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'apparent / actual / suspected self-inflicted harm' with three. The one unexpected death was an instance of 'apparent / actual / suspected self-inflicted harm'.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with seven reported.

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 zero never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the zero reported at the last inspection (1 October 2016 to 30 September 2017).

	Number of incidents reported				
Type of incident reported (SIRI)	**Apparent/actual/suspected self-inflicted harm**	**Slips/trips/falls**	**Pressure ulcer**	**Unauthorised absence**	**Total**
Osborne Ward	1	1	1	1	4
Seagrove Ward	1	1	0	0	2
Sevenacres General Area	1	0	0	0	1
Total	**3**	**2**	**1**	**1**	**7**

Reporting incidents and learning from when things go wrong

Staff recorded and reported all incidents on the trust electronic incident form. Staff reported all incidents that they should report and understood the duty of candour. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff received feedback on investigations of incidents. Staff received regular reflective practice sessions.

Managers had thoroughly investigated all serious incidents and lessons learned had been shared between staff. For example, following the incident managers held formal de-briefs for staff, once the incident had been investigated an action plan was drawn up which included a multi-agency case study learning event.

'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 two 'prevention of future death' reports sent to Isle of Wight NHS Trust, however none of these related to this service.

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment soon after admission. We reviewed nine patient care records across both wards and found that all nine care records had a thorough mental health assessment.

Patients' physical health needs were met on both wards. Staff on both wards consistently assessed patient's physical health on admission and there was evidence of ongoing assessment thereafter. Patients' physical health was monitored using the Modified Early Warning Score (MEWS) on a daily basis and patients' weight was monitored weekly.

Staff had developed care plans that met patients needs which were identified during the initial assessment. However, on Osbourne ward, seven out of seven care plans were not updated following an incident and were only updated at ward review which could be up to one week following the incident. On Seagrove ward, care plans were updated following incidents.

Best practice in treatment and care

Patients across both wards did not have access to psychological therapies. A new psychologist had been employed to work across four wards including Osbourne and Seagrove ward two days per week. Managers told us that the psychologist would be completing psychological formulations for patients but there was no capacity to deliver any of the recommended therapies from these formulations. On Osbourne ward a nurse was completing a course in cognitive behavioural therapy, however had not yet delivered any sessions to patients.

Staff on both wards ensured that patients had good access to physical health care. Records evidenced good liaison with other professionals regarding physical health care needs. For example, liaison with the diabetic clinic and the sleep clinic.

Staff on both wards monitored patients that were at risk of malnutrition. Food and fluid charts were in place where necessary and were up-to-date and filled in correctly.

Patients were supported to live healthier lives. Staff offered patients nicotine replacement therapy and counselling if they wished to stop smoking. Staff on both wards encouraged patients to order healthier food options. Patients could access the hospital gymnasium if staff assessed they were safe to do so.

Staff on both wards completed the Health of the Nation Outcome Scale (HoNOS), this was regularly repeated with a view to measuring health and social functioning for people with severe mental illness.

Local audits

This service participated in three clinical audits as part of their clinical audit programme 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Mental Health Clinical Outcome Review Programme (NCISH) Safer Care for Patients with Personality Disorder	Mental Health	Not specified	Clinical	Oct-18	Report currently being written
Mental Health Clinical Outcome Review Programme (NCISH) The Assessment of Risk and Safety in Mental Health Services	Mental Health	Not specified	Clinical	Oct-18	Report currently being written
NICE guideline QS95 Bipolar in Adults	Mental Health	Not specified	Clinical	Aug-18	Findings to be presented at weekly Chantry House meeting to raise awareness. - Checklist of NICE Bipolar disorder quality statements to be distributed to all relevant Chantry House staff members, to act as supplement to usual care plan. - Repeat reminder invitation letter to physical health check to be sent out to all patients. - Liaise with psychology team for ideas on how to improve offer of psychological intervention to patients.

Staff completed clinical audits on both wards. Audits included: ligature risks, missed dose of medicines, care planning and controlled drugs. We reviewed some of these audits during the inspection and observed staff had taken action following audits.

Skilled staff to deliver care

Patients had access to a range of specialists including; doctors, a nurse consultant, registered mental health nurses, support time recovery workers and occupational therapists. Staff could also refer patients to dieticians or speech and language therapists. There was a newly appointed psychologist but their capacity was limited.

Staff were experienced and had the right skills to carry out their roles.

All staff received a comprehensive induction workbook which included key policies, ward routine and professional expectations. New staff received at least one week as a supernumerary member of staff that was not counted in the daily numbers. Staff that were new to the trust received a two-day corporate induction. For clinical staff this induction increased to two weeks.

Appraisals for permanent non-medical staff

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 57%. This year so far, the overall appraisal rate was 69% (as at 8 February 2019). The ward with the lowest appraisal rate at 8 February 2019 was Seagrove Ward with an appraisal rate of 68%, while the Sevenacres Admin Team had an appraisal rate of 36%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 8 February 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Osborne Ward	32	26	81%	77%
Seagrove Ward	25	17	68%	59%
Sevenacres Admin Team	11	4	36%	8%
Core service total	**68**	**47**	**69%**	**57%**
Trust wide	**2724**	**2007**	**74%**	**66%**

During the inspection, we found these figures had increased. There had been a lot of new staff on the wards which meant that the compliance rate for staff having received an appraisal was lower than managers would have liked.

Appraisals for permanent medical staff

The trust has not provided any data relating to medical staff within this core service.

Medical staff received appraisals. Eight out of eight medical staff had received an appraisal within the last 12 months.

Clinical supervision for all staff

The trust has not provided clinical supervision data for this core service.

Managers provided staff with supervision. Records showed that staff received supervision at least every eight weeks and in addition received peer reflection and group reflective practice.

Managers ensured staff received the necessary training for their roles. For example, one nurse had been funded by the trust to complete a Masters degree in cognitive behavioural therapy and the nurse consultant had been funded by the trust to complete their non-medical prescribing course.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. Daily ‘patient safety at a glance’ meetings were held across both wards where staff discussed bed flow and current patient risk on the ward. All we staff we spoke to felt they could contribute to these meetings and would be listened to.

Ward staff held a handover at the beginning of every shift. Ward reviews for each patient occurred weekly and were attended by various members of the multidisciplinary team.

Records showed that staff on the wards liaised well with external agencies such as the local authority and care co-ordinators.

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

Mental Health Act training figures

As of 8 January 2019, 77% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was higher than the 72% reported for the previous year.

Staff had a good understanding of their responsibilities under the Mental Health Act (MHA). The code of practice could be accessed on the internet. There was a MHA lead within the trust and staff could access the MHA team for advice and support.

Staff referred patients to the Independent Mental Health Advocate (IMHA). Posters and leaflets advertising the IMHA were displayed on the wards.

Staff read patients their rights on admission and when the status of their detention changed. However, a recent MHA audit showed that staff had not repeated patients’ rights in line with the trust policy. An action had been put in place for managers to follow this up with staff.

Staff ensured that patients were able to take their leave. Records showed patients frequently leaving the ward to use the grounds or to go home. Patients told us they could use their leave if

staff felt it was safe for them to do so. There was a sign on both wards notifying informal patients they could leave the ward.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training figures

As of 8 January 2018, 77% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The training compliance reported during this inspection was higher than the 64% reported for the previous year.

Staff had a good understanding of the Mental Capacity Act (MCA) and its five principles. The trust had a MCA policy in place which could be accessed on the intranet. Records showed that patients either gave informed consent or there was a mental capacity assessment in place with a best interest decision. For example, staff on Seagrove ward had recently liaised with the local authority to hold a mental capacity assessment regarding managing a patient's finances in their best interests.

Deprivation of liberty safeguards

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 January 2018 to 31 December 2018.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness and respect. Staff knew the patients on the ward well and had built therapeutic relationships with them. Staff said they were confident to raise concerns if they felt patients were not being treated well.

Patients told us that staff were kind, friendly, supportive and helpful. Patients told us they could speak to any of the staff if they needed to. All seven patients spoke positively about the staff on both wards. Patients enjoyed the food.

Staff maintained patients' confidentiality. Patients electronic records and paper records were kept securely. Staff had individual passwords to access electronic records and paper records were locked away.

On Osbourne ward, patients' dignity was not always protected when they were in their bedroom. The viewing panels in the patients' bedroom doors did not close from the inside and were operated externally by staff. Unlike on Seagrove ward where patients could operate the viewing panel from the inside. Managers had put signs on patients' bedroom doors to advise staff of whether the patient preferred to have their viewing panel open 100% of the time or closed and only opened when checking the patients' whereabouts. However, staff did not follow this procedure and five out of 16 bedroom viewing panels were left open despite the request of the patient.

Patient-Led Assessments of the Care Environment (PLACE) - data in relation to privacy, dignity and wellbeing

The sites which deliver MH - Acute wards for adults of working age and psychiatric intensive care units within the Isle of Wight NHS Trust were compared to other sites of the same type and the scores they received for 'privacy, dignity and wellbeing were found to be about the same as the England average.

Involvement in care

Involvement of patients

Patients received a welcome pack when they arrived on the ward. The welcome pack included: information about advocacy, patients' rights, carers information, ward routine and items that were banned from the ward. Staff photographs were displayed on the ward, however, these were not up-to-date and some staff photographs were missing.

Staff involved patients in the care planning process where appropriate. Records showed that staff had given patients a copy of their care plans. Patients told us they were given time to discuss their care with their named or primary nurse.

Patients were given the opportunity to feedback about the care they received. Staff facilitated weekly community groups for patients. Staff provided feedback boxes for patients and questionnaires were given to patients on discharge. However, patients did not often complete feedback forms or questionnaires and we could not find examples of changes that had been made to the service as a result of feedback. There were no records of minutes from the community meeting and whilst there was a 'you said, we did' board on Osbourne ward, there was little evidence of actions that had been taken as a result of patients' comments. However, the majority of feedback was relating to estates work which was actioned.

Involvement of families and carers

Where appropriate and with consent, staff involved carers in patients' care. Friends, carers and relatives could visit the wards between certain hours. If carers and relatives were unable to visit during those hours, the staff tried to be flexible to ensure patients' maintained contact with those important to them.

On the mental health wards within the hospital there was a monthly service user and carers' forum attended by a senior manager. Additionally, the trust provided a carers' lounge which was situated in the main hospital. Leaflets with information for carers including how to access a carers' assessment could be found on both wards.

Is the service responsive?

Access and discharge

Bed management

Bed occupancy

The trust provided information regarding average bed occupancies for two wards in this service between 1 January 2018 and 31 December 2018.

Both of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 January 2018 – 31 December 2018) (current inspection)
Osborne Ward	90% - 121%
Seagrove Ward	67% - 122%

Staff on both wards explained that the last few months had seen a high acuity of patients. When the wards were fully occupied, additional patients had to sleep on the rehabilitation ward due to bed pressures as well as patients returning from leave that required a bed. Patients were often moved between wards due to bed pressures, although staff gave careful consideration to the most appropriate patient to move that presented the lowest risk. When patients were transferred or discharged, it happened at an appropriate time of day.

Average Length of Stay data

The trust provided information for average length of stay for the period 1 January 2018 to 31 December 2018.

Ward name	Average length of stay range (1 January 2018 – 31 December 2018) (current inspection)
Osborne Ward	9 – 45
Seagrove Ward	1 – 102

Out of Area Placements

This service reported one out area placements between 1 January 2018 to 31 December 2018. As of 2 June 2018 this service had no ongoing out of area placements. This placement amounted to 23 days.

This patient was placed with another provider due to capacity issues.

The number of out of area placements reported during this inspection was higher than the zero reported at the time of the last inspection (1 October 2016 to 30 September 2017).

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
1	0	1	23 days	0

Readmissions

This service reported 32 readmissions within 28 days between 1 January 2018 and 31 December 2018. 23 of readmissions (72%) were readmissions to the same ward as discharge. The average number of days between discharge and readmission was 11 days. There were three instances whereby patients were readmitted on the same day as being discharged and there were two instances where patients were readmitted the day after being discharged.

At the time of the last inspection, for the period 1 October 2016 to 30 September 2017, there were a total of 32 readmissions within 28 days. Of these, 23 were readmissions to the same ward (83%)

Therefore, the number of readmissions within 28 days has increased between the two periods.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Osborne Ward	23	19	83%	0 – 27	11
Seagrove Ward	9	4	44%	2 – 22	8

Discharge and transfers of care

Delayed discharges

Between 1 January 2018 and 31 December 2018 there were 244 discharges within this service. This amounts to 1% of the total discharges from the trust overall (31,679).

The delayed discharge data provided by the trust is inconclusive and has therefore not been included.

Staff planned for discharge from the start of a patient's admission. Staff completed care plans relating to patients' discharge. Daily bed flow meetings allowed staff to discuss as a multidisciplinary team what stage of the admission patients were at and what plans were in place for their discharge. Records showed good liaison with care coordinators and the local authority.

Facilities that promote comfort, dignity and privacy

Patients had their own en-suite bedrooms and did not have to sleep in a shared dormitory. Staff told us that patients could personalise their rooms but we found little evidence of personalisation in bedrooms.

Patients' bedroom doors were locked and they had to ask staff to open their doors to enter them. Bedroom doors could be opened from the inside without a key. However, there was no restrictions around when patients could access their bedrooms. Patients could keep personal possessions in lockers in a room on the ward, patients' restricted items were also locked away here and signed in and out by the allocated security person each shift.

Staff and patients on both wards had a full range of rooms and equipment to support treatment. Clinic rooms were big enough to see patients in if deemed safe to do so. There were a range of meeting rooms and activity rooms, a laundry room and patient kitchen. On Seagrove ward patients required supervision to use the laundry room and kitchen. On Osbourne ward, patients could use the kitchen freely and the laundry room after risk assessment. There were quieter areas on both wards where patients could meet visitors.

Staff provided patients with a range of activities Monday to Friday. Activities included; a daily coffee morning, mindfulness groups, cooking in the occupational therapy kitchen, arts and crafts, sessions in the gymnasium, table tennis, board games. Staff displayed an activities chart on the wall on the wards. However, two patients told us there was nothing to do at the weekend.

Patients could make telephone calls in private. Patients could keep their own mobile with them on the wards and if they did not have one, they could borrow a cordless telephone from the office.

Both wards had a garden area. On Seagrove ward, the garden area had to be supervised at all times due to existing ligature risks. On Osbourne ward there was a quiet garden which was supervised by staff and a main garden which patients accessed freely.

Patients on both wards had access to cold drinks. On Seagrove ward patients had to ask staff for hot drinks and snacks but accessed these when they wanted them. On Osbourne ward, patients could access the kitchen to make hot and cold drinks and snacks without asking the staff.

Patient-Led Assessments of the Care Environment (PLACE) assessments

The sites which deliver MH - Acute wards for adults of working age and psychiatric intensive care units within the Isle of Wight NHS Trust were compared to other sites of the same type and the scores they received for ‘ward food’ were found to be about the same as the England average.

Patients’ engagement with the wider community

When appropriate staff ensured that patients had access to education and work opportunities. On Seagrove ward, records showed that staff had taken a patient to an interview at a local college.

Meeting the needs of all people who use the service

The ward environments catered for patients with physical disabilities. The corridors were wide and there were disabled access bathrooms and en-suite wet rooms available. Both wards had links with the learning disabilities team within the trust and worked closely with them when they admitted patients with learning disabilities.

Staff could obtain information on treatments and local services and this could be requested in an accessible form through the trust.

The trust had a database of staff that could speak other languages and the trust had a telephone interpretation service available to patients. Staff could access patients’ rights in languages other than English through the trust.

Patients could access a choice of food to meet their dietary requirements. The hospital kitchen catered for meal choices from patients that had requirements from religious or ethnic groups. Meals were delivered hot from the main hospital kitchen and served by staff on the wards.

Patients had access to spiritual support. A multi faith Chaplin visited the wards on a weekly basis if requested. There was a chapel in the main hospital that patients could use if they had leave. Staff could escort patients to church or the local mosque if there were enough staff to facilitate this.

Patient-Led Assessments of the Care Environment (PLACE)

The sites which deliver MH - Acute wards for adults of working age and psychiatric intensive care units within the Isle of Wight NHS Trust were compared to other sites of the same type and the scores they received for 'disability' and dementia friendliness' were found to be about the same as the England average.

Listening to and learning from concerns and complaints

Formal complaints

This service received 12 complaints between 1 January 2018 to 31 December 2018. Three complaints related to staff values and behaviours and two related to prescribing.

	Complaint theme									
Ward name	**Values and Behaviours (Staff)**	**Prescribing**	**Other (Use with Caution)**	**Clinical Treatment - Psychiatry group**	**Patient Care**	**Clinical Treatment - General Medicine group**	**Admissions and discharges excluding delayed discharge due to absence of a care package**	**Communication**	**Facilities**	**Total**
Osborne Ward	2	1	1	0	1	1	0	0	0	6
Seagrove Ward	1	1	0	0	0	0	1	0	0	3
Sevenacres General	0	0	0	1	0	0	0	1	1	3
Grand Total	**3**	**2**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**12**

Patients knew how to raise complaints and felt they would be listened to. Patients had time to speak with their named nurse or primary nurse. The patient welcome pack included details of how to complain and there were leaflets and posters available on the wards.

We reviewed some of the complaints on both wards and found that staff had fully investigated the complaints and written to patients with the outcome. The outcomes of complaints were broken

down point by point and the complainant was informed about what was and was not upheld and any action taken as a result.

Compliments

This trust's mental health services received two compliments during the last 12 months from 1 January 2018 to 31 December 2018 which accounted for less than 1% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Staff spoke highly of leadership on the wards and managers were well respected. Leaders had a good understanding of the services they managed.

Leaders at a local level were visible in the service. Both ward managers' offices were on the ward and patients and staff described them as approachable. Staff told us that executives were not visible on the ward but were pleased there was mental health representation at trust board level. Staff told us that generally communication from the trust board had improved but could still be better.

Leadership opportunities were limited. The trust had supported ward managers to attend leadership courses but staff below ward manager level had not been encouraged to attend these courses. The trust had, however, supported staff with specialist roles such as non-medical prescribing and cognitive behavioural therapy training.

Vision and strategy

Staff were aware of the trust vision and values. The trust vision and values were communicated through the acute leads meeting, team briefings, the trust internet and via email.

Culture

Staff felt positive and proud about working in their teams. Staff felt supported, that morale was good and the teams worked well together.

Staff felt able to raise concerns. Staff felt they would be listened to by their manager and would feel confident to 'blow the whistle' if they had to. The speak up guardians and anti-bullying ambassadors for the trust were displayed on posters in the hospital.

Staff had access to support for their own physical and mental health needs. Staff could self-refer to the trust occupational health team and the trust had access to a counselling service.

The trust recognised staff success by holding a reward ceremony. The team on Seagrove ward recently won an award for team work and a member of staff recently won an award for the work they had been doing on a recruitment campaign.

Governance

There was a lack of robust governance within the service. Managers had not taken action to address the issues with insufficient monitoring of patients' physical health following rapid tranquilisation. Care record audits had not identified that staff did not update risk assessments following incidents. Managers had not identified that patients did not always receive their rights in line with the Mental Health Act code of practice.

Management of risk, issues and performance

Managers had access to the trust risk register. Managers were aware of what was on the risk register and were able to add risks to it as they arose. Staff could raise concerns about risk to the ward managers and they felt they were listened to. Staff concerns about risk matched those on the risk register. For example, high levels of ligatures on the wards and issues with recruiting staff to the island.

The wards had contingency plans for when things went wrong. Contingency plans such as; flu outbreak, flooding or fire were held on the trust intranet for each service.

Information management

The trust was in the process of updating a dashboard for managers to monitor the wards performance. In the meantime, managers had access to a range of systems which allowed them to have effective oversight of team performance.

There were enough IT systems to allow staff to carry out their roles. There was a sufficient number of laptops and the telephone system was effective. However, there were ongoing issues with the electronic patient records system that was used across the trust. Staff felt the system was cumbersome and found it difficult to find the documentation they needed. IT systems required an individual password for all staff to access the records which kept patient's information safe.

Staff made notifications to external bodies as needed such as the Care Quality Commission and the local authority.

Engagement

Staff had access to information about the work of the trust. Staff received up-to-date information through bulletins and the intranet. However, staff told us that the trust set up engagement meetings and either staff could not leave the ward to attend them or they were cancelled altogether.

Patients could give feedback through the feedback box or by speaking to a member of staff. Feedback questionnaires were given to patients on discharge but they were rarely completed.

The trust had recently employed three service user engagement coordinators to improve engagement. The roles were relatively new but the plan was that these roles would actively encourage service users to be involved in the design of services in mental health and learning disabilities.

Learning, continuous improvement and innovation

Seagrove ward was a member of the National Association of Psychiatric Care Units (NAPICU), who had recently visited to verify compliance. The outcome of this was not known at the time of our inspection.

Staff on Seagrove ward were involved in a national quality improvement project to reduce restrictive interventions. This project was in its infancy and required a longer timescale to see positive results.

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 of accreditation.

Accreditation scheme	Core service	Comments
Accreditation for Inpatient Mental Health Services – AIMS WA	MH - Acute wards for adults of working age and psychiatric intensive care units	Previously Accredited June 17 and awaiting overdue outcome of latest panel review
Accreditation for Inpatient Mental Health Services – AIMS PICU	MH - Acute wards for adults of working age and psychiatric intensive care units	Previously Accredited June 2017 and currently undertaking the self-assessment and review process.

Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Mary Rose Avenue	Woodlands	10	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Safety of the ward layout

Woodlands ward had twelve beds. The main ward environment was set over two floors, with bedrooms on both. Patients also had supervised access to a gym located within the basement of the building. Staff did not have a good view of the whole environment because of its layout. Staff mitigated this by completing regular observations of patients based on their risk level.

Staff carried personal alarms, which were regularly tested, to alert others in emergencies when necessary. The ward did not have emergency alarms installed for use by patients and visitors.

Same sex accommodation breaches

Over the 12-month period from 1 January 2018 to 31 December 2018 the trust reported no same sex accommodation breaches within this service.

Woodlands was a mixed sex ward. It had good separation between male and female sleeping areas and separate bathrooms and toilets. On mixed sex wards good practice requires a day lounge for use by women only (mandatory for services provided in facilities built or refurbished since 2000) as well as spaces where men and women can socialise and take part in therapeutic activities together. However, when we inspected we found because of its age and layout Woodlands did not offer a female only lounge. This is a breach of same-sex accommodation requirements. Staff sought to mitigate this by discussing the issue with patients and encouraging them to seek support if they felt uncomfortable in shared ward areas.

The number of same sex accommodation breaches reported in this inspection was the same as the zero reported at the time of the last inspection.

Ligature risks

The trust had previously undertaken work to reduce ligature points within the environment, but the ward continued to hold a number of features which could be used to ligature, such as window

handles, wall mounted lights, and structural supports in the conservatory (a ligature point is anything which could be used to attach a cord, rope or other material for hanging or strangulation). The ward kept and reviewed an extensive list of known ligature points within the building, but we found some ligature points were missing from the list. The ligature risk assessment was also in a format which made it hard to read and which may therefore have limited its usefulness for staff.

Staff told us they assessed patients individual ligature risk and made management plans when needed. However, while all patients had risk assessments some had not been reviewed in a timely way. For example, before or after a patients transfer from an acute ward to the rehabilitation ward.

Two patients transferred from acute wards had successfully tied ligatures while receiving treatment at Woodlands within the six months leading up to our inspection.

However, the ward had some fixtures and fittings which reduced the risk of fixed-point ligatures, and staff safely managed the risk of ligatures with observation levels based on a risk assessment for the majority of patients.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Woodlands Unit	All high risks mitigated or removed	No	The ligature assessment is a live document regularly monitored and updated by the ward managers. A full review is undertaken annually (last in Feb 2019).

Maintenance, cleanliness and infection control

The ward was clean, tidy and in a good state of repair. Staff carried out weekly environment checks.

Staff encouraged patients to clean and tidy their own bedrooms and en-suites as part of their rehabilitation. Staff assisted patients in maintaining cleanliness levels. The domestic staff cleaned communal areas and completed cleanliness checks.

Staff adhered to infection control principles, including hand washing and the disposal of clinical waste. The service displayed posters prompting staff and patients to wash their hands at basins. Staff could easily access hand washing basins or alcohol gel. Managers completed monthly hand hygiene audits.

The service had up to date health and safety risk assessments for fire, electrical, and water hygiene. Staff recorded regular fire safety checks, for example fire alarms, extinguishers and doors. Staff recorded regular water temperature readings to monitor for risk of legionella bacteria.

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

The Woodlands Unit site on Mary Rose Avenue did not take part in a PLACE assessment.

Clinic room and equipment

The clinic room was clean, and well stocked with equipment and emergency medicines.

All medical devices were clean, had been portable appliance tested and calibrated correctly. Staff could easily access a defibrillator and resuscitation equipment, and this was checked regularly.

Staff had access to sharps disposal and clinical waste bins. Staff had access to personal protective equipment, such as gloves and aprons.

Safe staffing

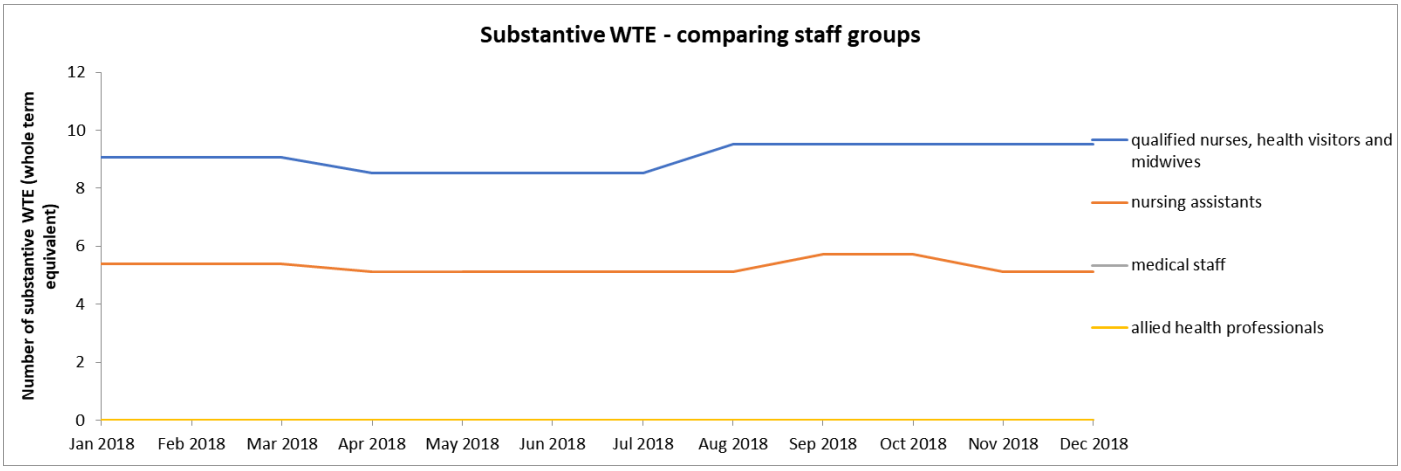
The ward had enough skilled staff to meet the needs of service users and had contingency plans to manage unforeseen staff shortages. There were two qualified nurses and one support worker on each shift throughout the day and night. In addition to this the manager worked Monday to Friday 9am to 5pm. An occupational therapist worked 3.5 days per week offering patients group and one to one sessions. A consultant psychiatrist provided two sessions per week but could be contacted outside of this time if needed. The service had recently recruited an agency therapist who worked 1.5 days per week.

The ward had cover arrangements for sickness, leave, and vacant posts. Managers covered shifts using bank and agency staff when needed.

The ward manager could increase the number of staff on the ward if needed. The manager reported 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 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.

The below chart shows the breakdown of staff in post WTE in this core service from 1 January 2018 to 31 December 2018.



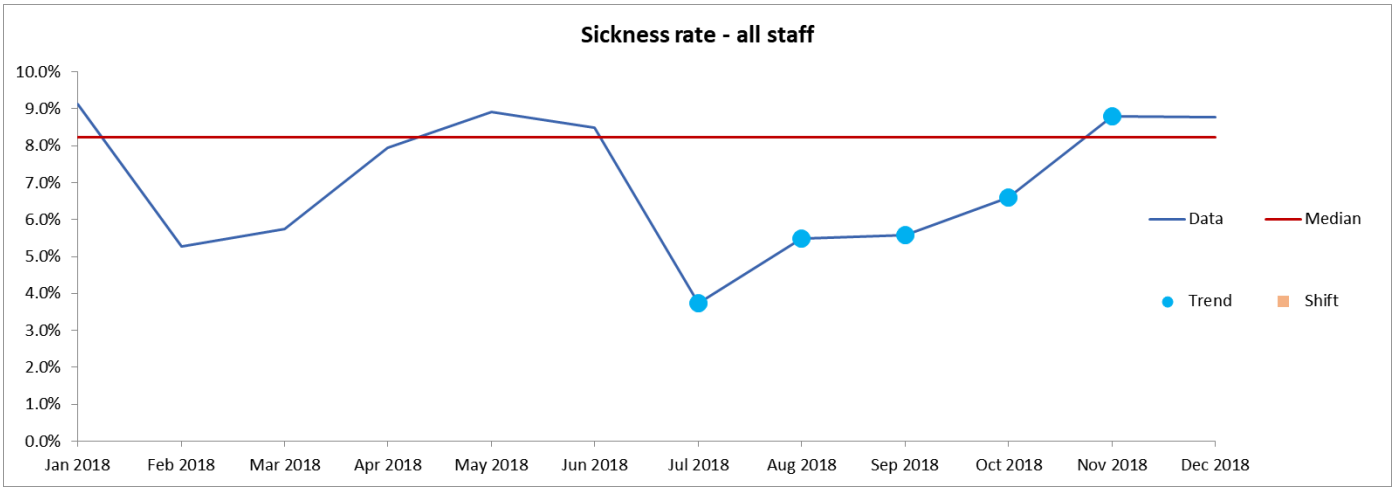
Annual staffing metrics

Core service annual staffing metrics

(1 January 2018 – 31 December 2018)

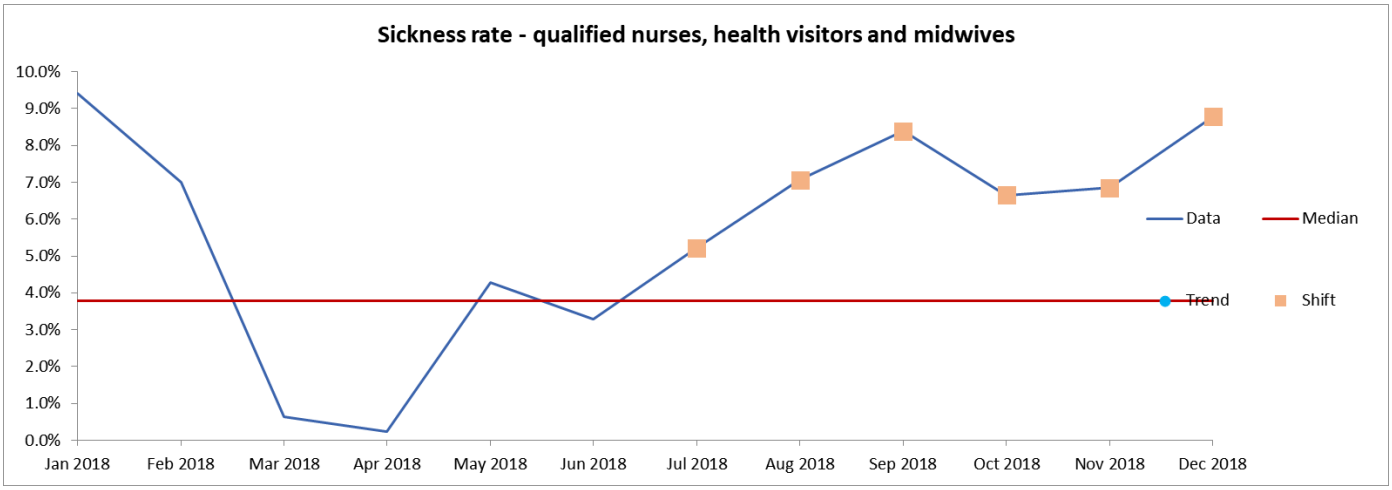
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual "unfilled" hours (% of available hours)
All staff	14.4	30%	4%	7.1%			
Qualified nurses	9.0	45%	6%	5.7%	473 (2%)	5015 (20%)	2234 (9%)
Nursing assistants	5.4	6%	0%	9.3%	1441 (13%)	0 (0%)	0 (0%)

All staff



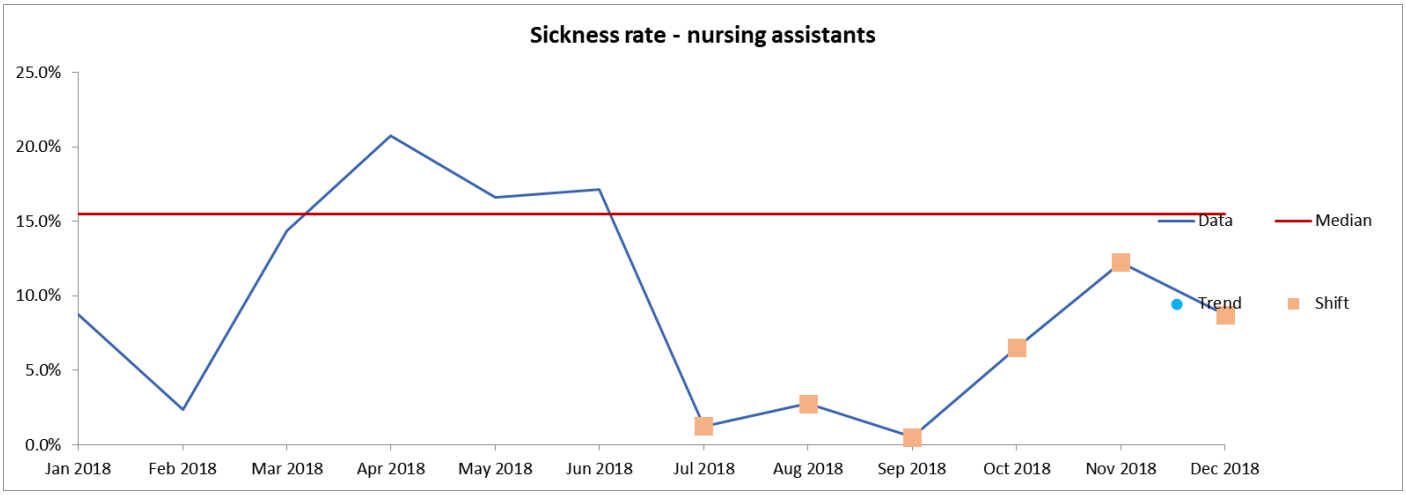
During the inspection the manager was unaware of a reason for the upward trend in sickness absence from July 2018 to November 2018. The manager reported they could access support to manage sickness absence when needed from human resources and occupational health. The service used a track and trigger system to alert leaders of patterns in sickness absence. Managers acted when required to address sickness absence.

Qualified nurses



During the inspection we found the service struggled to recruit registered nurses and had 4.8 registered nursing vacancies. The ward had three agency registered nurses working on the ward. All agency staff received an induction to the ward. The induction covered general information about the ward and patients.

Nursing assistants



Mandatory training

The compliance for mandatory and statutory training courses at 8 January 2019 was 90%. Of the training courses listed five failed to achieve the trust target and of those, two failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training.

The provider reports a rolling month on month training completion rate.

The training compliance reported for this core service during this inspection was higher than the 86% reported in the previous year.

Records reviewed during the inspection showed 91% of staff had completed mandatory and statutory training which had increased since the data request. Individual module compliance had also increased to the following; Mental Health Act 80%, Mental Capacity Act 80%, Children's Safeguarding Levels 2 & 3 100%, Adult Resuscitation 76%, and Preventing Radicalisation Level 3 82%. Other training compliance remained unchanged from the reported data.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ×	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Fire Safety Part 1 - Theory	16	16	100%	✓	↑
Health, Safety and Welfare	16	16	100%	✓	↑
Safeguarding Adults Lev 1	16	16	100%	✓	↑
Safeguarding Children Lev 1	16	16	100%	✓	↑
Infection Prevention & Control Level 1	16	16	100%	✓	
Safeguarding Adults Lev 2 Part 1	16	16	100%	✓	
Safeguarding Adults Lev 2 Part 2	16	16	100%	✓	
Mental Health Act	10	10	100%	✓	↑
Load Handling	16	15	94%	✓	↑
Preventing Radicalisation Level 1 & 2	16	15	94%	✓	↑
Safeguarding Children Lev 2	16	15	94%	✓	↑
Safeguarding Children Lev 3	10	9	90%	✓	↓
Fire Safety Part 2 - Extinguishers	16	14	88%	✓	↑
Infection Prevention & Control Level 2	16	14	88%	✓	
Hand Hygiene	16	13	81%	×	↓
Information Governance	16	13	81%	×	↓
Mental Capacity Act	16	12	75%	×	↓
Preventing Radicalisation Level 3	16	11	69%	×	
Adult Resuscitation	16	9	56%	×	↓
Total	**292**	**262**	**90%**	✓	↑

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed five patient records and found that they all had current risk assessments. All patients' records we reviewed had risk management plans. Staff used a standardised form in the electronic care records system to do this.

However, only one patient had a crisis and contingency plan in place. These plans support staff and patients to manage mental health emergencies.

Risk assessments were not of a consistent quality. Patients who had been on Woodlands ward for rehabilitation had detailed and comprehensive risk assessments. However, at the time of our inspection three patients had been transferred to Woodlands from an acute ward within the trust to relieve bed pressure. These patients had less comprehensive risk assessments which had been reviewed less often. Risk assessments were not always recorded before moving patients from acute wards to Woodlands ward. We reviewed two recent incidents where patients transferred from acute beds had successfully tied ligatures following their transfer. Woodlands staff had also needed to return patients who had absconded from the ward.

Patients at Woodlands ward were able to freely leave the building, could access sharp items, and the environment contained features which could be used for fixing ligatures. Subjected to risk assessment these would normally be considered appropriate for a rehabilitation setting but would not typically be found in acute wards. Woodlands staffing numbers were also reduced when compared to a typical acute setting. Woodlands staff were not trained in restraint techniques, which would be used as a last resort to prevent a person harming themselves or others. When we inspected we did not find evidence in patients' records of how these risks would be mitigated for the patients transferred from acute beds.

We found incidents where patient risk assessments and management plans may have been insufficient. Patients transferred from an acute ward had left the ward without permission, injured themselves, attempted to assault staff, and there were two incidents where patients had ligatured.

Management of patient risk

Ward staff identified and responded to changing risks to, or posed by, patients. Staff used de-escalation techniques and patients could access a low stimulus room. Staff used structured patient observation to manage patient risk. Staff understood how patient observations could be used to manage environmental ligature risk. However, staff did not receive training on restraint, or prevention and management of violence and aggression.

Staff followed the risk assessment template on the electronic records system. There were no blanket restrictions that were in place for the benefit of patients.

Staff followed the trust's search policy. They conducted searches when risks were identified, or situations warranted it under the policy.

All voluntary patients were able to leave the ward on request as the ward entrance door was not locked. No one could enter the ward from the outside without ringing the doorbell, for safety purposes. Staff completed a risk assessment, that checked patients were well enough to access the community, every time patients left the unit. Staff recorded these assessments in a timely way in patients records.

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. Staff offered patients nicotine replacement on admission. Staff organised smoking awareness and cessation sessions for patients.

Use of restrictive interventions

This service had zero incidences of restraint and zero incidences of seclusion between 1 January 2018 and 31 December 2018.

The number of restraint incidences reported during this inspection was the same as the zero reported at the time of the last inspection.

Segregation

There have been zero instances of long-term segregation over the 12-month reporting period. The number of incidences (zero) was the same as the previous 12-month period (zero).

The number of segregation incidences reported during this inspection was the same as the zero reported at the time of the last inspection.

Safeguarding

Staff knew how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training on how to recognise and report abuse and were able to apply it. Management worked with the local authorities safeguarding team and reported concerns when needed. The service had a safeguarding policy which staff could access.

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.

This trust made 149 Mental Health and learning disability service safeguarding referrals, however they have not provided a core service breakdown. Between 1 January 2018 and 31 December 2018, 73 safeguarding referrals concerned adults and 76 children.

The trust had submitted details of no serious case reviews commenced or published in the last 12 months (1 January 2018 and 31 December 2018) that relate to this service.

Staff access to essential information

Staff had timely and secure access to information through the electronic records system. 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 kept some paper records, such as specific pieces of Mental Health Act paperwork. Staff did not report any issues co-ordinating between paper and electronic records and we did not find any problems.

Medicines management

The trust pharmacy department supplied medicines as stock and dispensed for individual patients. Medicines were stored securely and in line with best practice guidance. Staff completed daily monitoring of storage temperatures and knew what to do if these were not in range. However,

records of storage temperatures did not capture the full range of temperatures during the period of monitoring (e.g. Minimum and maximum temperatures reached).

Medicines were administered in accordance with consent to treatment forms T2, T3 and section 62 of the Mental Health Act. However, where patients were prescribed high dose antipsychotic medicines, the trust lacked a policy to minimise the associated risks. We did not find evidence of this issue having harmed a patient, but we were not assured that patients prescribed high dose antipsychotic medicines were managed safely within this service.

Patients were encouraged to take responsibility for requesting their medicines from staff as a step towards the self-administration of medicines. The service was in the process of upgrading the patient's own medicines lockers, within their rooms with the intention of encouraging patients to self-administer their medicine within their rehabilitation pathway

All prescribing was completed and monitored by consultant psychiatrist or junior doctor.

A trust pharmacist supported the ward and completed regular audits of medicines management.

Track record on safety

Between 1 January 2018 and 31 December 2018 there was one serious incident reported by this service which was categorised as a 'slip/trip/fall'. There were no unexpected deaths.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with one reported.

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 zero never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the zero reported at the last inspection.

During our inspection, we identified a further two incidents where serious patient injury was avoided by the quick intervention of staff. These both involved clients attempting self-harm/ suicide by ligature. The ward had recorded details of these incidents on the electronic incident system and an investigation had occurred.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. Staff were open and transparent and gave patients a full explanation when things went wrong. Staff received feedback from investigation of incidents. Staff discussed learning from incidents in handovers and team meetings. Staff and patients received debriefs when needed following incidents.

The manager had access to all the reported incidents related to the ward. We checked three incidents identified during the inspection. The incidents we checked were reported and investigated.

The service made improvements in safety following incidents. The service put up warning signs, purchased a mobile phone for use in emergencies, and reviewed local thresholds for patient

observation following an absconsion from the ward which resulted in a patient injuring themselves when they jumped over a wall.

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 two 'prevention of future death' reports sent to Isle of Wight NHS Trust, however none of these related to this service.

Is the service effective?

Assessment of needs and planning of care

We reviewed the care and treatment records of five patients. All the care plans we reviewed were holistic and recognised a broad range of the patients' needs. The majority of care plans we reviewed were recovery orientated and personalised, reflecting the views of the patient and recognising their strengths and goals. However, most patients did not have a current crisis and contingency plan.

Staff reviewed care plans with patients. Staff offered all patients a copy of their care plan. We spoke to two patients who told us they understood their care plan.

Staff developed care plans that met the needs identified during the assessment for patients admitted for rehabilitation. We found the patients admitted for rehabilitation had care plans that focused on building the skills, knowledge, and confidence needed for recovery. However, patients transferred from acute beds to relieve bed pressure did not all have care plans to reflect the change of environment and therapeutic approach. Staff told us they felt concerned that patients could be transferred into Woodlands from acute beds without clear assessments of their rehabilitation needs, and that some patients subsequently refused to engage in the therapeutic programme which caused disruption.

Staff assessed patients' physical health. In line with best practice guidelines, staff carried out physical health checks of patients prescribed anti-psychotic medication, such as blood tests and monitoring of heart functioning. Staff supported patients to live healthier lifestyles, supporting them to shop for, meal plan, and cook healthier foods. Staff monitored the weight of all patients and supported patients to lose weight if needed, including via community-based support groups.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The service's expected lengths of stay, goals for recovery and levels of functioning reflected a recognisable community rehabilitation model. The ward was "open", staffed 24 hours by nurses and support workers with regular input from multidisciplinary team. Patients were expected to stay for 1-2 years. The majority of the ward's referrals came from acute units, but the ward also accepted referrals from community mental health teams.

The service offered a programme of occupational therapy, this included groups and individual work. For example, walking groups, weekend breakfast clubs, creative groups, mindfulness, and recovery workshops that covered topics such as self-esteem and sleep hygiene.

Patients were encouraged to self-cater, manage their own cleaning and laundry, and budget, with support from staff. Staff supported patients to develop relationships with family, engage in community leisure activities, and access volunteering and employment opportunities. Staff helped patients to develop the skills necessary to move on into supported accommodation.

At our last inspection June 2018, we told the trust they must provide inpatients with access to psychological input from appropriately qualified staff. The ward had employed an agency therapist three weeks before our inspection. The therapist had begun identifying clients and delivering basic psychological interventions. However, the ward did not yet have an embedded psychological therapy programme.

When we inspected in June 2018 we told the trust they must ensure systems were in place to support patients to manage their own medicines. Staff now supported patients to develop medicine management skills, but medicine lockers needed for patients to independently administer their own medicines had only recently been installed in the bedrooms and were not in use. The policies and guidance to allow patients to keep their medicines in their room and safely self-administer were not yet complete.

Staff followed National Institute of Health and Care Excellence (NICE) guidance on prescribing medicines. We looked at all the current patients 'medicine charts; staff followed best practice guidance.

Staff monitored patient's physical health and supported them to live healthier lives, for example by managing cardiovascular risks, healthy eating schemes, and smoking cessation programmes. Patients could access a well-equipped onsite gym, though patients were also encouraged to access community-based gyms and fitness classes. Ward staff used structured physical health assessment tools for monitoring patient's physical health.

At our last inspection in June 2018 we told the trust it must ensure it measures and reviews patients' outcomes to improve the service. At this inspection we found the ward did not use standardised outcome measures to improve the service (outcome measures capture the impact of a health care service or intervention on the health and wellbeing of patients). However, managers told us they were reviewing new outcome measures to identify one which was meaningful for the service. We found some evidence of staff using specific side effect, physical health, and psychosocial outcome measures but these were not completed consistently or with all patients.

Local audits

This service participated in three clinical audits as part of their clinical audit programme 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Mental Health Clinical Outcome Review Programme (NCISH) Safer Care for Patients with Personality Disorder	Mental Health	Not specified	Clinical	Oct-18	Report currently being written
Mental Health Clinical Outcome Review Programme (NCISH) The Assessment of Risk	Mental Health	Not specified	Clinical	Oct-18	Report currently being written

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
and Safety in Mental Health Services					
NICE guideline QS95 Bipolar in Adults	Mental Health	Not specified	Clinical	Aug-18	Findings to be presented at weekly Chantry House meeting to raise awareness. - Checklist of NICE Bipolar disorder quality statements to be distributed to all relevant Chantry House staff members, to act as supplement to usual care plan. - Repeat reminder invitation letter to physical health check to be sent out to all patients. - Liaise with psychology team for ideas on how to improve offer of psychological intervention to patients.

Skilled staff to deliver care

When we inspected in June 2018 the ward did not have access to a full range of mental health professionals. The team now included or had access to the full range of specialists required to meet patients' needs. The service employed a manager, a deputy manager, a part-time consultant psychiatrist, a part-time psychological therapist, a part-time occupational therapist and assistant, registered mental health nurses, and clinical support workers. The ward could access shared trust pharmacy services. The team had several vacancies and were seeking to recruit new staff.

Staff attended the trust's induction course and could access mandatory training. Staff were able to access training related to meeting patients' physical health needs, such as completing electrocardiograms and taking blood samples. Staff told us they could access additional training relevant to their roles when needed. However, staff did not receive specific training on the prevention and management of violence and aggression.

There was a local induction to the ward that explained the ward's routine, local policies and procedures.

When we inspected in June 2018 staff were not receiving regular supervision. At this inspection we found some staff received monthly supervision, but others had received supervision once or twice in the past 12 months. The manager reported difficulties engaging some staff in supervision

but when we inspected there was no action plan in place to address this. Staff reported a mixed response to supervision, some felt supported and that they received enough supervision while others felt unsupported.

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 71%. This year so far, the overall appraisal rates was 63% (as at 8 February 2019).

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 38% reported at the last inspection.

During this inspection we found that appraisal compliance had increased up to 100% for non-medical staff in this service.

No staff were being performance managed. The manager knew how to get information and support if they need to performance manage staff.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 8 February 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Woodlands	16	10	63%	71%
Core service total	**16**	**10**	**63%**	**71%**
Trust wide	**2724**	**2007**	**74%**	**66%**

The trust has not provided any data relating to medical staff within this core service.

The trust has not provided clinical supervision data for this core service.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. Staff attended weekly clinical and monthly business meetings. Ward staff invited the patients care co-ordinator, but they were not always able to attend.

Staff shared information about patients at handover meetings within the team. Staff shifts crossed over to allow staff to handover effectively. Staff used a standard template to ensure consistency during shift handovers.

The team reported good working relationships with other teams and agencies.

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

We found staff had a good understanding of the principles of the Mental Health Act.

Staff had access to the support of a Mental Health Act administrator based at a St Mary's hospital. Staff completed regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Staff upheld patients' rights under the Mental Health Act. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required, and recorded that they had done it. Patients could access independent advocacy. Staff requested reviews by a second opinion appointed doctor when necessary. Patients had applied for Mental Health Act tribunals and Mental Health Act managers meetings which indicated patients were aware of their rights to appeal.

There was an independent mental health advocate available and contact information was available for patients and staff knew how to refer patients. The manager told us that they visited when needed and attended care review meetings if the patient requested them to.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) where this had been granted.

Staff correctly stored copies of patients' detention papers and associated records. Staff had access to copies of leave papers and consent to treatment documents.

The service ensured informal patients were aware of their rights. The service provided written information to informal patients on their rights.

As of 8 January 2019, 100% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed two years.

The training compliance reported during this inspection was higher than the 60% reported at the last inspection.

Good practice in applying the Mental Capacity Act

Staff had a basic awareness of the principles of the Mental Capacity Act and how to assess and record capacity. The service displayed posters explaining the principles of the Mental Capacity Act.

Records showed decision-specific mental capacity assessments and staff told us best interest's meetings were completed when needed.

The service discussed and reviewed clinical applications of the Mental Capacity Act via multidisciplinary team meetings.

As of 8 January 2019, 75% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

When we inspected we found Mental Capacity Act training compliance within the service had increased to 80%.

The training compliance reported during this inspection was higher than the 10% reported at the last inspection.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 January 2018 and 31 December 2018.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed staff displaying positive attitudes and behaviours when interacting with patients. Staff listened, were respectful, supportive, and promoted patient recovery.

We spoke with two patients who described staff as approachable and helpful. Patients reported they got along well with staff. One patient told us how staff had provided them with extensive support, going the 'extra mile', following them losing a close relative.

Staff sought to accommodate patients' needs. For example, staff supported patients at a time that suited individuals routines. Staff planned activities based on patients likes and needs.

Staff supported patients to understand and manage their care, treatment and condition. Staff offered regular one-to-ones sessions. Patients told us staff provided them with extra support when they felt upset. Staff supported patients to make short, medium and long-term goals. Staff supported patients to make choices about their care and treatment

The service had clear confidentiality policies in place that were understood and adhered to by staff. At our last two inspections in November 2016 and June 2018 we expressed concern that patients were able to freely access the staff office where confidential information was visible. At this inspection we found staff had removed patient information from the walls of the office and discouraged patients from entering the staff office.

The Woodlands Unit site on Mary Rose Avenue did not take part in a PLACE assessment.

Involvement in care

Involvement of patients

We found that patients were orientated to the service and were given information on what help they would receive.

Patients told us they were involved in developing their care plans and understood their care and treatment. Some patients care plans were written in the first person.

The majority of patients had a recovery and risk management plan in place which reflected the individual's preferences, recovery capital and goals. Patients were regularly involved in reviewing their care and treatment.

At our last inspection in June 2018 we told the provider they should encourage patients to give feedback on the service. At this inspection we found the team had a patient feedback champion, paper forms were used to gather feedback from willing patients on the care and treatment they received. The results from patient feedback were displayed on posters.

Staff had not routinely encouraged patients to input into service development.

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 they 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

At the time of the inspection the service had nine patients admitted for rehabilitation, and three acute patients temporarily staying on the ward. Two of the rehabilitation patients were on extended leave from the ward to prepare them for discharge to supported accommodation. The ward did not use patients' beds whilst they were on leave.

The service worked with internal departments and partner agencies to coordinate admissions and discharges. For example, social services, acute wards and community mental health teams. The ward focused on meeting the needs of local patients and did not accept out of area placements.

The service aimed to complete a comprehensive assessment prior to a patient's admission for rehabilitation. Assessments identified the rehabilitation needs and suitability of patients. However, acute patients transferred to the ward were identified by senior managers. Ward staff told us that transfers often happened quickly and with little notice. The ward manager told us they felt senior managers would listen if they expressed safety concerns about a transfer, but that transfers did not always occur within their working hours.

The ward reported they had been able to transfer patients to acute or intensive care beds in an emergency. Patients could be transferred to local wards, so they could remain in contact with family and friends.

Bed management

The trust provided information regarding average bed occupancies for the one ward in this service between 1 January 2018 to 31 December 2018.

The wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 January 2018 – 31 December 2018) (current inspection)
Woodlands	71% - 116%

The trust provided information for average length of stay for the period 1 January 2018 to 31 December 2018.

Ward name	Average length of stay range (1 January 2018 – 31 December 2018) (current inspection)
Woodlands	0 – 662 days

This service reported no out of area placements between 1 January 2018 to 31 December 2018. The number of out of area placements reported during this inspection was lower than the three reported at the time of the last inspection.

This service reported no readmissions within 28 days between 1 January 2018 to 31 December 2018.

At the time of the last inspection, for the period 1 October 2016 to 30 September 2017, there were a no readmissions within 28 days.

Discharge and transfers of care

Between 1 January 2018 and 31 December 2018 there were five discharges within this service, none of which were delayed.

However, when we inspected the ward did not have a process to capture when patients were ready for discharge, and so could not identify delayed discharges.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms which they could personalise. Patients had keys to lock their bedroom door.

Staff and patients had access to an adequate range of rooms and equipment to support treatment and care, including a clinic room, group and therapy rooms. When we inspected in June 2018 we told the provider they should ensure patients could make private phone calls. We found patients could now make phone calls in private. Patients had mobile phones and could access a portable handset. There was also a small phone booth which patients could use.

Patients could access quiet areas within the building. Patients had access to outside space. The food was of a good quality and reflected patient preferences. When we inspected in June 2018 we told the provider patients should be able to access drinks 24 hours a day. At this inspection we found patients could make their own hot drinks and snacks 24 hours a day. Staff supported individual patients to plan and prepare their own meals. Patients were encouraged to cook a meal for their peers once a week. There were no identified spaces where patients could meet visitors but the ward had a dining room, lounge, conservatory, and meeting room which could be used if free.

The Woodlands Unit site on Mary Rose Avenue did not take part in a PLACE assessment.

Patients' engagement with the wider community

Patients accessed community groups, college courses, and volunteering opportunities. Patients were encouraged to develop new knowledge, skills and social networks.

Patients could maintain contact with family and friends. Staff supported patients to develop and restore relationships.

Meeting the needs of all people who use the service

The service made adjustments for disabled persons, for example the ward had a bedroom with widened doors, wet room and other features which supported access for disabled persons.

Staff could access information in different languages and an interpreter when needed.

The service could meet patients religious and spiritual needs. For example, patients could access the trusts chaplaincy service, a volunteer from the local priory visited the ward regularly, and staff supported patients to access community-based groups and organisations.

Leaflets were available about complaints, rights, advocacy, local groups, physical health, medication and the Mental Health Act.

The Woodlands Unit site on Mary Rose Avenue did not take part in a PLACE assessment.

Listening to and learning from concerns and complaints

This service reported it received no complaints between 1 January 2018 and 31 December 2018.

However, during our inspection records showed that the service had received three informal complaints in the last 12 months. The service had a complaints policy in place. Management kept detailed records of each complaint received. The service investigated and fed back the outcomes of complaints openly and acknowledged when mistakes had been made and where the service needed to improve. The ward manager provided an example of where a complaint was upheld, and the team changed the way they worked.

Patients knew how to make a complaint and staff knew their responsibilities in relation to dealing with complaints. Leaflets and posters were displayed on the ward explaining how to complain.

This trust's mental health services received two compliments during the last 12 months from 1 January 2018 to 31 December 2018 which accounted for less than 1% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Leadership had been effective in some areas of the core service. The ward had a dedicated ward manager. The ward manager had been working in their role for several years and they had made improvements to the service since the last inspection.

When we inspected in June 2018 we told the provider they should ensure staff felt able to approach their line managers with concerns. At this inspection staff told us they felt able to approach their line manager with concerns. However, not all staff felt their concerns were addressed in a timely way.

Not all staff received regular supervision. This could impact upon staff welfare, limit managers oversight of risks within the service, and impact upon their understanding of individuals practice and capability.

Managers demonstrated a knowledge and understanding of the service provided. Senior staff spoke of their ongoing plans to remodel the service in partnership with a local housing provider, staff planned to provide a rehabilitation service which supported patients to live more independently.

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.

The trust had begun to offer a discharge pathway for patients which included access to step down housing and providing supervised medicines administration for patients on extended leave. Patients also could continue to access some therapeutic and social groups run at Woodlands following discharge.

The service redevelopment plans which were discussed at our last inspection in June 2018 continued to be underway. The service planned to move to a new site, offering an alternative model of rehabilitation. Staff continued to be consulted in this process.

Culture

Staff were positive about the work they did and felt they worked well together. The majority of staff said they felt respected, supported and valued. Staff also said they felt proud working within their team. Staff believed in taking a multidisciplinary approach and valued the contribution of their colleagues.

Staff were aware of how to raise concerns including the whistle-blowing process and felt they could do so without fear of retribution. The manager felt supported and able to raise concerns with senior managers.

Sickness was lower at this core service than the average for the trust. Staff could access support when needed via the Trust's occupational health service.

During the reporting period there were no cases where staff have been either suspended or placed under supervision.

Governance

The quality of governance on the unit was mixed. Ward staff completed regular audits. For example, staff audited infection control, hand hygiene, use of personal protective equipment, waste management, patient care plans and risk assessments, equipment and the environment, and medicines. Audits were sufficient, and staff acted on the results when needed. However, there was no process for monitoring delayed discharge on the ward, and the team had no key performance indicators, which are used to measure the team's performance. It was unclear if senior managers had oversight over all of the audits completed by the ward staff.

The service ensured essential information, such as learning from incidents and complaints, was shared and discussed. All incidents were classified and reviewed for learning and identification of trends.

The service had sufficient governance measures to ensure compliance with the Mental Health Act 1983.

Management of risk, issues and performance

The ward maintained service level risk registers. The risks identified were escalated to senior managers when needed and were discussed at business meetings.

The service held a ligature risk assessment for the ward environment. However, this was a long and hard to read document which did not appear to accurately reflect all risks present within the ward environment.

No written quality improvement plans were shared for the ward.

Information management

The service had systems in place to manage confidentiality of patient records. The provider had a procedure for managing breaches of confidentiality. The service had no reported breaches of confidentiality in the last 12 months.

Patient records were electronic, with small number of documents being held in paper files. Paper based records were stored securely in the nursing office. Staff could safely dispose of confidential information.

Patients could access leaflets on information sharing and confidentiality.

The manager had access to information relating to incidents, safeguarding referrals, sickness and complaints. Learning from these was shared with staff in team meetings, during supervision or to individual staff in needed.

Staff had access to the equipment and information technology they needed to do their work. However, some staff reported difficulties navigating the trusts patient electronic records system.

Engagement

Staff encouraged patients to feedback on the service. For example, patients could provide feedback during one-to-one discussion, meetings, and feedback sheets. Staff acknowledged and acted upon patient feedback.

Managers engaged with some internal and external stakeholders. For example, the manager had worked with the trusts chaplaincy service to develop the wards ability to support patients' spiritual needs. Managers worked with care managers and care coordinators when required.

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.

This core service does not currently hold any accreditations.

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

Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
St Mary's Hospital	Home Treatment Team	Not provided	Mixed
St Mary's Hospital	Health based place of safety	Not provided	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Safety of the ward layout

Mental health crisis services

The home treatment team was based in the Sevenacres building on the St Marys hospital site. The offices were spacious and well equipped.

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. However, the equipment for monitoring physical health observations had not been tested for electrical safetysince 2017. The medicines were stored appropriately in locked cupboards. However, staff used baskets to transport medications to patient's homes and we found these to be disorganised. They also contained items such as empty medication foils and items unrelated to medication such as condoms and information leaflets.

Health Based Place of Safety

The health-based place of safety (HBPoS) was situated on Seagrove ward, a psychiatric intensive care unit. The unit was multi-functional and was used as an extra care area by the ward as well as a place of safety. There was an additional place of safety situated in the emergency department of St Mary's hospital.

Staff had access to personal alarms. 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.

During our last inspection the trust told us they had plans to refurbish the purpose-built Section HBPoS. However, we found that the seclusion room and the adjoining bathroom had been refurbished but not the section 136 suit itself. The environment used to detain and assess a

patient under Section 136 of the Mental Health Act was not welcoming and was in need of decorating and re-flooring. There was a room with a bed in it, but this room was not suitable for conducting an assessment. Staff told us that the area between the suite and the seclusion room was used for interviewing and this room contained a sofa and armchairs. However, the room was not set out in a manner which would enable an interview to easily take place and did not have any natural light.

Staff safely observed patients HBPoS bedroom as there was a glass window in the door.

Safe staffing

Nursing staff

Mental health crisis services

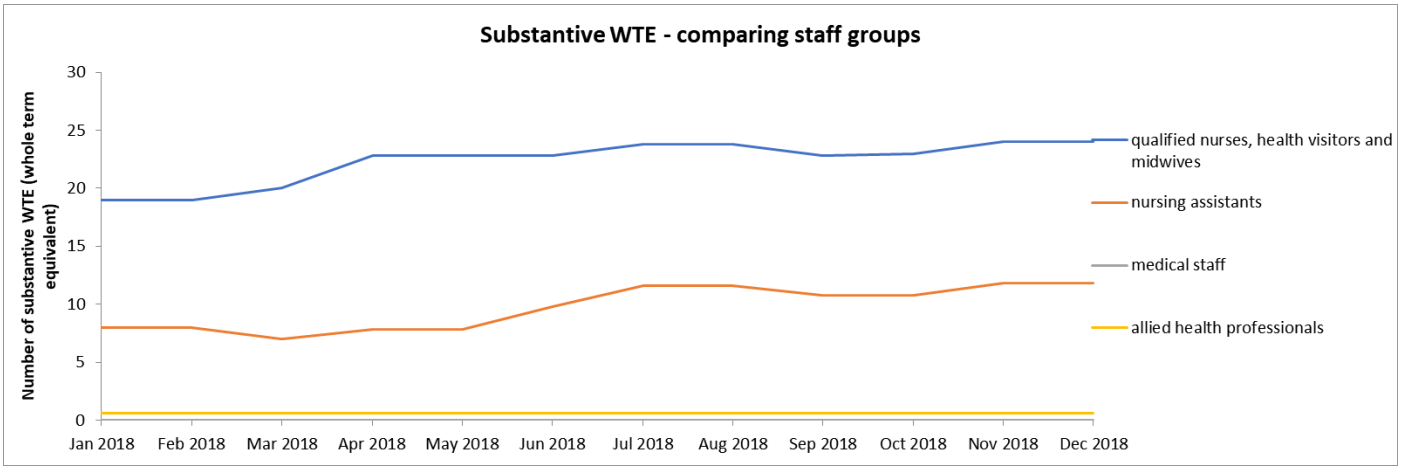
When we inspected in 2017 we found that staffing levels were not safe and required the service to address the issue. This primarily related to the single point of access team, which was moved from the crisis team to the community mental health team.

Staffing levels and skill mix in the home treatment team were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff can manage risks to people who use services.

Health Based Place of Safety

The HBPoS was staffed from the psychiatric intensive care unit. Staff told us that the staffing quota overnight had been increased to cover the operation of HBPoS and that during the day they were staffed to run the extra care area which would not be used if HBPoS was in use.

The below chart shows the breakdown of staff in post WTE in this core service from 1 January 2018 to 31 December 2018.

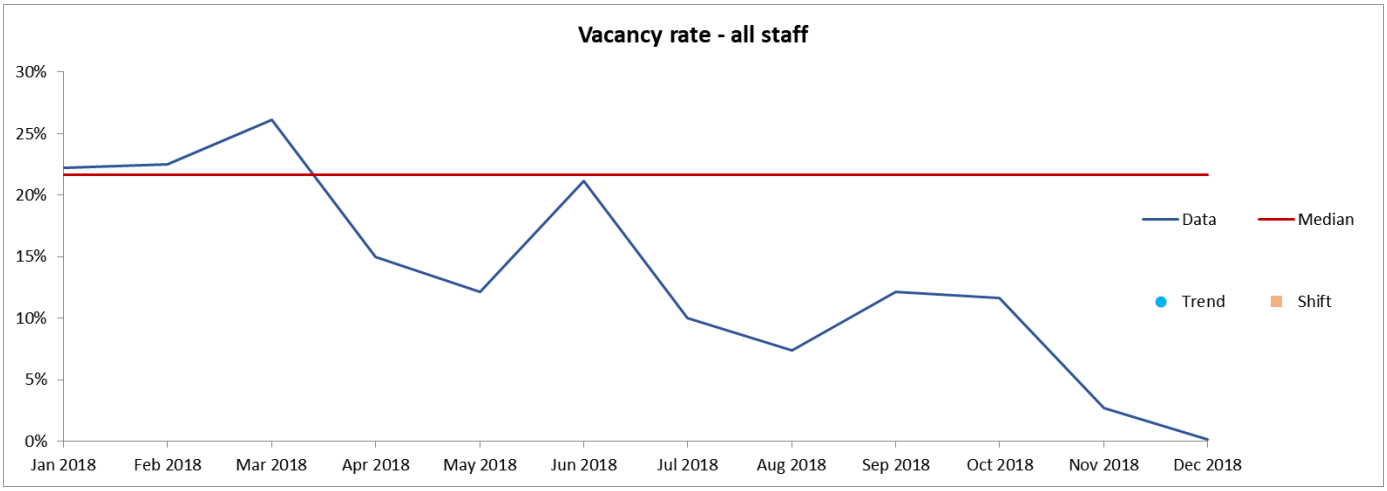


During the year to 31st December 2018 the home treatment team had no unfiled hours for nurses or health care assistance.

Annual staffing metrics

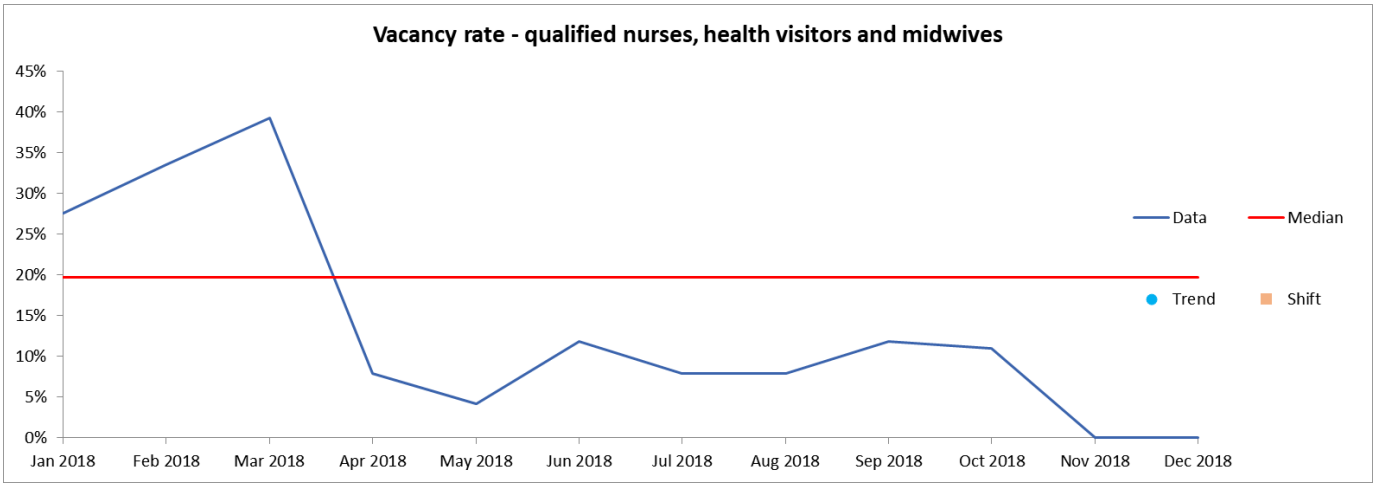
	Core service annual staffing metrics (1 January 2018 – 31 December 2018)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	36.4	14%	6%	5.2%			
Qualified nurses	24.9	14%	4%	4.5%	3534 (7%)	5172 (10%)	0 (0%)
Nursing assistants	11.6	14%	10%	7.1%	2026 (10%)	707 (3%)	0 (0%)

All staff

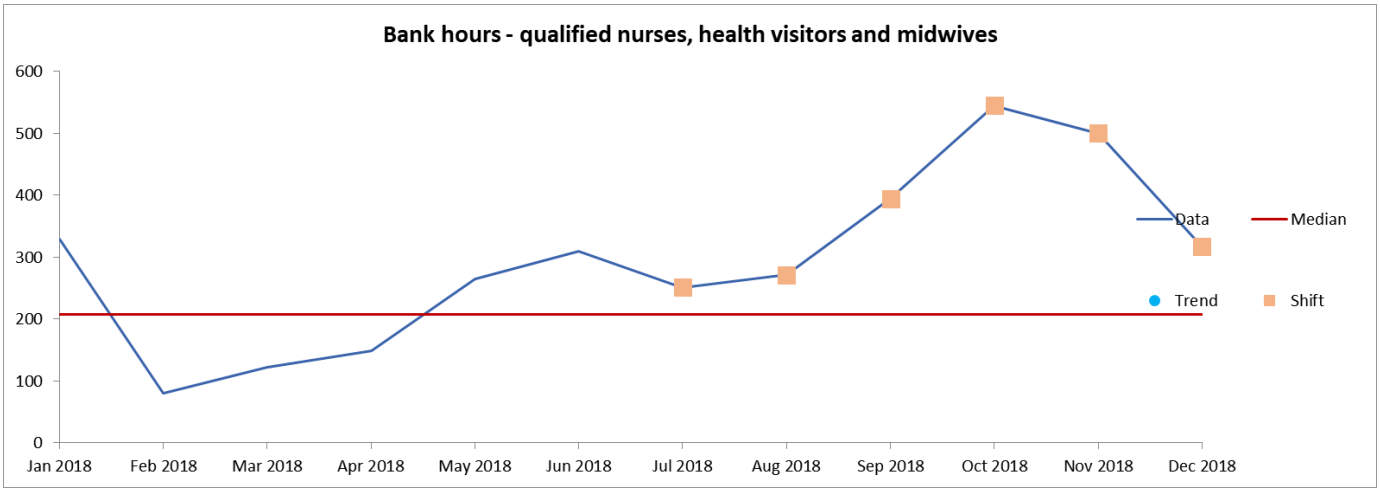


There were no indications of risk for all staff groups within this core service. Staffing figures within this core service were compared to other similar services and annual vacancy, sickness and turnover rates were found to be about the same as the national average. Monthly 'vacancy rates' over the last 12 months for all staff are not stable and may be subject to ongoing change. Further investigation should take place to better understand 'vacancy rates' for this service.

Qualified nurses



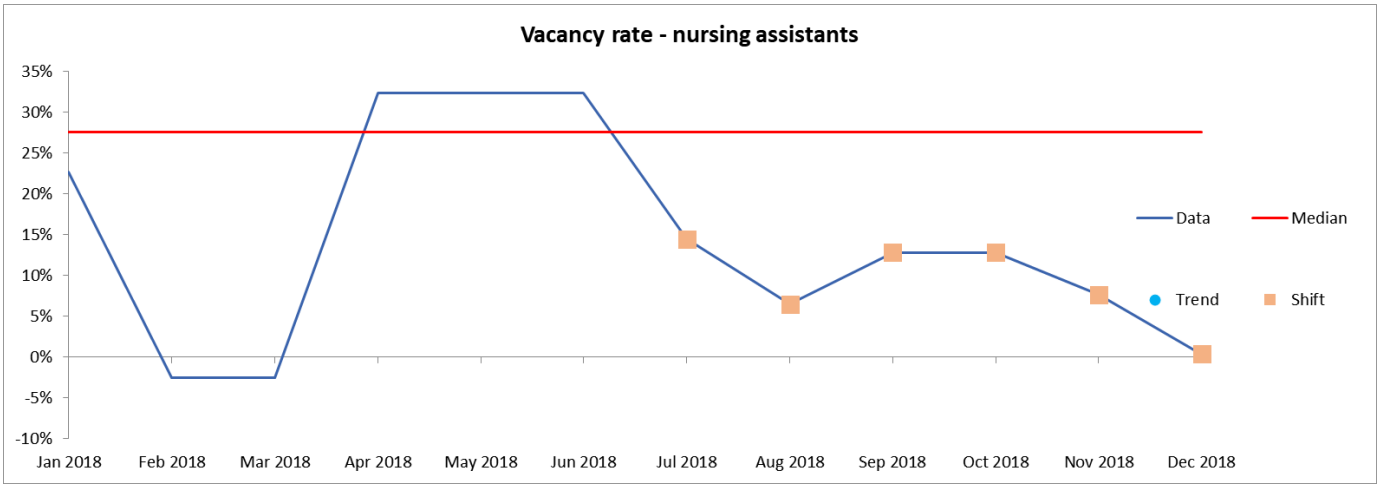
Monthly 'vacancy rates' over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change. Further investigation should take place to better understand 'vacancy rates' for this service.



The trust used bank and agency qualified nurses to mitigate against gaps in staffing within this core service. Annually, this core service relied more on agency staff than bank staff, although monthly 'bank hours' over the last 12 months for qualified nurses, health visitors and midwives shows a shift from July 2018 to December 2018. This could be an indicator of change. This merits investigation to find out the causes and impacts of the possible change, what has worked and how learning was shared more widely.

On site we found that the service did not use agency staff and the bank staff that were used had a good understanding of the service.

Nursing assistants



Monthly 'vacancy rates' over the last 12 months for nursing assistants shows a shift from July 2018 to December 2018. This could be an indicator of change. This merits investigation to find out the causes and impacts of the possible change, what has worked and how learning was shared more widely.

Staff joining the team received an induction as did bank staff.

Mandatory training

Training data summary

The compliance for mandatory and statutory training courses at 8 January 2019 was 73%. Of the training courses listed 10 failed to achieve the trust target and of those, all ten failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training.

The trust reports a rolling month by month training compliance.

The training compliance reported for this core service during this inspection was lower than the 75% reported in the previous year.

Figures provided by the trust on the 19th May 2019 show a mandatory training completion rate of 88% an improvement on the 75% during our last inspection.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✗	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Infection Prevention & Control Level 1	37	37	100%	✓	n/a
Fire Safety Part 1 - Theory	37	37	100%	✓	↑
Safeguarding Children Lev 1	37	37	100%	✓	↑
Health, Safety and Welfare	37	36	97%	✓	↑
Safeguarding Children Lev 3	26	25	96%	✓	↓
Safeguarding Adults Lev 1	37	35	95%	✓	↑
Preventing Radicalisation Level 1 & 2	37	34	92%	✓	↑
Safeguarding Children Lev 2	37	32	86%	✓	↓
Hand Hygiene	37	27	73%	✗	↑
Load Handling	37	26	70%	✗	↑
Safeguarding Adults Lev 2 Part 2	37	25	68%	✗	n/a
Safeguarding Adults Lev 2 Part 1	37	24	65%	✗	n/a
Fire Safety Part 2 - Extinguishers	37	24	65%	✗	↑
Infection Prevention & Control Level 2	37	21	57%	✗	n/a
Mental Capacity Act	37	19	51%	✗	↑
Information Governance	37	16	43%	✗	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Preventing Radicalisation Level 3	37	14	38%	✗	n/a
Adult Resuscitation	37	12	32%	✗	↓
Total	**655**	**481**	**73%**	✗	↓

Assessing and managing risk to patients and staff

Assessment of patient risk

Mental health crisis services

Staff in the home treatment team did not robustly record risk. We reviewed risk assessments in six patient records in the home treatment team; all had a risk assessment completed, however we found and staff reported that they felt the risk assessments were lacking depth and detail. Alongside the electronic system, the service used paper files which contained immediately relevant information. It was these files that staff used as a reference point and we found that they did not have a full overview of risk. Some risks present in the risk assessments were not referenced and those that were had only a brief description. There was very little context and the management plan relating to the risks was absent. We fed this back to the manager who informed us that the practice of using these files was under review.

Health-based place of safety

Staff in the HBPoS were not completing risk assessments for people being admitted to the HBPoS. The police completed a brief observational risk assessment, however staff were not consistently recording that they were reviewing a person's risk history on the electronic records system. A more comprehensive risk assessment was being completed as part of the mental health act assessment process, however this may occur some hours after the person had been admitted. Staff did not record risk robustly and relied on most patients' risks not changing as they were already known to the service and the staff.

The core service did not use additional risk assessment tools preferring to use the trusts own risk assessment document built into the core assessment.

Management of patient risk

Mental health crisis services

Care plans addressed issues identified in the assessments which included risk. 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.

However, home treatment staff used the paper records as a point of reference. In these files we found that the risk assessments and associated plans were not comprehensive.

The home treatment team had access to daily appointment slots with the team consultant psychiatrists which could be utilised should a patient's risk alter and require this level of intervention in order to manage the risk.

Health-based place of safety

The records being maintained by the HBPoS safety staff did not include a risk management plan relating to the period between detention and assessment under the Mental Health Act. The assessment carried out by the approved mental health practitioner and the section 12 approved doctors included a summary of the risks and how this should be managed. However, the patient may be being managed by HBPoS staff for some hours without a risk management plan. Staff in the HBPoS were trained in the management of aggression and physical intervention. They were confident in their ability to identify and manage presenting risks.

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.

This trust made 149 Mental Health and learning disability service safeguarding referrals, however they have not provided a core service breakdown. Between 1 January 2018 and 31 December 2018, 73 safeguarding referrals concerned adults and 76 children.

Members of staff across the core service understood the process for referring people at suspected risk to the local authority. They understood the different forms of abuse to children and adults and the risks posed to people with protected characteristics. However, there was a lack of understanding regarding county lines drug dealing and cuckooing.

Staff spoke with us about working with other agencies such as women's services, charities and the local authority to protect people from abuse and discrimination.

Serious case reviews

The trust has not submitted any details of serious case reviews commenced or published in the last 12 months (1 January 2018 to 31 December 2018) that relate to this service.

Staff access to essential information

Mental health crisis services

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 time consuming and involved the shift coordinator reading from printed pieces of paper. Staff also printed off paper copies of care plans and patient details and stored these in the home treatment team office alongside the electronic care records system. We found that these paper records lacked detailed information identified in the core assessment and care plans.

Health Based Place of Safety

Staff overseeing the HBPoS received information completed by the police at the time of detention under section 136 of the mental health act. This document had been developed by the local authority health care trust and police.

Medicines management

Mental health crisis service

The trust had systems in place for the safe storage, administration, prescribing and disposal of medicines. However, these were not always effective.

The trust pharmacy department supplied medicines as stock and dispensed for individual patients. These included pre-packs of medicines to treat patients for specific conditions either as TTO (To Take Out) packs. Medicines were stored securely. However, a few of the TTO packs had lost their labels or had expired.

Paper copies of patient group directions were available to staff with the TTO packs. However, these copies were not complaint with the legislation. Therefore, we were not assured the trust had adequate oversight of these process.

Staff could administer medicines patients had obtained via their GP, when appropriate. Staff recorded medicines administered on a chart. Three of the nine charts reviewed lacked the patient's allergy status.

If prescribing was indicated the senior house officer would request a GP summary and completed an assessment of the person. The prescription would then be undertaken using the trust electronic prescribing system.

The home treatment team was using a paper based prescribing system, whereas the wards used an electronic system. The rationale for this was that the service was classed as a community service. As well as prescribed medication the service used patient group directives, for example for diazepam and zopiclone.

The storage of medication was in line with best practice. However, the medication was transported from the clinic to the person's home in baskets which were untidy and contained used medication foils and items not related to medication.

Health-based place of safety

The suite did not have a dedicated clinic room, the staff used the clinic situated in the main psychiatric intensive care unit. Medication was stored in line with best practice.

Track record on safety

Serious incidents requiring investigation

Between 1 January 2018 and 31 December 2018 there were seven serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'apparent / actual / suspected self-inflicted harm' with three. There were no unexpected deaths reported by this service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with seven reported.

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 zero never events during this reporting period.

	Number of incidents reported				
Type of incident reported (SIRI)	**Apparent/actual/suspected self-inflicted harm**	**Treatment delay**	**Unauthorised absence**	**Pending review**	**Grand Total**
Crisis Resolution	2	2	1	1	**6**
MH - Home Treatment Team	1	0	0	0	**1**
Total	**3**	**2**	**1**	**1**	**7**

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 two 'prevention of future death' reports sent to Isle of Wight NHS Trust, however none of these related to this service.

There was limited use of systems to record and report safety concerns, incidents and near misses. Some staff told us that they did not report incidents of self harm, while others did state that attempted suicide would be reported. The trust incident reporting policy supported this position. The staff overseeing HBPoS did report all acts of self harm and attempted suicide.

Learning from incidents was not being shared across the core service. The service manager told us that learning was disseminated and there is a standing item on the team meeting agenda relating to learning. However, staff could not identify learning and did not feel that they understood how learning was spread across the organisation.

Is the service effective?

Assessment of needs and planning of care

Mental health crisis services

Staff completed initial assessments when patients were referred to the home treatment team. Assessments carried out by the home treatment team were holistic and covered peoples psychological, social and physical needs. We observed one handover meeting in the home treatment team where staff discussed referrals and assessment in detail.

We reviewed seven care plans across the home treatment team. The majority of care plans we reviewed were person-centred and holistic, they addressed the issues identified in the core assessment and were regularly reviewed. The voice of the patient was reflected in the plans. However, we found that the care plans were not goal orientated and lacked detail in respect of the actions being taken to address the identified needs. Clinicians were using printed copies of the care plans to inform the daily practice, but we found that the paper files did not always contain copies of the paper care plans.

Health-based place of safety

Patients in the HBPoS were assessed on admission and if necessary assessed by the junior doctor providing cover to the psychiatric intensive care unit. Assessments undertaken by the nursing staff in the HBPoS were recorded in clinical notes and were inconsistent in their depth and breadth. Assessments completed by doctor's were holistic.

The trust's section 136 policy was unclear regarding the level of assessment that somebody detained to the HBPoS should receive prior to the formal assessment under the Mental Health Act. We found that the assessments carried out under the Mental Health Act were of a good standard and met the expectations set out in the Mental Health Act code of practice.

Staff in the HBPoS did not complete care plans for people in their care. They told us that they had previously completed standard care plans, but these had been removed in favour of care being more personalised and as a result no plans were being completed.

Best practice in treatment and care

Mental health crisis services

Home treatment team staff used patient group directives (written *instructions* for the supply or administration of medicines to *groups* of *patients* who may not be individually identified before presentation for treatment) to provide medicine to patients in crisis. This ensured 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 (NICE) guidelines when prescribing medication.

The home treatment team 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. Following the inspection, the trust

had employed a lead psychologist who is developing a service, however this is yet to directly impact on the home treatment team.

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 home treatment team used a number of tools to measure patient improvement and outcomes. These included the Beck's inventory, the generalised anxiety disorder scale (GAD7), the patient health questionnaire (PHQ9) and the health of the nation outcome scales (HoNOS).

Local audits

This service participated in no clinical audits as part of their clinical audit programme 2018.

Skilled staff to deliver care

Appraisals for permanent non-medical staff

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 and 31 March 2018), the overall appraisal rate for non-medical staff within this service was 78%. This year so far, the overall appraisal rates was 82% (as at 8 February 2019).

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 14 reported at the last inspection.

The figures provided by the trust for the year ending 31st March 2019 show appraisal rates for the home treatment team at 95%.

Staff told us that the quality of managerial supervision was good and that they felt supported. However, clinical supervision was not always taking place.

The home treatment team employed nurses, social workers and community support workers. The team manager was a social. We were told that there is an aspiration to employ occupational therapists and job adverts were open to all allied professionals, however only nurses had applied up to now.

There continues to be no psychologist employed by or assigned to the team.

Medical cover was provided by two consultants with time allotted from a specialist registrar.

The team had an induction for new staff including bank staff. However bank staff tended to be drawn from a pool of people who know the team and client group.

Health based place of safety was operated by ward team on Seagrove ward consisting of nurses and healthcare assistants with medical cover being provided by the acute services medical team and out of hours provision. The operating of the HBPOS was included as part of the ward induction program which was explored in greater depth in the core service report for working age adults mental health wards report.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 8 February 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Crisis Resolution & Home Treatment Team	22	18	82%	78%
Core service total	**22**	**18**	**82%**	**78%**
Trust wide	**2,724**	**2,007**	**74%**	**66%**

Clinical supervision for non-medical staff

The trust has not provided clinical supervision data for this core service.

The staff and manager of the home treatment team told us that clinical supervision was being provided. The trust records show that in the year ending 31st March 2019 all staff had received appraisals.

Multidisciplinary and interagency team work

Mental health crisis services

The home treatment team held team meetings which occurred every three to four weeks. There was a standing agenda for these meetings. Staff told us that they were able to raise concerns and that they felt listened to. 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. The home treatment team and the community mental health teams were attempting to resolve these issues by holding regular management meetings to discuss patients in need of transfer. The home treatment team was also providing monitoring of patients over the weekends as part of an effort to work together to help people who are complex but not yet in need of home treatment.

Staff and managers from the home treatment team told us that they regularly work with colleagues within the local authority and housing departments. They regularly contribute to safeguarding meetings and benefits reviews.

Staff responsible for the HBPOS worked collaboratively with other agencies including the police. The trust coproduced the HBPOS policy used by the police and health care providers

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

Mental Health Act training figures

Mental health crisis services

As of 8 January 2019, the trust reported that there were no eligible staff for Mental Health Act training in this core service. The service manager told us that this decision has been challenged and the trust agreed to provide Mental Health Act training to the home treatment team. The team members we spoke with demonstrated a good understanding of the Mental Health Act.

Health Based Place of Safety

The HBPoS did not display the rights of patients detained under Section 136 of the Mental Health Act. However, we reviewed five care records which demonstrated patients were having their rights explained regularly during the period assessment.

During the year 2018 /19 seven people were seen with the trusts target. Of the remainder a reason for the delay was not recorded in 30 cases. During the year 2018 /19 45 people were detained to the HBPoS. The average length of stay was 10 hours 48 minutes in quarter one, seven hours 40 minutes in quarter 2, nine hours three minutes in quarter 3 and eight hours 37 minutes in quarter 4. The Mental Health Act code of practice states that people should be assessed within 24 hours of detention. The trusts section 136 policy states that normally assessment by a Section 12 doctor and approved mental health practitioner (AMHP) should be arranged as soon as possible. Unless there are clinical reasons for delaying the assessment the doctor and AMHP should attend within 3 hours. Any delay and reasons for the delay must be recorded on the section 136 monitoring form.

The section 136 policy provided by the trust had been updated in line with changes to the act and code of practice.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training figures

At the time of the inspection 85% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years. The training compliance reported during this inspection was higher than the 14% reported at the last inspection.

The care records reviewed in the home treatment team showed that mental capacity was assessed appropriately and recorded clearly in notes. Staff we spoke with in both the home treatment team and the HBPoS demonstrated an understanding of the Mental Capacity Act and how it applies to the patients under their care

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We accompanied home treatment staff on home visits and observed them 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. They said that 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 in the home treatment discussing the need to refer a patient to the CMHT to provide intensive support and access further resources following the crisis period and deterioration in health and wellbeing.

Involvement in care

Involvement of patients

The home treatment team was demonstrating patient involvement in care planning and care plans. We reviewed six care records and care plans within the home treatment team. All care plans reviewed contained language which reflected patient involvement and included the views and preference of the patient.

We spoke with four patients, three of these patients told us they had not received a copy of their care plan. However, they all felt that they had been involved in deciding what form their treatment should take. We observed two home visits were it was clear that patient and carer opinions were being taken into account.

Staff supported patients to access advocacy services and support groups. They were able to signpost to other agencies, such as housing and benefit support and had leaflets and contact details to provide to patients.

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 visits to provide support and advice for families who were supporting relatives during a crisis period.

Is the service responsive?

Access and waiting times

Referral to assessment and treatment times

The trust has not provided 'referral to initial assessment' and 'referral to treatment' times for this core service.

Mental health crisis services

Referrals to the home treatment team were being managed in a safe way. Calls were diverted to an available phone line with capacity to take numerous calls at the same time. Referrals were taken by an administrator, these were then handed to a coordinator who liaises with the referrer and triages the referral. The home treatment office was staffed during office hours with the phone being diverted to the team mobile phone out of hours if all staff were visiting people in the community.

There were clear referral and inclusion criteria. Patients were not excluded based on diagnosis.

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.

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.

Facilities that promote comfort, dignity and privacy

Mental health crisis services

Staff working in 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 in the Sevenacres building and were adequately soundproofed.

Health-based place of safety

During the year ending 31st March 2019 the HBPOS was used 45 times. The HBPOS was accessible 24 hours a day via an entrance separate from the ward therefore maintaining privacy and dignity. The police were able to drive up to the doors of the HBPOS as such people are not required to walk long distances and the entrance is accessible to people with mobility needs.

There was no access to outside space for people detained to the HBPoS. The staff did not have an appropriate area in which to interview patients detained to the HBPoS, they either had to interview the patient in the bedroom or in the corridor / lounge area. This area was not furnished in a manner which was conducive to carrying out an assessment.

The HBPoS in the emergency department was situated away from the main department with easy access to toilet facilities. This room was adequately sound proofed and fit for purpose.

Patients' engagement with the wider community

Staff supported patients to maintain and build relationships with families and support networks in the wider community. During a home treatment team handover meeting 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

Mental health crisis services

The home treatment team had a bank of resources which could be accessed to provide information and psycho-education 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 including British sign language interpreters.

The home treatment team was able to meet the needs of those unable to be visited at home by bringing them in to the local inpatient unit where they would be able to be assessed. The HBPoS was accessible to people with mobility issues as were the interview rooms used by the home treatment teams.

Formal complaints

This service received seven complaint between 1 January 2018 to 31 December 2018.

	Complaint theme					
Ward name	**Values and Behaviours (Staff)**	**Communication**	**Access to Treatment or drugs**	**Appointments**	**Trust admin / policies / procedures including patient record management**	**Total**
Crisis Response Team	0	2	1	1	0	**4**
Crisis Resolution	2	0	0	0	1	**3**
Core service total	**2**	**2**	**1**	**1**	**1**	**7**

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. The log of formal complaints was held centrally. Informal complaints were resolved by members of the team and the team leader. The team held no register of informal complaints, this meant the manager could not identify themes in complaints and take appropriate action.

Compliments

This service received no compliments during the last 12 months from 1 January 2018 to 31 December 2018.

Is the service well led?

Leadership

The mental health crisis service and health-based places of safety had a new operational manager who staff told us was visible and accessible. The clinical team leaders were committed to delivering services which met the needs of patients. The leadership of both the home treatment team and HBPOS had received management training put in place by the trust. The manager of the home treatment team was new in role and as such was yet to fully establish her leadership. However, the team were very positive about her. The HBPOS manager ad recently returned from maternity leave and was still in a transitional period. However she clearly understood her clinical area and was fully able to manage her service.

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. The staff we spoke with had a strong sense of the team's vision and strategy. However, they could not articulate the trust's vision and felt that metal health was not a priority.

Staff told us that they had not been involved in the development of the trust's strategy or vision.

Culture

Staff 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 staff felt that the wider trust culture had little impact on them as they did not feel particularly connected to the executive team.

We were told that there had previously been a culture of bullying and harassment but that this was no longer the case. We were told about the trust's anti bullying advisor.

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.

All of the staff we spoke with understood the whistle blowing policy and felt confident to raise issues. None of the staff knew who the speak up guardian was.

Governance

The trust had not provided a risk register for this inspection. During our inspection we were told that the urgent care division held a risk register, however there were no team level risk registers. The home treatment team manager and the divisional manager felt that this was adequate.

Referral times were not being monitored via a key performance indicators set by commissioners, however it was apparent that the team manager was fully aware of the waiting times and was maintaining the services quick response. The governance processes in the crisis service and health-based places of safety were not yet embedded.

There was evidence of regular governance meetings taking place at team level and at divisional level. Managers had access to performance dashboards via which they could track performance.

Managers were carrying out audits into areas such as care planning. However, managers and staff were not involved in the central audit programme.

Management of risk, issues and performance

Processes to manage risk and issues of performance were not robust. Staff told us that they did not receive feedback from the trust if they raised concerns and that they did not feel they received learning from incidents. However, staff working in the home treatment team were able to escalate concerns about risk, particularly the impact of the low staffing levels. Staff told us that they felt listened to by the immediate service managers.

Information management

Staff in both the home treatment and single point of access teams told us they found the electronic records system difficult to use and operate. This made finding information difficult and has led to the home treatment team using paper records which were not of a high standard and were missing important information. This had the potential to lead to clinicians seeing patients without full knowledge of risk and other issues.

Engagement

Staff had access to the trust intranet and were able to keep up to date with developments, news and changes. However, staff did not feel that the senior management team was particularly engaged with their service.

Patients were offered a feedback form on discharge, the feedback was collected and correlated centrally.

Learning, continuous improvement and innovation

Staff were not engaged in any quality improvement initiatives within this service. The acute pathway had recently appointed a quality improvement officer to oversee future quality improvement developments.

Accreditation of services

NHS trusts can 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 trust reported that this core service does not currently hold any accreditations. However, the team manager told us that the team had previously been accredited under the home treatment accreditation scheme and she is planning to work towards regaining accreditation in the future.

Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
St Mary's Hospital	Afton	10	Mixed
St Mary's Hospital	Shackleton	4	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Safety of the ward layout

Staff on Afton ward completed checks of the care environment at the beginning of each shift.

Afton ward had been undergoing refurbishment to make improvements to the ward environment. The nursing office had been removed from the centre of the ward and was now in a room of its own. The previous nursing office had been unsuitable due to issues around confidentiality of patients' records; this was no longer a concern.

The building's redesign removed and reduced ligature risks, these included anti-ligature doors on the en-suite 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 installed anti-ligature paper towel and hand soap dispensers. The trust replaced 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. There was a second bathroom, which was low risk and therefore left open. This demonstrated staff assessed and mitigating environmental risk appropriately. Unfortunately, one of the bathrooms had been out of use for the last month due to the ongoing building works and necessity to store equipment there on a temporary basis. Staff assured us the bathroom would reopen within the next week.

Shackleton ward had been closed for nine weeks to refurbish the ward environment and retrain staff. At the time of our inspection, Shackleton ward had been open 10 days.

Staff did not always prioritise security on Shackleton ward. For example, one of the two clinic room doors on Shackleton ward was unlocked consistently throughout the day of the inspection. There was an anticipated risk that medicine cupboards could have been left unlocked and unauthorised people could have had access to them. Additionally, the reception desk was left unmanned at one point and patients or visitors could remove staff keys which were within reach.

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. During this inspection, we found that the trust had made significant changes to the environment to allow better lines of sight. The ward was now more open plan, brightly lit and there was an adequate dining area.

The garden on Afton ward had raised, wheelchair friendly flower beds so that patients could participate in gardening and there was a range of plants, flowers and vegetables growing. The floor had been covered with a resin that would give a softer base if a patient fell on it. At our last inspection in 2018, the garden improvements were not complete, and patients had not been able to access the garden for a year. At this inspection we found that patients regularly used the garden area.

On Shackleton ward, the garden was downstairs and along a corridor. For patients to access the garden, staff needed to go with them and supervise which might not have always been possible depending upon staffing levels and the acuity of patients on the ward. At our last inspection in 2018, we did not think patients had access to fresh air either in the garden or when using section 17 leave. However, on this inspection, records showed patients had regularly used the garden in the 10 days since the ward reopened.

Staff on both wards carried personal alarms to be used in an emergency. Patients had access to call bells in their bedrooms and in communal areas.

Same sex accommodation breaches

Over the 12-month period from 1 January 2018 to 31 December 2018 there were no same sex accommodation breaches within this service.

The number of same sex accommodation breaches reported in this inspection was lower than the three reported at the time of the last inspection.

Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse.

During the last inspection in 2018, we found that male patients on Shackleton ward were often using the female lounge. During this inspection we found that there was a dedicated female-only day room which male patients did not enter.

Ligature risks

Both wards in this core service had a ligature risk assessment in the last 12 months.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Afton Ward	All high risks mitigated or removed	No	The ligature assessment is a live document regularly monitored and updated by the ward managers. A full review is undertaken annually (last in Feb 2019).
Shackleton Ward	All high risks mitigated or removed	No	The ligature assessment is a live document regularly monitored and updated by the ward managers. A full review is undertaken annually (last in Feb 2019).

During our inspection on Shackleton ward, we found that the ligature risk assessment had not been completed prior to the reopening of the ward. Since there had been significant structural changes to the ward, the ligature risks had changed. The ligature risk assessment had not been fully completed and the risk management plans for each identified risk were not individual or detailed. Some ligature risks had not been mitigated as well as they could have been. For example, there were metal hooks behind the television in the female lounge which the television unit was hung from rather than fixing them flush to the wall. The staff that completed the risk assessment were not trained to complete the tool and were asked to complete the tool on their own without support.

Maintenance, cleanliness and infection control

Both wards were clean and tidy. All furnishings were well maintained, there were bright stimulating pictures on the walls which had all been freshly painted. Cleaning records were up-to-date and staff followed infection control procedures.

Patient-Led Assessments of the Care Environment

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

The site which delivers MH - Wards for older people with mental health problems within Isle of Wight NHS Trust was compared to other sites of the same type and the scores they received for ‘cleanliness’ and ‘condition, appearance, and maintenance’ were found to be about the same as the England average.

Clinic room and equipment

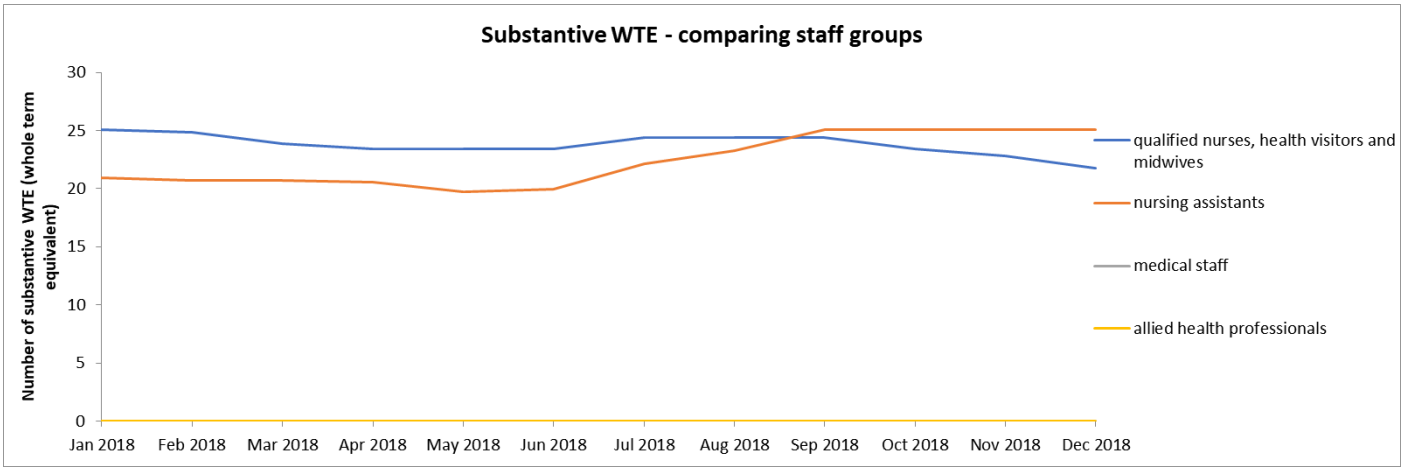
The clinic rooms on both wards were fully equipped with accessible resuscitation equipment and emergency medicines which staff checked regularly. Staff maintained equipment, kept it clean and ensured it was calibrated. Staff stored ligature cutters accessibly in the clinic room. However, on Shackleton ward, during the inspection, the clinic room was consistently left unlocked which meant patients could potentially access the ligature cutters.

Safe staffing

The trust had calculated the number and grade of nurses and healthcare assistants. Managers could adjust staffing levels depending upon patient acuity. On Shackleton ward, prior to closing, there were 10 shifts in March where the ward was below the calculated numbers. The interim ward manager stated that when this happened they covered this gap with staff working a middle shift. There was one day where the low numbers had not been covered by a middle shift.

On Afton ward, staffing levels were good and so staffing levels did not affect patients' ability to use their leave or participate in ward-based activities. However, on Shackleton ward we did not observe any activities and there was poor documentation around any activities that had occurred on the ward so we were not clear as to what activities took place and how often. We reviewed the staffing rosters and whilst there were some gaps in filling shifts, these had been mitigated by utilising the staff working a middle shift. Despite this, there was a lack of activities on offer on the ward. Patients had not used any section 17 leave in the 10 days since the ward reopened but had been to the garden with staff several times. There were enough staff on both wards to carry out physical interventions when necessary.

The below chart shows the breakdown of staff in post WTE in this core service from 1 January 2018 to 31 December 2018.



Annual staffing metrics

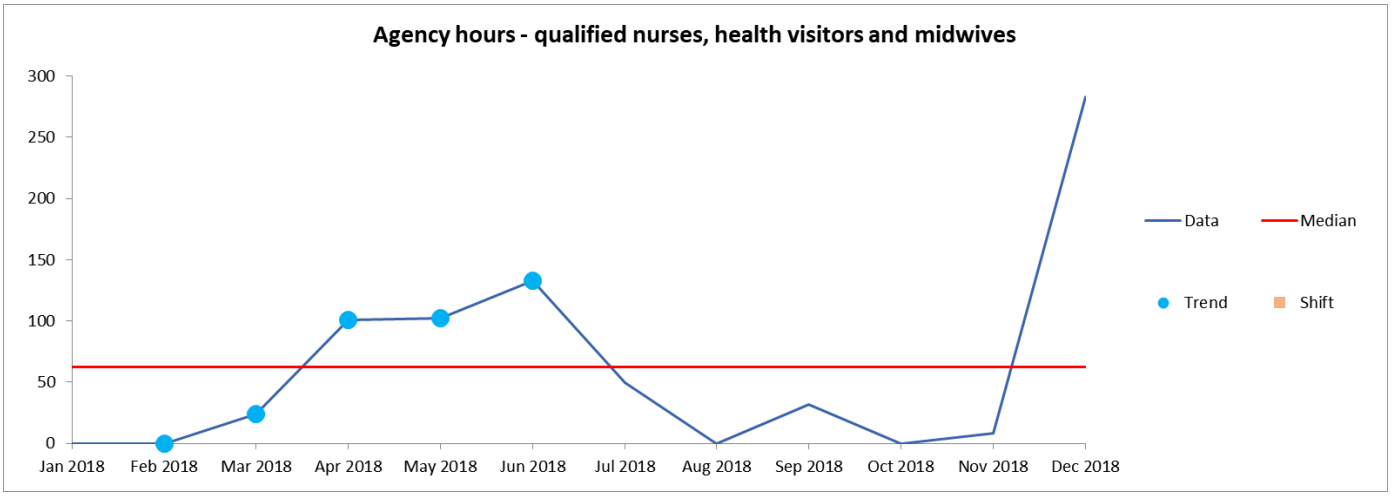
	Core service annual staffing metrics (1 January 2018 – 31 December 2018)						
Staff group	**Annual average establishment WTE**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**

All staff	51.3	9%	2%	6.1%			
Qualified nurses	24.0	10%	4%	7.6%	2004 (4%)	732 (1%)	1211 (2%)
Nursing assistants	27.4	8%	0%	4.9%	6761 (15%)	0 (0%)	0 (0%)

At the time of our inspection, Shackleton ward had 5.4 WTE vacancies for staff nurses and 1 full time activities coordinator. Afton ward had no staff vacancies.

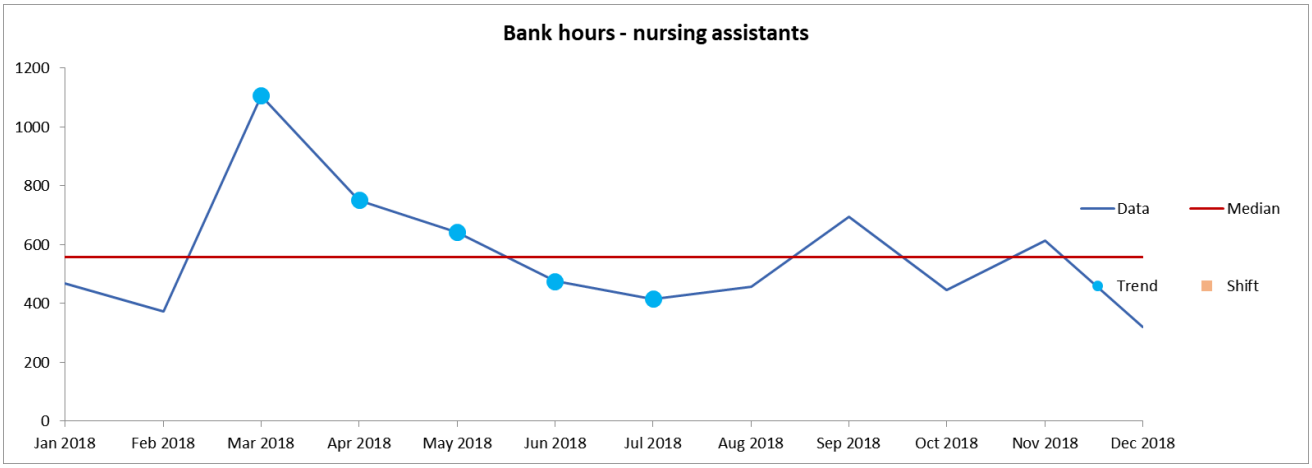
All staff

Qualified nurses



There is a mixed picture in qualified nursing staffing data. Both annual vacancy and turnover rates for qualified nurses were in the lowest 25% when compared to other similar core services. However, annual sickness rates were in highest 25% when compared to other similar core services. Despite an annual sickness rate of 7.6% and vacancy rate of 10%, only 5% of available hours were filled by either temporary bank or agency staff. Monthly 'agency hours' over the last 12 months for qualified nurses from February 2018 to June 2018. This merits investigation to find out if this trend has continued and to learn about the cause, impact and possible actions undertaken by the provider.

Nursing assistants



Mandatory training

Training data summary

The compliance for mandatory and statutory training courses at 8 January 2019 was 91%. Of the training courses listed four failed to achieve the trust target and of those, two failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training.

The provider reports a rolling month on month training completion rate.

The training compliance reported for this core service during this inspection was higher than the 86% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Health, Safety and Welfare	56	56	100%	✓	↑
Load Handling	6	6	100%	✓	↑
Safeguarding Adults Lev 1	56	56	100%	✓	↑
Adult Resuscitation - Non-Clinical	5	5	100%	✓	↑
Infection Prevention & Control Level 1	56	56	100%	✓	
People Handling	50	50	100%	✓	↑
Fire Safety Part 1 - Theory	56	55	98%	✓	↑
Fire Safety Part 2 - Extinguishers	56	55	98%	✓	↑
Preventing Radicalisation Level 1 & 2	56	55	98%	✓	↑
Safeguarding Children Lev 2	38	36	95%	✓	↓
Mental Health Act	19	18	95%	✓	↑
Hand Hygiene	56	53	95%	✓	↑
Safeguarding Children Lev 1	56	53	95%	✓	↓
Safeguarding Children Lev 3	23	21	91%	✓	↓
Safeguarding Adults Lev 2 Part 1	56	51	91%	✓	
Safeguarding Adults Lev 2 Part 2	56	51	91%	✓	
Infection Prevention & Control Level 2	56	50	89%	✓	
Mental Capacity Act	56	48	86%	✓	↑
Preventing Radicalisation Level 3	55	45	82%	✗	
Information Governance	56	44	79%	✗	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Adult Resuscitation	51	33	65%	✗	↓
Adult Resuscitation - ILS	22	12	55%	✗	
Core Service Total	**997**	**909**	**91%**	✓	↑

We asked managers about the low completion rate for immediate life support training. On Afton ward we reviewed records which suggested this data was out of date and the overall completion rate for this training topic was 85%. However, on Shackleton ward, managers did not have access to the training system, so we could not be assured of the accurate completion rate.

Assessing and managing risk to patients and staff

Assessment of patient risk

Risk management was inconsistent across the two wards. On Afton ward we reviewed four patients' risk assessments, all four assessments clearly identified the risks and the interventions required to reduce the risks. Risks were documented on the electronic record keeping system. However, on Shackleton ward, we reviewed three patients' risk assessments. One risk assessment only showed brief demographics, the level of risk had not been identified and it did not have a risk management plan in place. Another did not identify any risks or the level of risk and did not have a risk management plan in place and the third had a large section incomplete and left blank. The level of risk was not rated and there was no management plan in place.

Management of patient risk

Management of specific risk issues was inconsistent across the two wards. On Afton ward specific risk issues such as falls and diabetes management were clearly documented. However, on Shackleton ward, specific risk issues were not managed. For example, there was no tissue viability care plan for a patient at risk of skin breakdown and no falls risk management plan for a patient that was high risk of falls.

Staff on Afton ward responded to the changing needs of the patients. Staff had recently introduced a crisis card that patients carried with them when on leave from the hospital or when discharged. The card had contact numbers for the trust crisis team and the community mental health team for use in an emergency; this was part of the 'safe wards' strategy that both wards had signed up to.

Staff on both wards followed good policies and procedures for the use of observation. Staff were present in communal areas at all times and regularly checked that patients were safe.

The trust did not operate a smoke free policy. Staff offered nicotine replacement therapy to those patients that wanted it.

Use of restrictive interventions

Restrictive Interventions

This service had 44 incidences of restraint (22 different service users) and one incidence of seclusion between 1 January 2018 to 31 December 2018.

The below table focuses on the last 12 months' worth of data: 1 January 2018 to 31 December 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Afton Ward	0	26	10	0	7 (27%)
Shackleton Ward	1	18	12	0	3 (17%)
Core service total	**1**	**44**	**22**	**0**	**10 (23%)**

Restraint

There were no incidences of prone restraint. Over the 12 months, incidences of restraint ranged from one to fifteen per month. The number of incidences (44) had increased from the previous 12-month period (32).

There were 10 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from zero to two (1 January 2018 to 31 December 2018). The number of incidences (10) had increased from the previous 12-month period (six).

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (zero) was the same as the number of incidences from the previous 12-month period (zero).

The number of restraint incidences reported during this inspection was lower than the 148 reported at the time of the last inspection (1 October 2016 to 30 September 2017).

Staff on both wards only used restraint after de-escalation had failed. We observed a restraint on Afton ward during the inspection. Staff attempted verbal de-escalation, but restraint was necessary to prevent an increase in agitation. Staff worked together as a team and handled the situation with kindness and professionalism. Staff fully documented the incident on the trust restrictive intervention form and on the electronic reporting system. A note was made to provide a debrief with the patient when appropriate.

Staff on both wards followed National Institute of Health and Care Excellence guidelines when administering rapid tranquilisation. Post physical health monitoring was completed in line with these guidelines. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others and allow them to receive the medical care that they need.

Seclusion

There had been one instance of seclusion over the reporting period. The number of incidences (one) had decreased from the previous 12-month period (two).

The number of seclusion incidences reported during this inspection was lower than the 67 reported at the time of the last inspection (1 October 2016 to 30 September 2017).

Staff on Shackleton ward told us there had been no episodes of seclusion in a very long time and they knew that seclusion should only be used as a last resort.

Segregation

There have been no instances of long-term segregation over the 12-month reporting period. The number of incidences (zero) was the same as the previous 12-month period (zero).

The number of segregation incidences reported during this inspection was the same as the zero reported at the time of the last inspection (1 October 2016 to 30 September 2017).

Safeguarding

Staff on both wards understood their safeguarding responsibilities. Safeguarding referrals were made through the trust safeguarding team and recorded on the electronic incidents reporting system. There was a safeguarding lead within the trust; staff knew how to contact them should they need advice and they attended any risk meetings on the ward. Records showed staff had worked with other agencies when safeguarding referrals had escalated.

Children visited patients on the wards. Children were permitted on both wards. This was risk assessed by staff. Staff did not supervise visits but were always available nearby. There had been no adverse incidents concerning children visiting the wards.

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.

This trust made 149 Mental Health and learning disability service safeguarding referrals, however they have not provided a core service breakdown. Between 1 January 2018 and 31 December 2018, 73 safeguarding referrals concerned adults and 76 children.

Serious case reviews

The trust has submitted no details of serious case reviews commenced or published in the last 12 months (1 January 2018 to 31 December 2018) that relate to this service.

Staff access to essential information

Staff used a combination of paper and electronic records on both wards. The daily notes, care plans and risk assessments were stored electronically, observations, food and fluids and continence records were kept in paper format and later uploaded electronically. All staff had a log on to access the electronic system.

Medicines management

The trust had systems in place for the safe storage, administration, prescribing and disposal of medicines. However, on Afton ward, we were not assured that mental capacity was assessed prior to administering medicines covertly or appropriate mental health processes followed.

The trust pharmacy department supplied medicines as stock and dispensed for individual patients. Medicines were stored securely. However, the fridge temperature records on Afton ward stated the fridge had been outside of its recommended temperature range and no actions had been taken. As Shackleton ward had recently reopened, there was a lack of clarity between the staff and the records concerning the status of the patients under the Mental Health Act and the associated authorities to administer medicines.

The clinic rooms on both wards contained oxygen cylinders within them. There was no sign on the door to advise fire officers of this should there be a fire on the wards. Managers on both wards assured us they would put this in place.

Track record on safety

Serious incidents requiring investigation

Between 1 January 2018 to 31 December 2018 there were two serious incidents reported by this service, both categorised as ‘sub-optimal care of the deteriorating patient’. There were no unexpected deaths.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with two reported.

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 zero never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the zero reported at the last inspection.

	Number of incidents reported	
Type of incident reported (SIRI)	**Sub-optimal care of the deteriorating patient**	**Total**
Afton Ward	1	1
Shackleton Ward	1	1
Total	**1**	**1**

Staff had fully investigated both serious incidents and learning had been clearly documented.

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 two ‘prevention of future death’ reports sent to Isle of Wight NHS Trust, however none of these related to this service.

All staff knew what incidents to report and how to report them. All staff said they were familiar with the incident reporting procedure. We reviewed records which showed that incidents had been clearly documented by staff and followed up by managers. Learning was documented on the form and shared with staff teams. Staff debriefed patients and staff following incidents.

Staff understood their duty of candour and were open and transparent with patients and carers when things went wrong. Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff were aware of the need to be open and transparent when things went wrong. The service had a duty of candour policy. Staff understood the importance of needing to be open, transparent and apologise to clients when things went wrong.

Is the service effective?

Assessment of needs and planning of care

All seven patients across both wards had a full mental health assessment in their care records. All patients had a mental state examination on admission.

Patients' physical health needs were not always met on Shackleton ward. Care plans relating to specific needs such as skin integrity, falls, mobility, visual impairment and hearing impairment were not present for one patient. However, staff took patients’ physical observations regularly and the junior doctor had physically checked the patients on admission.

Patients on Afton ward had their weight and nutrition monitored monthly. Care plans were in place relating to physical health needs such as skin integrity and diabetes. 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.

Staff on Shackleton ward did not complete holistic, goal focussed personalised care plans for patients. Goals were not identified, did not reflect individual preferences and did not detail nursing interventions.

Staff on Afton ward completed holistic care plans that met patients’ needs. However, they were not always goal focussed. Staff regularly updated care plans on Afton ward. Patients had only been on Shackleton ward for up to 10 days since the ward reopened, all care plans had been written within the last 10 days.

Best practice in treatment and care

Staff on Afton ward provided a range of care and treatment interventions as recommended by the National Institute of Health and Care Excellence. For example, patients were offered combined

healthy eating and physical activity opportunities and meaningful activities such as anxiety management. There was a trainee clinical psychologist on Afton ward who delivered anxiety management sessions and cognitive behavioural therapy.

Staff on Shackleton ward did not provide care and treatment interventions in line with these guidelines. There were no meaningful activities identified within an activity plan, we did not observe any activities during the inspection and there was no activities coordinator or occupational therapy input. Staff could request an occupational therapist from the memory clinic to visit the ward, but this had not been done in the 10 days since the ward opened. The service was due to interview for an activity's coordinator imminently, but they could not start until the necessary recruitment checks were in place. Patients on Shackleton ward did not have any psychological input or therapy.

Staff on Shackleton ward did not assess and meet patients' needs for fluids. One of the three patients on the ward had a very low fluid intake and was at risk of dehydration, there had been no escalation to a doctor or nursing plan to manage this and there was no fluid target identified for daily fluids. We escalated this at the time of the inspection and were assured that staff would prioritise the patient's physical health needs and take appropriate steps to ensure the patient was safe. We had no concerns about patients' food or fluid intake on Afton ward.

Staff supported patients on Afton ward to live healthier lives. Patients on Afton ward participated in yoga and meditation, walking sessions and armchair exercises. On Shackleton ward we did not see evidence of similar activities on offer to patients. Both wards offered nicotine replacement therapy if patients requested it.

Staff on Afton ward participated in clinical audit. Staff completed audits in care planning and care programme approach, environmental audits, medicines and falls.

Staff on Shackleton ward could not identify any audits that were being undertaken on the ward.

Local audits

This service participated in three clinical audits as part of their clinical audit programme 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Mental Health Clinical Outcome Review Programme (NCISH) Safer Care for Patients with Personality Disorder	Mental Health	Not specified	Clinical	Oct-18	Report currently being written
Mental Health Clinical Outcome Review Programme (NCISH) The Assessment of Risk and Safety in Mental Health Services	Mental Health	Not specified	Clinical	Oct-18	Report currently being written
NICE guideline QS95 Bipolar in Adults	Mental Health	Not specified	Clinical	Aug-18	Findings to be presented at weekly Chantry House meeting to raise awareness. - Checklist of NICE Bipolar disorder quality statements to be distributed to

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					all relevant Chantry House staff members, to act as supplement to usual care plan. - Repeat reminder invitation letter to physical health check to be sent out to all patients. - Liaise with psychology team for ideas on how to improve offer of psychological intervention to patients.

Skilled staff to deliver care

The team on Shackleton ward did not have access to a full range of specialists. There was no occupational therapist or activities coordinator assigned to the ward and no psychologist. There were occupational therapists that worked within the memory service, but staff had not utilised them in the 10 days since the ward had reopened. We were not assured that all staff had the right skills and knowledge to meet the needs of the client group; we did not see meaningful engagement between staff and patients.

On Afton ward, the team had access to a trainee psychologist for one day per week, access to occupational therapists who regularly visited the ward and two activities coordinators. Staff on Afton ward knew the patients well and had the right skills to meet patients' needs. We observed meaningful interaction between staff and patients throughout the day including de-escalation skills when patients were in distress.

Staff referred patients to the dietetic team or the speech and language team through the electronic trust system. Staff told us specialists were responsive following these requests.

Staff on both wards had received an appropriate induction. Bank staff and student nurses also received an induction to support them to carry out their role.

The trust provided opportunities for staff to develop their skills. For example, some staff had begun an apprenticeship through the open university and others were working towards becoming a nurse associate.

Appraisals for permanent non-medical staff

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 49%. This year so far, the overall appraisal rates was 78% (as at 8 February 2019). The ward with the lowest appraisal rate at 8 February 2019 was Shackleton Ward with an appraisal rate of 52%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 53% reported at the last inspection (1 October 2016 to 30 September 2017).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 8 February 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Afton Ward	34	32	94%	76%
Shackleton Ward	21	11	52%	19%
Core service total	**55**	**43**	**78%**	**49%**
Trust wide	**2724**	**2007**	**74%**	**66%**

Appraisals for permanent medical staff

The trust has not provided any data relating to medical staff within this core service.

Clinical supervision for all staff

The trust has not provided clinical supervision data for this core service.

During the inspection we found that supervision of staff on Shackleton ward was insufficient, there were gaps in records that showed staff did not receive essential supervision in their role. Prior to the ward closure, staff did not receive management supervision. Management supervision had only just started since the ward had reopened and they had supervised approximately 50% of the staff. There was a newly created management supervision structure in place with staff allocated a supervisor. Staff chose their own clinical supervisor and were required to log on a record to notify managers that they had received supervision. However, the clinical supervision record showed that 12 staff had never received clinical supervision. One member of staff received supervision in May and prior to that just three staff had received supervision in March, six in February and three in January. Eight staff had received supervision since the ward reopened.

On Afton ward, staff received regular supervision. Staff told us they were supervised and supported to undertake their roles.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary team meetings. We observed one multidisciplinary team meeting on Shackleton ward which was attended by one nurse, a junior doctor and the consultant psychiatrist. Appropriate discussions were held including referrals to specialists. On Afton ward, records showed full multidisciplinary attendance at meetings where essential information about patients was shared and discussed.

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

Staff on both wards had access to advice and support from the Mental Health Act administration team. Patients on both wards had access to independent mental health advocates. Patients received their rights in line with legislation and local policy.

Patients on Afton ward used their section 17 leave. Patients on Shackleton ward had not used their leave in the days leading up to the inspection, but they had regularly been taken to the garden for fresh air.

Informal patients might not have known they could leave the ward. There was no sign on either Afton or Shackleton ward that advises informal patients they could leave the wards if they wished to.

Mental Health Act training figures

As of 8 January 2019, 95% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every two years.

The training compliance reported during this inspection was higher than the 91% reported at the last inspection (9 October 2017).

Good practice in applying the Mental Capacity Act

There was inconsistency amongst staff in the understanding of the Mental Capacity Act. Staff on Shackleton ward had a limited understanding of the Act and its principles. Staff on Afton ward had a good understanding of the principles of the Mental Capacity Act. There was a mental capacity lead within the trust that staff could request advice from. However, staff on both wards had failed to make an application under the Deprivation of Liberty Safeguards for one patient on each ward. This meant that those patients were not protected by the safeguards of the Act such as the right to advocacy or right to appeal.

On Shackleton ward one patient with an infection had refused antibiotics for four days. Staff had not escalated this to a doctor to consider whether a Mental Capacity Assessment and best interest decision to administer medicines covertly was necessary. This meant the infection remained untreated. We raised this at the time of the inspection and staff were considering this option of medicines administration. On Afton ward medicines were potentially being administered covertly. Records reviewed lacked assurance that the patients' mental capacity had been assessed and documented. Therefore, we were not assured that medicines were managed safely in relation to the Mental Capacity Act within this service.

Mental Capacity Act training figures

As of 8 January 2018, 86% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The training compliance reported during this inspection was higher than the 62% reported at the last inspection (9 October 2017).

Deprivation of liberty safeguards

The trust told us that eight Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 January 2018 to 31 December 2018.

The greatest number of DoLS applications were made in October 2018 with three.

CQC received three direct notifications from the trust between 1 January 2018 to 31 December 2018. This is lower than the six notifications that the trust have stated that they sent to the CQC in 2018.

The number of DoLS applications made during this inspection was higher than the four reported at the last inspection (1 October 2016 to 30 September 2017).

	Number of 'Standard' DoLS applications made by month												
	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Total
Standard applications made	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Standard applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**
	Number of 'Urgent' DoLS applications made by month												
	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Total
Standard applications made	0	0	1	0	0	0	0	0	2	3	0	1	**7**
Standard applications approved	0	0	0	0	0	0	0	0	1	0	0	0	**1**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff on both wards showed kindness and respect to patients. All nine patients and five carers we spoke with spoke positively about the staff on the wards.

Staff on Afton ward understood the patients' individual needs. There was a large 75" television at one end of the lounge which was used to stream calming soundtracks and outdoor scenes for patients when they were feeling agitated. Staff had considered what patients' individual preferences were around this. For example, staff had streamed motorbike racing clips for one patient who liked motorbikes. Staff also used the television to stream yoga sessions which allowed patients to relax and meditate.

Staff said they could raise concerns about disrespectful or discriminatory behaviour. Staff felt they would be taken seriously, and action would be taken by managers.

Staff did not consistently keep patients' confidential information safe. At our last inspection in 2018, the ward office on Afton ward was not secure; the door was unlocked and patients and visitors could hear staff speaking because there was a gap at the top of the nurses' station. During this inspection, we found the office was now located in a secure side room. Confidential information about patients was kept safe and there were no concerns about visitors and patients hearing confidential information about patients.

During our last inspection in 2018 on Shackleton ward, we found patients confidential information left out in communal areas consistently throughout the day. During this inspection, we found that staff were still leaving confidential information about patients in communal areas. There was a lockable filing cabinet containing further confidential patient records, but it remained unlocked during the inspection. In addition, on one occasion we found a computer in a communal area had been left logged on. This could have led to unauthorised access to patient information.

Patient-Led Assessments of the Care Environment (PLACE) - data in relation to privacy, dignity and wellbeing

The site which delivers MH - Wards for older people with mental health problems within Isle of Wight NHS Trust was compared to other sites of the same type and the score it received for 'privacy, dignity and wellbeing' was found to be about the same as the England average.

Involvement in care

Involvement of patients

Staff on both wards fully orientated patients to the ward on admission. Patients were informed about the daily routine, the menu and who their named nurse was going to be.

Patients were involved in their care plans on both wards. Patients on Shackleton ward were not given copies of their care plans. Staff on Afton ward completed care plans with the patients and then printed a copy off for them if they wanted it. Patients on Afton ward said they felt involved in the care planning process. Patients on Afton ward were involved in meal planning, patients bought the ingredients with staff and supported the patients to cook the meal.

Patients on Afton ward were given a feedback questionnaire upon discharge. Changes had been made because of the feedback and those changes were displayed on the performance board. On Shackleton ward there were no opportunities to formally feedback.

The trust had not involved patients in the redesign of either of the wards.

Informal patients did not always have access to advocacy. Patients on Afton ward accessed the local advocacy provider. When we asked managers on Shackleton ward about this, they were unaware of what advocacy support was available for informal patients.

Involvement of families and carers

On Shackleton ward, one carer said they had been involved in the care planning process since admission and one carer said they were not involved in the care planning process. Carers on Shackleton ward all said they felt staff kept them involved and were kept up-to-date with their relatives' care. We only spoke with one carer on Afton ward who spoke positively about how staff involved them.

The trust had not involved carers in the redesign of either of the wards.

On Afton ward, there were opportunities for carers to feedback about the service including a discharge questionnaire and a visual performance board which showed the action staff had taken because of feedback. On Shackleton ward, staff told us there were no opportunities to formally feedback.

The trust provided carers with information about how to access a carers' assessment. There were leaflets on the wards and there was a carers' lounge within the hospital that carers visited for advice and support.

Is the service responsive?

Access and discharge

Bed management

Bed occupancy

The trust provided information regarding average bed occupancies for two wards in this service between 1 January 2018 and 31 December 2018.

Both wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 January 2018 – 31 December 2018) (current inspection)
Afton Ward	76% - 99%
Shackleton Ward	100% - 100%

Staff on Afton ward supported patients with a range of needs that fell outside of the scope of functional mental illness for older people. For example, Afton ward regularly admitted patients from Shackleton ward, the acute or psychiatric intensive care wards or the general hospital. Staff had adapted to ensure they could meet patients needs. Staff had recently admitted a number of patients that had end of life needs. To ensure patients received the right standard of care, staff had received online training in end of life, could access the trust end of life link nurse and had support through a bleep system 24 hours per day. Additionally, staff audited their end of life care and developed action plans to drive improvements.

On Afton ward, there was always a bed available when patients returned from leave, although it may not have been the original bed they were staying in. Patients on both wards were only transferred at an appropriate time of day.

Average Length of Stay data

The trust provided information for average length of stay for the period 1 January 2018 and 31 December 2018.

Ward name	Average length of stay range (1 January 2018 – 31 December 2018) (current inspection)
Afton Ward	10 – 69 days
Shackleton Ward	14 – 160 days

Out of Area Placements

This service reported no out of area placements between 1 January 2018 and 31 December 2018.

The number of out of area placements reported during this inspection was the same as the zero reported at the time of the last inspection.

However, since the trust provided the above data, there had been some out of area placements. This was because during the time that Shackleton ward was closed, some patients had to be looked after out of area as Afton ward was full and there was no appropriate bed availability elsewhere in the trust. This had caused some distress to patients and their families because they had to travel a long distance to visit their loved ones.

Readmissions

This service reported nine readmissions within 28 days between 1 January 2018 and 31 December 2018. Seven of the readmissions (78%) were readmissions to the same ward as discharge. The average of days between discharge and readmission was 11 days. There were no instances whereby patients were readmitted on the same day as being discharged but there was one where a patient was readmitted the day after being discharged.

At the time of the last inspection, for the period 1 September 2016 to 31 August 2017, there were a total of no readmissions within 28 days.

Therefore, the number of readmissions within 28 days had increased between the two periods.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Afton Ward	7	5	71%	2 – 24	13
Shackleton Ward	2	2	100%	1 – 2	2

Discharge and transfers of care

Delayed discharges

Between 1 January 2018 and 31 December 2018 there were 77 discharges within this service. This amounts to less than one percent of the total discharges from the trust overall (31,679).

The delayed discharge data provided by the trust is inconclusive and has therefore not been included.

Staff reported difficulties in discharge planning. Historically, the trust social worker had attended multidisciplinary team meetings, but this person had left the trust. The local authority did not have the capacity to send a social worker to all multidisciplinary team meetings. The local authority had advised staff they should only refer patients when they were ready for discharge. This meant that at the point patients were ready to be discharged, there could be a delay in finding them a placement.

Facilities that promote comfort, dignity and privacy

Patient-Led Assessments of the Care Environment (PLACE) assessments

The site which delivers MH - Wards for older people with mental health problems within Isle of Wight NHS Trust was compared to other sites of the same type and the score it received for 'ward food' was found to be about the same as the England average.

All patients on both wards had their own bedrooms and were not expected to sleep in bays or dormitories. Patients could personalise their rooms if they wished to. Both wards had access to a clinic room to examine patients and a nursing station which was used to deliver handovers from shift to shift. There were no activities rooms on either ward, on Afton ward, activities were delivered in the communal area. Afton ward had a secure garden adjoining the ward. This had been recently renovated, was laid out with raised flower and vegetable beds and a greenhouse. The area was both tidy and well cared for. Staff and patients had grown a range of fruit and vegetables in the garden and we observed staff picking strawberries for the patients to have with their evening meal.

Patients could not always make a telephone call in private. On Shackleton ward there was no phone for patients' use. However, on Afton ward there was a mobile phone that patients could use to make a call in private.

Both wards had access to outside space. On Afton ward the new garden which was adjacent to the ward was unlocked and patients could freely come and go. However, the garden on Shackleton ward was away from the ward and involved the patients either using the stairs or lift and walking down a corridor to get to it. It was always kept locked and required staff supervision.

Patients on both wards had access to hot and cold drinks and snacks throughout the day. At our last inspection in 2018 we found that patients on Shackleton ward had to request drinks and snacks from staff. This meant that patients that did not have the cognitive ability to make these requests may not have had drinks and snacks when they needed them. During this inspection, we found hot and cold drinks and snacks were available to patients on Shackleton ward. On Afton ward, patients continued to have access to hot and cold drinks and a range of snacks.

Patients' engagement with the wider community

Staff on both wards supported patients to maintain contact with their families and carers. On Shackleton ward there were no protected visiting times and a relative had recently spent the night on the ward as part of the ward's 'safe wards' strategy. Families were encouraged to have dinner with the patients. On Afton ward, visiting hours were 4pm-9pm and open visits at the weekend. Staff told us they could be flexible about visiting hours in certain circumstances.

Meeting the needs of all people who use the service

The trust had made adaptations to ensure the service met the needs of those with physical disabilities. There were adapted bathrooms on both wards and on Afton ward there was an adapted en-suite. The recent structural changes to the environment meant that most areas of the wards were wheelchair friendly. There were hand rails in corridors and toilets at low level to support patients' mobility.

On Afton ward, there were leaflets available to patients about how to complain should a patient wish to. There were also leaflets that provided information about the independent mental health

advocates, information about pressure care, the trust carers' lounge and a local domestic abuse service. On Shackleton ward, there were leaflets about how to complain but these were located outside of the main doors meaning that patients could only see them if they left the wards. There was also a poster advertising the Alzheimer's café but the poster was out of date as the event occurred in 2018. Staff on both wards told us they could access information for people whose first language was not English through the trust and interpreting services were available.

Patients on both wards told us the food was good. Patients said they got a choice from the menu and there was always enough. Staff told us they could request special diets such as halal or kosher if a patient was admitted that had specific dietary needs.

Staff ensured that patients had access to appropriate spiritual support. A chaplain visited both wards weekly. When patients were admitted from different faiths, the chaplaincy service put staff in touch with the necessary spiritual support.

Patient-Led Assessments of the Care Environment (PLACE)

The site which delivers MH - Wards for older people with mental health problems within Isle of Wight NHS Trust was compared to other sites of the same type and the score it received for 'disability' and dementia friendliness' was found to be about the same as the England average.

Listening to and learning from concerns and complaints

Formal complaints

This service received no complaints between 1 January 2018 to 31 December 2018.

However, during the inspection we found there had been some complaints on both wards since the above time frame. We reviewed two complaint; one on each ward, the complaints had been fully investigated by the trust and the outcome was given to the complainant. The trust apologised to complainants when things went wrong.

Compliments

This trust's mental health services received two compliments during the last 12 months from 1 January 2018 to 31 December 2018 which accounted for less than 1% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Managers had the right skills and experience to perform their roles. However, managers on Shackleton ward had not been supported to prepare them for the reopening of the ward. As a result, the interim ward manager did not have a good understanding of the service they managed, the model of care or the underpinning governance arrangements. There was no process in place to review key items such as the strategy, values, objectives, plans or the governance framework. Managers on Shackleton ward had no understanding of governance arrangements including; any audits, staff training completion rates, the ward risk register, complaints, staff appraisals and access to the electronic incident register.

On Shackleton ward, there was a lack of senior clinical support for managers. The direct line managers of the newly appointed interim ward manager did not have a clinical background. When managers requested support from their line manager, it was not available. There was some support from Afton ward but not enough to support a new manager into post.

Managers on Afton ward had a good understanding of the service and could clearly explain how teams were working to provide high quality care.

Managers, up to band 8, were visible in the service. Band 8 managers had attended team meetings on Afton ward. Staff told us that more senior managers visited the wards when there were problems but not as a matter of course. However, managers felt there was a higher level of recognition regarding the mental health directorate at board level.

The trust had recently implemented a leadership development plan. Two staff on Shackleton ward had already completed this and it was to be rolled out to other staff from band 6 level, up to executive level.

Vision and strategy

The trust had clearly communicated its vision and strategy to frontline staff within the service. The trust had consulted staff about revising the vision and communicated the new vision through emails, engagement meetings and the intranet. Staff on both wards had been consulted and had contributed to the redesign of both wards.

The trust had not explained the strategy for Shackleton ward. Staff and managers did not know what the action plan was in reopening the ward or whether they were on target for meeting the action plan. Staff did not understand how their role contributed to achieving the strategy.

Culture

Frontline staff on both wards felt supported and valued. Staff were positive about the service they worked in and proud of their team. However, staff on Afton ward felt they had lost their identity as a ward for older people with a functional mental illness as they admitted patients that were outside of the scope of the service. Whilst staff had managed well despite bed pressures from other wards, the situation had affected staff morale.

Staff on both wards felt able to blow the whistle should they need to. Staff felt they could raise concerns to their managers and would be listened to.

Staff on both wards worked well together, Staff did not report any ongoing conflict or difficulties within the teams.

Appraisals on Afton ward included conversations about staff development. We were unable to access individual appraisals on Shackleton ward.

The trust ensured staff had access to support for their own physical and mental health. Staff could self-refer to the mental health practitioner who was based in occupational health. The trust also provided free of charge counselling service for up to six sessions. Staff could fast track physiotherapy assessments and could also access discounted massages through occupational health.

The trust held a bi monthly, mental health staff engagement group. Staff on Afton ward had won awards at these events and the team had won an award for most highly performing team.

Governance

The trust had not supported managers on Shackleton ward by setting the governance arrangements prior to reopening the ward. The governance arrangements and their purpose were unclear. There was no process in place to review key items such as the strategy, values, objectives, plans or the governance framework. Managers on Shackleton ward had no understanding of governance arrangements including; any audits, staff training completion rates, the ward risk register, complaints, staff appraisals and access to the electronic incident register.

On Afton ward, there was a clear framework of what must be discussed at ward level and directorate team level to ensure essential information was shared. For example, lessons learned following serious incidents and safeguarding cases, any complaints and outcomes from local audits. Staff on Shackleton ward were unaware of the governance arrangements or what meetings they should attend.

Staff on Afton ward participated in a range of audits, the outcomes of these were fed back at team meetings and an action plan was developed. Staff on Shackleton ward were unaware of what audits should take place.

Management of risk, issues and performance

Managers on Afton ward had access to the risk register, knew what was on it and added to it as new risks arose. However, the trust had not explained to managers on Shackleton ward the purpose of the risk register or how to access it.

Managers were aware of the emergency plans for the wards. Mangers accessed contingency plans through the trust intranet. For example, in the event of a flu outbreak.

Information management

Staff had access to the equipment and information technology needed to carry out their roles. There were enough computers and the telephone system was working at the time of the inspection. However, there were ongoing issues with the electronic patient records system that was used across the trust. Staff felt the system was cumbersome and found it difficult to find the documentation they needed.

Staff made notifications to external bodies as needed such as the Care Quality Commission and the local authority.

Engagement

Staff had access to information about the work of the trust. Staff received up-to-date information through bulletins and the intranet.

The trust had engaged with staff about the redesign and the vision for the service but there had been no engagement with patients or carers.

Learning, continuous improvement and innovation

Both wards had signed up to the safe wards programme and had begun to embed these strategies into their practice.

Accreditation of services

NHS trusts can 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.

There were no accredited teams within this core service.

Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Mary Rose Ave	Reablement Team	Not provided	Mixed
St Mary's Hospital	Single Point of Access team	Not provided	Mixed
Chantry House	Community Mental Health Services	Not provided	Mixed

Newport	Early intervention into Psychosis (EIP)	Not provided	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

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 environment of Chantry House was clean and tidy. However, it was old and in need of updating. One member of staff told us that they did not think the environment was appropriate for patients due to it being outdated. Senior managers told us that they had tried to relocate the service to a new building, but they had not been able to get the lease arranged so they were looking for a new location.

Ligature points within the building had been assessed and there were ligature cutters available to staff.

There were personal alarms in each room which were tested weekly and one room was used for use with patients identified as being a risk of violence towards staff.

The clinic room in Chantry House had the equipment needed to carry out physical health monitoring. However, there was no record of when the equipment had last been checked or cleaned. The chairs were not designed to be cleaned easily and therefore were an infection control risk.

The Early Intervention in Psychosis team were based in an office in Newport. There was no external signage to identify it as a mental health service and it appeared like a contemporary business location. It was well furnished and had a light and airy feeling. There were alarms in rooms where patients were seen and the environment was clean, tidy and in a good state of repair.

Safe staffing

At the last inspection we were concerned by the number vacancies and the high use of agency staff and the impact it had on the care provided by the community mental health service. At this inspection there were three and a half vacancies and the service had reduced the use of agency staff. However, there remained a high turnover of staff and this continued to affect the consistency and quality of care offered by the service. For example, patients with a care co-ordinator would be placed back on the waiting list if the care co-ordinator left.

The community mental health service was split across three teams and each had a clinical team leader. At our previous inspection we were concerned that clinical team leader posts were being

filled on an interim basis and often by agency staff who would change regularly. At this inspection only one clinical team leader was in post and one was due to start shortly. Both were permanent staff. The current team leader felt it remained difficult to recruit staff but was trying new strategies, such as advertising posts as band 5 development posts so they could attract less experienced and newly qualified staff.

At the previous inspection we were concerned about the number of patients on clinical staff's caseloads. At this inspection we reviewed five staff members caseloads and saw that they all had more patients than were agreed by the trust. The manager told us that they reviewed patients with staff members monthly to review the caseload acuity and identified patients that could be safely discharged back to primary care. However, this did not lead to many discharges as the current practice was that patients remained on staff caseloads. The manager was unable to tell us how many patients had been discharged.

The service had started a nurse led clinic to help address the number of patients on the community team caseload. Patients under the care of the nurse led clinic were reviewed every six weeks to six months. However, there were currently over 400 patients being reviewed by the nurse led clinic and senior managers told us that many of these could be discharged back to primary care or a third sector provider, but staff remained cautious about doing this.

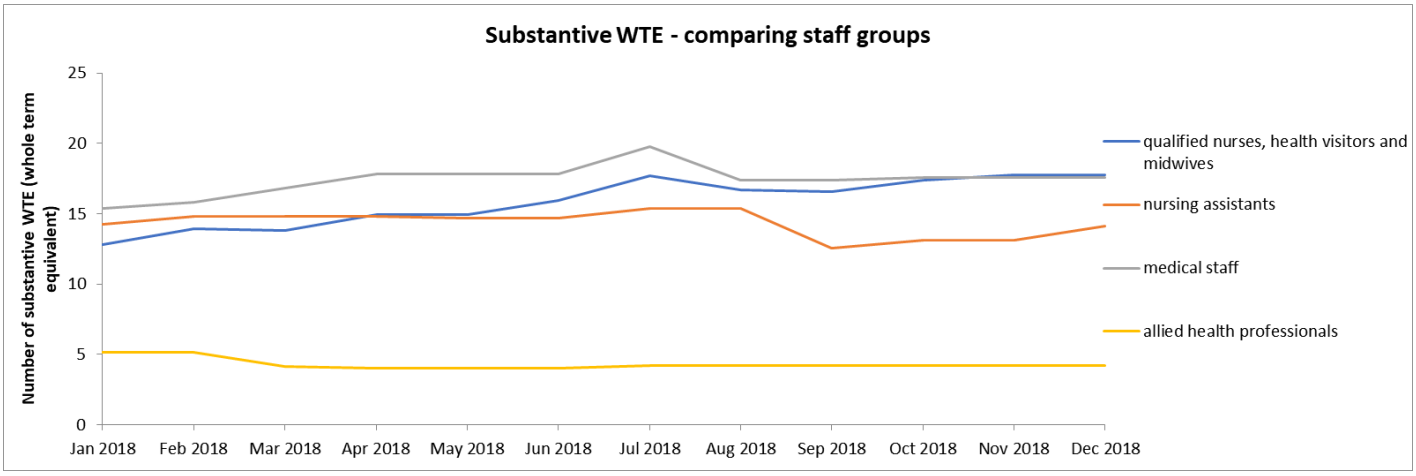
There was a waiting list of 180 patients to be allocated to the community team across the three teams. There was a psychological therapy waiting list of 196 and 129 people were waiting for group work. Managers were not aware of how many people appeared on more than one waiting list.

At the time of the inspection there was one vacancy at the early intervention in psychosis team (EIP) and this was filled with an agency staff member. The agency member of staff was on a longer-term contract, was very experienced and knew the patients well. The team manager was in an interim post, but they explain to the inspection team that this was their choice as they had transferred from another team.

There was no waiting list for the EIP.

The Single Point of Access Team (SPA) had no vacancies and a permeant manager.

The below chart shows the breakdown of staff in post WTE in this core service from 1 January 2018 to 31 December 2018.



Annual staffing metrics

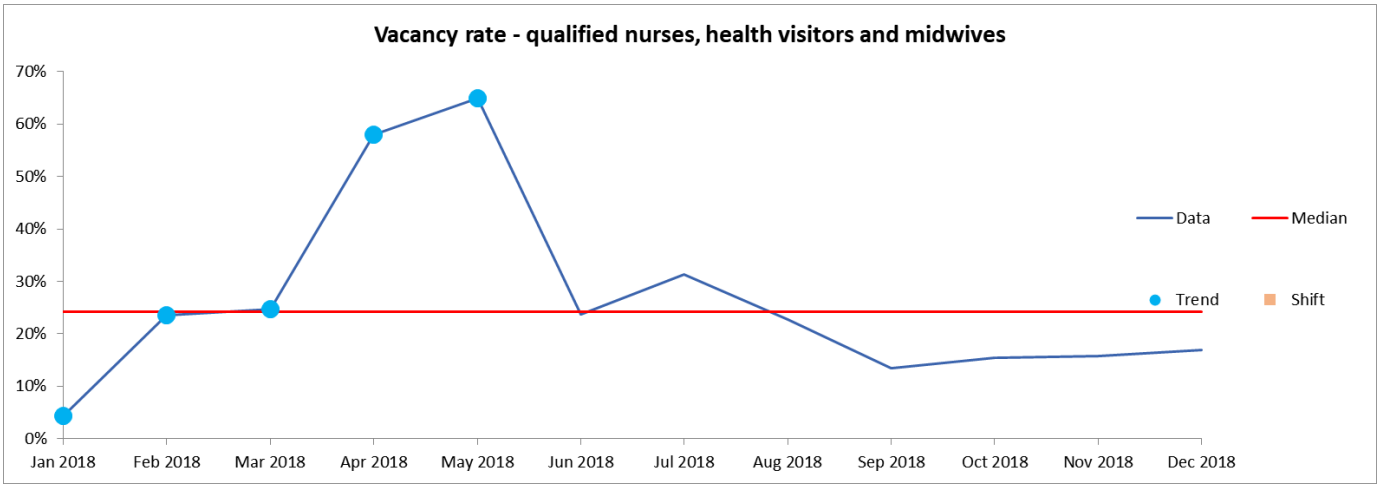
	Core service annual staffing metrics (1 January 2018 - 31 December 2018)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	71.0	19%	15%	8.8%			
Qualified nurses	23.2	25%	12%	18.3%	630 (1%)	17,532 (30%)	413 (1%)
Nursing assistants	17.8	4%	7%	7.1%	726 (2%)	0 (0%)	2,066 (7%)
Medical staff	13.8	37%	26%	4.7%	0	0	0
Allied Health Professionals	4.9	35%	23%	2.9%			

NOTE: The trust has been unable to provide a team breakdown of vacancy data.

All staff

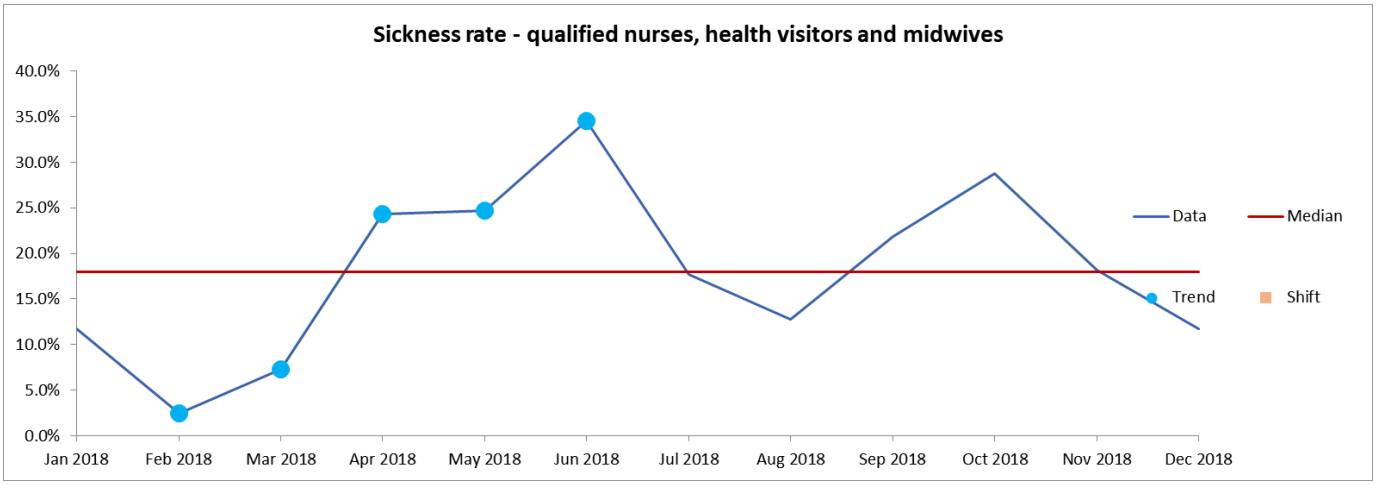
There were indications of risk within the staffing data for this core service. The average vacancy rate, turnover rate and sickness rate were in the highest 25% when compared to other core services nationally. Change over time analysis for all staff groups suggests this was a consistent theme throughout the reporting period.

Qualified nurses

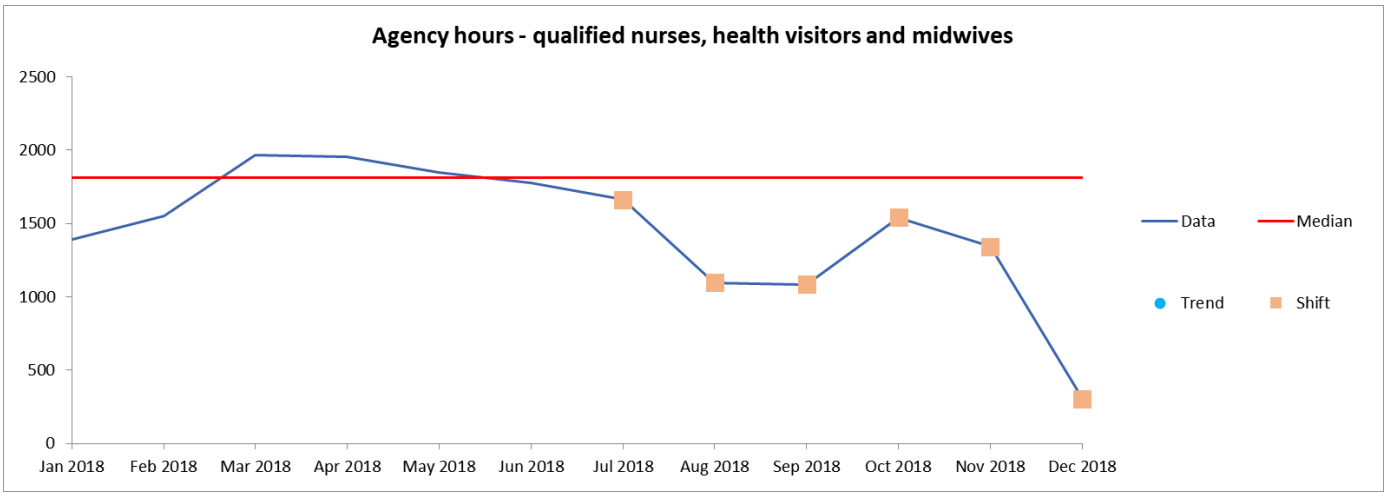


The average vacancy rate for qualified nurses was in the highest 25% when compared to other similar core services nationally. Monthly 'vacancy rates' over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from January 2018 to May 2018. This could be an early indicator of deterioration. This merits investigation to learn about the cause,

impact and possible actions undertaken by the provider to reverse the deterioration.

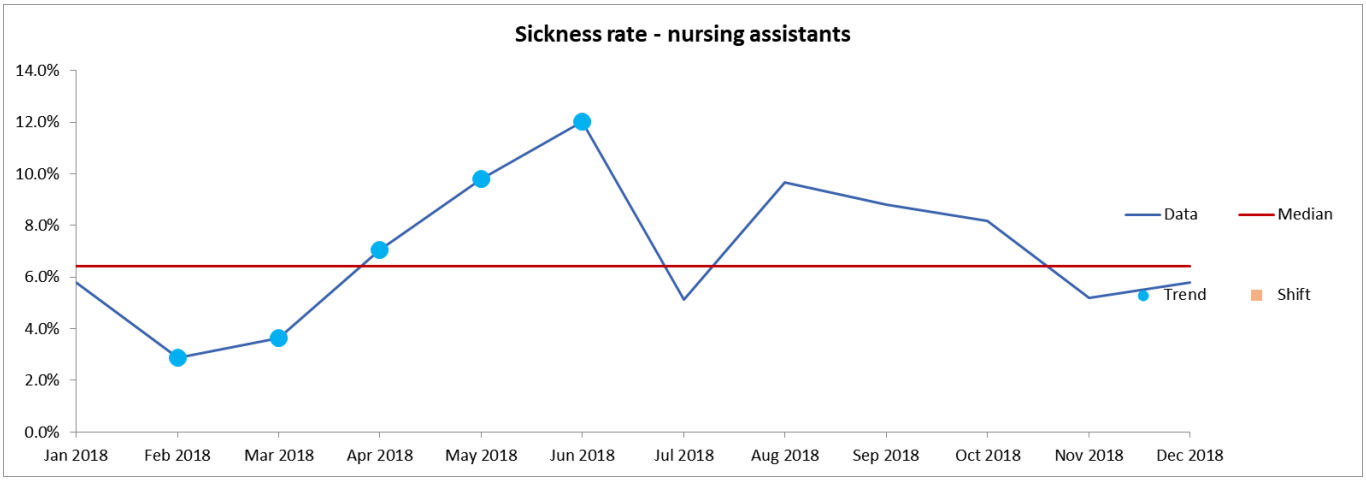


Coinciding with an upwards trend in vacancies, monthly 'sickness rates' over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from February 2018 to June 2018. This could be an early indicator of deterioration. This merits investigation to find out if this trend has continued and to learn about the cause, impact and possible actions undertaken by the provider to reverse the deterioration. The average sickness rate for qualified nurses was in the highest 25% when compared to other similar core services nationally.



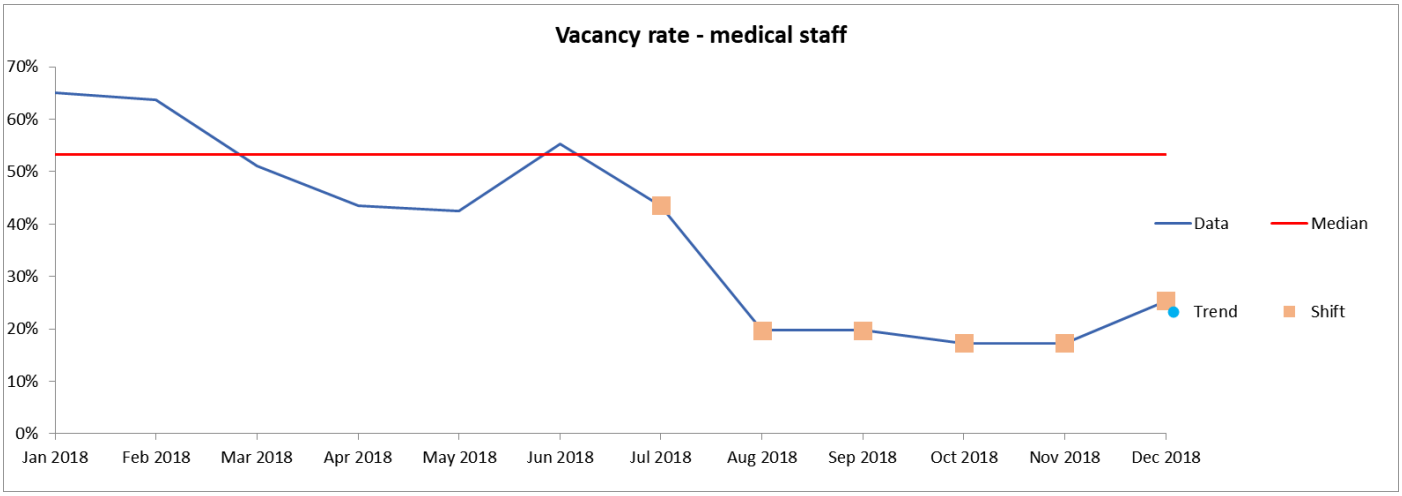
The trust used agency qualified nurses to mitigate against high sickness and vacancy rates in this core service, however did not rely on bank nurses to cover staffing gaps. Monthly 'agency hours' over the last 12 months for qualified nurses, health visitors and midwives shows a shift from July 2018 to December 2018. This could be an indicator of change. This merits investigation to find out the causes and impacts of the possible change, what has worked and how learning was shared more widely.

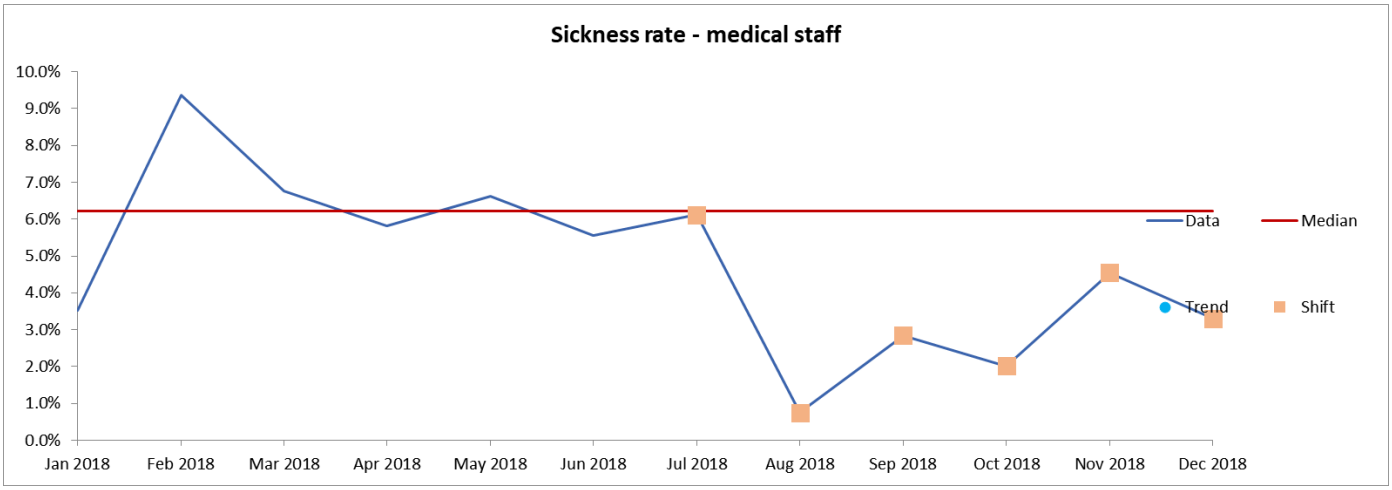
Nursing assistants



Despite high vacancy and sickness rates in other staff groups, there is no evidence of the trust upfilling nursing shifts with nursing assistants within this core service. However, coinciding with and upward trend in qualified nurse sickness rates, monthly 'sickness rates' over the last 12 months for nursing assistants shows an upward trend from February 2018 to June 2018. This could be an early indicator of deterioration. This merits investigation to find out if this trend has continued and to learn about the cause, impact and possible actions undertaken by the provider to reverse the deterioration. There was an indication of assurance for this staff group as the annual turnover rate for nursing assistants was in the lowest 25% when compared to other similar core services nationally.

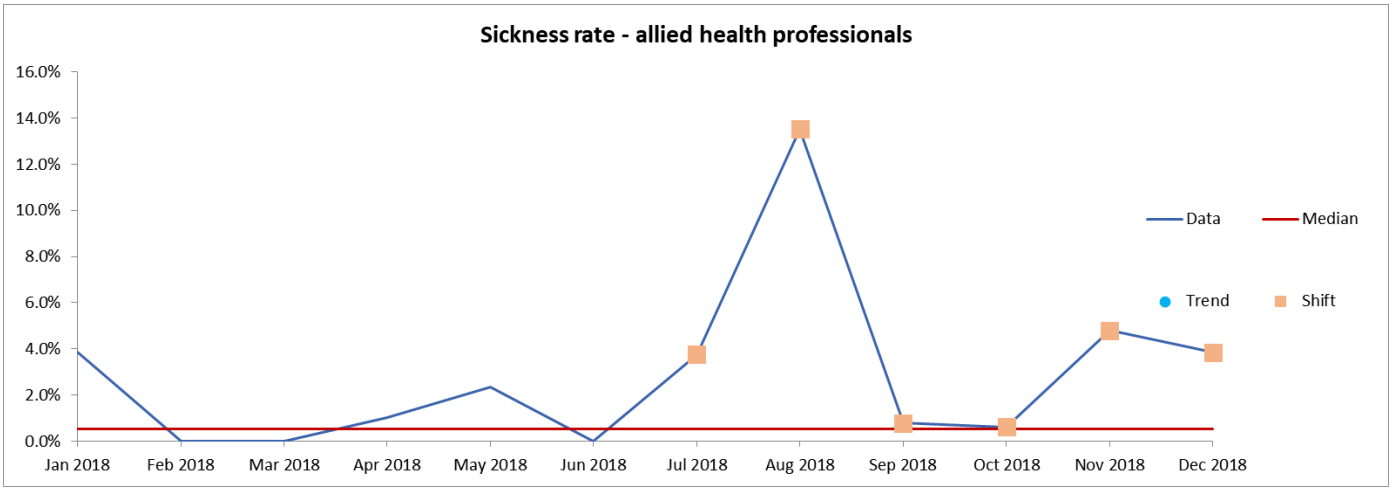
Medical staff





There were indications of risk in the staffing data for medical staff. Annual vacancy, turnover and sickness rates were all in the highest 25% when compared to other similar core services. However, both monthly 'sickness rates' and ‘vacancy rates’ over the last 12 months for medical staff show a shift from July 2018 to December 2018. This could be an indicator of change. This merits investigation to find out the causes and impacts of the possible change, what has worked and how learning was shared more widely.

Allied Health Professionals



There were indications of risk in the staffing data for Allied Health Professionals. Annual vacancy and turnover rates for nursing assistants were in the highest 25% when compared to other similar core services nationally. In addition, monthly 'sickness rates' over the last 12 months for allied health professionals shows a shift from July 2018 to December 2018. This could be an indicator of change. This merits investigation to find out the causes and impacts of the possible change.

Mandatory training

Training data was not provided at a team level. Managers had to review individual staff members training to see if they reached the trusts target of 85% completion.

Training data summary

The compliance for mandatory and statutory training courses at 8 January 2019 was 73%. Of the training courses listed 15 failed to achieve the trust target and of those, nine failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training.

The provider reports a rolling month on month training completion rate.

The training compliance reported for this core service during this inspection was lower than the 80% reported in the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✗	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Mental Health Act	2	2	100%	✓	↑
Fire Safety Part 1 - Theory	79	75	95%	✓	↑
Safeguarding Adults Lev 1	79	75	95%	✓	↑
Safeguarding Children Lev 1	79	74	94%	✓	↓
Adult Resuscitation - Non-Clinical	20	18	90%	✓	↓
Health, Safety and Welfare	79	71	90%	✓	↑
Infection Prevention & Control Level 1	79	70	89%	✓	n/a
Preventing Radicalisation Level 1 & 2	79	68	86%	✓	↑
People Handling	6	5	83%	✗	↑
Safeguarding Adults Lev 2 Part 2	72	59	82%	✗	n/a
Safeguarding Children Lev 2	61	49	80%	✗	↓
Fire Safety Part 2 - Extinguishers	79	63	80%	✗	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults Lev 2 Part 1	72	55	76%	✗	n/a
Medicines Management Practical Assessment	4	3	75%	✗	↑
Safeguarding Children Lev 3	44	31	70%	✗	↓
Load Handling	73	51	70%	✗	↓
Infection Prevention & Control Level 2	55	33	60%	✗	n/a
Mental Capacity Act	69	37	54%	✗	↓
Hand Hygiene	55	26	47%	✗	↓
Information Governance	79	37	47%	✗	↓
Preventing Radicalisation Level 3	60	22	37%	✗	n/a
Adult Resuscitation	59	21	36%	✗	↓
Medicines Management Theory	8	2	25%	✗	↑
Total	**1292**	**947**	**73%**	✗	↓

At the time of our visit mandatory training was 81% for the community team, 80% for the early intervention in psychosis team and 77% for the single point of access team. Manager were able to check staff training compliance on the trust electronic record and would send reminder via emails and during team meetings and supervision for staff training.

Assessing and managing risk to patients and staff

Assessment of patient risk

The SPA team completed a risk assessment for all patients it assessed. We reviewed eight care records and saw that they all had a risk assessment and that it was reviewed as needed. The team used the risk assessment template on the electronic patient record and would also complete a Threshold Assessment Grid (TAG), which is used to identify the acuity of a patient's mental health issues and help identify what services they may need.

Staff from the adult community team undertook risk assessments of patients, however there was variation in the quality and they were not always comprehensive. We reviewed 11 sets of care records, three did not have a risk assessment and in two records the risk assessment had not been reviewed for a year. The trusts data told us that 47% of people on Care Programme Approach (CPA) or on the waiting list for a CPA did not have a risk assessment completed. The trusts data showed us that 77% of patients not on a CPA, either open to the team or on the waiting list, did not have a risk assessment. Risk assessments for patients not on a CPA were included in a letter rather than in a risk assessment section. However, the electronic notes were difficult to

follow, staff often had to go through each individual entry to identify if risk behaviour had been followed up and to locate other documentation such as letters.

The Early Intervention in Psychosis team should risk assess all patients on its caseload. We reviewed nine case records and saw that risk assessments were not always completed and when they were the quality was inconsistent. The team leader told us that they now ensured that all new referrals would be risk assessed and this was reviewed in supervision. This was supported by the records we reviewed.

Staff did not always formulate crisis plans to mitigate risks for patients in the event of experiencing a mental health crisis. This meant that patients did not have a clear process to follow when they needed additional support.

Management of patient risk

There was inadequate oversight of patient risk while on the community mental health teams waiting lists. There were several waiting lists in operation. These held patients waiting for allocation, group work and psychological therapies. There were 432 patients on internal waiting lists waiting for treatment and 180 people waiting allocation. The trust could not be certain that patients on the waiting lists were reviewed regularly and consistently, as there were different systems in place for reviewing waiting lists. The psychological therapies team stated they reviewed patients every six weeks to six months. However, the trust could not audit this to demonstrate it was happening. Staff would need to go through every entry in the electronic record system to identify when it was completed. The duty team would review five patients a week, on the waiting allocation list. However, they always reviewed the patients they felt most at risk first, which meant the trust could not be assured that all patients were being reviewed.

The trust had reviewed all patients waiting allocation for CPA and had given them a red, amber or green rating based on the level of risk. In the five weeks prior to the inspection a senior member of the trust leadership team reviewed patients rated red on the waiting list and allocated any patients that needed immediate allocation. There was no process in place to review patients not waiting a CPA. This meant that patients who present a less immediate risk would always be moved down the waiting list and not be allocated.

Safeguarding

Trust data showed that the service had not met the agreed target of 85% compliance in four of the six safeguarding training courses staff should complete. The service was below 75% compliance in Safeguarding children level three. However, staff we spoke to understood their responsibility in safeguarding vulnerable people and knew how to make a referral when they needed to. The trust had a mental health lead for safeguarding who was available to discuss issues with staff and the staff we spoke to knew how to contact them. Staff knew how to make referrals directly to the local authority safeguarding team and could contact them to discuss any concerns they had.

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.

This trust made 149 Mental Health and learning disability service safeguarding referrals, however they have not provided a core service breakdown. Between 1 January 2018 and 31 December 2018, 73 safeguarding referrals concerned adults and 76 children.

Serious case reviews

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 January 2018 and 31 December 2018) that relate to this 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 January 2018 found that the system was not fit for purpose. Staff continued to raise concerns with inspection staff. The trust had made the core assessment a CPA assessment which meant there was nowhere for staff to record risk assessments for other patients. This meant risk assessments were recorded in letters making them difficult to find and update. Staff continued to spend many hours to complete assessments and care plans on the electronic record.

Finding information on the system was very difficult and took up a lot of staff time. For example, staff could not search progress notes to find entries on a topic, they needed to read each individual entry to ensure they had all the information. If a patient was seen by another mental health service run by the trust this would not be immediately obvious to the service and they relied on the other service informing them.

Staff continued to raise their concerns about the electronic record with the senior managers. Mangers were review the electronic record at the time of our inspection, but no plans had been agreed about what action would be taken.

Medicines management

At our last inspection in 2018 we had serious concerns over the management of medication at Chantry House. The trust could not be assured that medication was stored safely and disposed of when it went out of date. At this inspection we found that all medication was in date and stored correctly. The trust had introduced a new system of managing depot medication. It was now ordered weekly and disposed of each week to make sure it was always in date. The team also recorded batch numbers when giving depot injections.

At the EIP we found some medication that was out of date, we were assured by the team that this had not been used and was disposed of during our visit. We also found that on two records they had not recorded the batch number of the depot when it was administered.

Track record on safety

Serious incidents were recognized and escalated accordingly.

Serious incidents requiring investigation

Between 1 January 2018 and 31 December 2018 there was 11 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'medication incidents' with five. This core service did not report any unexpected deaths.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 11 reported.

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 zero never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the zero reported at the last inspection.

	Number of incidents reported				
Type of incident reported (SIRI)	**Apparent/actual/suspected self-inflicted harm**	**Medication incident**	**Sub-optimal care of the deteriorating patient**	**Treatment delay**	**Total**
Acute and Recovery Team (Chantry House)	3	1	1	1	**6**
Community Mental Health Service	1	1	0	0	**2**
Single Point of Access (SPA)	0	1	1	0	**2**
Recovery and Reablement Team	1	0	0	0	**1**
Core service total	**5**	**3**	**2**	**1**	**11**

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents using an electronic incident reporting system and learning from incidents was cascaded to staff through the team meetings. During this inspection, there remained a positive approach to reporting and learning from incidents. Team leaders were able to demonstrate learning, for example, the team had changed the 'did not attend' policy so that people who had missed appointments at the depot clinic were followed up by the duty staff.

Staff told us they would have a debrief with managers following an incident.

'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 two 'prevention of future death' reports sent to Isle of Wight NHS Trust, however none of these related to this service.

Is the service effective?

Assessment of needs and planning of care

At the previous inspection in 2018 we found that assessments of patient's mental health needs varied in quality. We also found assessments were not always complete and were stored inconsistently on the electronic record. At this inspection we found that assessments were comprehensive and of a good quality. The manager of the SPA team had introduced a standardised assessment template and completed monthly audits of care records to ensure they were complete and of an appropriate quality.

Assessment and monitoring of patients' physical health was inconsistent. We reviewed 28 records across the three services and found that 10 did not have physical health information completed. In three of the ten records without physical health assessments, it was recorded that the patients' GP was managing their physical health. However, it was not recorded to show if there were any concerns that the team needed to be aware of.

Care plans were not always completed for patients. At the SPA the staff did not complete a care plan as after assessing patients they were referred on to another service who would complete a care plan. At the adult community teams, we found that seven out of 11 records and at the EIP five out of nine patient records we reviewed did not have a care plan present.

When care plans were present, at the adult community team, their quality was inconsistent. Care plans were not personalised and it was unclear how the patient had been involved in developing the plans. The clinical team leader told us that the team developed care plans based on the stage of the patient's treatment, therefore patients were only involved once they were able and willing to be involved in developing their own care plans. At the EIP when care plans were present they were of good quality and recovery focused.

Best practice in treatment and care

The service provided a range of interventions to meet patients needs, these included pharmacological and psychological therapies. Since our last inspection the service had trained staff in working with eating disorders. Although there was still no psychologist in post, one had recently been appointed and was due to start soon. However, the service was not set up to provide effective and prompt interventions based on NICE guidance. The standard operating procedure, for the service, had identified the need for clear treatment pathways to be developed in 2016 and again in 2017 when it was reviewed. During this inspection we were told that there were draft care pathways, but they had not been ratified and none were currently in use. However, the EIP did follow a recognised national care pathway.

The adult community team had introduced a member of staff to provide physical health monitoring for patients that were open to the team, this post was currently vacant. However, it was not clear in

the patients' records we reviewed that patients were having their physical health needs met. We did not see any evidence of patients being offered healthy lifestyle advice such as help with weight loss or to stop smoking.

The adult community team had not embedded individual service-user rating scales and outcome measures as part of standard practice. Staff clustered patients in relation to the intervention offered using health of the nation outcome scales (HONOS) rating their severity. However, as there were no recognised pathways for patients there was no clear finish point at which staff could measure outcomes of treatment. However, the EIP did use outcome measures when identified in the care pathway.

Local audits

This service participated in three clinical audits as part of their clinical audit programme 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Mental Health Clinical Outcome Review Programme (NCISH) Safer Care for Patients with Personality Disorder	Mental Health	Not specified	Clinical	Oct-18	Report currently being written
Mental Health Clinical Outcome Review Programme (NCISH) The Assessment of Risk and Safety in Mental Health Services	Mental Health	Not specified	Clinical	Oct-18	Report currently being written
NICE guideline QS95 Bipolar in Adults	Mental Health	Not specified	Clinical	Aug-18	Findings to be presented at weekly Chantry House meeting to raise awareness. - Checklist of NICE Bipolar disorder quality statements to be distributed to all relevant Chantry House staff members, to act as supplement to usual care plan. - Repeat reminder invitation letter to physical health check to be sent out to all patients. - Liaise with psychology

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					team for ideas on how to improve offer of psychological intervention to patients.

Skilled staff to deliver care

All three services included a full range of professionals that would be expected in an adult community team. This included registered mental health nurses, social workers, psychiatrists, support workers, administrators and therapists. The service was in the process of employing peer workers, people who had used similar services in the past. There were appropriate inductions for new staff and agency staff.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group.

Clinical team leaders gave staff monthly clinical supervision and records reviewed confirmed this. There were weekly team meetings where staff could have multidisciplinary discussions about patients, allocate patients from the waiting list and get updates about the service.

Appraisals for permanent non-medical staff

The trust's target rate for appraisal compliance was 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 57%. This year so far, the overall appraisal rates was 74% (as at 8 February 2019). The team with the lowest appraisal rate at 8 February 2019 were Adult Mental Health Medics (Nurses) with an appraisal rate of 0%, Early Intervention Psychosis with an appraisal rate of 63% and CMHS WS at 69%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 41% reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 8 February 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
OT Psychiatry Adult	4	4	100%	0%
Single Point of Access, Crisis and Serenity	19	17	89%	n/a
CMHS WS	35	24	69%	64%
Early Intervention Psychosis	8	5	63%	56%
Adult Mental Health Medics	2	0	0%	n/a
Core service total	**68**	**50**	**74%**	**57%**
Trust wide	**2724**	**2007**	**74%**	**66%**

Appraisals for permanent medical staff

The trust's target rate for appraisal compliance is 85%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for medical staff within this service was 38%. This year so far, the overall appraisal rates this was 25% (as at 8 February 2018).

The rate of appraisal compliance for medical staff reported during this inspection was lower than the 71% reported at the last inspection.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 8 February 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Adult Mental Health Medics	8	2	25%	38%
Core service total	**8**	**2**	**25%**	**38%**
Trust wide	**150**	**48**	**32%**	**33%**

Clinical supervision for non-medical staff

The trust has only provided clinical supervision data for the CMHS team for this core service.

Between 1 January 2018 and 31 December 2018 the average rate across the CMHS team in this service was 77%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
CHMS Qualified Nurses	137	106	77%
Core service total	n/a	n/a	n/a
Trust Total	n/a	n/a	n/a

At the last inspection there was no specialist training available for the teams. At this inspection the situation had improved. Staff had completed training in eating disorders, behaviour family therapy training and staff had applied to go on cognitive behaviour therapy training.

Clinical team leaders gave staff monthly clinical supervision and records reviewed confirmed this.

Managers told us that they could get support for performance management issues from the trust, when needed.

Multidisciplinary and interagency team work

Staff reported they had good links with other services such as social services and the local safeguarding team. However, staff also told us relationships were not as good with the local approved mental health practitioners. For example, it was difficult to discuss patients with them outside of a formal process, this meant they sometimes made inappropriate referrals.

Staff held daily multi-disciplinary team meetings to discuss those most at risk on the caseload. There were weekly team meetings where team leaders shared information from the trust and any identified learning from incidents. At the last inspection staff told us that it was difficult for all staff to attend due to the size of the rooms at Chantry House. During this inspection we attended a meeting and saw this remained an issue.

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

Staff understood their responsibilities under the Mental Health Act and knew where to get support if they needed to. Records reviewed showed that staff followed the guidance of the Mental Health Act code of practice when working with patients who were subject to conditions under the Mental health Act. For example, staff ensured that patients knew their rights.

Mental Health Act training figures

As of 8 January 2018, 100% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory, (however only two staff were eligible), and renewed every two years.

The training compliance reported during this inspection was higher than the 0% reported at the last inspection.

Good practice in applying the Mental Capacity Act

Staff worked within the guidance of the Mental Capacity Act. We found good examples of capacity assessments, which demonstrated staff understood their role under the Mental Capacity Act. Staff could explain what actions they would take if they were concerned about a patient's capacity. For example, having a best interest meeting.

Mental Capacity Act training figures

As of 8 January 2018, 54% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The training compliance reported during this inspection was higher than the 19% reported at the last inspection.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

All episodes of care we observed during the inspection demonstrated staff treated patients in a kind, compassionate and respectful manner. Staff were responsive to patients needs. For example, a patient complained that they had not received a response to a referral the team had made. The staff member contacted the other service and updated the patient about the referral. All patients we spoke to told us that they had good relationships with the team.

Staff understood patients needs and helped them to manage them. We observed staff discuss with patients what they needed to do to stay healthy and their crisis plans during appointments.

Staff felt able to raise concerns with managers about the treatment of patients.

Involvement in care

Involvement of patients

We there were care plans staff involved patients in their care planning and risk assessment when it was appropriate to do so. Patients we spoke to told us they had been able to help develop their care plans. Staff told us about how they involved patients in care and gave them copies of their care plans. Staff discussed care plans with patients during visits and updated risk management plans.

Staff encouraged patients to complete feedback forms and there were suggestion boxes at Chantry House and the EIP. Staff told us that they did not get much feedback as patients declined to complete them.

Staff referred patients to advocacy services when it was appropriate and if the patient requested them to do so.

Involvement of families and carers

Staff told us how they involved families and carers in patients' care by inviting them to meetings and asking for information during assessments. Patients confirmed that families were invited to be involved in their care and families were present during appointments.

There was a forum that carers could attend that help give information about changes in the trust to families. The teams would refer families for carers assessments.

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. However, the Early Treatment in Psychosis Team was available to patients aged 14 – 65. The single point of access team assessed and triaged referrals through to the community mental health service. The Single Point of Access team target times for referral to assessment of patients were 28 days for routine referrals, seven days for urgent referrals and four hours in an emergency. The single point of access team met these time frames. Team leaders at Chantry House allocated referrals to staff when the single point of access team considered patients met the criteria for the service.

Patients referred to the community team were allocated depending on their urgency. At the last inspection we identified there were extensive waiting lists for patients awaiting treatments. This was the same at this inspection with 180 patients on the waiting list. Once allocated to a health care professional there were additional waiting lists for specific treatments. For example, there where 196 people on a waiting list for psychological therapies and 129 patients on waiting lists for group work. Managers told us there were patients on the waiting list with more urgent needs than patients who had been allocated.

The trust had undergone a push to discharge patients from the caseload. The trust had introduced nurse led clinics during our last inspection to help reduce the overall caseload of the team. This was for patients that no longer needed a CPA approach but required some monitoring before discharge. During the last inspection we were told that this was not a clearly defined service. This was the same at this inspection. For example, the case load of the nurse led clinic had increased from 232 patients to 407, this included all the patients awaiting psychological therapies which had waiting times of two years. There was no clearly defined pathway for patients to be discharged from the Nurse led clinics.

Referral to assessment and treatment times

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘referral to treatment’.

The service met the referral to treatment target in zero of the targets listed.

Name of hospital site or location	Name of Team	Days from referral to initial assessment		Days from referral to treatment	
		Target	Actual (median)	Target	Actual (median)
Sevenacres	Single Point of Access	**Emergency Referrals: - response** within 4 hours **Urgent referrals**: - 24 hours for initial contact, 72 hours for face to face assessment if required. **Routine referrals: -** contact	Not given	Not given	46 days

Name of hospital site or location	Name of Team	Days from referral to initial assessment		Days from referral to treatment	
		Target	Actual (median)	Target	Actual (median)
		within 7 days, face to face assessment within 28 days if required.			

Staff worked to provide a service to patients who had difficultly engaging with mental health services or did not attend appointments. Staff offered a variety of appointment times and visited patients at their own homes as well as offering appointments in their office locations. Since the last inspection the trust had put in place a 'did not attend' policy. Staff would try to contact patients who had missed their appointments and if they had not been able to contact them within 48 hours this would be passed on to the duty member of staff.

Patients we spoke to told us that appointments were often cancelled. We spoke to the team manager who told us that they often needed to cancel group work appointments. The current resilience course had so far cancelled three of its eight planned sessions and that two complete courses had been cancelled due to a lack of staff to carry out the work.

Facilities that promote comfort, dignity and privacy

The premises at Chantry House and the Single point of Access team had remained unchanged from the previous inspection. At Chantry House there were rooms for therapies and clinic rooms to provide physical health care. Rooms were sound proofed and private and there were waiting areas. Due to the size of the rooms group sizes were limited to four patients, which increased the waiting times for groups. The Early Intervention in Psychosis team building also had a good-sized therapy kitchen, to provide healthy eating courses.

Patients' engagement with the wider community

At the last inspection staff told us there was a lack of third sector services for patients to access. This led to staff keeping people on the team caseload after they were ready for discharge back to primary care services. At this inspection we were told that a new third sector provider had started to provide group work and the team would be able to transfer patients to them and reduce the team caseload.

Meeting the needs of all people who use the service

There was suitable disabled access at all the sites we visited. Staff were able to access interpreters for patients and had information available about different support groups for patients including support for LGBT.

Listening to and learning from concerns and complaints

Patients we spoke to told us they knew how to complain and felt able to do so. Patients gave examples of complaints they had made, including appointments being cancelled and the long wait for treatments. Patients told us they did receive feedback but the situation remained the same.

At the last inspection the trust could not give us complaint information specific to this core service. During this inspection the trust were able to provide specific information. The trust was also now able to review complaints by themes which allowed them to identify any trends that were developing. The top complaints related to communication and access to treatment. Staff recorded both formal and informal complaints on the trust electronic incident system.

Formal complaints

This service received 27 complaint between 1 January 2018 to 31 December.

	Complaint theme									
Team name	**Communication**	**Access to treatment or drugs**	**Appointments**	**Clinical Treatment - Psychiatry group**	**Values and Behaviours (Staff)**	**Patient Care**	**Admissions and discharges excluding delayed discharge due to absence of a care package - see integrated care**	**Prescribing**	**Unknown**	**Total**
Acute and Recovery Team (Chantry House)	7	5	1	1	2	1	1	1	1	20
Community Mental Health Service	0	0	2	2	1	1	0	0	0	6
Single Point of Access (SPA)	0	1	0	0	0	0	0	0	0	1

	Complaint theme									
Team name	Communication	Access to treatment or drugs	Appointments	Clinical Treatment - Psychiatry group	Values and Behaviours (Staff)	Patient Care	Admissions and discharges excluding delayed discharge due to absence of a care package - see integrated care	Prescribing	Unknown	Total
Grand Total	**7**	**6**	**3**	**3**	**3**	**2**	**1**	**1**	**1**	**27**

Compliments

This trust's mental health services received two compliments during the last 12 months from 1 January 2018 to 31 December 2018 which accounted for less than 1% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

The service manager and clinical managers were skilled and experienced in their roles. At the time of the inspection there were two vacancies in leadership roles within the teams. This had an effect on the development of the service as those in post had to focus more time on providing support to staff members rather than introducing the new models of care.

Staff spoke highly of the local leadership team and service manager. They told us leadership were visible, approachable and would find time to speak with staff regularly.

Vision and strategy

Staff understood the trust's vision and values. Staff could explain how their team was working towards these goals and how changes to the service would help the team meet them. However, staff expressed concerns that there remained very limited third sector service provision for people on the Isle of Wight, which affected their ability to discharge from their caseloads. Managers could explain how the service was functioning and the changes needed to develop the service. They told us that planned changes to the service would address the issues with caseload size, waiting times and help the team achieve the trust's vision and values.

Culture

Team managers were positive and felt that changes were planned that would help to improve the service. All staff were positive about having a mental health director and the service manager. However, they felt disconnected from the wider trust and told us that they had not been visited by board members and that arranged visits were always cancelled.

Morale was generally good in the single point of access and EIP teams. However, morale remained low in the adult community team. Staff felt frustrated that waiting times remained high and that the trust had stopped using agency staff to reduce the waiting times. We spoke to several members of staff who told us they were considering leaving. Some staff had changed roles as they had felt under too much pressure in their previous role. There were concerns in the team about the new third sector provider and the impact it might have on staff. For example, some staff were concerned they would be transferred to the service from the NHS.

Managers told us how they had dealt with performance issues and how they were supported by the trust. Staff told us they felt they could raise concerns with managers. However, not all staff felt appropriate action would be taken. For example, meetings with senior managers and human resources took a long time to arrange and had been cancelled without warning.

Sickness and vacancy rates were high when compared to similar services nationally. However, sickness rates were improving and in the month before the inspection no staff had been sick in EIP. The three services also reported using the trust sickness management policy to support staff to reduce sickness. There was space in the weekly team meeting to celebrate staff members achievements. During the meeting we observed, staff were recognised for good practice and for getting promotions.

Governance

The previous inspections had identified that the trust could not identify performance issues with the services because they did not have any standards to measure performance against. While this had improved in the SPA and EIP, it remained and issue with the adult community team. This was because there was still no care pathway to follow. Whilst the data that was collected had improved, there remained little assurance around the quality of patient records and the safety of patients on the waiting lists.

Oversight by senior management of the adult community teams waiting list had only began in the five weeks prior to the inspection and only focused on patients requiring CPA. There was no clear guidance or consistency on managing waiting lists and caseloads. This meant that the service continued to have high caseloads, waiting list and clinic 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. There continued to be measures in place to stop staff caseloads becoming too large and there was a service redevelopment plan to address the model of the service. However, discharges remained low which meant waiting times and caseload sizes had not changed since the last inspection.

Management of risk, issues and performance

Staff could record risks on the trust's electronic incident recording system and add them to the trust risk register. Concerns around staffing, waiting times and the electronic record had been raised on the system, which were the same as the concerns raised with us by staff.

Information management

Since our last inspection the trust had now issued some laptops to the community teams to allow them to do remote working. This has allowed staff to update records when they were away from the team base. The electronic record system remained an issue with staff, it was difficult to navigate and this meant staff continued to spend excessive amounts of time completing records. Patients not on a CPA had care plans and risk assessments in progress notes and clinic letters rather than the imbedded template and the trust could not extract this information from the system in a timely fashion.

Information was stored securely on computers and paper records were kept in locked cupboards.

Engagement

Staff felt they could give feedback to management about service development. The trust gave information about changes to the service via team meetings, emails and they continued to hold events to allow staff to raise concerns and give information about improvements they were making.

All services had suggestion boxes and encouraged patients to use them but told us there was a low up take. The trust had a forum for patients and carers that allowed them to give feedback to the trust. Patients and carers could also sign up for email updates about the trust and leave feedback directly on the website.

Learning, continuous improvement and innovation

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.

This core service does not hold any accreditations at the time of the inspection.

Ambulance services

Emergency and urgent care

Facts and data about this service

The Isle of Wight Ambulance Service's (IOWAS) resources (999 emergency ambulances and rapid response vehicles, first responders and patient transport services) are strategically deployed across the island based on expected and past demand and taking account of any special circumstances such as large events. Depending on how busy the service expects to be there will, at any particular time, be:

- four to six 999 emergency ambulances
- one or two rapid response vehicles

The service works with a range of partners including the Police and Fire & Rescue Service and volunteers from organisations such as British Red Cross, St John Ambulance, RNLI, and independent lifeboats, IoW Search and Rescue and HM Coastguard. At times of pressure ambulance resources from the British Red Cross, St John Ambulance, mainland services (such as South-Central Ambulance Service) and the private sector may be brought onto the Island to assist.

(Source: Trust website - https://www.iow.nhs.uk/our-services/acute-care-services/ambulance/ambulance-services.htm*)*

The Isle of Wight Ambulance Service (IOWAS) is part of the Isle of Wight NHS Trust. The emergency and urgent care service (EUC) for IOWAS has one ambulance station which is located on the site of St. Mary's Hospital in Newport. There are two stand-by points which are co-located within fire stations on the island, in Ryde and Shanklin.

During our inspection, we spoke with 38 staff within the emergency and urgent care service, inspected eight vehicles and observed five episodes of care.

The staff we spoke with included frontline ambulance crew (paramedics and emergency vehicle operatives), student paramedics, staff on induction, the resourcing team, community practitioners, members of first responders, 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?

Mandatory training

Staff had not achieved the trust required level of compliance, 85%, for some of the mandatory training modules. Mandatory training in key skills was provided for all staff and managers monitored compliance. Action was being taken to address the short fall in the completion of mandatory training.

Managers monitored compliance with mandatory training and reminded staff of upcoming training to complete every month. Ambulance crews kept track of their own training using the trust's 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 at this meeting; 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. The service had devised and introduced an annual training plan. The plan allowed for staff to be stood down from three shifts, giving them 36 hours training time. This included time for self-directed learning to be used for the individual to complete mandatory training.

The service had also re-introduced group learning sessions for mandatory training as part of the plan, in addition to self-directed eLearning, following feedback from staff. Staff had expressed how they had benefited from learning with colleagues in a group environment.

Staff told us they welcomed this initiative as the training was planned into their rota for the year. Managers told us this allowed the service to manage training and resources across the year with minimal disruption to frontline crew availability. We were told this was protected training time, however in exceptional circumstances training may be interrupted for operational issues.

Following the National Ambulance Resilience Unit (NARU) and our inspection the trust had taken immediate action and had worked with NARU to ensure they provided the required training. During our inspection we saw staff from the service undertaking chemical, biological, radiological and nuclear defence (CBRN) awareness and simulation training. This was part of NARU requirements and demonstrated the service were committed to fulfilling national requirements.

Mandatory training completion rates

The trust set a target of 85.0% for completion of mandatory training.

A breakdown of compliance for mandatory courses for April 2018 to January 2019 for all staff in emergency and urgent care is below:

All staff groups

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	98	98	100.0%	85.0%	Yes
Health, Safety and Welfare	98	98	100.0%	85.0%	Yes
Load Handling	5	5	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	98	98	100.0%	85.0%	Yes
People Handling	91	93	97.8%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	95	98	96.9%	85.0%	Yes
Paediatric Resuscitation	84	89	94.4%	85.0%	Yes
Adult Resuscitation	83	89	93.3%	85.0%	Yes
Hand Hygiene	88	98	89.8%	85.0%	Yes
Information Governance	62	98	63.3%	85.0%	No
Medicines Management Theory	2	4	50.0%	85.0%	No
Infection Prevention & Control Level 2	47	97	48.5%	85.0%	No
Adult Resuscitation - Non-Clinical	1	5	20.0%	85.0%	No
Medicines Management Practical Assessment	0	2	0.0%	85.0%	No

In emergency and urgent care the 85.0% target was met for nine of the 14 mandatory training modules for which staff were eligible.

The trust also provided a breakdown of mandatory training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in emergency and urgent care for April 2018 to January 2019 is shown below:

Qualified ambulance service staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	55	55	100.0%	85.0%	Yes
Health, Safety and Welfare	55	55	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	55	55	100.0%	85.0%	Yes
People Handling	55	55	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	53	55	96.4%	85.0%	Yes
Adult Resuscitation	51	55	92.7%	85.0%	Yes
Hand Hygiene	51	55	92.7%	85.0%	Yes
Paediatric Resuscitation	51	55	92.7%	85.0%	Yes

Information Governance	34	55	61.8%	85.0%	No
Infection Prevention & Control Level 2	29	55	52.7%	85.0%	No

In emergency and urgent care the 85.0% target was met for eight of the 10 mandatory training modules for which qualified ambulance service staff were eligible.

Support to ambulance service staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	40	40	100.0%	85.0%	Yes
Health, Safety and Welfare	40	40	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	40	40	100.0%	85.0%	Yes
Load Handling	5	5	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	39	40	97.5%	85.0%	Yes
Paediatric Resuscitation	32	33	97.0%	85.0%	Yes
Adult Resuscitation	31	32	96.9%	85.0%	Yes
People Handling	33	35	94.3%	85.0%	Yes
Hand Hygiene	36	40	90.0%	85.0%	Yes
Information Governance	27	40	67.5%	85.0%	No
Infection Prevention & Control Level 2	16	39	41.0%	85.0%	No
Adult Resuscitation - Non-Clinical	1	5	20.0%	85.0%	No

In emergency and urgent care the 85.0% target was met for nine of the 12 mandatory training modules for which support to ambulance service staff were eligible.

Support to doctors and nursing staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Adult Resuscitation	1	1	100.0%	85.0%	Yes
Health, Safety and Welfare	1	1	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	1	1	100.0%	85.0%	Yes
Infection Prevention & Control Level 2	1	1	100.0%	85.0%	Yes
Information Governance	1	1	100.0%	85.0%	Yes

People Handling	1	1	100.0%	85.0%	Yes

In emergency and urgent care the 85.0% target was met for all of the six mandatory training modules for which support to doctors and nursing staff were eligible.

Nursing and Midwifery staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	2	2	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	2	2	100.0%	85.0%	Yes
Health, Safety and Welfare	2	2	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	2	2	100.0%	85.0%	Yes
People Handling	2	2	100.0%	85.0%	Yes
Infection Prevention & Control Level 2	1	2	50.0%	85.0%	No
Medicines Management Theory	2	4	50.0%	85.0%	No
Adult Resuscitation	0	1	0.0%	85.0%	No
Hand Hygiene	0	2	0.0%	85.0%	No
Information Governance	0	2	0.0%	85.0%	No
Medicines Management Practical Assessment	0	2	0.0%	85.0%	No

In emergency and urgent care the 85.0% target was met for five of the 11 mandatory training modules for which nursing and midwifery staff were eligible.

(Source: Trust Provider Information Request – Mandatory training)

Safeguarding

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

Safeguarding policies were clear, reflected national guidance and the ambulance service had additional safeguarding protocols for vulnerable groups.

At our last inspection training rates for safeguarding were low. During this inspection we found training rates had improved.

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 and demonstrated the process for raising a safeguarding alert. We saw frontline staff were stood down during their shift to enable them to complete the safeguarding telephone call to the relevant agency and referral form. Crews could be interrupted and allocated Category 1 or Category 2 calls once they completed the telephone call. However, once the second

job had been completed the crew would be stood down until the paperwork had been completed for both jobs.

The service could identify, and monitored, individuals who were frequent safeguarding concerns and re-referred them to the relevant, most appropriate agency. At the time of our inspection the service did not have detailed statistics regarding the impact this was having on patients.

Managers told us they were aware the process for completing a safeguarding referral was time-consuming for frontline crews. Data provided by the service demonstrated during the period January to May 2019 the hours spent on safeguarding was in excess of 120 hours. This meant frontline crews were unable to respond to emergency calls during this time.

Managers had started to analyse the data to enable them to identify issues and drive improvements in the process. To improve the outcome for patients and reduce 'lost hours' for frontline crews.

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.

Safeguarding training completion rates

The trust set a target of 85.0% for completion of mandatory training.

A breakdown of compliance for safeguarding courses for April 2018 to January 2019 for all staff in emergency and urgent care is below:

All staff groups

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children Lev 1	98	98	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	94	98	95.9%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	86	98	87.8%	85.0%	Yes
Safeguarding Children Lev 2	69	93	74.2%	85.0%	No
Safeguarding Children Lev 3	8	13	61.5%	85.0%	No
Safeguarding Adults Lev 2 Part 2	54	98	55.1%	85.0%	No
Safeguarding Adults Lev 2 Part 1	53	98	54.1%	85.0%	No
Preventing Radicalisation Level 3	40	90	44.4%	85.0%	No

In emergency and urgent care the 85.0% target was met for three of the eight safeguarding training modules for which staff were eligible.

The trust also provided a breakdown of safeguarding training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in emergency and urgent care for April 2018 to January 2019 is shown below:

Qualified ambulance service staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children Lev 1	55	55	100.0%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	53	55	96.4%	85.0%	Yes
Safeguarding Adults Lev 1	53	55	96.4%	85.0%	Yes
Safeguarding Children Lev 2	44	55	80.0%	85.0%	No
Safeguarding Adults Lev 2 Part 2	37	55	67.3%	85.0%	No
Safeguarding Adults Lev 2 Part 1	33	55	60.0%	85.0%	No
Preventing Radicalisation Level 3	25	55	45.5%	85.0%	No

In emergency and urgent care the 85.0% target was met for three of the seven safeguarding training modules for which qualified ambulance service staff were eligible.

Support to ambulance service staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children Lev 1	40	40	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	38	40	95.0%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	30	40	75.0%	85.0%	No
Safeguarding Children Lev 3	2	3	66.7%	85.0%	No
Safeguarding Children Lev 2	22	35	62.9%	85.0%	No
Safeguarding Adults Lev 2 Part 1	20	40	50.0%	85.0%	No
Preventing Radicalisation Level 3	15	32	46.9%	85.0%	No
Safeguarding Adults Lev 2 Part 2	15	40	37.5%	85.0%	No

In emergency and urgent care the 85.0% target was met for two of the eight safeguarding training modules for which support to ambulance service staff were eligible.

Support to doctors and nursing staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	1	1	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	1	1	100.0%	85.0%	Yes
Safeguarding Adults Lev 2 Part 2	1	1	100.0%	85.0%	Yes
Safeguarding Children Lev 1	1	1	100.0%	85.0%	Yes
Safeguarding Children Lev 2	1	1	100.0%	85.0%	Yes
Preventing Radicalisation Level 3	0	1	0.0%	85.0%	No
Safeguarding Adults Lev 2 Part 1	0	1	0.0%	85.0%	No

In emergency and urgent care the 85.0% target was met for five of the seven safeguarding training modules for support to doctors and nursing staff were eligible.

Nursing and Midwifery staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	2	2	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	2	2	100.0%	85.0%	Yes
Safeguarding Children Lev 1	2	2	100.0%	85.0%	Yes
Safeguarding Children Lev 2	2	2	100.0%	85.0%	Yes
Safeguarding Children Lev 3	1	1	100.0%	85.0%	Yes
Safeguarding Adults Lev 2 Part 2	1	2	50.0%	85.0%	No
Preventing Radicalisation Level 3	0	2	0.0%	85.0%	No
Safeguarding Adults Lev 2 Part 1	0	2	0.0%	85.0%	No

In emergency and urgent care the 85.0% target was met for five of the eight safeguarding training modules for which nursing and midwifery staff were eligible.

(Source: Trust Provider Information Request – Mandatory training)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They generally kept equipment and the premises visibly clean. However, the cleanliness of some of the rapid responsive vehicles was not being maintained.

At our last inspection the service did not have an infection prevention control policy specific to the ambulance service but worked with the trust's policies. The service now had a link to the hospital infection prevention and control (IPC) team and since our last inspection had worked to develop ambulance specific policies. These reflected national guidance, complimented existing trust policies and were accessible to staff.

However, in some areas the service had not managed all the risks and put in place appropriate actions to control infection. For example, we inspected three rapid responsive vehicles (RRV) and found the interior of the vehicles, and the equipment kept in them, to be visibly dirty. The service kept no records relating to the cleaning and no records concerning the equipment and contents of the RRVs. We highlighted this to the service during the inspection who took immediate action to rectify the issue. The vehicles were immediately taken off the road, stripped, cleaned and re-stocked before being allowed to resume operational duties.

All the ambulances 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. During the deep clean, staff told us that all equipment was removed, cleaned and checked. However, the service was not auditing the cleaning and deep cleaning records to ensure consistency and effectiveness. For example, swabs were not routinely taken for testing to monitor the effectiveness of the deep clean.

We were told by the make ready team that if the vehicle had transported a patient known to be infectious then the trust's infection prevention and control team would swab the vehicle post deep clean to ensure there were no signs of any residual risk.

Staff had access to spare linen on the vehicle and could re-stock their vehicle with linen from the emergency department (ED). We observed staff cleaning stretchers and equipment 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 spreading infection. Cleaning products were stored securely and in line with the Control of Substances Hazardous to Health (COSHH) requirements.

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 daily.

Staff were responsible for cleaning their own uniform. Staff were provided with sufficient uniform, so they could change during their shift if necessary. Should their uniform become soiled or contaminated during their work then it could be disposed of in the clinical waste at the station. Replacement uniform would be provided as required.

We saw staff followed best practice and the trust's 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.

Hand hygiene audits were undertaken as part of individual observed practice audits. Individual actions resulting from these audits were identified and documented. We review three observed practice documents in which there was evidence of compliance with hand hygiene requirements.

Most staff we observed adhered to the bare below the elbow guidance. However, there were 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.

Environment and equipment

The design, maintenance and use of facilities, premises and vehicles mostly kept people safe. Staff were trained to use equipment and staff managed clinical waste well. However, the system for ensuring consumables were within their use by dates for the RRV's was not effective and keys to vehicles were not always securely stored.

In early 2019 the service had an audit of its estate and facilities carried out by internal trust staff. They had found improvements in the general appearance and tidiness of the garage, offices and crew rooms since the last similar audit in 2017. However, they described concerns regarding the working environment for the staff (make ready team) who worked in the garage area cleaning and stocking the ambulances. For example, the garage was secure and closed however there was no working extraction unit to clear vehicle fumes.

There were also concerns regarding the general estate and fabric of the building, with many high and low surfaces dusty or dirty and there were limited facilities for storage of equipment. Our observations were broadly similar and correlated to the trust's own audit findings. The service had plans to address audit findings but they involved capital investment from the trust which had yet to be agreed.

During the inspection we found all vehicles locked when not being used by crews or being attended to by the make ready team. Operational staff on shift kept vehicle keys with them and other keys were stored on the station. Although vehicle keys were stored in lockable cabinets we found the cabinets to be unlocked and we could gain access to vehicle keys without challenge. Although the station building was secure there was a risk vehicles could be accessed by unauthorised staff.

We saw evidence that security was due to be enhanced with the installation of closed circuit TV cameras throughout the station and parking bays. The installation work was scheduled to commence shortly after our inspection and would provide additional security for the building, vehicles and staff.

Each vehicle had the capability to transport children safely. Crews had access to a car seat at the station and ambulance stretchers and seating had additional straps so that children could be secured safely.

Make ready staff used visual aids as a guide for re-stocking vehicles. This ensured consistency, as equipment was stored 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.

Rapid response vehicles (RRV) were maintained by the crew member assigned to the vehicle for that shift. This was usually an on-call manager, community practitioner or paramedic. These vehicles were often utilised 24/7, with limited downtime. We inspected three RRVs and found them over-stocked with out of date consumables and medical equipment outside of its service date. One RRV had three pieces of equipment used to monitor oxygen saturation with only one within its service date. We highlighted this to the service who acted immediately. The vehicles were taken out of service, emptied of all equipment and re-stocked before being allowed out on the road.

Medical devices were maintained by the trust's 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 three items out of service date or it was unclear when servicing was due. We checked these items on the Medical Electronics Department asset and servicing log. We found they were outside their recommended service period meaning staff could not be assured they were working correctly. However, evidence received from the trust showed these items had been serviced immediately after our inspection.

The maintenance of manual handling equipment on vehicles, such as stretchers, was managed by the trust fleet department. They arranged for engineers from the manufacturer to carry out inspections of stretchers. The engineer also inspected other manual handling equipment carried on vehicles. The engineer carried out repairs and maintenance on equipment inspected as required. We found eight stretchers on vehicles and on the station had stickers which indicated they were beyond their next service date. We were told manufacturers guidelines recommend annual servicing for stretchers. In an attempt to be pro-active with servicing, the trust had set themselves an internal target of six-monthly servicing but due to problems getting an engineer to the island had breached their own target. This meant that staff could not be assured if equipment had just breached the trust's service target date or was outside of manufacturers servicing guidelines.

At the last inspection, there were issues with the mobile data terminal on vehicles. The data terminals were used by crews to send and receive information from the operations centre regarding emergency calls, jobs to attend and patients. The issue remained due to an unreliable network across the island. This meant that crews often found the mobile data terminals lost connectivity to the system while on a call and driving around the island.

This was also a potential risk to crews, due to the unreliable network connectivity issues. The operations centre were sometimes not aware of the exact location of crews. This also affected the satellite navigation system used by the crews, which meant they had to rely on their local knowledge or map of the island to find an address. This was an issue outside of the control of the service as it related to general mobile network connectivity across the island.

All vehicles had an up-to-date MOT, annual service and were insured. Each vehicle had a safety inspection every six weeks. This meant staff, and patients, could be assured the vehicles were safe to be used.

Following a previous National Ambulance Resilience Unit (NARU) inspection it had been identified that the decontamination of chemical, biological, radiological and nuclear defence (CBRN) suits 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. During this inspection we saw the trust had been able to re-instate its CBRN capability. The trust had received new suits and had completed training in their use and decontamination.

Limitations

As a result of national risk assessments the Isle of Wight was not deemed to be a model response site location and as a result there was not a Hazardous Area Response Team (HART) capability based on the island. The trust were required by NARU to provide some elements of a specialist response capability. 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. They included vehicles such as a major incident command vehicle and a CBRNe vehicle. The trust did not have a mass casualty vehicle as agreed within the contract with NHSE, but they did have a vehicle to transport multiple patients in one journey.

We inspected the multi transporting vehicle referred to locally as the Jumbulance and found a number of out of date consumables. We highlighted to the service during the inspection who immediately acted to remove the out of date items.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

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. Staff had access to the latest version JRCALC via an application on their smartphones.

Patients in the care of staff were monitored using the national early warning scoring system (NEWS2). Staff used NEWS2 to detect signs of deterioration during their assessments.

Frontline crews had access to additional clinical support via the clinical support desk (CSD). Calls to the CSD were taken by staff with additional training and skills, including doctors and pharmacists. Staff confirmed they could call the CSD while on scene with a patient and had done so successfully.

Staff had access to care pathways and they could access these via the portal on their laptops. For example, there was a cardiac pathway based on the British Heart Foundation algorithm.

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 using their radios, using an agreed pre-alert process, to escalate the priority level.

The service used co-responders and community first responders to support their service. These were volunteers trained by the service to respond to emergencies quickly while an ambulance or other response was en route to the scene. 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 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 within

the children's area within ED. All staff we spoke with where 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.

Staff told us they were experienced at transporting patients experiencing a mental health crisis, although they had not completed specific training on this. Staff described how they gained experience and understanding of support patients suffering a mental health crisis from colleagues and through dealing with the calls.

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

The service had enough staff with the right qualifications, skills, training and experience to fill current rotas. However, rotas were outdated and did not meet current demand. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

Staffing levels were sufficient to meet the current planned levels and populate the current rotas. However, managers told us staffing levels and rota patterns had not been reviewed for at least three years prior to our inspection. Frontline crews reported being tired and felt as if they were going from job to job with very little downtime. Managers confirmed what frontline crews told us.

The service had recently installed a new computer aided dispatch (CAD) system (November 2018). It was anticipated this would provide sufficient meaningful data to enable the service to carry out demand modelling of their service and therefore inform their workforce strategy. Some initial work had been carried out to model demand against capacity, however the service did not yet have a full year's data to be confident in the results. We were told the previous CAD system had limited capability to provide accurate data to allow for demand modelling.

The service planned to staff for a minimum of six double crewed ambulances Monday to Thursday during the day and four double crewed ambulances Monday to Thursday during the night. The service planned for a minimum of seven double crewed ambulances Friday to Sunday during the day and five double crewed ambulances Friday to Sunday during the night. A double crew is defined as one paramedic and one Emergency Vehicle Operator (EVO).

Operational staffing issues meant the service could not always provide enough staff to crew seven ambulances during the day. The service set a minimum safety level of five ambulances and adjusted rotas to ensure this minimum level was achieved. We attended the trust's daily operational meeting at which the ambulance service had a presence. Frontline crew availability and staffing levels were highlighted and discussed at this meeting with actions taken to address or manage shortfalls.

Performance Support Officers (PSO) provided management, leadership and operational support to frontline crews during their shifts. At our last inspection we identified there was no 24-hour PSO cover at the ambulance station. This remained the position however cover had been extended to 01.00 am on weekdays.

PSOs worked 6.30am to 4.30pm and 1.30pm to 01.00am on weekdays and 7am to 7pm during weekends. After 01.00am until 6.30am during weekdays and between 7pm and 7am at weekends, there was a PSO on call should they be required.

Frontline crews and support staff, based at the station, reported they did not always have direct access to a manager at the station. However, they could access support through the CSD and staff did not report this as being a concern.

Frontline ambulances were occasionally required to transport patients off the island or to repatriate patients back to the island. Given the nature of travel, and crews having to leave the island, the service attempted to plan such journeys with the trust so the frontline capability of the service was not compromised. During the day four ambulances were planned to start between 6am-8am in the morning, with a further two ambulances commencing shifts from midday. This reduced to four ambulances at night and at weekends. Staff worked 12 hours shifts, which included a paid 30-minute meal break.

In addition to the frontline ambulances, the service utilised rapid response vehicles (RRV) as an available resource. RRV's are single crewed vehicles which are deployed, during the day, as per the service's operating model. Whilst targeted at specific categories of emergency calls to reduce the burden on ambulances, they will go to any call as directed by the EOC. They are staffed by trained paramedics known as community practitioners with additional training.

The duty manager of day also had an RRV and would attend calls as directed by the EOC to support frontline crews. They could also be deployed if no ambulance resource was available. We saw this happen during the inspection when there was no immediate ambulance for a report road traffic collision. This ensured the patients involved received an ambulance service response to assess the patient and situation before the ambulance could attend.

At our last inspection we found additional ambulance cover was provided by a private ambulance provider during the day. The service confirmed that they no longer used private providers and filled vacant shifts using their own internal bank staff.

The resourcing team based in the Hub managed the shifts and rotas. The Hub was where the operations centre for the ambulance service was based. This was located on the hospital site and near the ambulance station.

The resourcing team confirmed shifts were routinely planned eight to twelve weeks ahead, giving staff advance knowledge of work patterns. The resourcing team worked with staff and managers to cover shifts with staff being swapped or staff working additional hours. The resource team used a messaging system to alert staff to outstanding shifts and shifts that had become available at short-notice, for example due to sickness. The total hours worked by staff were also monitored by the resourcing team to ensure staff did not work more than allowed by Working Time Regulations. They also monitored annual leave to ensure the service provided at least the minimum cover allowed by the trust.

Managers told us due to operational pressures and staff sickness, they occasionally 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 and impact this had on the service.

Managers within the service had drafted a revised meal break policy for frontline crews. At the time of the inspection this was being ratified by the trust’s Human Resource department. The policy had been revised due to concerns raised by staff that the guidance was not being adhered to and breaks were not being given or they were being disturbed for non-emergency operational reasons.

The revised policy 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.

Planned vs actual

The trust has reported their staffing numbers below for emergency and urgent care as of April 2018 to March 2019.

Staff group	April 2018 to March 2019		
	Actual WTE staff	Planned WTE staff	Fill rate
Allied Health Professionals	56.2	51.9	108.2%
NHS Infrastructure Support	5.4	5.4	100.0%
Support to Ambulance Service Staff	27.9	31.9	87.4%
Total	**89.5**	**89.3**	**100.3%**

(Source: Trust Routine Provider Information Request– Total staffing)

Vacancy rates

From January to December 2018 the trust reported an annual vacancy rate of -2.4% for emergency and urgent care. The trust has not set a target for vacancy. Negative vacancy rates have been reported for qualified ambulance service staff and the trust have stated that this is due to an over establishment of staff.

A breakdown of vacancy rates by staff group is shown below:

- Support to ambulance service staff: 5.0%
- Qualified ambulance service staff: -7.2%

Turnover rates

From January to December 2018 the trust reported an annual turnover rate of 5.3% for emergency and urgent care. The trust target turnover rate is 5.0%.

A breakdown of turnover rates by staff group is shown below:

- Qualified ambulance service staff: 7.8%
- Support to ambulance service staff: 3.6%
- NHS infrastructure support staff: 0.0%
- Qualified nursing midwifery staff: 0.0%

(Source: Trust Provider Information Request– Turnover)

Sickness rates

From January to December 2018 the trust reported an annual sickness rate of 7.1% for emergency and urgent care. The trust target sickness rate is 4.5%.

A breakdown of sickness rates by staff group is shown below:

- Qualified nursing midwifery staff: 13.7%

- Qualified ambulance service staff: 7.8%
- NHS infrastructure support staff: 5.9%
- Support to ambulance service staff: 4.1%

(Source: Trust Provider Information Request– Sickness)

Nursing and medical bank and agency/locum staff usage

From January to December 2018, the trust reported that no bank or agency staff were used in emergency and urgent care to cover shifts for nursing and medical staff.

(Source: Trust Provider Information Request – Bank agency locum tab)

Temporary staff usage

This refers to staff that are not qualified nursing or medical and dental staff. It can apply to paramedics, operations centre staff or any other core service specific roles within the trust.

From January to December 2018, the trust reported a bank usage rate of 1.4% in emergency and urgent care for qualified ambulance service staff.

Team	Total shifts available	Bank Usage		Agency Usage	
		Shifts	%	Shifts	%
Emergency Ambulance	4,766	65	1.4%	0	0.0%

From January to December 2018, the trust reported a bank usage rate of 12.4% in emergency and urgent care for support to ambulance service staff.

Team	Total shifts available	Bank Usage		Agency Usage	
		Shifts	%	Shifts	%
Emergency Ambulance	4,497	556	12.4%	0	0.0%

(Source: Trust Provider Information Request – Temp staff tab)

Records

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

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), based on the new computer aided dispatch (CAD) system, which followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.

If the ePRF system went down, and staff could not access it, they completed a paper record and passed these to staff in the ED during handover. 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. However, there was no audit of paper records against

patients seen. This meant the service did not know if there was a record missing and if the patient record was complete.

Despite the metal box being locked we could access and retrieve copies of patient records. We also found a patient record in an RRV containing full patient details following an episode of care from the month prior to the inspection. We alerted managers at the station who immediately retrieved the record and confirmed they would address the security of the records stored in the metal box.

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.

Audits of patient records were carried out as part of clinical supervision and the findings were detailed in individual learning plans (ILPs) for individual staff. We review three sets of audit documentation which all included competency statements, expected level of competency, whether competency had been evidenced and detailed any subsequent actions or comments.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, there was not always clear over sight of the use of Patient Group Directions (PGDs) within the service.

Paramedics and community practitioners used medicines covered by Patient Group Directions (PGDs). A 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 must receive appropriate training and be assessed as competent to administer these medicines and there were guidelines available to support them.

However, we checked the documentation for three of five PGDs and established that not all relevant staff had signed to confirm they had completed the training. PGD 1. (heparin) 35 out of 60 staff (58%) had not signed, PGD 2. (tranexamic acid) 32 out of 60 staff (53%) had not signed.

Following further checks it was established that one medicine, heparin, had been given four times since December 2018 when the PGD had been introduced. Of the four clinicians who had given the medicine two had not signed the PGD which confirmed they were competent to give that medicine.

During the inspection the service undertook a review and established 346 medicines covered under five PGDs had been used during the past 12 months. Of which six individual doses (1.7%) had been given by a clinician without PGD sign off. The service confirmed no evidence of adverse impact on the patients was found.

After the concerns with PGDs had been raised the service responded swiftly and appropriately to understand the situation. They then put in place immediate and remedial actions, together with long-term solutions.

During the inspection the service immediately undertook a review to determine compliance with PGD signing requirements. Within 24 hours the service had improved the signing compliance to 68% and had established action plan to achieve full compliance. The service also issued a clinical directive to all staff outlining the issue and confirming the requirement for staff to sign the PGDs. They also contacted the trust's clinical governance committee to add PGD assurance as an agenda item for future meetings.

At our last inspection security of the medicines room and the ambulance storage spaces was a concern. We saw new locks had been fitted to the medicines rooms and to cabinets on the ambulances. These locks restricted access to authorised staff only.

The trust pharmacy department supplied medicines as stock and prepacked tagged bags for use on the vehicles. These supplies included pre-packs of medicines to treat patients for specific conditions either as single doses or TTO (To Take Out) packs. Medicines and controlled drugs were stored securely within computer-controlled cabinets which allowed medicines to be requisitioned automatically and for remote monitoring by the pharmacy team. Since our last inspection the trust had stopped storing medical gases at the ambulance station and these were now sourced from the main hospital gas store when required.

Medicines were stored in tagged bags or boxes on the vehicles. At the beginning of a shift paramedics checked the bags had green or yellow tags and therefore fit for use. If used during a shift pharmacy would check and repacked bags.

The pharmacy department monitored room temperatures and fridge temperatures centrally. This ensured that medicines were stored at their optimum temperature.

Medicines 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.

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.

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.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and made it publicly available.

There was an escalation process in place for seriously ill patients, this involved crews pre-alerting the emergency department clinicians.

Escalation plans were in place at the hub with other providers, these included NHS England, and other agreed health care providers.

Staff had access to the CSD for advice and information on patient condition as a preventative solution if a patient was not required to be conveyed.

Business continuity management identified and mitigated risk and disruptions that could affect the performance of the organisation.

All staff we spoke with told us they had received training in response to major incidents and was part of their mandatory training. All managers we spoke with had completed a level of national ambulance resilience unit training appropriate to their role in a major incident.

Each vehicle contained action cards and patient priority tags and it was the responsibility of the make ready team to place these on each vehicle. Major incident vehicles were available, stocked and ready for use in an event of a major incident.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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, the feedback process from incidents was for staff to receive feedback through line managers. Managers issued memos to all crews for issues and information relevant to the whole service.

The service carried out root cause analysis (RCA) for all serious incidents reported. The service utilised a range of recognised RCA tools to assist any investigation and staff were trained how to use them. We reviewed two completed RCAs, documentation we saw demonstrated that a structured approach was taken during the investigation.

There was evidence of local audit by the service of reported incidents to determine if there were any emerging themes. We saw examples of cases studies on display which related to incidents from not only this service but from other ambulance trusts and what actions had been put in place following the incident. For example, following a previous audit which highlighted verbal abuse towards staff body-worn cameras had been introduced. Staff reported these worked well and had reduced the number of incidents.

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 could describe the requirements DoC and gave examples of when DoC had been invoked following an incident.

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 January to December 2018, the trust reported no incidents that were classified as a never event in emergency and urgent care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in emergency and urgent care which met the reporting criteria set by NHS England from January to December 2018. These are broken down as follows:

- Operation/treatment given without valid consent – one incident
- Major incident/ emergency preparedness, resilience and response/ suspension of services – one incident
- Treatment delay meeting SI criteria – one incident
- Apparent/actual/suspected self-inflicted harm meeting SI criteria – one incident

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

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.

We observed the system of pre-hospital assessment and initial treatment of patients with possible sepsis, resulting in the administration of IV fluids and antibiotics by paramedics prior to arrival in ED. We saw one patient arrive who had received time critical treatment within one hour as per NICE guidance.

Staff could access up to date JRCALC guidance using an application on their smartphones. The trust ensured that this had been purchased for staff to use. In addition, the clinical support desk (CSD), located within the emergency operations centre, provided enhanced clinical advice and support via the telephone for crews.

Staff were aware of ‘see and treat’ and the importance of maintaining patient independence by not taking them to hospital if it was not clinically necessary.

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.

Evidence based care bundles and pathways were available in all the vehicles we inspected and could be accessed via the ePRF system. 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.

Staff compliance with guidelines were assessed through clinical supervision, appraisal and through their individual learning plan (ILP) review. We looked at five sets of reviews which

contained evidence of clinical supervision, discussions regarding outcomes of clinical audits and adherence to JRCALC guidance.

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 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 reviewed a range of clinical newsletters and updates distributed to ambulance staff and posted on noticeboards in the crew room. They provided updates on clinical matters, changes to clinical practice, NICE guidelines, review of any procedures, information governance and details of both internal and external training courses that were available.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief advice in a timely way.

Paramedics were trained and able to give a range of pain relief 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 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 poster displaying a visual pain tool. This meant that patients who were young, unable to communicate verbally or did not speak English could point to a face which best represented their level of pain.

Response times

The service monitored agreed response times so that they could facilitate good outcomes for patients. They are using the findings to make improvements.

The introduction of the new CAD system in November 2018 had allowed the service to capture and analyse data more accurately regarding capacity vs demand. The service had begun to compare the data and use it to determine if existing resources matched the demands made on the service. The demand modelling was in its initial stages and at the time of our inspection results had not yet been finalised or published.

The service did not achieve the national standards in three of the four Category 1 standards. They performed better than average for the two Category 2 standards. For Category 3 standards the

service performance had improved in the 3 months prior to inspection. It did not meet the standard but was better than the England average. Finally, for Category 4 standards the service had not met the standards in the last two months.

See below for a more detailed explanation of the national standards.

Ambulance systems (AmbSYS) indicators introduced under the NHS England Ambulance Response programme (ARP):

The following measures were introduced for this trust in April 2018 to reflect the new way of working under the ARP.

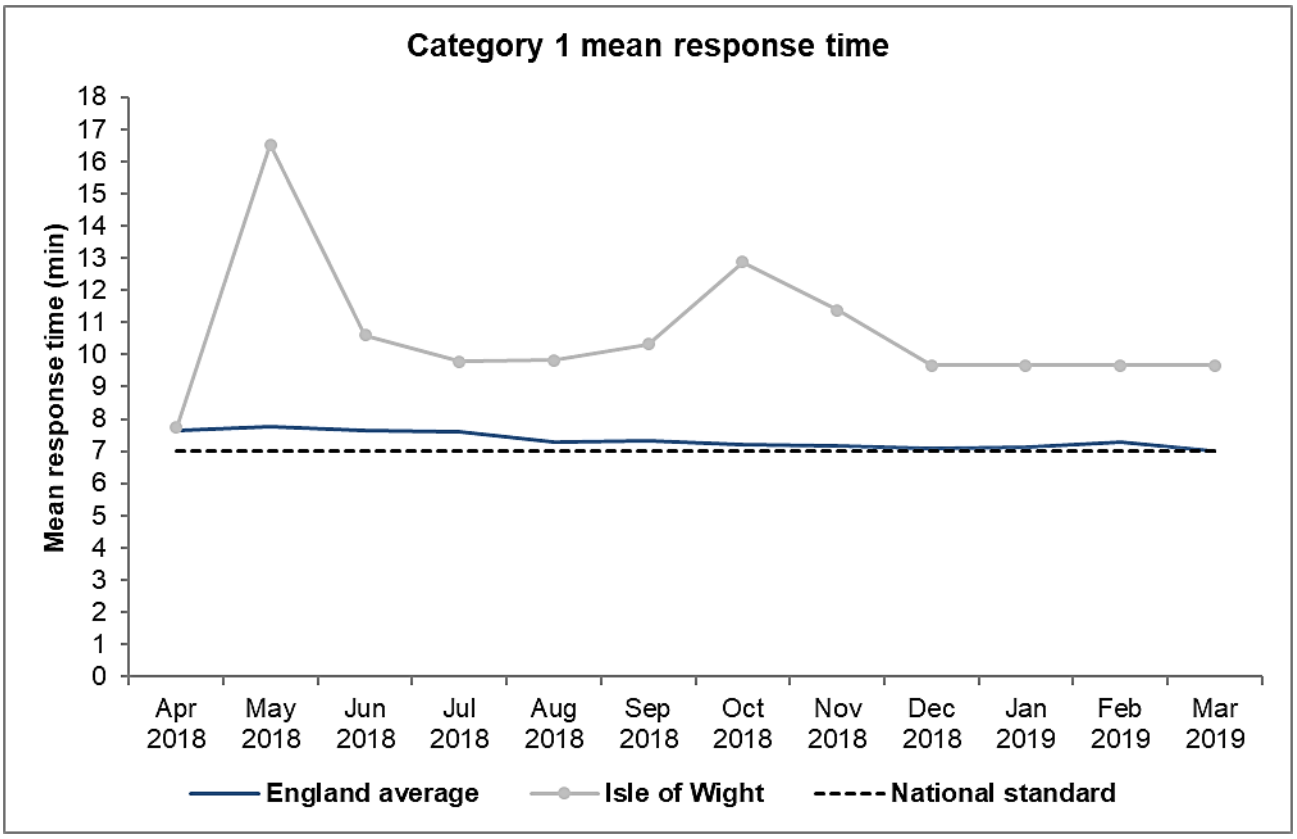
Response times

Under ARP four new categories of call were introduced with new national standards. Mean (average) and 90th centile measures were introduced to help improve performance management of response times.

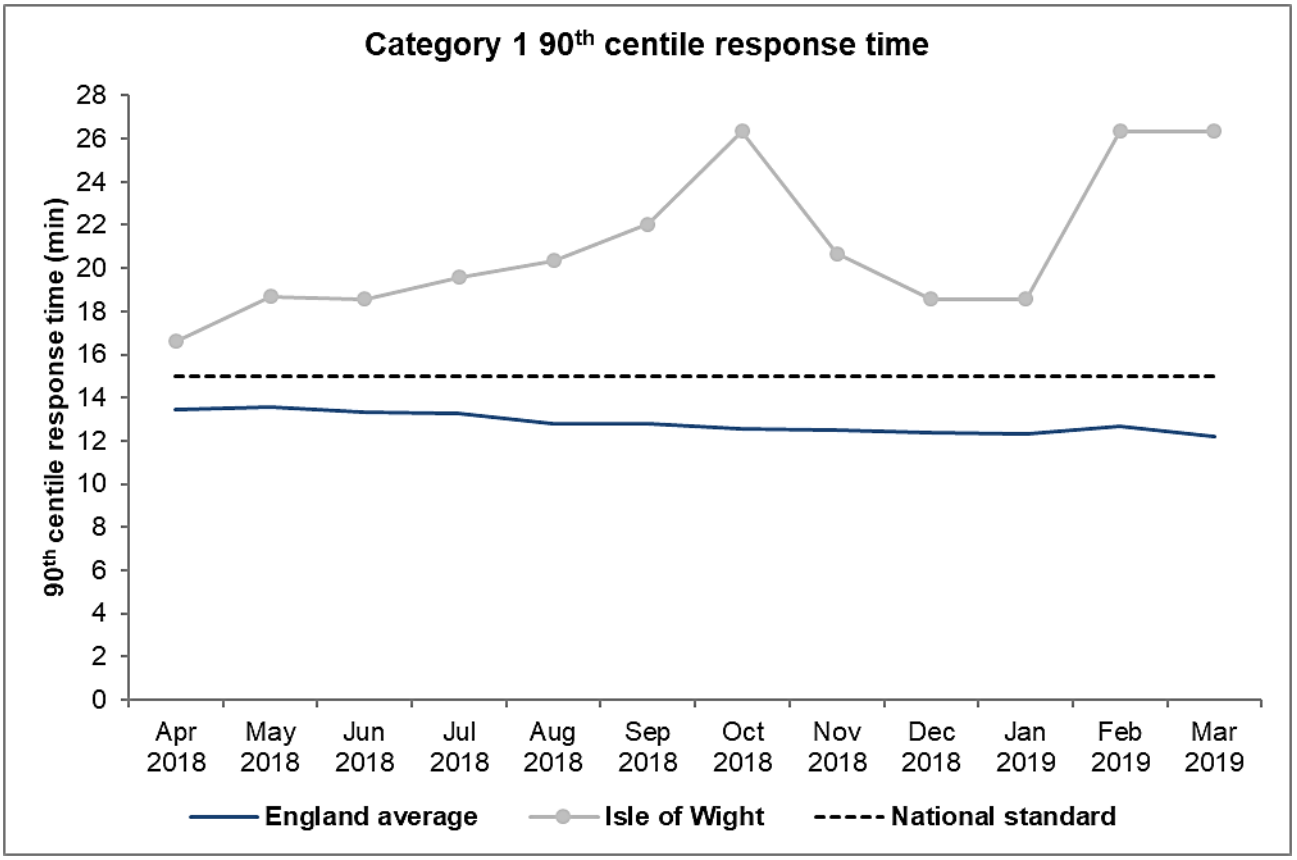
Please note for category 3 and 4 calls there are no mean response time standards, only 90th centile measures.

- **Category 1: Calls regarding people with life threatening illnesses or injuries** such as cardiac arrests and serious allergic reactions. These calls should be responded to in an average time of seven minutes, with 90% of all calls responded to within 15 minutes.
- **Category 1T: Life threatening illnesses or injuries with transport**. This is an additional category 1 transport standard to ensure that these patients also receive early ambulance transportation. These calls should be responded to in an average time of seven minutes, with 90% of all calls responded to within 15 minutes.
- **Category 2: Emergency calls** dealing with conditions and injuries such as strokes, epilepsy and burns. These calls should be responded to in an average time of 18 minutes, with 90% of all calls responded to within 40 minutes.
- **Category 3: Urgent calls** dealing with conditions such as late stages of labour, non-severe burns and diabetes. In some instances, patients may be treated by ambulance staff in their own homes. 90% of these calls should be responded to within 120 minutes (2 hours).
- **Category 4: Less urgent calls** dealing with conditions such as diarrhoea and vomiting and urine infections. In some instances, patients may be given advice over the phone or referred to another service such as a GP or pharmacist. 90% of these calls should be responded to within 180 minutes (3 hours).

Category 1 calls:

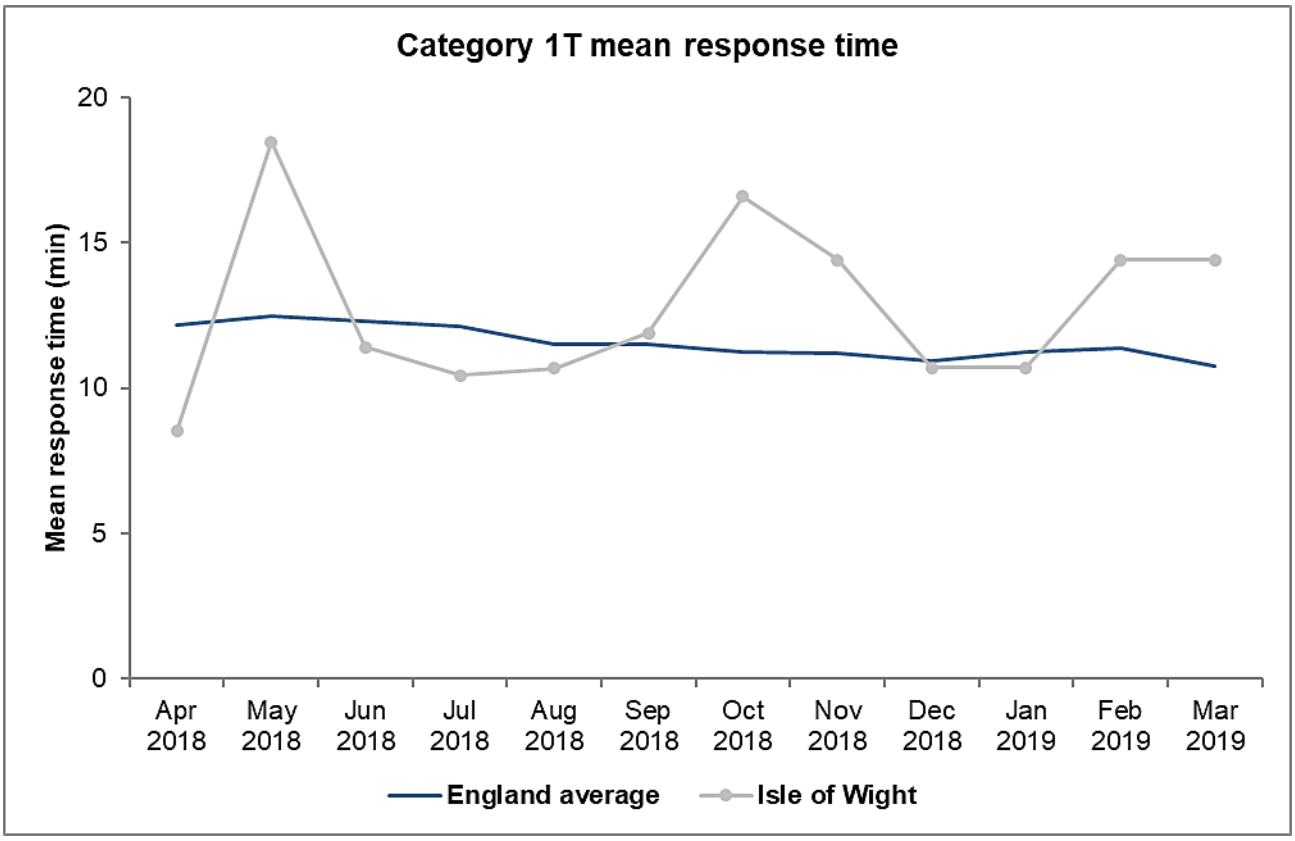


From April 2018 to March 2019, the trust did not meet the seven-minute national standard, and performed worse than the England average since May 2018. Over the 10 months, the trust performance ranged from 07:44 to 16:31. In March 2019 the trust did not meet the national standard and performed worse than the England average.

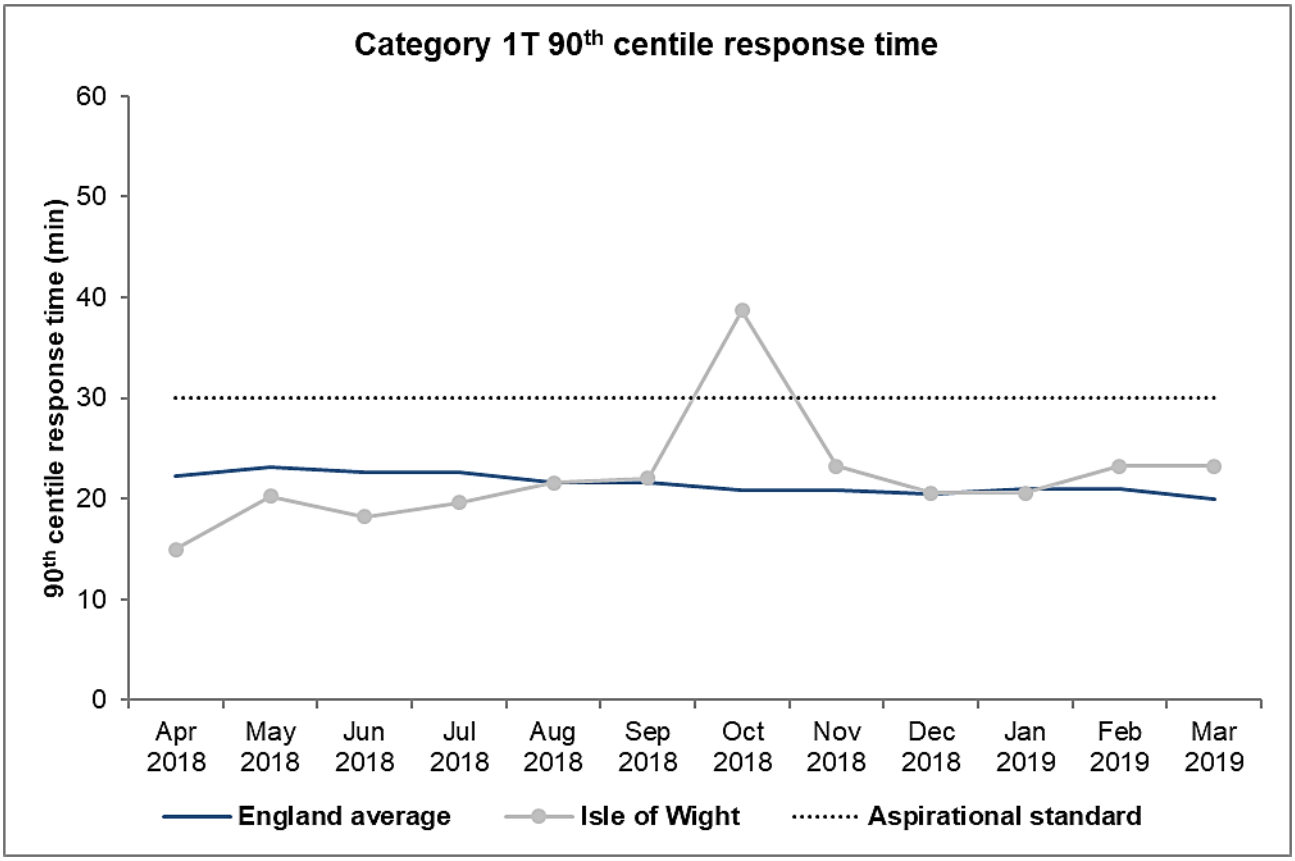


From April 2018 to March 2019 the trust did not meet the 15-minute national standard, and performed worse than the England average in all months in the period. Over the 12 months, the trust performance ranged from 16:37 to 26:20. In general, from April 2018 to March 2019 there was a deterioration in the trust's performance against this metric, although performance did improve in the winter months from November 2018 to January 2019.

Category 1T calls:

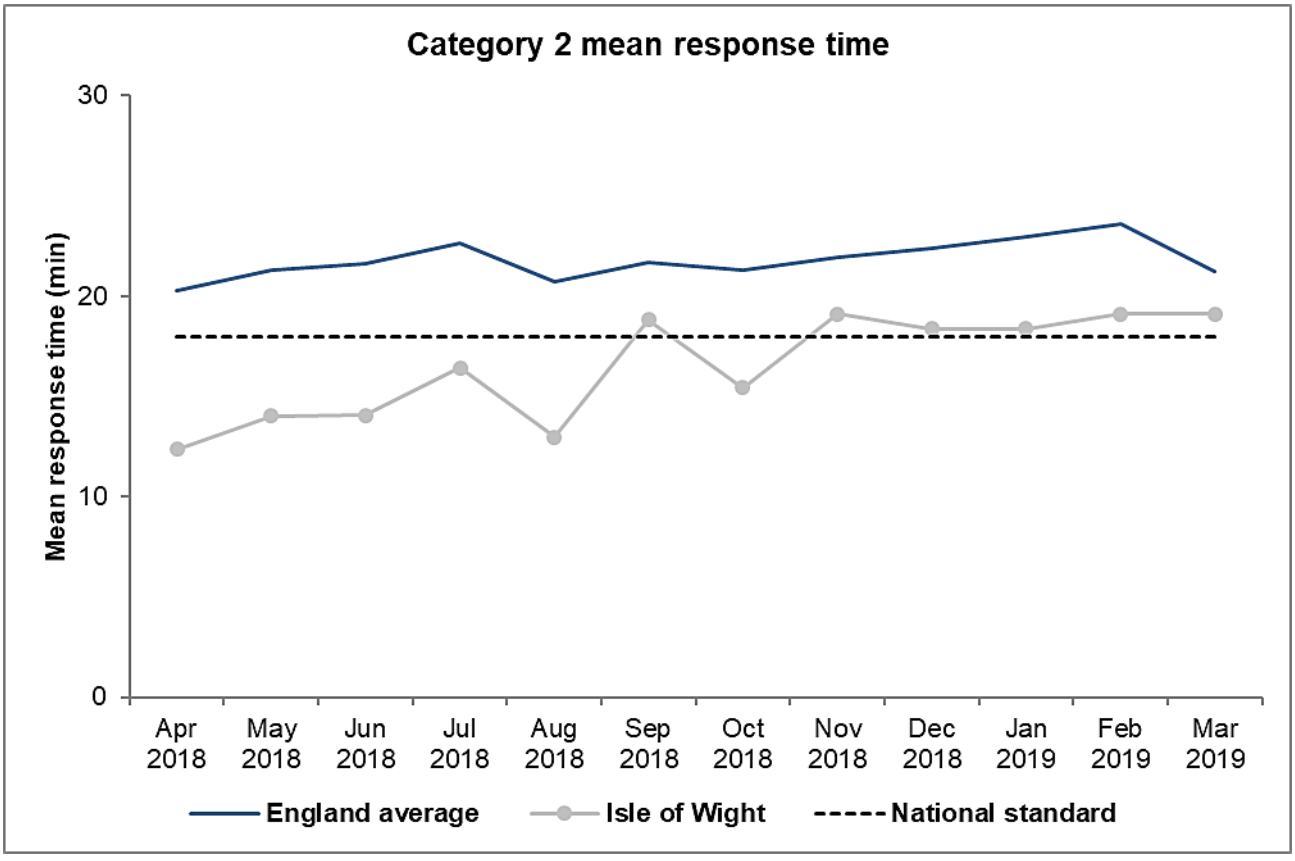


From April 2018 to March 2019, the trust performance fluctuated above and below the England average. Over the 12 months, the trust performance ranged from 08:31 to 18:28. In March 2019, the trust performed worse than the England average.

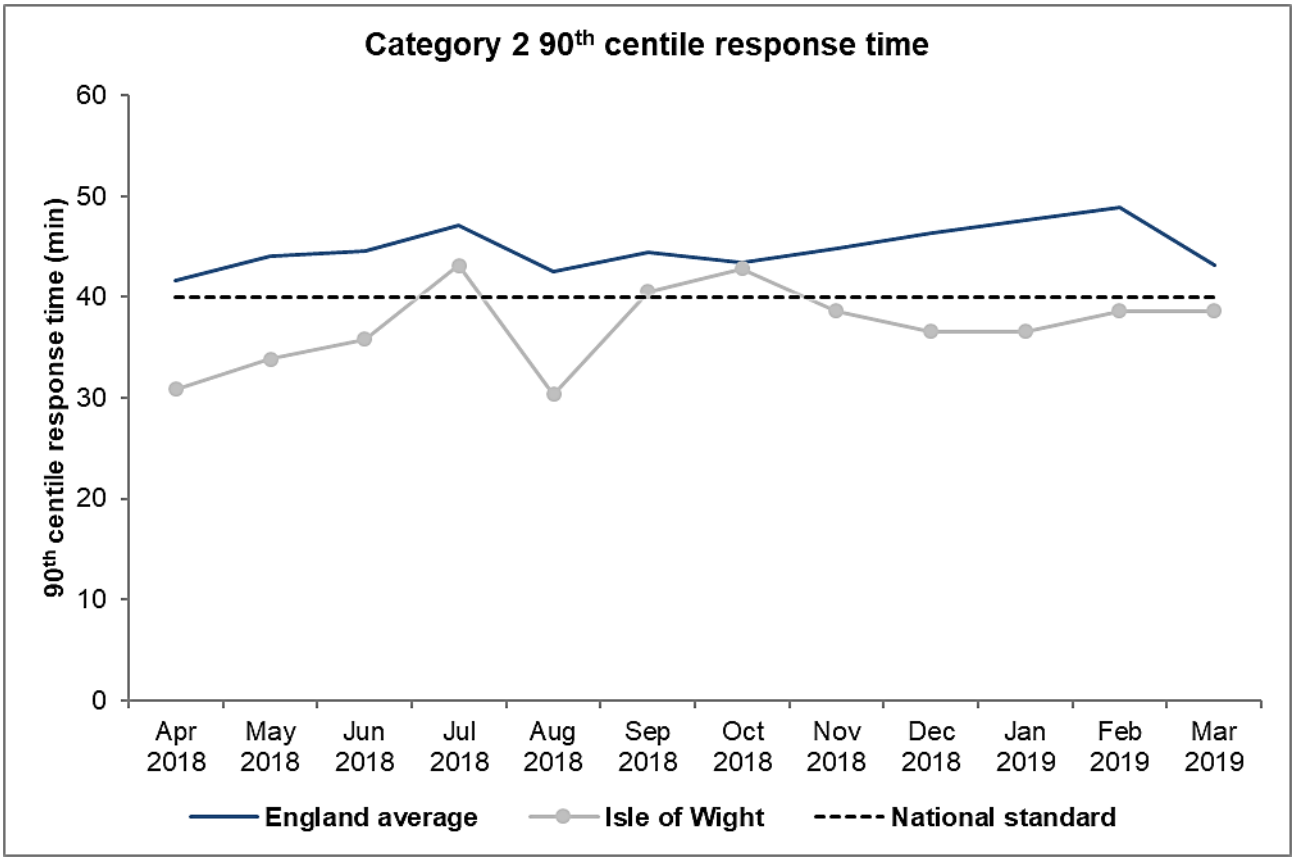


From April 2018 to March 2019, the trust met the 30-minute aspirational target in all but one month (October 2018). Over the 12 months, the trust performance ranged from 14:58 to 38:41, with response times gradually increasing over time. In March 2019, the trust met the national standard and performed worse than the England average.

Category 2 calls:

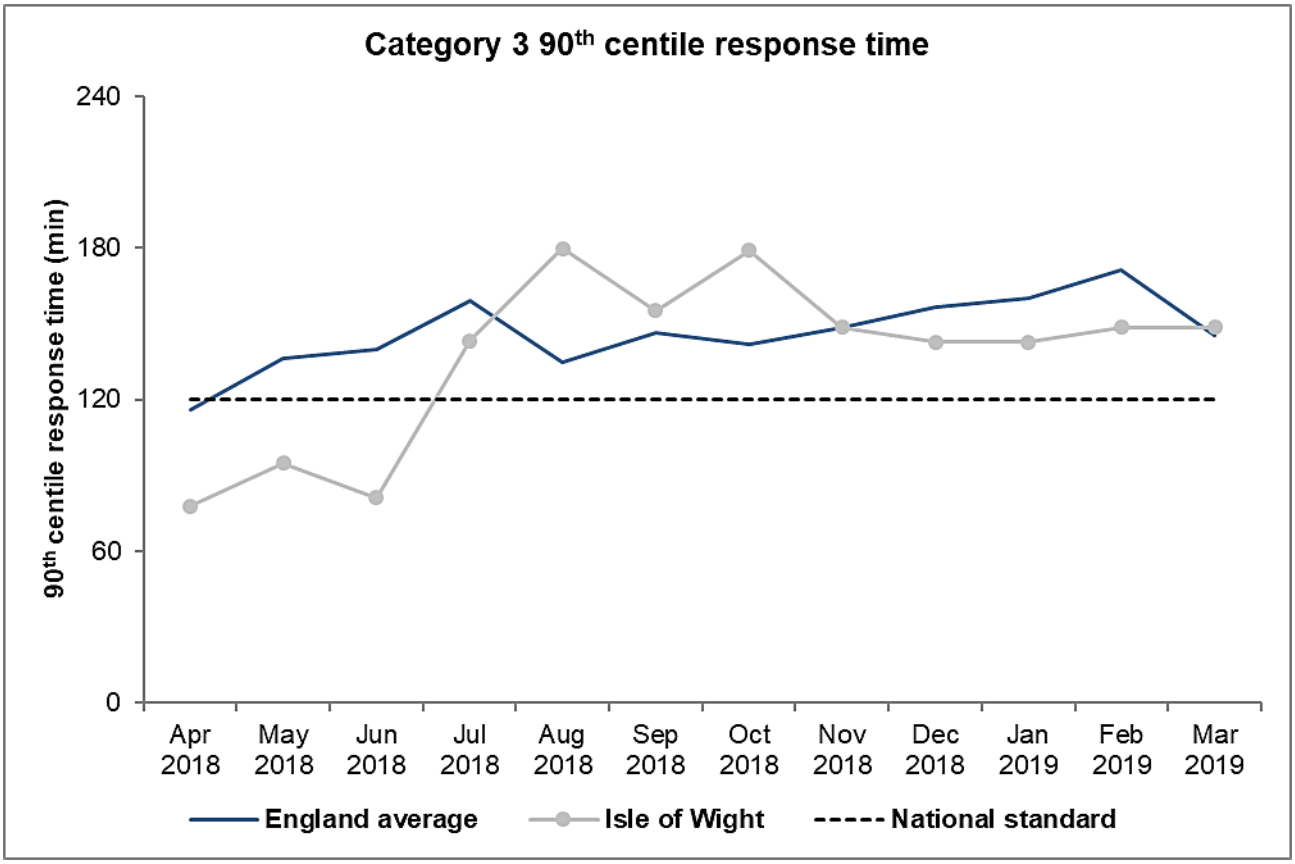


From April 2018 to March 2019, the trust met the 18-minute national standard in six months in the period. The trust's performance has deteriorated over time and the trust has failed to meet the standard in each of the last five months, although performance was better than the England average in all months in the period. Over the 12 months, the trust performance ranged from 12:21 to 19:07.



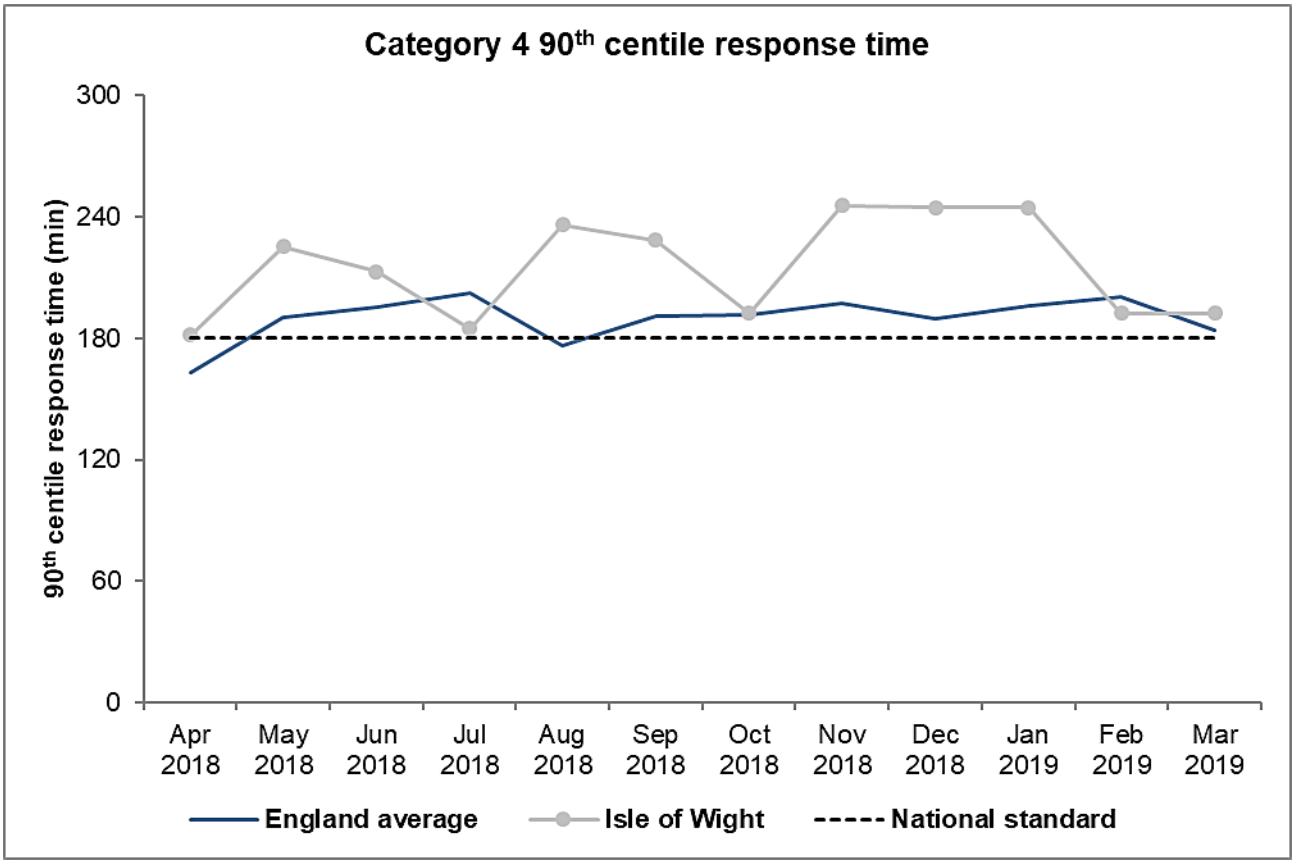
From April 2018 to March 2019, the trust met the 40-minute national standard in nine of the 12 months and performed better than the England average. Over the 12 months, the trust performance ranged from 30:52 to 43:10.

Category 3 calls:



From April 2018 to March 2019, the trust failed to meet the national standard in nine of the 12 months. The trust's performance deteriorated in July 2018, and the national standard has not been met in any month since (July 2018 to March 2019). From April 2018 to June 2018, the trust performance ranged from 1:17:58 to 1:34:53, whereas from July 2018 to March 2019, trust performance ranged from 2:22:50 to 2:59:04.

Category 4 calls:



From April 2018 to January 2019, the trust failed to meet the national standard in all 12 months in the period. Over the 12 months, the trust performance ranged from 3:01:40 and 4:05:39.

(Source: NHS Digital – Ambulance System Indicators (AmbSYS))

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The size of the service, the population and geography it served meant there were low numbers of patients in certain categories ambulance services were usually monitored on. The addition of one patient or the absence of any patients meant statistics could sometimes be skewed.

However, the service measured patient outcomes and took part in national and local audits. Where patient outcomes did not meet national targets, the service introduced action plans to improve. For example, the service undertook audits of patients who were classed as long waiters. We saw evidence that all such cases were clinically reviewed to determine if; treatment was in line with JRCALC guidance and local protocols, there was evidence of negative impact on the patient's condition and if there was evidence that impacted on patient experience. Any actions as a result of the audit were documented.

The service used audit of individual staff competency, through clinical supervision, appraisal and ILP process, to monitor outcomes. Concerns or issues identified were addressed through further training and development.

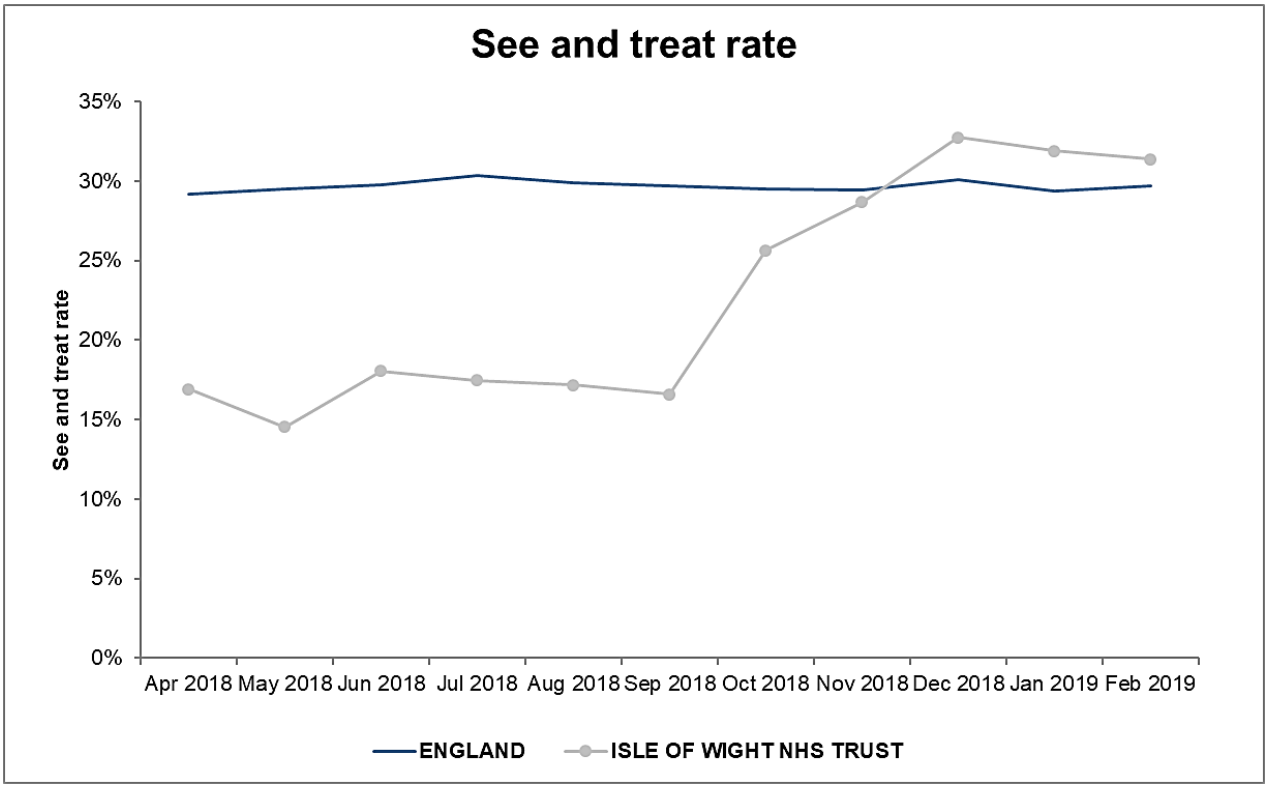
The service reviewed the effectiveness of care and treatment that staff provided through local and national audit along with benchmarking against other ambulance services in England.

Evidence from minutes of governance meetings showed patient outcome data was reviewed. The trust routinely collected and monitored information about patients care and treatment and

produced ambulance clinical quality indicators. These indicators measured the overall quality of care and outcomes for patients following treatment.

See and treat

Of the calls that receive a face-to-face response from the ambulance service, proportion managed without need for transport to Type 1 and Type 2 A&E.



From April 2018 to February 2019, the trust proportion of face-to-face calls without the need for transport was generally lower than the England average, although the proportion has increased since September 2018. The trust's performance ranged from 14.5% to 32.7%.

(Source: NHS England – Ambulance Quality Indicators – Systems indicators)

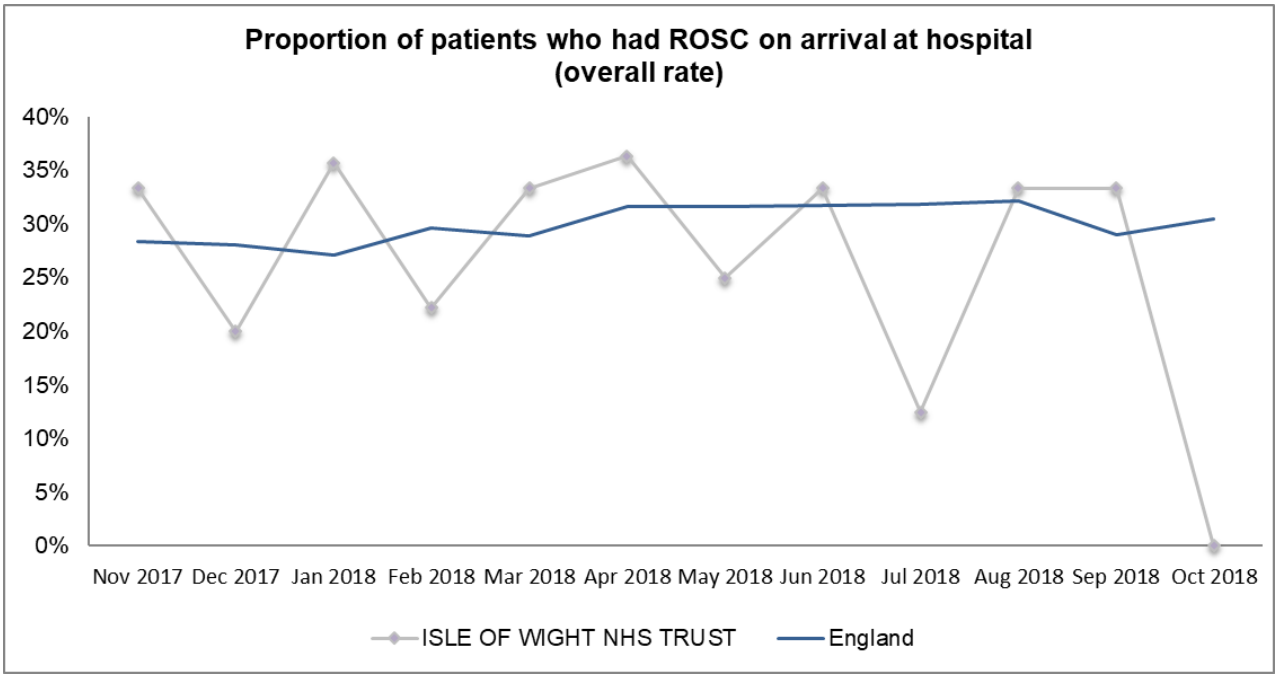
Ambulance Quality Indicator Clinical Outcomes (AmbCO)

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

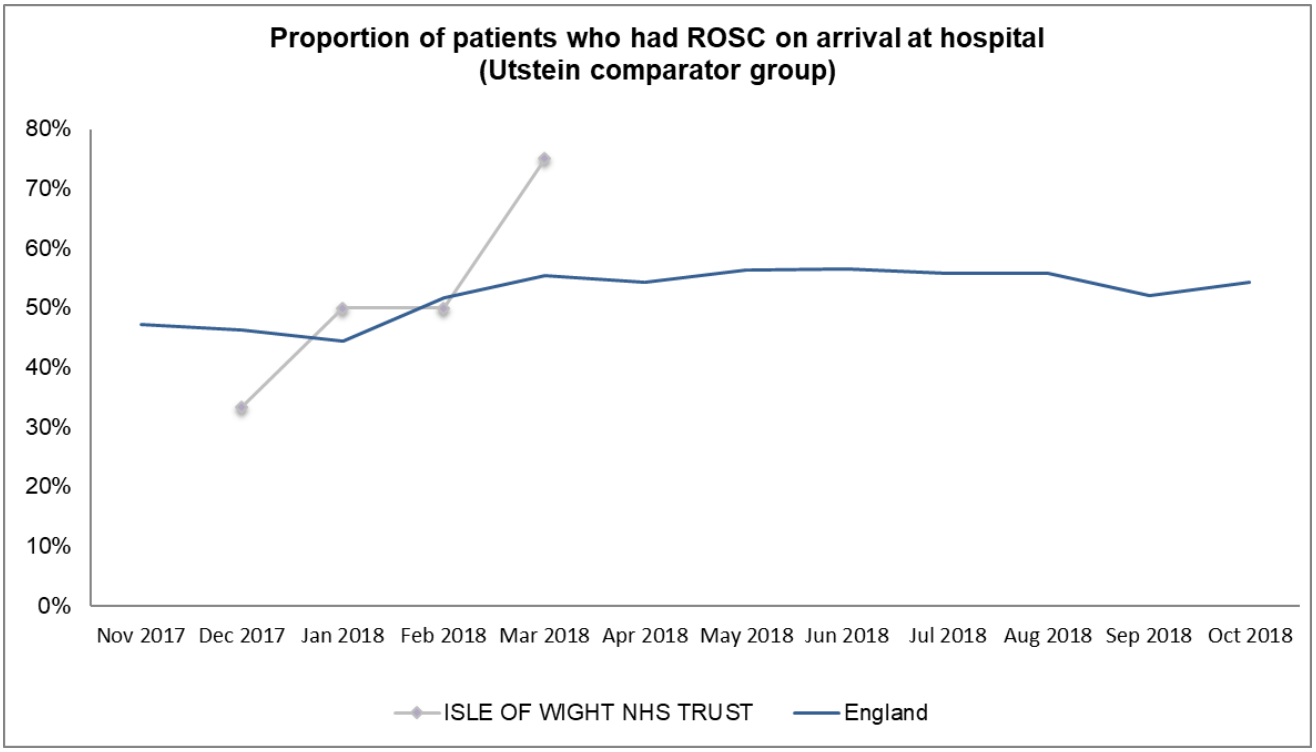
The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests.



From November 2017 to October 2018, the trust's overall proportion of patients who had return of spontaneous circulation (ROSC) fluctuated above and below the England average. The trust's performance ranged from 0.0% to 36.4%. Care should be taken when interpreting this data due to a low number of eligible patients at the trust. In October 2018, none of the eligible patients at the trust had ROSC on arrival at hospital.

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 November 2017 to October 2018, there were only four months in which there were eligible patients at the trust from the Utstein comparator group who received treatment for cardiac arrest. From December 2017 to March 2018 the trust's performance ranged from 33.3% to 75.0%. Care should be taken when interpreting this data due to a low number of eligible patients at the trust. In November 2017 and in the months from April 2018 to October 2018, there were no eligible patients at the trust.

(*Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)*

Post-ROSC care bundle

Delivery of the post-ROSC care bundle aims to improve outcomes in patients with out-of-hospital cardiac arrest. This new measure reflects the ability of the ambulance trust to deliver all aspects of the care-bundle. In order to give Ambulance Services time to develop new measures for 2018, data will only be collected and published for April, July, and October.

The metric excludes the following patient groups:

- Traumatic Cardiac Arrest
- Patients successfully resuscitated before the arrival of ambulance staff
- Patients aged less than 18 years.

Date	Isle of Wight NHS Trust	England
February to April 2018	25.0%	53.1%
May to July 2018	0.0%*	57.3%
August to October 2018	n/a**	65.3%

From February to July 2018 and also from May to July 2018, the trust performed worse than the England average.

*Care should be taken when interpreting data for the trust as a low number of eligible patients were reported for both periods.

** From August to October 2018 there were no eligible patients at the trust.

(*Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)*

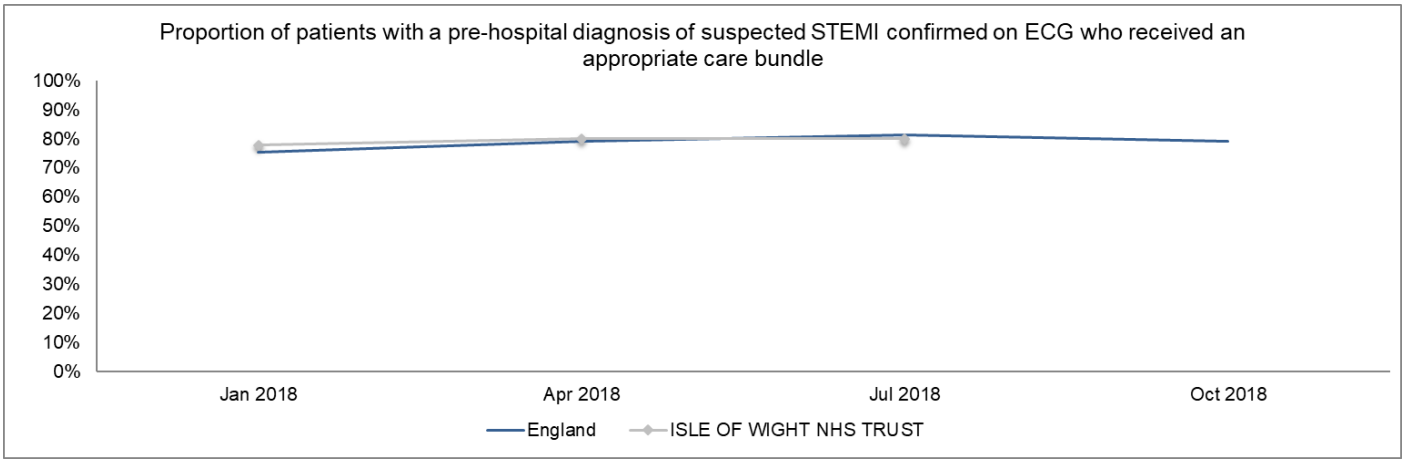
Outcome from acute ST-elevation myocardial infarction

Heart attack, or ST-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 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 of patients with a pre-hospital diagnosis of suspected STEMI confirmed on electrocardiogram (ECG) who received an appropriate care bundle



From January 2018 to October 2018, the trust proportion of patients with a pre-hospital diagnosis of suspected STEMI confirmed on electrocardiogram (ECG) who received an appropriate care bundle was similar to the England average. Over the period, the trust performance ranged from 77.8% to 80.0%. Care should be taken when interpreting this data due to a low number of eligible patients at the trust. In October 2018, there were no eligible patients at the trust.

(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.

Outcome from stroke: patients that were FAST-positive and / or had a provisional diagnosis of stroke

From November 2017 the metric above was replaced by three new metrics relating to time from call for help to hospital arrival for patients that were FAST-positive and/or had a provisional diagnosis of stroke. Both patient groups are included in the new metric, because acute trusts can record equivalent clinical episodes under either of these two categories. Patients can be excluded if they are found to have had a transient ischemic attack (TIA) and their symptoms resolve whilst with the ambulance crew.

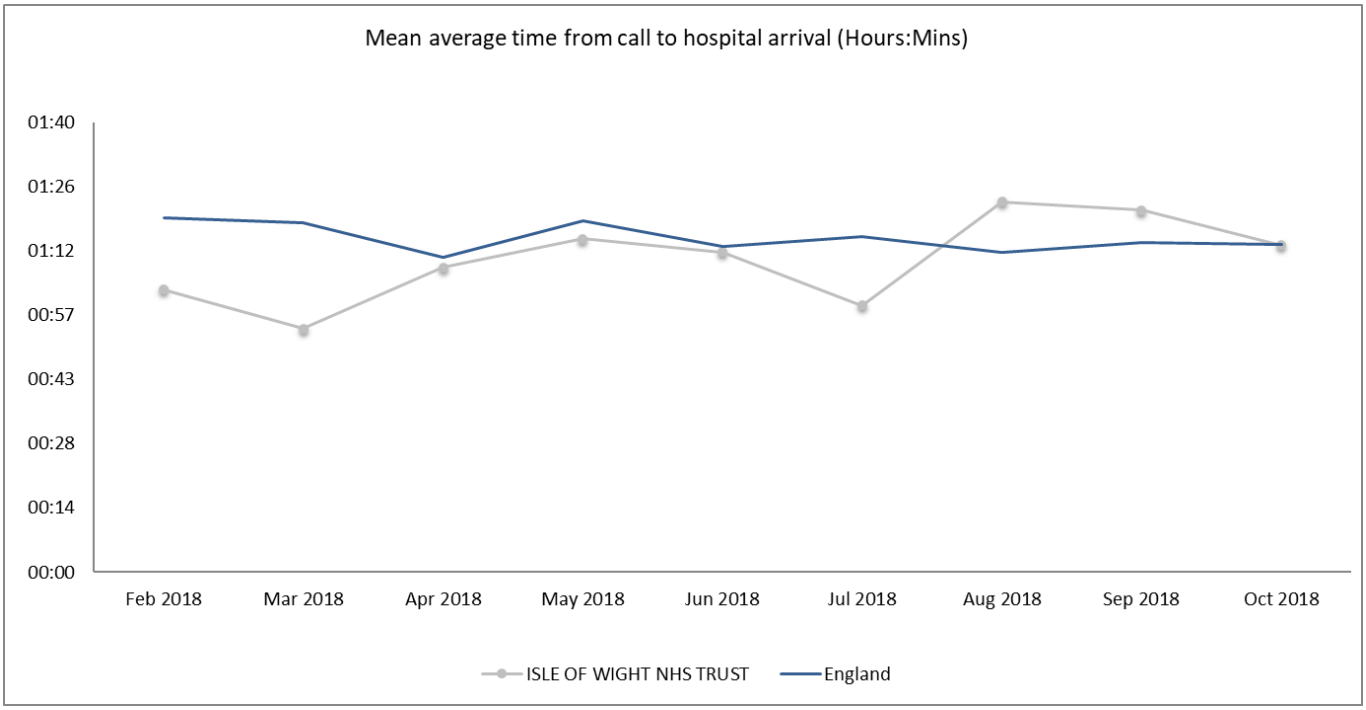
The three new metrics, all measured as mean median and 90th centile, are:

- Call to door (Number of patients either FAST positive, or with provisional diagnosis of stroke, transported by ambulance service)
- Door to scan (timings related to stroke patients in SSNAP who had a CT scan)

- Door to thrombolysis (timings related to stroke patients in SSNAP who had thrombolysis)

Door to **scan / thrombolysis measures are contextual measures** as they are beyond the control of the ambulance service. They are included to give an indication of the system response to stroke patients - this takes account of service pressure, reconfigurations (that increase journey times), hospital handover times and speed of CT Scan, CT reporting and access to thrombolysis / specialist stroke care.

Call to door: time from call for help to hospital arrival for patients that were either FAST positive, or had a provisional diagnosis of stroke



From February to October 2018, the trust mean call to door time from call for help to hospital arrival for patients that were either FAST positive or had a provisional diagnosis of stroke generally performed better than the England average, although in more recent months performance was worse or similar to the England average. Over the nine months, the trust performance ranged from 00:54:30 and 01:22:55.

Door to scan: time from hospital arrival to CT scan for stoke patients in SSNAP (hours: minutes), October 2018

Metric	Trust	England
Mean	04:00	03:01
Median	00:12	00:42
90th centile	01:56	03:52

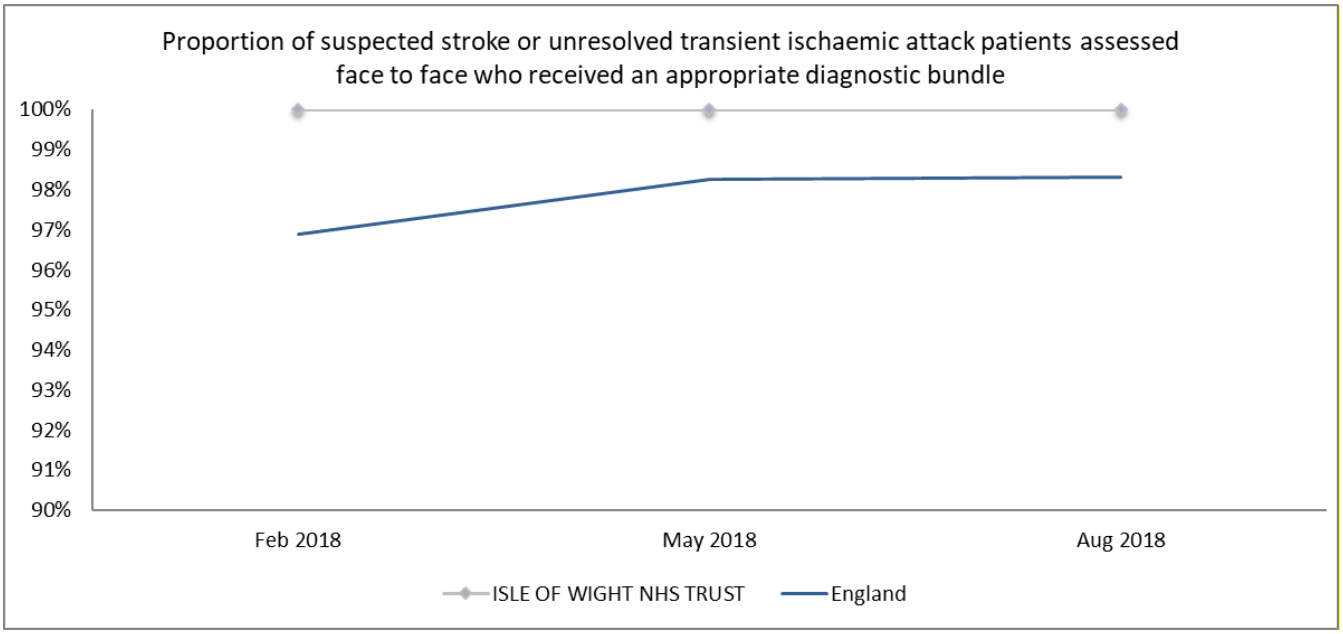
For October 2018, the trust's mean and 90th centile waiting times from door to scan were worse than the England average and the median was similar to the England performance.

Door to thrombolysis: time from hospital arrival to thrombolysis for stoke patients in SSNAP (hours: minutes), October 2018

No data was available for this trust for this metric.

(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes – October 2018)

Proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate diagnostic bundle



From February to August 2018, the trust proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate diagnostic bundle was better than the England average. In addition, the trust performance was at 100% during the period. Care should be taken when interpreting this data due to a low number of eligible patients at the trust.

(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)

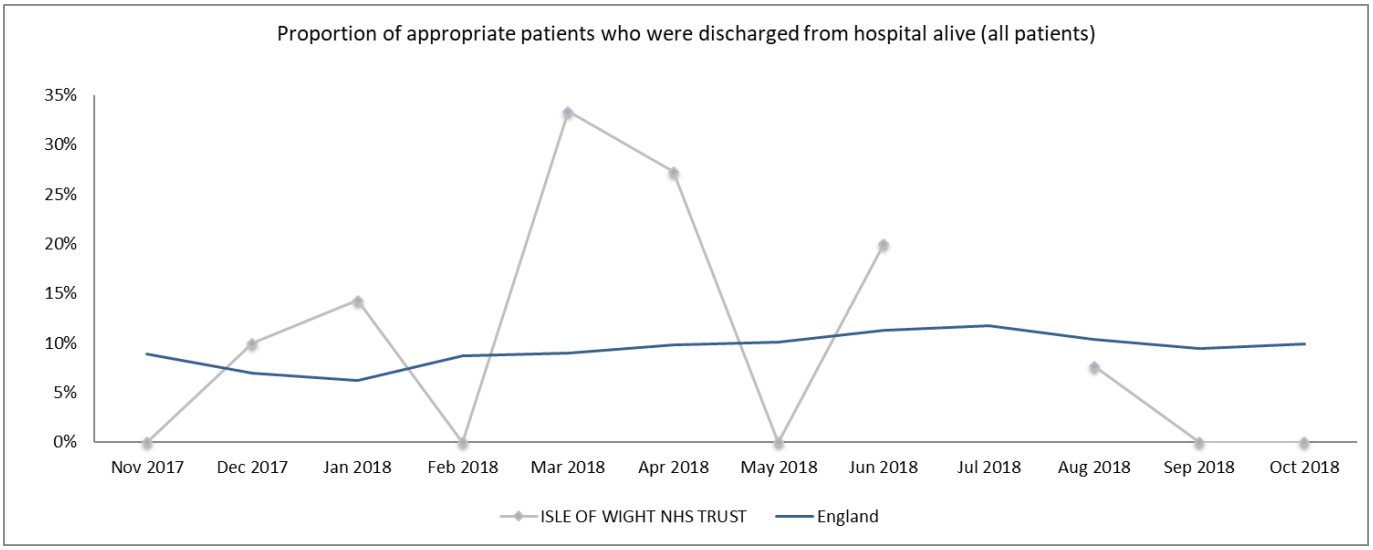
Survival to discharge following cardiac arrest

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.

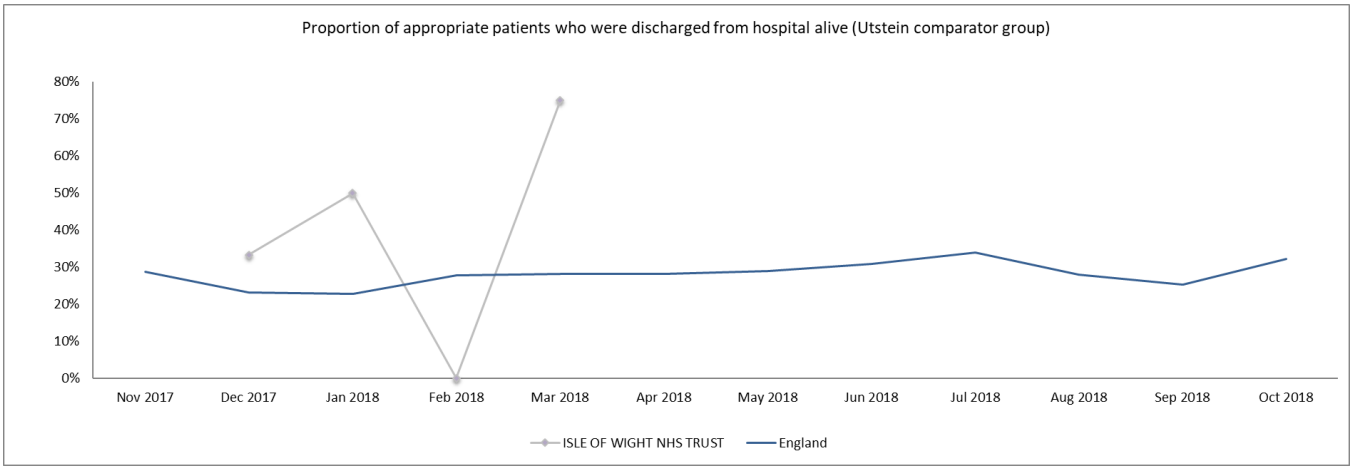
Survival to discharge is calculated for two patient groups; the overall group, and the Utstein comparator group.

Proportion of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest who were discharged from hospital alive – all patients



From November 2017 to October 2018, the trust proportion of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest who were discharged from hospital alive (all patients) varied between 0.0% and 33.0%.Care should be taken when interpreting the chart due to a low number of eligible patients seen by the trust.

Proportion of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest who were discharged from hospital alive – Utstein comparator group



From December 2017 to March 2018, the trust proportion of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest who were discharged from hospital alive (Utstein comparator group) varied between 0.0% and 75.0%. Care should be taken when interpreting the chart due to a low number of eligible patients seen by the trust. In November 2017 and also in the months from April 2018 to October 2018, there were no eligible patients at the trust.

(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)

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 development. However, not all staff had received an appraisal during the past 12 months.

Initial data supplied by the service meant we were not assured all staff received an appraisal every year. This meant not all staff were given the opportunity to discuss their development and have a discussion with their manager. Data provided during the inspection showed an improved position with 100% of managers, training staff and emergency planning staff having received an appraisal in the last 12 months.

Of the remaining staff defined as working in the ambulance emergency services division, data showed 63% of staff had received an appraisal in the previous 12 months.

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. Some staff reported appraisals had not been carried out by their line manager. Instead another manager had carried out the review and this had left them feeling undervalued.

Managers were aware appraisals and supervision was a challenge and had introduced a new process to enable higher compliance rate regarding appraisals for all staff. Staff training and appraisals were planned into rotas by the resourcing team. Staff were stood down from operational duties to enable appraisals and training to be completed.

Prior to our previous inspection it had been noted the service identified a gap within their training and had employed an ambulance educator to oversee and manage the clinical governance and training for EVOs. The ambulance educator also provided preceptor support to Newly Qualified Paramedics (NQP) in line with the national agreed NQP program. At the time of this inspection the role had been in place for approximately 18 months, both managers and staff reported the positive impact on training the role had produced.

Managers described the ambulance educator role 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.

Feedback from all staff we spoke with was training opportunity had improved for all grades of staff. The ambulance educator arranged training courses for staff to attend and paramedics from the mainland had also attended. This gave staff from the service opportunities to share ideas and knowledge with colleagues from other ambulance services. Staff told us this was a welcome development and they were actively requested to provide feedback following courses and this was used to develop and inform future programmes.

During our inspection we observed new staff to the service, who were qualified paramedics, receiving induction training and local equipment training. Feedback provided by those on induction was positive regarding quality of the training and the knowledge of the trainers.

The service utilised Community Practitioners (CP) as an additional resource to support frontline crews during the day. At night CPs were utilised by the trust to cover out of hours GP for patients across the island, A CP was a qualified paramedic who received additional clinical supervision from an emergency department (ED) doctor. 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 end of life training for all frontline staff.

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. Managers told us the service had staffing and financial challenges but were working hard to identify courses and funds for staff to access. We spoke with staff who had progressed from EVO to paramedic and had been supported

to do so by the service. We were also told of staff from the make ready team who were on courses to enable them to become an EVO.

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 monthly, 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 was not able to staff a full 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.

At our last inspection the service had been inspected by the National Ambulance Resilience Unit (NARU) and were found to be non-compliant against some national requirements. This included having enough suitably trained staff available to deal with chemical, biological, radiological and nuclear (CBRN) incidents.

The service had staff trained in specialist areas such as marauding terrorist attack (MTA) and CBRN. During our inspection we saw staff undertaking CBRN equipment familiarisation and training.

Appraisal rates

From April 2018 to February 2019, 55.8% of staff within the emergency and urgent care at the trust received an appraisal compared to a trust target of 85.0%. The trust target was not met for any staff group working in the service.

The breakdown by staff group is shown below:

Staff group	April 2018 to February 2019				
	Number of staff received appraisal	Number of required staff	Appraisal rate	Trust Target	Met (Yes/No)
Estates and Ancillary	24	36	66.7%	85.0%	No
Allied Health Professionals	27	53	50.9%	85.0%	No
Additional Clinical Services	2	4	50.0%	85.0%	No
Administrative and Clerical	0	1	0.0%	85.0%	No
Nursing and Midwifery Registered	0	1	0.0%	85.0%	No

(Source: Trust Provider Information Request – Appraisals)

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

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.

At our last inspection, some ambulance crews told us 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.

Staff told us during this inspection that this had improved and there was a more integrated approach to the management of patients from ambulance crews to ED.

Ambulance crews could use a docking station or the WiFi within ED to upload the ePRF directly into the ED system. Crews told us, and we saw, the docking station did not always work meaning delays for ED staff accessing patient information.

Staff described the agreed process in place, if a crew saw signs of deterioration with their patient. They contacted the ED by telephone, using a pre-alert process, to escalate the priority level. We saw this in operation with a crew contacting the Hyper Acute Stroke Unit.

There were links with other emergency services including the coast-guard and air ambulance services, who played a key role when transporting patients quickly on or off the island.

We attended a multi-disciplinary team meeting where we observed good team work. The meeting was a debrief following a major incident on the island and representatives from the ambulance service, together with all other agencies involved, attended. A variety of staff from all disciplines and grades were present and everyone was given an opportunity to speak and everyone listened. The discussion was open and honest, and included things which could have been done differently, as well as praise given for things which went well.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

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 (the Hub).

For patients who they did not convey to hospital and refer to another service they provided additional advice. For example, they advised patients to contact 111 for advice or dial 999 if their condition deteriorated or they were concerned.

The trust provided occupational health services for all staff covering sickness absence, assessments and reviews, new started medicals, needle stick management and vaccination programmes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff demonstrated good understanding around the principles and values that underpinned the legal requirements in the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. For example, that a person must be assumed to have capacity unless it was established that they lack capacity.

Staff could demonstrate good understanding of the need to gain full consent prior to any treatment and clinical interventions. Staff told us they acted in the 'best interest' of patients who were critically unwell, unconscious and unable to verbally consent.

Staff we spoke with had a good knowledge of assessing capacity and what to do if a patient lacked capacity to consent to treatment.

Staff we spoke with were aware of the Gillick competence, which is a term, used in medical law to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need for parental permission or knowledge.

The ePRF included capacity assessment with useful prompts and up to date guidance for staff to follow including outcomes from the assessment.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion rates

The trust reported that from April 2018 and January 2019, Mental Capacity Act (MCA) training was completed by 91.5% of staff in emergency and urgent care compared to the trust target of 85.0%.

The breakdown by staff group was as follows:

- Support to doctors and nursing staff: 100.0%
- Nursing and midwifery staff: 100.0%
- Support to ambulance service staff: 91.7%
- Qualified ambulance service staff: 90.9%

The trust has reported that the Mental Capacity Act training module incorporates the Deprivation of Liberty Safeguard training.

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff speaking with patients respectfully and using preferred choice of name. Staff introduced themselves before any interactions with their patients and their loved ones; we observed staff to be respectful, polite, and friendly.

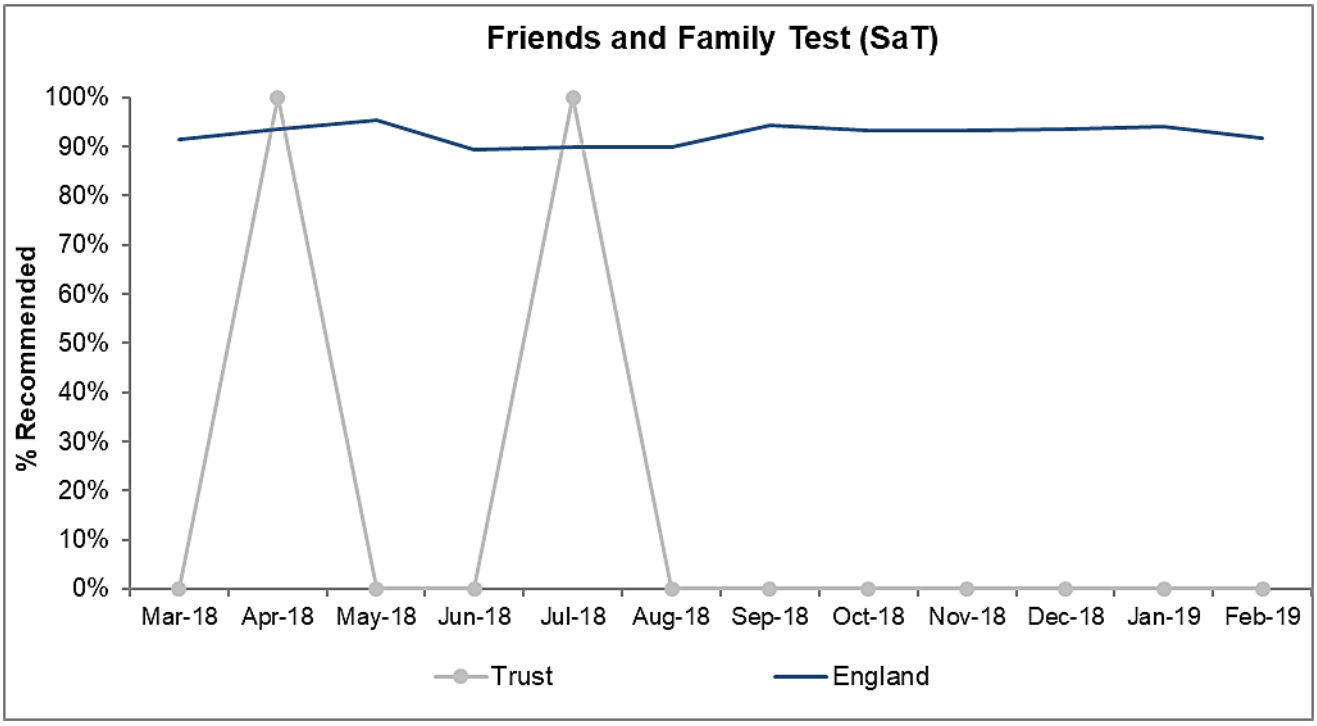
During our observations of care delivery, staff delivered compassionate care to all patients in ambulances, patient's homes and in the emergency department. We saw staff asking patients if they were comfortable during the journey to hospital, maintaining their dignity and keeping them warm.

Staff took the necessary time to engage with patients, with a caring manner and were always calm despite being very busy, this did not reflect, or impact patients care.

We saw thank you letters, and cards displayed in the staff rooms from patients which all provided positive feedback for staff.

Friends and Family test performance – see and treat

The Friends and Family Test for see and treat (SaT) between March 2018 and February 2019 the trust scored better than the England average for recommending the trust as a place to receive care for the two months where data was available. Over the 12-month period, there were 10 months where data was suppressed due to low numbers (March 2018, May 2018, and August 2018), no responses were received (June 2018 and December 2018 to February 2019) or no data was available for the trust (September 2018 to November 2018).



(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We saw staff consistently checked patients' wellbeing, in terms of physical pain, discomfort, and emotional wellbeing.

There were messages of thanks and appreciation from patients on display on notice boards. We saw ambulance staff making conversation with patients during ambulance journeys and asking questions about their lives in an appropriate manner which helped put patients at ease.

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.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff asked questions in a calm manner and demonstrated an empathetic approach to information gathering when communicating with patients, relatives and carers. 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.

We observed staff involving patients and their family or carers in their care. Staff fully informed them of their treatment. We observed ambulance staff explaining potential treatment options where possible, to allow patients to have input into their own care and sought consent at every stage of treatment. Staff gave patients time to ask questions and answered these clearly and thoroughly.

Where a patient did not require hospital treatment, staff said they would explain this with the patient and their family and would refer to another care provider, for example their GP.

Staff showed respect towards relatives and carers of patients and always maintained an effective communication.

We saw staff talking to patient's family members whilst their colleagues attended to the patients. This ensured joint working and allowed patients and their relatives to be cared for.

Staff maintained patient confidentiality by handing over patients in hospital's as privately as possible.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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 and visitors to the island.

The introduction of the new computer aided dispatch (CAD) system in November 2018 had allowed the service to capture and analyse more accurate data regarding capacity vs demand.

At the time of our inspection the service did not have a full year of data to be able to accurately and confidently model demand. However, early results from demand modelling indicated the service required additional frontline resource to be able to deliver on the new national standards. The service was working with its partners to review the modelling and to develop sustainable solutions to meet demand.

The trust had a helicopter landing pad (helipad) located on-site. The helipad was provided for medical emergency use for hospital purposes only and for the operation of an air ambulance service. The helipad provided access to; 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.

Prior to our previous inspection and in response to a change in community nursing cover at night, the trust had created a new role of community practitioner (CP). CPs were qualified 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.

CPs were used as an additional frontline resource during the day to support the ambulance service in an RRV. 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.

The island hosted several major events during the year for example Cowes sailing week and various music festivals. These events increased the population on the island and elevated potential risk. The trust had developed a positive relationship with event management teams who provided on-site medical support. In addition, the National Ambulance Resilience Unit (NARU) provided additional support and capability at specifically agreed events.

We saw bariatric vehicles were available along with suitable bariatric equipment. EOC ensured they requested a bariatric vehicle on dispatch. If a bariatric patient was being brought in by ambulance to the hospital, ambulance staff would notify hospital staff ahead of arrival to ensure the hospital had equipment readily available on admission.

The service had access to a 4x4 vehicle which meant that support could be provided during extreme weather conditions and in more rural areas where regular ambulances may not be able to access.

Meeting people’s individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Vehicles we inspected had a multi-lingual phrase book to help staff communicate with patients and their families where English was not there first language. Interpreter services, via a language line, were also available for patients and relatives if their first language was not English. Although staff told us they rarely needed to use the service.

Ambulances had pictorial pain charts to help staff support patients who were unable to communicate verbally.

The service had supported two members of emergency ambulance staff to undertake British Sign Language courses.

The service had developed and delivered ambulance specific dementia training to frontline ambulance staff. After the training the service had completed a snapshot audit of conveyance rates for patients living with dementia was carried out. Outcomes demonstrated a higher level of non-conveyance for patients with dementia and how staff used the training to find alternative, more appropriate care for this group of patients.

All staff were trained to use bariatric specialist equipment and ambulances we inspected had stretchers 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, prescribed by their GP, to help keep patients comfortable who were end of life. Ambulance staff did not administer these medicines; instead 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. Staff told us they should contact the police, via the clinical support desk in the emergency operations centre, if required to assist these patients.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

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 could contact control and make themselves unavailable if cleaning would take longer.

Patients arriving by ambulance were taken to an assessment area, which was staffed by a registered nurse, and a healthcare assistant and a doctor. There were three cubicles and a seating area. The area was frequently crowded and one staff member told us, at times there are up to 15 patients in this area, which is designed for a quick assessment and turnaround. When there is no flow, this area becomes blocked. We were told this resulted in ambulance crews being delayed waiting for a handover to nursing staff. During periods when crews are delayed ambulance managers would attend the ED to assist crews and nursing teams with patient flow.

We saw efficient handovers by the crews, one of the crew sat at the desk with the registered nurse and the handover was discussed between them and documented straight into the electronic system. Each of the four patients we saw were triaged within five minutes.

The assessment area is small, which means that during ambulance handover, patients sitting in the area can easily overhear the handover.

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.

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.

Data received from the service after the inspection indicated the average times responders waited for an ambulance crew to attend to category 1 or 2 calls were; January 2019 14 minutes, February 2019 18 minutes, March 2019 17 minutes, April 2019 12 minutes and May 2019 12 minutes. Responders we spoke with reported they had no concerns regarding the time they waited for a crew to arrive on scene. They told us at no point had they been left unsupported and had contacted the CSD for advice when they felt they need it.

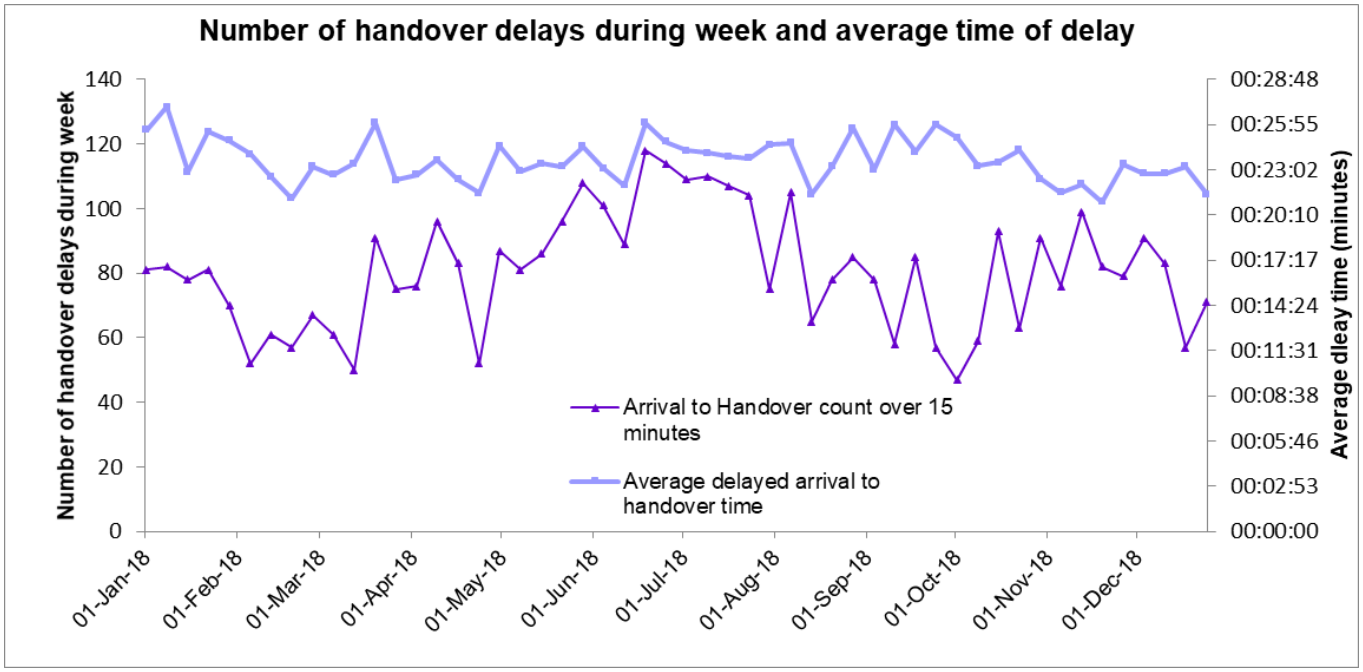
Handover delays

Handover start time is defined as the time of arrival of the ambulance at the Emergency Department (ED), with the end time defined as the time of handover of the patient to the care of ED staff. Best practice is considered to be 15 minutes, but handover time is a contextual measure to indicate time lost from waiting to handover patients at emergency departments, and is not a measure of performance.

The trust provided weekly handover time data from week commencing 1 January 2018 to week commencing 24 December 2018. The average number of delays per week was 81.

Over the 52-week period, there was an average delay of over 15 minutes in all weeks.

The below chart shows the number of delays each week:



(Source: Trust Provider Information Request – Handover delays)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

At our last inspection we did not find information for patients on how to complain on the vehicles we inspected. We found this had improved during this inspection. We saw leaflets and posters within ambulances providing patients with appropriate information about how to make a complaint.

The ambulance service monitored complaints through its divisional quality committee, which in turn report to the ambulance divisional board. The ambulance service was also represented on the patient experience committee where complaints were reviewed and monitored.

We saw noticeboards in the station and in the Hub which detailed case studies resulting from complaints received. These outlined the complaint raised, the investigation carried out and the relevant actions or changes to procedure as a result. The service recognised they were a small service and so included case studies from other ambulance services to widen the learning for its own staff.

For example, the service had received a complaint following the death of a patient with learning difficulties. Following a review of the case it had been determined that, although the death was unlikely to have been preventable, further training regarding learning difficulties and communication would be beneficial for staff. Training was developed and delivered by the service and staff now had access to additional resources from external sources such as the National Autistic Society.

We saw appraisal and Individual Learning Plan (ILP) documentation which had sections to be completed relating to lessons learnt, serious incidents and clinical reviews.

Summary of complaints

From January to December 2018 the trust received 14 complaints in relation to emergency and urgent care. The trust took an average of 28.9 days to investigate and close complaints, and 57.1% were closed within 30 working days. This is not in line with their complaints policy, which states that 75% of complaints should be closed within 30 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Transport (ambulances)	8	57.1%
Values and behaviours (staff)	4	28.6%
Communication	2	14.3%
Total	**14**	**100.0%**

(Source: Trust Provider Information Request – Complaints tab)

Number of compliments made to the trust

From January to December 2018 there were 100 compliments about emergency and urgent care at the trust. The trust stated compliments often acknowledge staff as being caring, informative, compassionate and polite.

(Source: Trust Provider Information Request – compliments)

Compliments received by the service highlight staff as being caring, informative, compassionate and polite even during the most difficult of circumstances. Compliments we saw in the form of thank-you cards and letters also described how staff adopted a calm manner and that did not go unnoticed by patients, relatives and carers.

Is the service well-led?

Leadership

Leaders in the service had integrity and were developing the skills and abilities to run the service. They were beginning to understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

At the last inspection there were concerns regarding quality and stability of the leadership of the service. There had been a lack of a stable leadership team, a lack of succession planning and development of new leaders and little representation of ambulance services at board level. During this inspection we found the trust and service had made significant improvements in this area.

At the time of this inspection the ambulance service formed part of the Integrated Urgent & Emergency Care Division, which was being trialled as a pilot divisional structure. This comprised of the ambulance service and the emergency department with one over-arching executive management team. The executive management team reported directly to the trust board, giving the ambulance service direct access to the board. Managers reported that the pilot was working well and gave the service stability. Leaders in the service told us the pilot would be evaluated once completed in July 2019. Senior staff in the service told us they were not aware of what the future plans for the integrated urgent care division were. Therefore, it was not clear what the ongoing leadership and support arrangements would be.

Previously we had found many local managers were in interim roles, which they and staff had reported stifled development of the service and themselves.

During this inspection all managers were now in substantive posts and had individual development plans. Managers we able to describe their role and how they fitted into the service and its on-going development. Staff reported a more settled structure within the service. Staff all at levels within the service described local managers as open and approachable.

Managers told us about leadership courses they had attended as part of their personal development. Some courses were sponsored by the trust and some involved area's new to them, for example finance and budget setting. Staff could describe how they had received support and coaching from the trust finance team.

Staff who perform operational and tactical command on-call roles confirmed they had completed appropriate National Ambulance Resilience Unit (NARU) approved courses. This ensured these members of staff could perform their duties effectively and to the required level.

The service now had a substantive lead for emergency preparedness, resilience and response (EPRR) who worked in conjunction with the trust EPRR lead. The EPRR role ensures the major incident response plan in place is kept up to date, accessible, elements of which are tested regularly, and specifically addresses any potential causes of a major incident for which the trust is at particular risk. The service EPRR role was filled by an individual with knowledge in this area and who was supported by the service to attend all relevant training courses.

Ambulance 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.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

The ambulance service had developed a strategy with involvement from staff which had been approved by the ambulance division board and the trust board. Four further enabling strategies had been or were being developed at the divisional board level with input from staff.

These included; the work-force strategy – this was being consulted on at the time of our inspection; the ambulance quality strategy, the ambulance staff engagement strategy and the ambulance public engagement strategy had all been in place since August 2018. There was also an annual business plan to support the division in delivering their strategy which had been agreed by the trust leadership team.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

At the previous inspection poor culture was a concern. Staff development had not been given sufficient priority. Staff had told us there was a reluctance to speak up about concerns.

During this inspection we found the trust and service had made significant improvements in this area.

Improving the culture was now seen as an on-going priority, with managers at local level actively working to change the culture within the service. Staff reported a more open culture starting to emerge. The trust had a Freedom to Speak Up Guardian, with local champions within each service. We saw posters with names and photos of the guardian and champions. Champions wore lanyards which identified their additional role. Although staff we spoke knew about the Guardian and the champions, no one told us they had spoken with them in those roles.

Staff within the service were 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 in a fair and impartial manner.

Staff told us morale had improved within the service, despite the pressures of frontline operational duties. They told us management appointments within the service had contributed to the way staff were feeling. Staff told us there was a feeling of cautious optimism amongst frontline staff that things would change for the better.

Trauma Risk Management (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. The service had staff trained to use the TRiM model to provide support to staff, for example after attending a distressing incident. The TRiM trained staff had written a referral protocol for colleagues in the control room to use to identify staff who may require support.

In the month prior to the inspection, there had been a major incident declared which the service had attended and managed. We spoke with staff who had attended and had been involved in the incident. They described how TRiM had been employed and had benefited them after the incident. Staff told us they received debriefs, counselling, peer support and had been stood down from operational duties in the days immediately after the incident. They also told us that support was on-going, based on their own personal need,

Frontline staff told us that opportunities for development and training had improved within the service. The role of the ambulance educator had developed during the past 12 months and staff were positive about the impact this role had had on training.

Governance

Leaders operated governance processes, throughout the service and with partner organisations, however the governance structures and processes were in their infancy and it was too early to establish whether they were effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At our last inspection, we found the governance structures were complex and ineffective. Since then, the governance structures had been redefined and there was a now a more streamlined system. However, the systems were new and had yet to be fully embedded into the service. Therefore, we were unable to establish whether the new arrangements were impacting on the service in driving through consistent positive change.

There had been an interim ambulance advisor to the board, which had led to the trial of the integrated urgent and emergency care division, which had an executive lead and care group director and was the division in which the ambulance service sat.

The ambulance division had a meeting structure which provided oversight of both operational performance and quality. The ambulance divisional board met on a monthly basis and received input reports from two subcommittees, the ambulance performance and ambulance quality committees. The divisional board also reviewed: risks which scored over 15; a quality strategy update; EPRR update; a workforce up date from their business partners including mandatory training, appraisal rate and sickness rate; and a finance up date from their finance partner.

The quality committee reviewed serious incidents, complaints, review of clinical national guidance, audit outcomes and patient experience. The performance committee focused on operational performance, human resources issues and finance.

The ambulance performance committee received operational performance information from the weekly operational team meeting which comprised of PSO’s, clinical support staff and the service delivery manager. PSO’s fedback that the meetings were more structured and less time consuming than before. There were set agenda items under the headings of safe, effective, caring, responsive and well led domains.

Meeting minutes from the ambulance divisional performance committee of 18 March 2019 showed set agenda items included strategy and planning, performance and assurance, finance and workforce performance. For example, we saw the current mandatory rates and appraisal rates for March 2019 were highlighted along with updates on training courses and recruitment.

The ambulance divisional board signed off the ambulance division board summary which reported into the trust leadership committee. The ambulance service worked independently of the rest of

the division. There was not one board for the urgent and emergency care division however each service under the division was presented to the trust board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated most risks and issues, however some of the quality monitoring systems had not been fully effective. They had plans to cope with unexpected events

The service had a risk register in place. The risk register included a description of each risk, an assessment of the likelihood of the risk materialising, possible impact and those who responsible for review and monitoring was also included. We saw that risks were reviewed regularly and updated when any changes to mitigation had been taken.

Risk scoring 15 and above were discussed at the ambulance divisional board, those risks scoring above 12 were discussed at the sub committees to the board. There was also a monthly risk register review workshop. We were informed risk could be discussed at the CQEG and then escalated with recommendations to the quality committee for ratification.

The introduction of the new computer aided dispatch (CAD) system had enabled the ambulance service to have access to real time information. The trust was also now able to submit a full set of data to the national Ambulance Response Programme (ARP). This meant the service could be accurately benchmarked against other NHS ambulance trusts, who all used the same reporting system.

Some of the quality monitoring systems had not been fully effective. We found dirty RRV's which the services had not identified through their infection control monitoring systems and incomplete processes, designed to support the safe administration of medicines which again had not been identified by the systems to provide assurance around the safe administration of medicines.

The service had an up to date Resource Escalation Action Plan (REAP) and a member of staff in the role of EPRR manager. 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.

We saw evidence in the form of feedback from external agencies regarding the professionalism, conduct and training of staff during a recent declared major incident on the island. Feedback described how the scene had been managed by ambulance staff in an expert and calm manner. This allowed clinicians and other emergency services to prioritise, treat and remove casualties in a safe, effective and orderly manner.

Information management

The service was developing systems to analyse the reliable data and information they were now able to collect. Staff, using the data now available to them, were beginning to understand how the service was performing. This was still in the early stages, so it was not possible to see how this information had been used in making decisions about service improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had previously identified that their CAD system was outdated, and so this was replaced and upgraded in October 2018.

The service was now in a better position to comply with and contribute to national ambulance reporting requirements and the new CAD helped ensure data provided was accurate and reliable.

As the CAD system, had only recently been installed, utilisation and effectiveness of this information was still in its infancy. The service recognised, now they had implemented the system they needed to collect and use the information to drive service improvement. This was part of the services Phase two CAD process, and the service had just started to enter this phase in more depth.

Managers attended a weekly operations meeting with the senior operations manager to discuss staffing, resources, incidents, issues and future planning. Minutes for the meeting were not produced, however actions were agreed to address issues. We saw email evidence that actions had been agreed and discussed.

Staff had access to information displayed in the operations centre (Hub) and ambulance station, mostly relating to risk management, staffing, governance, safeguarding, and freedom to speak up guardians.

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.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partners organisations to help improve services for patients.

At previous inspections we found there has been no formal process for engaging with patients or staff. We found an improvement in this area during this inspection.

The service had developed and launched an Ambulance Staff Engagement Strategy in September 2018. In this the service described the strategy as aiming at improving the way in which they engaged with staff and increasing staff response rates to staff surveys. The trust had an aspiration to improve the way all their staff rated their engagement with services, leadership, and change processes.

We saw results of the annual national NHS ambulance staff survey in which staff from the service had participated. There were 10 themes which formed the framework for the survey, these included (but were not limited to): equality, diversity and inclusion, health and wellbeing, immediate managers, morale. In six of the 10 themes, the Isle of Wight trust ambulance service was the same or better than the England average.

In April 2019 we saw the service had carried out an internal staff survey. The ambulance service lead responded individually to staff who completed the survey and who had raised specific questions. We reviewed a selection of the personalised responses which demonstrated comments from all contributors to the survey had been read and reviewed.

Staff welfare was also on display in the newsletter. Staff changes and appointments were highlighted, along with congratulations for those staff members who had become parents. Volunteers for staff representatives were requested and dates for staff meetings for the year were promoted.

The service had revised the meal break policy for frontline crews and this was outlined in the newsletter. In addition, operational performance for the service was included, so staff could be aware of how the service was contributing to care of their patients on the island.

We saw examples of clinical newsletters produced by the service. The contents included; service updates, clinical audit results and operational notices. There was also a section on training and education events, both planned and feedback from those events that had taken place.

Public engagement had improved since the last inspection. We saw evidence that the service had attended local school events, such as a local Emergency Service Week at a primary school. The service attended local Beaver and Scout group meetings. We saw an example of a local child who had written to the service asking to look around the station. The service was keen to develop interest in what they do and staff showed the interested child around an ambulance and the station.

The service continued to build on its development of the community first responder programme and held training events throughout the year to encourage volunteers to join. In addition, the service undertook basic life support training to local groups across the Island including Restart a Heart Day 2018 which was recognised nationally by the Resuscitation Council (UK).

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had hosted its first College of Paramedics CPD (continuing professional development) event on the island. This brought together colleagues from different services and agencies for a series of theoretical and practical sessions.

We identified areas of improvement and innovation within the service, which included;

- An updated pre-hospital sepsis treatment protocol, with new screen and treat tools and change of antibiotic in line with microbiology recommendations.
- A RAG (red/amber/green) rating for elderly fallers to assist in correct care pathway managements which has led to reductions in admissions to hospital.
- All patients who die whilst in the care of the ambulance service were clinically reviewed as per the mortality review standard operating procedure.
- All patients non-conveyed (not taken to hospital) and also attended to twice within a 24-hour period were reviewed to look for lessons learned or patient harm from non-convey decision (as per standard operating procedure).
- Commencement of the delivery of pre-hospital antibiotics for open fractures as per National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.
- The service validates (review) all calls classed as category 2. Approximately 50% of calls found alternative pathways to ambulance response and no evidence of patient harm as a result.
- Development of the Community practitioner role down the Masters pathway of advanced clinical practitioner and working to achieve NICE guidance (NG94).

- The service had commenced trials to deep clean ambulances with vapour spray.

Patient Transport Services

Facts and data about this service

The Patient Transport Service (PTS) provides transport seven days a week for service users in cases of medical need for outpatient appointments, admissions, discharge and transfer. Bookings for the PTS are made by either the GP Practice or hospital staff.

The trust has detailed the following service users that are eligible for PTS:

- Service users who require the continual support and skill of PTS staff to enable them to travel.
- Service users who have received treatment which requires the skill of PTS staff to ensure a safe journey home (i.e. this does not include service users who are suitable to travel in a taxi).
- Service users with dementia or other mental health conditions who require PTS staff to ensure a safe journey.
- Service users who are required to travel by stretcher.
- Inter hospital transfers. i.e. journeys to specialist units within Southampton and Portsmouth and possibly further afield.

(Source: Trust website - https://www.iow.nhs.uk/our-services/ambulance-services/patient-transport.htm)

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 journeys included collecting and returning patients to their home addresses for routine hospital appointments, returning patients' home following medical treatment at the hospital and repatriating patients to their home NHS trusts.

During our inspection we spoke with 17 staff including the service's Head of Operations for Ambulances, Fleet and Operations Manager, Performance and Support Officer, PTS dispatcher, Quality Manager for Community and Ambulance, contracted and bank patient transport staff and a member of the fleet administrative staff. We also spoke with an additional five staff members who worked closely with the PTS; including two patient discharge assistants, two dispatchers and a washer/stocker of the ambulances. We also observed an early morning bed meeting at St Mary's Hospital which included nursing staff and a member of staff from the PTS.

We spoke with six patients and asked for their experiences of receiving support from the PTS. We reviewed four patient risk assessments and reviewed policies and procedures and documents relating to the running of the PTS. These included three complaints, the services asset register, service's risk register, staffing rotas, seven staff inductions and appraisal information. We also viewed 36 customer feedback reports relating to the quality of service provision.

We inspected five ambulances assessing their ability to meet patient's needs. During the inspection we were present during five patient transport journeys observing patient and staff interaction.

This was an announced comprehensive inspection. The provider was given four 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

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The provider set a target of 85.0% for completion of mandatory training.

A breakdown of compliance for mandatory courses for April 2018 to January 2019 for all staff in patient transport services is below:

All staff groups

Name of course	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Adult Resuscitation	14	14	100.0%	85.0%	Yes
Fire Safety Part 1 - Theory	20	20	100.0%	85.0%	Yes
Health, Safety and Welfare	20	20	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	20	20	100.0%	85.0%	Yes
Load Handling	6	6	100.0%	85.0%	Yes
People Handling	14	14	100.0%	85.0%	Yes
Information Governance	19	20	95.0%	85.0%	Yes
Infection Prevention & Control Level 2	17	18	94.4%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	18	20	90.0%	85.0%	Yes
Adult Resuscitation - Non-Clinical	5	6	83.3%	85.0%	No
Hand Hygiene	13	19	68.4%	85.0%	No

Paediatric Resuscitation	0	1	0.0%	85.0%	No

In patient transport services the 85.0% target was met for nine of the 12 mandatory training modules for which staff were eligible.

The provider also provided a breakdown of mandatory training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in patient transport services for April 2018 to January 2019 is shown below:

Support to ambulance service staff

Name of course	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Adult Resuscitation	14	14	100.0%	85.0%	Yes
Fire Safety Part 1 - Theory	19	19	100.0%	85.0%	Yes
Health, Safety and Welfare	19	19	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	19	19	100.0%	85.0%	Yes
Load Handling	5	5	100.0%	85.0%	Yes
People Handling	14	14	100.0%	85.0%	Yes
Information Governance	18	19	94.7%	85.0%	Yes
Infection Prevention & Control Level 2	17	18	94.4%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	17	19	89.5%	85.0%	Yes
Adult Resuscitation - Non-Clinical	4	5	80.0%	85.0%	No
Hand Hygiene	13	19	68.4%	85.0%	No
Paediatric Resuscitation	0	1	0.0%	85.0%	No

In patient transport services the 85.0% target was met for nine of the 12 mandatory training modules for which support to ambulance service staff were eligible.

NHS infrastructure support staff

Name of course	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	1	1	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	1	1	100.0%	85.0%	Yes
Health, Safety and Welfare	1	1	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	1	1	100.0%	85.0%	Yes

Information Governance	1	1	100.0%	85.0%	Yes
Load Handling	1	1	100.0%	85.0%	Yes
Adult Resuscitation - Non-Clinical	1	1	100.0%	85.0%	Yes

In patient transport services the 85.0% target was met for all seven of the mandatory training modules for which NHS infrastructure support staff were eligible.

(Source: Trust Provider Information Request – Mandatory training)

During the inspection it was identified PTS exceeded the provider's training target for all training courses listed above. At the time of the inspection, the PTS overall staff training completion rate was 94%.

Where completion had not met 100% such as information governance (96%), fire safety (87.5%) and adult resuscitation (96%) for example, this still exceeded the provider's target of 85% and staff training had been booked to ensure this was completed.

The newly appointed performance support officer and team leader monitored staff's compliance with mandatory training using an online management system. The service had also developed a staff training tracker alongside this programme. This enabled managers to identify and book staff training dates weeks in advance of their expiry dates minimising the risk of staff falling to complete as required.

Staff received training in both face to face and electronic learning packages. Staff were able to access their training courses from computers placed within the hospital grounds and a remote base station. This meant staff could complete training modules whilst awaiting deployment.

The service was supported by the emergency ambulance staff who provided 'train the trainer' training. This meant staff from the emergency ambulance services provided manual handling training to several PTS staff. These PTS staff then took responsibility to disseminate that training within the teams. Staff spoke positively of the training made available to them.

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.

Safeguarding training completion rates

The provider set a target of 85.0% for completion of mandatory training.

A breakdown of compliance for safeguarding courses for April 2018 to January 2019 for all staff in patient transport services is below:

All staff groups

Name of course	April 2018 to January 2019

	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	20	20	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	20	20	100.0%	85.0%	Yes
Safeguarding Children Lev 1	20	20	100.0%	85.0%	Yes
Preventing Radicalisation Level 3	16	18	88.9%	85.0%	Yes
Safeguarding Adults Lev 2 Part 1	15	18	83.3%	85.0%	No
Safeguarding Adults Lev 2 Part 2	15	18	83.3%	85.0%	No
Safeguarding Children Lev 2	1	2	50.0%	85.0%	No
Safeguarding Children Lev 3	0	1	0.0%	85.0%	No

In patient transport services the 85.0% target was met for four of the eight safeguarding training modules for which staff were eligible.

The provider also supplied a breakdown of safeguarding training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in patient transport services for April 2018 to January 2019 is shown below:

Support to ambulance service staff

Name of course	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	19	19	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	19	19	100.0%	85.0%	Yes
Safeguarding Children Lev 1	19	19	100.0%	85.0%	Yes
Preventing Radicalisation Level 3	16	18	88.9%	85.0%	Yes
Safeguarding Adults Lev 2 Part 1	15	18	83.3%	85.0%	No
Safeguarding Adults Lev 2 Part 2	15	18	83.3%	85.0%	No
Safeguarding Children Lev 2	1	2	50.0%	85.0%	No
Safeguarding Children Lev 3	0	1	0.0%	85.0%	No

In patient transport services the 85.0% target was met for four of the eight safeguarding training modules for which support to ambulance service staff were eligible.

NHS infrastructure support staff

Name of course	April 2018 to January 2019

	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	1	1	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	1	1	100.0%	85.0%	Yes
Safeguarding Children Lev 1	1	1	100.0%	85.0%	Yes

In patient transport services the 85.0% target was met for all three safeguarding training modules for which NHS infrastructure support staff were eligible.

(Source: Trust Provider Information Request – Mandatory training)

At the time of completing the provider's information request, the PTS had recruited five additional staff members, which had impacted on the overall compliance rate of safeguarding training. During the inspection it was identified training for PTS staff exceeded the provider's target of 85% for staff completion.

PTS all staff

Name of course	January 2019 to May 2019		
	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Adults Lev 2 Part 1	100%	85.0%	Yes
Safeguarding Adults Lev 2 Part 2	96%	85.0%	Yes
Safeguarding Children Lev 1	100%	85.0%	Yes
Safeguarding Children Lev 2	100%	85.0%	Yes

Following our last inspection in January 2018, we told the provider they must act to ensure all staff received safeguarding children (level two) training to support them in their role. At this inspection we identified this work had been completed and all staff had received this training.

Staff we spoke with were aware of who they would speak with, internally and externally, if they had to submit a safeguarding 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.

The provider had safeguarding children and adults' policies and procedures which provided guidance and support to staff on how and when to raise a concern. This information was clearly displayed in the team office with contact details for relevant parties, internal and external, to whom concerns could be raised.

Staff evidenced, through conversations held and records viewed, they could recognise and take appropriate action when they identified a potential safeguarding situation, raising appropriate referrals where required.

We reviewed a recently reported safeguarding concern by the PTS team. The concern had been recognised and reported appropriately with action taken in response. Staff told us they received feedback on their concerns, so they were aware action had been taken to keep patients safe.

Staff described the action they would take if they identified potential concerns with a patients living environment. This included returning the patient to the hospital if they felt they were at risk of self neglect.

Staff were also able to seek support from the provider's Crisis Response team in the event of a patient concern. This team was based within the provider's operations hub and comprised of a lead nurse supported by two nurses and two emergency vehicle operatives. This team were able to support patients by organising care packages or house cleaning if it was felt a patient was at risk of self neglect in their living environment.

The Counter Terrorism and Security Act 2015 introduced a duty for public bodies including the NHS to provide 'Preventing Radicalisation' training. This training helps staff to recognise patients at risk of radicalisation. Staff were able to describe their learning and said the training had been a positive experience. Staff had completed all three levels of Preventing Radicalisation Training.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff used personal infection control measures to prevent the spread of infection however, other methods were not effective as the ambulances were not kept clean.

Following our last inspection in January 2018, we told the provider they must act to ensure systems were in place to assess, monitor and mitigate the risk relating to the health, safety and welfare of service users and others who may be at risk. This included the safe auditing of infection control practices followed by staff, to ensure they were safe. At this inspection we identified some improvements had started, however, there had been a decline in the cleanliness of the PTS ambulances.

The provider's infection prevention and control lead had conducted an audit of the cleanliness of two PTS ambulances one week prior to our inspection. This had identified one ambulance was not fit for use until the seats had been re-upholstered. Tears in the fabric made safe cleaning practices difficult to complete. The other ambulance had been identified as requiring additional cleaning.

At this inspection, we saw one ambulance had been taken off the fleet for re-upholstering, however, the other ambulance remained in use and had several tears in the fabric of the seats.

We saw dust, dirt and damage present on each of the five ambulances reviewed, including a broken finger nail in the door pocket of one ambulance. The five ambulances reviewed included the ambulance which had been identified as requiring further cleaning in the provider's audit the week before. The dirt and dust was across all areas of the ambulances including the cab where the driver sat, walls, windows, ceiling, floor and seats.

The PTS shared their cleaning facilities with the emergency ambulance service and washer/stocker staff were responsible for cleaning all ambulances including those belonging to the PTS. The washer/stocker told us they completed this daily and documented these on daily and deep clean schedules. However, despite documented cleaning and a monthly deep clean, a build-up of dust and dirt had accumulated on the ambulances. Fabric on the chairs of the ambulances were also torn, which meant there was a risk they could not be cleaned effectively following the transfer of an infectious patient.

The service had taken action to identify key quality and safety standards in the ambulance cleaning processes. This involved creating a spreadsheet which documented the type of cleaning completed by the washer stocker team, such as general cleaning, deep clean and barrier wash for

example. Staff had recently created this spreadsheet to allow for the auditing of the work completed by the washer stocker team.

Staff told us they did not receive training regarding the cleanliness of ambulances and were not responsible for keeping the ambulances clean. The emergency ambulance washer/stocker confirmed PTS staff did not clean the vehicles and only they had received this training to complete the work.

We brought the cleanliness of the ambulances to staff attention who acknowledged the vehicles were old, however, did not feel it was their role to keep them clean.

Following the first day of inspection PTS staff remained to clean the ambulances, however the next day, there was still dirt and dust within the ambulances on areas we had identified including the previously noted broken finger nail in the door pocket. The infection prevention and control lead attended the service during the inspection and removed another ambulance from the fleet. The ambulance was put out of service until the seats had been repaired and cleaned safely.

The service had also requested the provider's infection prevention and control team to complete a cleanliness audit of the service's ambulances. This was to allow the service to create a baseline of what was expected in terms of safe and effective cleaning, and enable the service to accurately audit future cleaning practices against known parameters. This visit had been completed a week prior to the inspection, so the auditing processes had not commenced, and we could not comment on its effectiveness.

Most PTS staff had received training on infection, prevention and control which was repeated on an annual basis. The provider's infection prevention and control lead confirmed staff received training on personal and environmental cleaning.

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. In the event of a contamination staff would dispose of 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. A uniform policy was clearly displayed in the staff room identifying the correct uniform washing procedures to take, the contents of which was known by staff.

Staff had access to appropriate equipment and facilities including personal hand sanitisers, to complete safe hand hygiene practices which we saw were followed. Staff were bare below the elbows and watches, where worn, were washable to enable their safe and effective cleaning.

Hand hygiene audits were annually completed as part of the crew observation process to ensure staff followed safe and effective hand washing practices. The service had equipment which enabled them to assess the safety and effectiveness of staff hand cleaning, which was included as part of the auditing process.

Environment and equipment

The design, maintenance and use of facilities, premises, and equipment kept people safe. Staff were trained to use them. However, ambulances, whilst mechanically maintained for safe usage, did not always have damaged areas within replaced or repaired when necessary.

Following our last inspection in January 2018, we told the provider they must properly maintain equipment used in the service to ensure it remained safe for use. At this inspection we saw work

had been taken to ensure all equipment was listed, serviced and maintained in line with manufacturers guidance.

The provider had created an asset register to ensure each piece of equipment was fully documented. This allowed the service to monitor equipment service and maintenance dates to ensure all equipment was safely maintained. Each piece of equipment was labelled, registered and recorded on the asset register with a number of key details including description, serial number, service provider, date of last and date of next service. Asset stickers were used on equipment to identify to staff when a service was due.

We reviewed equipment and the register and found some stickers indicated a service had been required a month before the inspection. We raised this and identified the servicing had been booked for a month after the inspection. The registered manager identified items of equipment were being routinely tested every six months instead of the manufacturers twelve month recommendation. This was to ensure ongoing safety as the responsible company was not situated on the island and twice yearly testing was a precautionary measure.

Equipment was available to meet specific patient need, this included having access to bariatric equipment and an ambulance from the emergency ambulance service which would enable them to provide support to bariatric patients. PTS staff had the ability to secure cots within the ambulances and had access to children's harnesses, however this was not routinely required by PTS staff.

During the inspection, we saw staff ensured patients were safely strapped into their seats to minimise the risk of injury during their journey.

Staff used mobile data terminals to display their patient transfer details. At the last inspection we identified these did not always provide staff with all the information they required to support them with their transfer requests. For example, if a patient had a risk assessment relating to their mobility or health needs, this would be highlighted on the screen, but staff could not physically access that information. Staff would have to return to the staff room in order to locate the relevant risk assessment. This was due to improve with the introduction of a new computer aided dispatch (CAD) programme, however this had not yet been implemented within the PTS but development was ongoing at the time of the inspection.

Staff said satellite navigation systems could work intermittently on occasions, but were due to improve with the new CAD implementation. Staff said if they were unaware of a location they would liaise with their crew mate or use their mobile phones to guide them to a patients' address. Staff said the radios enabled them to liaise with the emergency operations centre and colleagues across the island and found they were able to make connection when required.

Ambulances keys were suitably secured in a locked key cabinet to ensure they were always available and not in public view.

The service had enough ambulances to meet patient need. The service had eight ambulances available for patient transport, following two ambulances being removed from service until internal repairs had been completed. The emergency ambulance service had offered use of an additional ambulance should the need arise, whilst these ambulances were not available. PTS ambulances were stored on the hospital site with easy access to cleaning and stock replenishment items, a role completed by washer/stocker personnel.

In the event of an ambulance defect being identified, most staff said they would make senior staff aware on the radio and return to base to complete an ambulance defect form. This action was observed during the inspection. The provider used an external commercial garage service to complete required mechanical tasks and servicing to ensure the ambulances maintained their

MOT. Ambulance defect forms were used to inform the fleet administrator if ambulances were unavailable for use. We reviewed ambulance defect sheets and saw timely action was taken to ensure repairs were completed when they were identified and documented.

Ambulances were mechanically maintained to remain safe for use. Ambulances were subject to a six or eight weekly routine servicing and safety inspections to ensure their ongoing suitability and availability for use. The fleet administrator maintained detailed records which evidenced all ambulances were serviced, had in date MOT certificates and were insured. The fleet administrator compiled a monthly report identifying when ambulances were due routine servicing. This enabled ambulances to be changed over to ensure safe numbers of ambulances were always available.

During the inspection however, we identified seats which had not been repaired or replaced once torn, damage to the walls from the use of the turning chairs and a cupboard within one ambulance which did not close properly. This meant items from within were at risk of movement during journeys and created a potential risk to patients during the journey and whilst mobilising. The PTS had secured funding for the replacement of two ambulances and were awaiting final costings, so this work could commence. It was unknown when this would be completed however.

Assessing and responding to patient risk

Staff completed and updated risk assessments for patients when required, and acted to remove or minimise risk. Staff could identify and act upon patients at risk of deterioration.

Information about patients, such as their mobility needs, were collected at the point of booking. Only identified and trained health and social care professionals could request a patient transfer journey. This ensured the patient eligibility criteria was met and appropriate information was collected at the time of booking.

Booking details requested included information about patient's level of mobility, their medical needs and any physical needs which would require the use of additional equipment to support them safely.

Staff who had received additional training in manual handling completed patient risk assessments, where possible, three days in advance of the requested transfer. This enabled staff to ensure the required appropriate actions were identified, with mitigating actions documented, to keep patients safe.

Patient mobility information was communicated to staff via their radio and mobile data terminals. This enabled staff to complete a dynamic risk assessment prior to an on-the-day patient transfer, to ensure they had the skills and appropriate equipment to meet the patient's needs.

Risk assessments viewed were appropriately completed, with clear identified risks and the actions required to support patients safely, before, during and post transfer. These were routinely updated when a change in a patient's condition had been identified, to ensure their ongoing safety.

Most patients using the PTS were not acutely ill, therefore they were able to be transported without paramedic or technician support. Staff however, visually and verbally continuously assessed patients during their transfer to ensure they remained fit for the journey.

Staff observed patients during their transfer, which allowed them to respond appropriately by providing first aid if they witnessed a decline in a patient's condition. Staff told us if additional medical intervention was required they would seek support from the emergency ambulance team.

Staff were trained and able to use the ambulances emergency light operation lights to provide an immediate emergency transfer. This was only necessary if it was believed there would be a delay in waiting for an emergency ambulance which may impact on the patient's health and wellbeing.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank staff a full induction.

Planned vs actual

The provider has reported their staffing numbers below for patient transport services as of April 2018 to March 2019.

Staff group	April 2018 to March 2019		
	Actual WTE staff	Planned WTE staff	Fill rate
Support to Ambulance Service Staff	13.2	21.1	62.4%
NHS Infrastructure Support	2.2	0.0	-
Total	**15.4**	**21.1**	**72.9%**

(Source: Trust Routine Provider Information Request– Total staffing)

Vacancy rates

From January to December 2018, the provider reported an annual vacancy rate of 41.8% for patient transport services. The provider has not set a target for vacancy.

A breakdown of vacancy rates by staff group is shown below:

- Support to ambulance service staff: 42.9%
- NHS infrastructure support staff: 0.0%

(Source: Trust Routine Provider Information Request– Vacancy)

Turnover

From January to December 2018 the provider reported an annual turnover rate of 6.0% for patient transport services. The provider target turnover rate is 5.0%.

A breakdown of turnover rates by staff group is shown below:

- Support to ambulance service staff: 7.0%
- NHS infrastructure support staff: 0.0%

(Source: Trust Routine Provider Information Request– Turnover)

Sickness

From January to December 2018 the provider reported an annual sickness rate of 8.9% for patient transport services. The provider target sickness rate is 4.5%.

A breakdown of sickness rates by staff group is shown below:

- Support to ambulance service staff: 12.3%
- NHS infrastructure support staff: 2.6%

(Source: Trust Routine Provider Information Request– Sickness)

Nursing and medical bank and agency/locum staff usage

From January to December 2018, the provider reported that no bank or agency staff were used in patient transport services to cover shifts for nursing and medical staff.

(Source: Trust Provider Information Request – Bank agency locum tab)

Temporary staff usage

This refers to staff that are not qualified nursing or medical and dental staff. It can apply to paramedics, operations centre staff or any other core service specific roles within the trust.

From January to December 2018, the provider reported a bank usage rate of 63.5% in patient transport services for support to ambulance service staff.

Team	Total shifts available	Bank Usage		Agency Usage	
		Shifts	%	Shifts	%
Patient transport service	2,748	1,744	63.5%	0	0.0%

(Source: Trust Provider Information Request – Temp staff tab)

The PTS staff team, consisted of a manager, a performance support officer, team leader, contracted patient transport staff and non-contracted patient transport staff. The teams were additionally supported by fleet administrators, dispatchers, washer/stockers, departure lounge staff, training and recruitment teams.

Non-contracted bank staff were available for use in unforeseen events such as an emergency, or staff sickness, for example. This allowed for continuity of service for patients using the PTS. This also supported patients who needed to complete longer journeys away from the island to receive their care. The availability and use of bank staff minimised the disruption on existing patient transfers and offered more flexibility to on the day requests for patient support.

The resourcing team, in conjunction with the service, coordinated, planned and published staff rotas approximately 12 weeks in advance. Staff rotas were organised and displayed in the staff room at the PTS base. We saw these figures were consistent and sufficient to meet patient needs.

In the event where shifts were not fully staffed, such as staff sickness or a last minute request for transfer, the team leader and performance support officer were able to deploy to assist patients. This ensured continuation of service delivery and ability to meet on the day requests for patient transfer.

Staff were supported out of hours by PTS and emergency ambulance service dispatchers and the emergency ambulance service performance support officer. They organised PTS crews and were present as a point of reference and managerial support for staff. Staff told us they felt supported in their role.

The resourcing team electronically created the rotas which ensured staff were provided with a minimum of 11 hours between their shifts, as per the requirements of the Working Time Directive. Staff told us this was monitored closely to ensure this was achieved.

Staff were provided with protected meal times to ensure they received a break from driving and were able to maintain their wellbeing. We saw staff took their meal breaks in the staff room without disruption, they were also able to seek shorter comfort breaks between patient transport journeys.

Records

Staff kept detailed records which were clear, up-to-date, stored securely and easily available to all staff providing care

The service kept mainly electronic patient records, information could be accessed via the services and emergency operations hub computers and staff's mobile data terminals. The only paper form of patient data which was transported, were copies of 'Do not attempt Cardio Pulmonary Resuscitation' forms where patients had these in place. These however, were left with the patient upon their arrival at their destination.

The dispatcher and PTS staff collected information about patients' individual needs from completed journey booking forms. These included information regarding a patient's medical condition, age, gender and mobility. This ensured staff were aware of the patient's condition allowing them to plan appropriately for their journey.

During the inspection we reviewed four patient records. These contained sufficient details to ensure staff were aware of patients' needs and risks prior to their journey. They also included additional information such as whether the patient required a wheelchair to transfer to and from the ambulance.

We observed handovers between PTS staff and ward staff, these were detailed and contained all the information needed to allow for the patients ongoing healthcare and wellbeing needs to be met.

Staff were made aware of any additional risks associated with a patient or their property. A special marker was attached to an address or patient if there was a risk identified, such as violence or aggression. This was highlighted on staff's mobile data terminal to enable them to review the associated risk assessment and take the appropriate action to keep the patient, and themselves, safe.

At our last inspection we identified a mobile data terminal had been left visible within an ambulance and could be viewed by a member of the public. At this inspection we saw staff took care to ensure the mobile data terminals were not visible by people who had no necessity to view, and to protect patient's privacy.

Medicines

The service mainly followed best practice when handling and storing medicine which, at this service, was oxygen. However, when used during patient journeys oxygen tanks could not be secured safely and became a risk to patient safety in the event of an accident.

The only medicine available to staff was oxygen. Where this was stored on ambulances we saw cylinders were appropriately secured and the oxygen levels were sufficient to meet patient need.

Oxygen was only used when pre-prescribed by healthcare staff prior to patient transfer. Staff facilitated patients to self-administer by assisting the swap of their oxygen tanks if required but did not take responsibility for administering which included the flow and rate. This was supported by the use of a 'Use of Oxygen' policy which was in place.

Staff confirmed they received training regarding oxygen use and toxicity. They described how they would support patients by changing oxygen tanks prior to and post transfer, if required, but would not be directly involved in administering.

During the inspection, we identified oxygen cylinders were appropriately secured when not in use, however, staff told us when in use during transport, patients, or their escort, would be responsible for maintaining control of the tank. It would not be securely stored, which placed patients at risk in the event of an accident where the cylinder could move around the ambulance.

Staff did not take ownership or responsibility for transporting medicines. Medicines to accompany discharged patients were kept within a sealed bag and the patient, or their escort, would maintain possession and control of these.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. If things went wrong, staff knew to apologise and give patients honest information and suitable support.

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 January to December 2018 the provider reported no incidents that were classified as a never event for patient transport services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the provider reported no incidents which met the reporting criteria set by NHS England from January to December 2018 occurring within patient transport services.

(Source: Strategic Executive Information System (STEIS))

Following our last inspection in January 2018, we told the provider they should share the learning from incidents with staff to minimise the risk of reoccurrence. We saw learning from incidents was shared with internal and external parties, where required, and staff told us they received feedback once incidents had been investigated.

The service had policies and guidance to help staff identify and adverse incident and the correct action to take when one occurred. The provider's 'Incident Management Policy' provided guidance

to staff on what situation would require reporting. This included incidents, accidents, adverse outcomes, near misses, hazards and serious untoward outcomes.

Staff were aware of their roles and responsibilities for reporting incidents. Staff told us they were confident to report incidents and were able to complete this on the provider's electronic reporting system. There was also an incident reporting book in the staff room which staff completed. This was reviewed daily by senior staff so they were aware when an incident had been reported.

We reviewed six incidents and found they were investigated fully and learning shared, where identified. Staff used this learning to minimise the risk of patients experiencing similar or repeat incidents. For example, a patient had been discharged with a cannula in their arm. Upon the completion of the patient transfer the receiving location had not been made aware and the patient had suffered some discomfort during their journey as a result. Following review, the PTS wrote a new policy advising staff of the need to ask the discharging ward whether a cannula was in situ and the actions to request them to complete if found to be the case. Staff told us they were aware of the implementation of the new policy.

Staff were aware of their legal responsibilities to patients when incidents occurred. The Duty of Candour (DoC) is a regulatory duty which relates to openness and transparency. The duty requires providers of health and social care services to notify patient (or other relevant person) of 'certain notifiable incidents' and provide reasonable support to that patient. Staff told us they were of the need to be open and honest with patients when a notifiable incidents had occurred. At the time of the inspection there had been no incidents since the previous inspection which had required the DoC to be followed for the service.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Following our last inspection in January 2018, we told the provider they must act to ensure there was an agreed process in place for reviewing the service provision against national guidance. At this inspection we saw action had been taken to complete this work. The provider had a trust lead for reviewing national guidance monthly, when identified, new guidance was shared with the PTS to implement any changes.

Staff had guidance available to them on how to complete their role effectively. We saw they provided care in line with the Joint College Ambulance Liaison Committee clinical practice guidelines and the National Institute for Health and Care Excellence. This included safely securing patients within the ambulances, and that the right patients were going to the right appointments.

Staff confirmed they had access to policies and procedures available to them on the provider's computer system. When a new policy was published this was emailed to staff, displayed within the services staff room, discussed between staff and their team leader when seen on each shift and discussed at team meetings.

All policies and procedures we checked were up to date and detailed to provide sufficient evidence to staff when required. This included policies relating to uniform cleaning, duty of candour, incident reporting and the ambulance service conveyance policy.

The service assessed staff understanding and application of policies and procedures by completing observations of staff practice on a quarterly basis. This was undertaken to ensure staff completed their role following best practice and guidance. This included ensuring do not attempt cardio pulmonary resuscitation forms were obtained where required, medicines were checked appropriately, and manual handling equipment was used appropriately.

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 to booking services. The system, and the provider's website, clearly identified whether the PTS ambulances was the most appropriate method of transport for that patient. It provided information about other transport services available 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.

The provider's dispatchers were responsible for allocating PTS workload and 24 hours prior to patient journeys, when pre-booked, dispatchers contacted the patient. This was a further eligibility check and ensured patients using the service were those who genuinely needed it.

Nutrition and hydration

Food and drink were not routinely required during patient journeys. Staff however, had access to bottled water on board ambulances. Patients on a longer transfer had a packed lunch made available to meet their needs.

Staff ensured patients had enough to eat and drink to ensure their wellbeing. Ambulances carried bottled water to meet patient's hydration needs, especially in the hot weather. However, due to the nature of the service, food and drink was not routinely provided. During the inspection we saw patients being offered water to have during their journey as it took place during warm weather.

Patients due to undertake longer journeys, such as in the event of an off the island transfer for example, had a packed lunch organised by the ward to have during their journey. Staff told us, and patient feedback confirmed, PTS staff made sure patients had a drink and food accessible to them before leaving them at their home address.

Response times

The service was not monitoring their response times and therefore were unable to identify if they were being met and facilitating good outcomes for patients.

Following our last inspection in January 2018, we told the provider they should develop key performance indicators to enable them to monitor performance of the service

The service had created key performance indicators to assess, measure and improve the quality and safety of the service. These included monitoring patient collection and travelling times to ensure they were completed within a set time period. However, this work had not progressed as changes in the services' computer aided dispatch (CAD) system, had impacted on their ability to collect the required information.

Booking processes remained the same for the original requester, these were completed electronically, however, the system had changed upon receipt of these by the service. Information was being received via email and then printed by administrative staff prior to passing to the PTS

dispatchers. This meant information was being printed and stored in paper form so booking on the current CAD system could take place.

Dispatchers and staff told us the current paper based system did not lend itself to the capture of the required data for the activities levels or PTS response times. Dispatchers could only plan journeys on paper and would not see bookings on the computer system until the day of travel. This meant the service could not identify when patients had been collected from their originally requested time and when they had reached their requested destination.

The provider recognised this was an ongoing situation which was a temporary solution until the new CAD system could be implemented. While no specific time frames were available for when this piece of work would be completed we were told the development of the system was on going and additional funding was awaiting approval.

Staff informed dispatchers of any delay in arrival to collect or return a patient due to circumstances out of their control, such as increase in traffic or a later than anticipated patient discharge. This allowed dispatch staff to contact patients and advise them of any potential delay in their collection. In the event of a late patient collection dispatch staff also contacted the patient's receiving location such as clinics and wards for example, to advise them. This allowed for the movement of appointments to ensure patient appointments were accommodated.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held documented meetings with them to provide support and development.

Appraisal rates

From April 2018 to February 2019, 76.9% of staff within patient transport services at the trust received an appraisal compared to a provider target of 85.0%.

The breakdown by staff group is shown below:

Staff group	April 2018 to February 2019				
	Number of staff received appraisal	Number of required staff	Appraisal rate	Trust Target	Met (Yes/No)
NHS infrastructure support	1	1	100.0%	85.0%	Yes
Support to ambulance service staff	19	25	76.0%	85.0%	No

(Source: Trust Provider Information Request – Appraisals)

Following our last inspection in January 2018, we told the provider they should fully complete induction procedures for new members of staff. At this inspection we identified this work had been completed, a structured and documented induction process was in place for all new members of staff.

New staff to the service completed an induction programme which involved eLearning, face to face training and practical shadowing. 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 'three manning' shifts, three as an addition to existing staff numbers, three where they are additional on what was a single staffed crew and three mentored shifts where they were observed. Staff spoke positively of the induction process in place to support them in their role.

New staff were required to complete an operational competency assessment. They were observed by the performance support officer or team leader to assess their knowledge and ability to perform their role. Competency assessments for seven members of staff were viewed, which indicated they were up to date with their induction training and observed practice.

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 disability awareness, hand hygiene and adult resuscitation. Records confirmed staff completed these within the required time frame.

The service completed, as part of the annual appraisal process, staff driver licence checks. This was to ensure staff had the required driving category allowing them to drive the ambulances. We reviewed seven records which identified these checks were current and up-to-date.

Staff were encouraged to undertake further training to enhance their role. The service had introduced a new appraisal system which actively encouraged staff to identify key aspirations and how they wished to develop their skills. We viewed three staff appraisals and saw their career aspirations were discussed. Actions were documented to ensure opportunities for development were identified and implemented. For example, some staff wished to develop their roles and experience other opportunities, such as working as an emergency vehicle operative or within the emergency operations hub. The service had identified what experiences would allow them to develop their skills and sought opportunities for staff to complete these. For example, staff who identified an interest in becoming dispatchers were provided with time to spend working in the emergency operations hub. The performance support officer and team leader maintained a tracker of these identified learning requests to ensure actions were taken to meet staff need.

Information provided before the inspection identified 76% of staff had received an appraisal which did not meet the provider's target of 85% completion. This was due to the recent recruitment of five additional staff who were in the process of fully completing their induction. Records confirmed contracted and bank staff had received an appraisal in the previous year. Most staff we spoke with felt the appraisals were a good and useful tool for development.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked in conjunction with other health and social care providers such as doctors, nurses and social care staff to ensure patient's needs were met before, during and after their transfer.

PTS staff had a positive working relationships with GPs and the hospital which had developed from training provided by PTS staff on how to use the operational booking system and day to day engagement.

During the inspection we observed the services performance support officer (PSO) attend the hospital's weekday bed meeting. Senior representatives from all departments and wards came together each morning to discuss any challenges to service delivery. This included actions

required to discharge patients and any concerns such as diarrhoea and vomiting at any wards or social care premises which may impact on hospital discharges. The discussions were inclusive of all attendees and PTS were able to offer support, and seek support, from senior staff present.

Most staff spoke positively of the multidisciplinary team working approach to patient care and observed handovers confirmed this positive relationship. During the inspection we observed handovers of patients between PTS and ward staff. These were respectful with clear, additional discharge information sought and noted by PTS staff to ensure ongoing patient safety and wellbeing.

The PTS service worked well with dispatchers in the emergency operations hub who were recruited and managed by the hub team. Following each mornings bed meeting the PSO visited the dispatchers to make them aware of any discussed and potential work which may require staff being made available.

Links with social services had been developed to benefit patient wellbeing. In the event of a social care service closure, PTS staff were requested to help support patients moving between services. There had previously been delays in allowing this work to be completed whilst costings and additional crew deployments were agreed. A billing account agreement had been developed which allowed PTS staff to bring in extra crews as required and complete the transfers immediately staff were available. PTS staff spoke positively of the professional relationships which had developed as a result of this work.

Staff told us they worked well with the emergency ambulance services and provided examples of when both services supported each other in their roles. This included PTS assisting emergency ambulance services with transporting patients from doctors' practices to hospitals in non-life threatening circumstances.

Health promotion

Staff gave patients practical support and advice to lead healthier lives

The service used electronic patient records when providing services. Upon a transport request being made, details were sought about patient health and care needs. This enabled additional support to be given where necessary, for example, people who required equipment to aide their moving.

We observed staff supporting patients to retain their independence as much as they were able. Staff asked patients about their ability to mobilise, rather than make assumptions of their abilities. Patients were encouraged to walk between their appointments and staff offered safe but non obtrusive support. This enabled patients to retain an element of independence and encourage their overall health and wellbeing.

The provider had a Crisis Response Team available to support patients if identified they required additional support, such as health or social care intervention. If PTS staff identified concerns with a patient's ability to manage independently at home or had concerns regarding their physical or mental wellbeing, the team could be requested. The team supported patients by organising care packages and equipment or sought alternative accommodation arrangements to ensure patient's health needs were met.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion rates

The provider reported that from April 2018 to January 2019, Mental Capacity Act (MCA) training was completed by 100.0% of staff in patient transport services compared to the provider's target of 85.0%.

The breakdown by staff group was as follows:

- Support to ambulance service staff: 100.0%

The provider reported that the Mental Capacity Act training module incorporates the Deprivation of Liberty Safeguard training.

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

PTS staff achieved a 100% compliance rate with Mental Capacity Act 2005 (MCA) training and during the inspection we observed staff evidencing their awareness and application of the Act. The MCA code of practice states all practical and appropriate steps must be taken to ensure patients are able to make a decision for themselves. We saw staff requesting patient consent throughout their interactions. This enabled patients to make an informed choice regarding If they wished to continue with their transport.

Staff were aware of a patients' right to make an unwise decision, which would include refusing to continue with their journey, which could impact on their health and wellbeing. Staff identified they would offer support and advice for patients and their family members on the purpose of their transport, however, if patients were deemed to have capacity, it was their right to refuse. If staff identified a patient did not have capacity to agree to their transport they discussed this need with the patient's family, health and or social care professional known to the patient. A joint decision would then be reached in the patient's best interest and they would be accompanied by someone known to the patient to minimise any distress they could experience.

Most staff were aware of a Deprivation of Liberty Safeguards (DoLS) to keep patients safe. The DoLS is the procedure prescribed in law when it is necessary to deprive a patient of their liberty when they lack capacity to consent to their care, to keep them safe from harm. Whilst staff were not involved in the process of applying for DoLS, they were aware that a patient with a DoLS would be accompanied by a health or social care professional and were not be left alone.

The provider did not routinely transport children under the age of 18, staff estimated they had completed only two child patient transfers in the previous year. Any patient under this age were required to be escorted for their journey, by either a nurse from the children ward or a parent. This would be arranged prior to booking the service.

Patients suffering from a mental health condition which adversely affected their behaviour, were not transported by PTS. On these occasions the emergency ambulance service would be required to support the patient with their transport needs. The patient would then be accompanied on their transfer by a healthcare professional known to them, such as a nurse or doctor.

If a patient displayed behaviours which could challenge staff during their journey, staff would maintain patient safety and seek support from the emergency ambulance service.

Is the service caring?

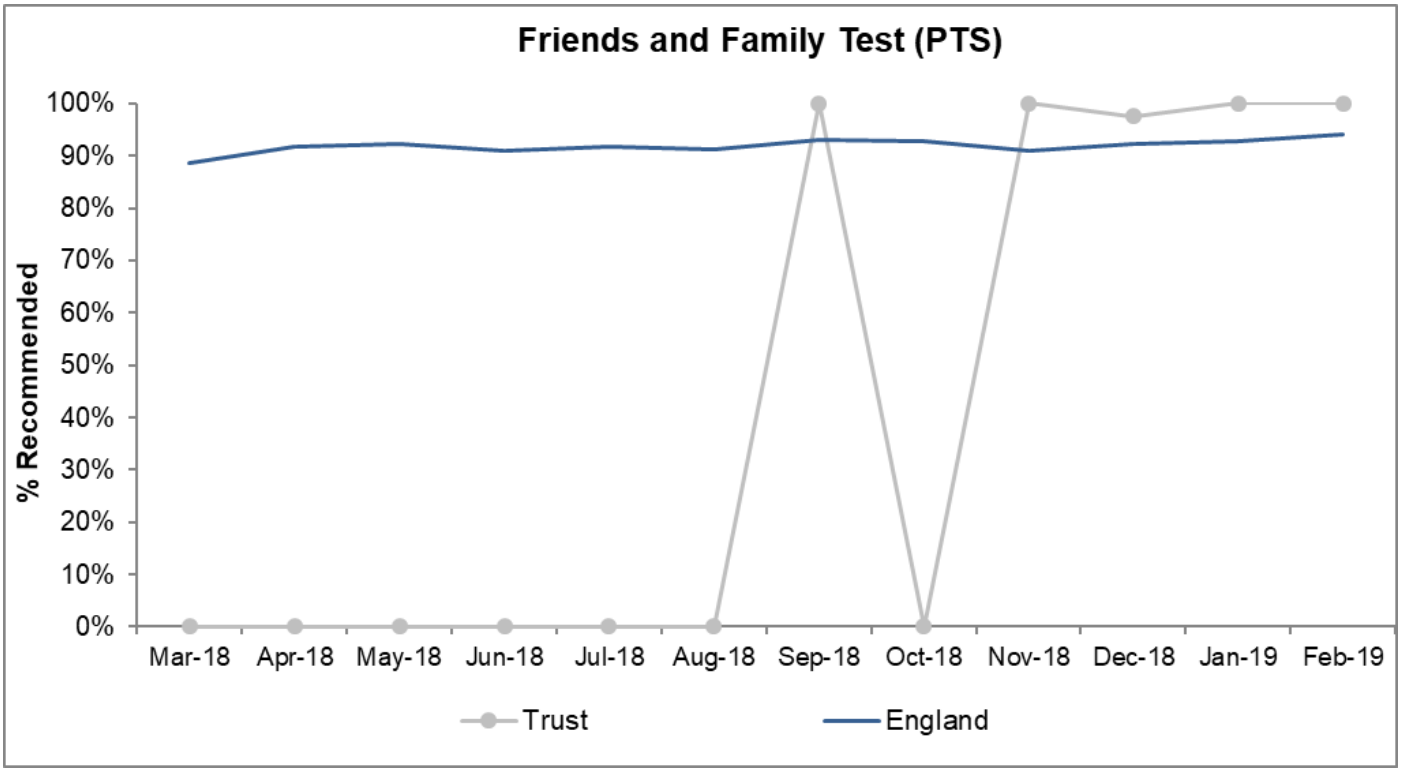
Compassionate care

Staff treated patients with compassion and thoughtful kindness, respected their privacy and dignity, and took account of their individual needs. Staff acted to provide personalised high quality compassionate care.

Friends and Family test performance

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 Friends and Family Test overall response rate for patient transport services at the trust was 1.5% from March 2018 to February 2019, which was higher than the England average of 0.4% for the same period. The provider performed better than the England average in the months from November 2018 to February 2019. The provider received no responses in the months from March 2018 to August 2018 and in October 2018.



(Source: NHS England Friends and Family Test)

Information provided by the service prior to the inspection, indicated they had not received any feedback in the months identified in the analysis above.

During the inspection, it was identified the procedure to process friends and family feedback had changed following the last inspection. This had resulted in the feedback being collated and documented as a batch by a team independent to the PTS rather than in individual months.

This feedback processing system was altered in November, which meant feedback was submitted and processed on the month it was received.

Patients and hospital staff spoke positively of the caring nature of the PTS staff, offering examples where staff had acted above and beyond their role, to promote patient's wellbeing. This included staff listening and understanding patients' needs, seeking opportunities to ensure these were met and exceeded. For example, one patient mentioned to staff they had not visited the sea for several months due to ill health. Staff recognised the opportunity to provide an extremely personalised service and took the patient along the seafront during their journey, so they could see the sea. This was met with gratitude from the patient.

Other examples of this personalised compassionate care were provided. On one occasion staff transported a patient in the late evening following a long hospital stay. Upon returning the patient home they identified the patient had very little food provisions. Staff found out the patient's care package was not due to start until the following day. To support the patient and protect their wellbeing staff made the patient tea and completed a small shop so they had food and drink available overnight. This was repeated with a further patient where staff purchased an evening meal for them and a small amount of groceries whilst the patient awaited the commencement of their care package.

During the inspection patients told us the service and staff were 'Fantastic'. Written feedback provided by patients consistently praised staff highlighting their ability to offer compassionate care which exceeded their expectations. One patient had written, 'The service was extremely good, our driver could not have been more helpful, thank you so very much'. Other written comments included, 'Excellent service as always', 'The staff are, in my opinion, excellent', 'Very helpful staff. Very attentive to my needs. Very reassuring' and 'Excellent care from all ambulance staff, thank you very much'.

We observed extremely caring and reassuring interactions during patient transfer journeys. Patient's dignity was respected before, during and after their journeys. This included lowering the data mobile terminals which were situated in the front of the ambulances, which meant patient details could not be viewed by other patients travelling in the rear of the ambulances. Patients were not rushed during staff interactions and were continuously reassured during their journeys with staff engaging in an appropriate way to meet individual patient needs.

During the inspection we observed staff calmly and professionally managing patient behaviour which could have impacted on those around them. It was observed a patient's language and conversation was becoming inappropriate to be heard by those around them. Staff quickly recognised and continuously guided conversations to more appropriate subjects when this occurred, to minimise any potential distress or upset on those around them.

Throughout the inspection spoke professional and fondly of patients who used the services. They were observed expressing their concern and warmth towards those who had become too ill to use the PTS and sadness when discussing patients who had passed away. This evidenced staff had built familiar, professional and caring relationships with their patients with genuine warmth and empathy towards them and their families.

We saw where staff had concerns about a patients' welfare, they raised incidents and contacted the safeguarding team or Crisis Response Team to escalate issues. Staff spoke of situations where they had concerns regarding the care package in place for the patient at the point of returning home. Staff immediately acted to ensure patients were within a caring and supportive environment, even if this meant taking the patient to a hospital instead of their booked destination.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' needs and took a person centred approach to meeting and exceeding these need.

Staff provided emotional support during journeys and adapted their communication styles to do so. For example, we saw evidence were staff had responded appropriately to a patient who nearly fell whilst they were mobilising. Staff supported the patient and immediately crouched down to speak with them at eye level rather than talk from a standing position, this ensured engagement and provided comfort and reassurance when needed.

Another patient was transferred to their home address for a trial run of new manual handling equipment. The patient was not medically fit for discharge, however, there was the need to ensure new equipment in place would support them safely. The patient had additional educational needs which meant they were unable to communicate clearly. Staff took the additional time required to calm the patient as they became emotional upon returning home. Written feedback to the service expressed, 'Both (staff) interactions with the patient to calm them and very patiently explain (the situation) to them was amazing, it was an emotional moment for both (the patient) and the person who ran the care home'.

Staff provided emotional support throughout their interactions, actively engaging with patients and relatives where possible. Staff provided examples of where they supported patient's emotional wellbeing upon receiving negative news after treatment or diagnoses. This included being aware of people around the patients and their need for privacy, especially if transferring on the ferry. Staff described the actions taken to ensure patients distress was minimised for them and their family.

Staff repeatedly demonstrated they understood how to ensure patient's emotional needs were met and how they acted to maintain patient's health and wellbeing. For example, one patient became distressed during their transfer journey. In response staff sought to make extra time available to help manage the patient's anxiety. This included stopping at the seafront, buying the patient a cup of tea and sitting with them on the bench watching the waves until their anxiety eased. This reassured and relaxed the patient who was able to continue with their journey.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Staff evidenced they clearly thought of the wellbeing of the patient's support network to ensure their ongoing care.

We saw staff continually interact with patients before, during and after their journeys to ensure patients, and relatives, knew where they were going in the hospital and the reasons why. Staff checked patients were comfortable and asked them questions evidencing they were centre to the care provided. We observed staff did this consistently with all patients. We observed detailed handovers where the patient's needs were clearly and respectfully explained to hospital staff, showing a clear understanding of the patient's health and wellbeing.

Staff considered not only the patient's wellbeing but an understanding of how the wellbeing of the patient's support network could impact on patient care. They took steps to support both the patient and their family. One patient mentioned an issue, which they had been unable to resolve preventing them from using a room in their home. Staff recognised it was an easily resolved issue, purchased the required items and completed the required task refusing to accept any payment.

Both the patient and their family member were extremely grateful, and staff described to staff ‘it was one less worry for them to consider’.

Another patient had written to the service expressing their gratitude towards staff for their care and patience on what had been a traumatic day for them and their family. Staff demonstrated they took a holistic approach to patient care ensuring those around the patient received the support they needed to stay well.

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, which offered clear advice on eligibility for the service and alternative guidance on the transport options available to patients, including the use of volunteer drivers or taxis. This guidance supported decision making on the patient’s behalf, so they received the most appropriate service to meet their specific needs.

When patients had questions, we saw staff answered these clearly and kindly. Time was allowed for questions to be asked and staff responded patiently in all observed cases.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people and the communities served.

The PTS provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition or mobility.

The service was available to meet patient’s needs at the time it was required. The service operated from 7:45am Monday to Friday (6:45am for a mainland transfer) until 10:30pm and from 9am until 6.30pm at the weekend.

Shift times were altered in line with patient demand and when the island ferry timetables changed. In February 2019 it had been identified shifts did not always support patients who needed to return to the mainland later in the evening. As a result, the late shift finishing times were amended to ensure patient needs were met.

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 contracted targets. The service, however, could evidence their ability to meet patient’s needs. The service predominately worked on pre-booked and pre-planned transfers, however, data showed, on average, 39% of the patient transfer requests completed in the two years prior to the inspection were same day requests, which were met by the service.

During the inspection, we observed staff reorganising teams and seeking bank staff support to facilitate unexpected demands on the service to ensure patients received the transport they required. The use of bank staff allowed the service the flexibility to meet this high proportion of same day journeys whilst continuing to conduct off the island transfers and regular, routine planned work.

Meeting people’s individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Following our last inspection in January 2018, we told the provider they should fully comply with the Accessible Information Standards ensuring all persons who experience difficulties communicating could receive additional support. At this inspection we identified this work had been completed and patients could access support as required to meet their individual needs.

Each ambulance contained a 'Pre-Hospital Communication Guide' which included visual cues, prompts and images to help patients to communicate their needs with staff. This booklet was written in simple English and provided patients with the ability to identify whether there were any physical, hearing or visual impairment which may limit their ability to communicate clearly. They also supported staff in identifying, using pictorial flags, if an interpreter was required, which could be arranged via the clinical support desk in the emergency operations hub.

The booklet also provided guidance to staff on how to aide communication with patients with a learning difficulties and those with an autistic spectrum diagnoses, who could need additional support to make their needs known.

Patients living with dementia were supported by staff who had received training on how to identify and respond to patient needs. All staff spoke positively about dementia training which had recently been delivered. They said this had provided them with a greater understanding of patient need and improved their ability to interact in a positive way with patients. Staff demonstrated an understanding of the additional needs of those living with dementia and how they would be able to recognise and respond to their individual needs.

Specialist equipment was available to support patient's individual needs. The PTS had ambulances which were fitted with bariatric equipment to ensure patients could safely and comfortably complete their journey.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

People could access the service when they needed it. The service was, at the time of the inspection, however, unable to monitor waiting times for transport to enable them to act to improve where required.

The PTS was in the process of changing their computer aided despatch (CAD) system which supported staff in arranging and planning patient bookings. This impacted on the service's ability to monitor if patients were experiencing excessive waits for transport.

There had been no changes to requesting services, health or social care professionals continued to complete an electronic booking form on patient's behalf. However, there had been a change in the processing and monitoring of these requests. This meant booking requests were manually processed and documented in paper form. Each morning staff worked with the dispatchers reviewing the days planned journeys, allocating workload and ambulances accordingly.

Staff used their data mobile terminal to document when patients were collected and had completed their journey, however, this information was not measurable. This meant it could not identify if patients were late for appointments or had waited excessively for collection. The provider was in the process of sourcing and implementing a new CAD system which would enable this work to be completed.

At the time of the inspection, the service was dependent on patients' feedback if they had waited excessively or had been late for an appointment. The service had not received any formal complaints about waiting times since the last inspection.

In the event of a same day request for an off the island transfer, the performance support officer (PSO) and team leader, in conjunction with the dispatchers worked together to review and reallocate staff workload. If they were unable to achieve this, support was requested from bank staff via a 'fast text' system which sent a message to all staff offering the opportunity to complete the work. The PSO and team leader were also available during the day for patient transfer journeys and would join staff to ensure patients did not have to wait unnecessarily for their treatment or care.

In the event of an unavoidable delay to services such as in the event of a traffic incident for example, staff informed dispatchers in the emergency operations hub. Dispatchers contacted patients and their receiving clinics or wards to make them aware and seek alternative, later appointments so patients could continue with their planned journey.

In the summer months the PTS staffed an additional call in crew to meet patient repatriations. This is when visitors to the island require transporting to their home NHS trust. This ensured suitable numbers of crews were available to meet patient demands.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Summary of complaints

From January to December 2018, there were three complaints about patient transport services. The trust took an average of 50.0 days to investigate and close complaints, and one complaint was closed within 30 working days. This was not in line with their complaints policy, which states that 75% of complaints should be closed within 30 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Transport (ambulances)	2	66.7%
Values and behaviours (staff)	1	33.3%
Total	**3**	**100.0%**

(Source: Trust Provider Information Request – complaints)

Number of compliments made to the trust

From January to December 2018 there were 10 compliments about patient transport services at the trust. The provider stated compliments often acknowledge staff as being caring, informative, compassionate and polite.

(Source: Trust Provider Information Request – compliments)

During the inspection it was identified the data supplied in the Provider Information Request relating to complaints was incorrect. We reviewed the three documented complaints with the quality manager for community and ambulance services. During this process it was identified staff within the quality team had incorrectly linked two emergency ambulance complaints to the PTS. The PTS registered manager raised this issue with the quality team to ensure complaints were correctly allocated to the emergency ambulance service.

Following our last inspection in January 2018, we told the provider they should respond to patient complaints in line with their complaints policy and procedure. During this inspection we saw the one complaint the service had received had been dealt with, and responded to, in line with the provider's timescales as detailed in their complaints policy and procedure.

We saw ambulances contained complaints leaflets on how to make a complaint if required. The leaflets contained information on how patients could access services to raise a formal complaint. Patients told us, whilst 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. Reported PTS incidents documented where patients had been encouraged to make a complaint if they were unhappy with how an incident had been resolved.

The only PTS complaint was reviewed, we saw it had been investigated thoroughly, a local resolution reached, and feedback supplied within the provider's 30 working day timescale.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service. They supported staff to develop their skills and take on more senior roles.

Following our last inspection in January 2018, we told the provider they should review their succession planning processes to ensure positions of leadership were not left vacant. At this inspection we identified a new managerial structure was in place, which included a performance support officer to support both the team leader and the registered manager. Succession planning was identified and included in staff performance development review processes.

The structure of the ambulance service had been reviewed and all areas now had managers in substantive roles. These included the Hub or control centre; the ambulance station; patients transport service; ambulance preparedness, resilience and response (EPRR) lead; commercial training and community first responders; clinical quality lead and business manager.

These members of staff reported to the head of the ambulance service who in turn reported directly to the director of integrated urgent and emergency care. The head of the ambulance service aimed to hold weekly informal one to one meetings with the leadership team, which we were told by the leaders was, in general, being achieved. They also undertook their appraisals and the leaders told us they had completed meaningful appraisals with both business objectives and personal objectives agreed.

The managers and leaders had attended a leadership conference earlier in the year and all were being supported to take part in the compassionate leadership program.

The ambulance service had been working as a standalone division for a year. The integrated urgent care division was a new division which had been operational for five months, it was described as undergoing a 'proof of concept'. The ambulance service, including PTS, were part of this division although they had continued to function independently.

The director of integrated urgent and emergency care was an interim role with the current post holder due to leave the provider in July 2019. Leaders in the service told us the pilot would be evaluated once completed in July 2019. Senior staff in the service told us they were not aware of what the future plans for the integrated urgent care division were. Therefore, it was not clear what the ongoing leadership and support arrangements would be.

The leadership team were aware of the issues identified during this inspection, such as the condition and cleanliness of the ambulances, as well as the lack of performance management data. There were temporary solutions in place to mitigate these risks. These included the creation of new cleanliness tracking and auditing processes for ambulances and the development of key performance indicators, whilst awaiting longer term solutions. However, influences such as finance, not directly in control of the PTS, were inhibiting their ability to address these in their entirety. Management from all levels were aware of these needs and acting to resolve them.

Staff told us their leadership team were visible and could speak with them at any time. They spoke positively of management accessibility, including the head of operations and chief executive, if required. One member of staff told us, "(head of ambulance service) comes down here and sees how things are and she's been ever so good", another member of staff said they had "An open and honest manager".

Following our last inspection in January 2018, the PTS had integrated their succession planning within staff performance development and review processes. This identified staff who wished to progress to consider lead roles and put actions in place to support them with their personal development. In the event of management changes suitable processes were in place to ensure the PTS had a developed management structure in place.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and most staff understood and knew how to apply them and monitor their progress

The ambulance service had developed a strategy which had been approved by the ambulance division board and the provider's board. Three further enabling strategies had been or were being developed at the divisional board level with input from staff. These included the work force strategy, the ambulance quality strategy; ambulance staff engagement strategy and ambulance public engagement strategy. There was also an annual business plan to support the division in delivering their strategy which had been agreed by the provider's leadership team.

The provider's vision was identified as, 'Working with our Island partners and others, we will be national leaders in the delivery of safe, high quality and compassionate integrated care; putting those who use our services at the centre of all we do'. These were supported by the values and tag line of '**C**ompassionate, Te**A**m-working, Imp**R**oving, Valu**E**d. 'Care' is the golden thread running through everything we do'. The service had worked to develop their own objectives to support the delivery of the vision and values. The objectives for the ambulance service, which included the PTS, was, 'To achieve the national quality standards and clinical requirements. To provide the right service to our community with the right care, in the right place, at the right time,

with the right skills. To provide high quality planned patient care services which are valued by users and ensure our workforce including volunteers feel valued, safe and respected'.

Most staff we spoke with were aware of the services visions and values and felt they were "Embedded in the PTS". These were also discussed at yearly staff annual appraisals. Staff were asked to provide evidence in their personal development process to identify how they were meeting the provider's aims and objectives.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they enjoyed their role and felt they worked effectively as a team with their immediate colleagues. They said they felt respected by their team members, their managers and worked within a supportive environment. One member of staff told us, of the managers, "They're accessible if needed, absolutely, there's always somebody about". Another member of staff told us, "I feel more cared for here than I did in (previous career), they really want you to improve here".

Staff said managers and their colleagues demonstrated openness and honesty throughout their interactions. We saw this during conversations between staff and managers throughout the inspection.

Staff told us the service acted when staff behaviours did not meet the provider's visions and values. Processes were followed to offer staff support before disciplinary action was taken to ensure the ongoing performance of the service.

The service had whistleblowing information clearly displayed on the notice board in the staff room. This provided staff with a 24 hour available telephone number and email addresses to contact in the event of raising concerns about working practices. Staff we spoke with felt confident to raise concerns via speaking with managers or by whistleblowing if required.

The provider had freedom to speak up guardians and anti-bullying advisors available for staff. Contact information for these staff, were published on the notice board in the staff room. Staff knew how to access this support if required.

Staff felt the culture of the service was designed and delivered to meet patient need. One member of staff told us, "Staff genuinely care about the patients, they want to do a good job…I love being out on the ambulances and dealing with patients, I get the satisfaction of knowing I've put a smile on the patient's face'". Another member of staff told us of the culture, "It's feels worthwhile, if we go home and I know my patients are treated as they are here we've done a good job, I know it's done".

Staff we spoke with understood the duty of candour (DoC) and their role in being open and honest with patients. Information was available on the staff policies and procedures board which advised staff on actions to take when the DoC required complying with.

An employee assistance programme was available for staff who required support outside of work. This included access to counselling services when required. Staff were provided with protected lunch and regular breaks which were planned into their workload, which we saw were adhered to.

Governance

Leaders operated governance processes, throughout the service and with partner organisations, however the governance structures and processes were in their infancy and it was too early to establish whether they were effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At our last inspection, we found the governance structures were complex and ineffective. Since then, the governance structures had been redefined and there was a now a more streamlined system. However, the systems were new and had yet to be fully embedded into the service. Therefore, we were unable to establish whether the new arrangements were impacting on the service in driving through consistent positive change.

There had been an interim ambulance advisor to the board, which had led to the trial of the integrated urgent and emergency care division, which had an executive lead and care group director and was the division in which the ambulance service sat.

The ambulance division had a meeting structure which provided oversight of both operational performance and quality. The ambulance divisional board met on a monthly basis and received input reports from two subcommittees, the ambulance performance and ambulance quality committees. The divisional board also reviewed: risks which scored over 15; a quality strategy update; EPRR update; a workforce up date from their business partners including mandatory training, appraisal rate and sickness rate; and a finance up date from their finance partner.

The quality committee reviewed serious incidents, complaints, review of clinical national guidance, audit outcomes and patient experience. The performance committee focused on operational performance, human resources issues and finance.

The ambulance performance committee received operational performance information from the weekly operational team meeting which comprised of PSO's, clinical support staff and the service delivery manager. PSO's fedback that the meetings were more structured and less time consuming than before. There were set agenda items under the headings of safe, effective, caring, responsive and well led domains.

Meeting minutes from the ambulance divisional performance committee of 18 March 2019 showed set agenda items included strategy and planning, performance and assurance, finance and workforce performance. For example, we saw the current mandatory rates and appraisal rates for March 2019 were highlighted along with updates on training courses and recruitment.

The ambulance divisional board signed off the ambulance division board summary which reported into the trust leadership committee. The ambulance service worked independently of the rest of the division. There was not one board for the urgent and emergency care division however each service under the division was presented to the trust board.

Management of risk, issues and performance

Leaders and teams did not always have the systems in place to manage performance effectively. Risk management processes had not always identified and escalated relevant risks such as the cleanliness and condition of ambulances. Where other issues had been identified, actions had been taken to reduce their impact. They had plans to cope with unexpected events.

We saw the service conducted non-clinical audits which were used to improve the quality of service delivery, which was not directly related to performance. For example, we saw the completion of the PTS vehicle inspection booklets were audited. The results of these were used to increase staff compliance with their completion. However, processes in place had not clearly identified concerns regarding ambulance cleanliness and their physical condition.

It had been acknowledged by the PTS that a number of ambulances required replacing. The trust had allocated money to complete this work however, circumstances outside the provider's control meant this had been delayed. Monitoring processes in place however, had not correctly identified the level of risk regarding the cleanliness and physical condition of the ambulances. No mitigating actions had been put in place to ensure the vehicles remained fit for use whilst replacement work was ongoing. A new auditing tool had been created to document the cleaning routines completed and a base line for cleanliness had been sought from the provider's infection, prevention and control lead. These processes however, had not been fully implemented at the time of the inspection and no mitigating had been taken to ensure the ambulances suitability whilst this work was completed.

The service had a risk register for patient transport services. These comprised of a number of identified high and moderate risks which were subject to regular review. This included risks regarding ambulance replacement and the risk of patient transport needs not being effectively managed, due to non-operation of the electronic booking system. At the time of inspection, we saw control measures were in place to mitigate the risk caused by the lack of CAD system. This included the employment of a bank administrator to help input information. We saw this risk was reviewed monthly with actions completed, identified and allocated to an owner, with a date for completion.

Risk scoring 15 and above were discussed at the ambulance divisional board, those above 12 discussed at the sub committees to the board. There was also a monthly risk register review workshop. We were informed risk could be discussed at the CQEG and then escalated with recommendations to the quality committee for ratification.

The provider was awaiting the introduction of a new computer aided dispatch (CAD) system for PTS which had been implemented within the emergency ambulance service. This provided the emergency ambulance service with access to real time and auditable performance data. A system was in the process of being developed for the PTS but was awaiting software development and final provider financial support. It was unclear when this would be introduced to PTS, however, until such time the service was unable to evidence their compliance against their key performance indicators.

Contingency plans were available for unexpected events or emergencies, such as extreme weather conditions or loss of communications. In the event of a communicable disease outbreak the service had access to sufficient numbers of bank staff to enable the continuation of service delivery.

Following our last inspection in January 2018, the service had developed an Ambulance Improvement plan to address the issues raised at that inspection and drive performance. This included the creation of new standard operating procedures and the delivery of a business case for additional provider funding to support service delivery.

The service monitored this improvement plan using a performance report titled, 'Getting to Good, our improvement journey'. This report was based on the Care Quality Commissions key lines of enquiry of safe, effective, caring, responsive and well led. This reviewed the risks/challenges, successes, opportunities and actions taken/planned to ensure compliance. This report was used

as a meeting tool and discussed monthly to ensure actions were continually monitored. We saw these were updated monthly with details of actions taken to mitigate challenges to service delivery.

Information management

The service could not collect reliable data to analyse it. Staff could not find the live time data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

At the time of the inspection the service did not have access to electronic systems to manage information about service delivery. The introduction of a new CAD system for emergency ambulance services had impacted on the previously available electronic PTS system. This meant the service were unable to create, store or review information regarding live time performance data.

The service had access to the previous two years' worth of performance data up to the date of October 2018. This was prior to the decommissioning of the CAD system in November 2018. The service had used this information to help design services including the alignment of shift times to identified patient demand.

The software required to enable future information management was in the process of being developed and awaiting financial agreement before it could be implemented within the service.

Public and staff engagement

Leaders and staff actively and openly engaged with patients, staff and the public to plan and manage services.

The service sought patient feedback on how to develop and improve the quality of the service delivered. Ambulances contained details on how patients could provide their views on the service they received. Feedback leaflets were available on the ambulances for patients to complete.

The PTS website had links to a 'Tell us about your experience' webpage. This contained information for patients, and the public, on how to raise a concern or provide feedback. It also provided information for the public on how to access Patient Experience Officers who would support people to access departments and services. This included support in offering feedback, compliments or complaints.

Where patients had provided feedback regarding service delivery, staff acted to address this. Some patients had provided feedback regarding late discharges which then impacted on patient transport services. In response, the service liaised with the provider's pharmacy to prioritise the take home medicines for patients awaiting the use of the PTS. This work was in the process of being completed at the time of the inspection.

We saw results of the annual national NHS ambulance staff survey in which staff from the service had participated. There were 10 themes which formed the framework for the survey, these included (but were not limited to): equality, diversity and inclusion, health and wellbeing, immediate managers, morale. In six of the 10 themes, the Isle of Wight trust ambulance service was the same or better than the England average.

The service had developed a regular schedule for staff meetings in response to staff feedback. These were held quarterly, and minutes were taken for those staff unable to attend. We saw these

meetings were well attended with a structured agenda where service delivery and changes in policy and process were discussed.

Staff were encouraged to provide feedback on how they felt service delivery could be improved. The ambulance service had a staff engagement strategy which contained information on 'you said, we did' which listed staff feedback and actions taken in response. This evidenced staff had provided feedback which had been acted upon by the service. This included using radios as telephones, implementation of weekly drop in sessions with the head of service, staff meeting dates published in advance and time off in lieu being provided for attending a team meeting on a day off.

The service made effort to develop relationships with another PTS to share learning regarding information management systems. Staff told us this had been a useful link to identify which system would be suitable for the PTS and improve overall service delivery.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Following our last inspection in January 2018, the PTS had instructed a research project to review other patient transport services to identify best practice which could be implemented within this service. This had resulted in the creation of key performance indicators which were published, publicised and awaiting review once the new CAD system had been implemented. The service identified other services had website content for healthcare professionals to highlight the importance of cancelling booked transport when a hospital appointment was cancelled or changed. The service, in response, stated they would ensure clarity in the new booking programme which was in development at the time of the inspection.

The service identified good work and ensured staff were recognised by providing positive feedback which was clearly displayed in the staff room. Recent thank you cards and emails from colleagues, including Head of Operations and Head of Nursing, were openly displayed on staff notice boards. The trust also had a staff recognition scheme which provided staff with an acknowledgement certificate when they had been nominated by colleagues for completing good work. We saw this information was also displayed on the staff board.

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.

In 2018 the emergency operations centre handled 17,760 emergency calls and 82,987 NHS 111 calls. The division supported the dispatch of 30,403 emergency vehicles.

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

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and managers monitored compliance. We saw plans to show those staff who had not completed training were booked on courses within the next three months.

Mandatory training completion rates

The trust set a target of 85.0% for completion of mandatory training.

A breakdown of compliance for mandatory courses for April 2018 to January 2019 for all staff in emergency operations centre is below:

All Staff Groups

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	67	72	93.1%	85.0%	Yes
Infection Prevention & Control Level 1	66	72	91.7%	85.0%	Yes
Health, Safety and Welfare	65	72	90.3%	85.0%	Yes
Hand Hygiene	55	61	90.2%	85.0%	Yes
Load Handling	61	68	89.7%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	57	72	79.2%	85.0%	No
Information Governance	56	72	77.8%	85.0%	No
People Handling	3	5	60.0%	85.0%	No
Infection Prevention & Control Level 2	29	61	47.5%	85.0%	No
Adult Resuscitation	22	60	36.7%	85.0%	No
Paediatric Resuscitation	16	58	27.6%	85.0%	No
Adult Resuscitation - Non-Clinical	3	12	25.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for five of the 12 mandatory training modules for which staff were eligible.

The trust also provided a breakdown of mandatory training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in the emergency operations centre for April 2018 to January 2019 is shown below:

Support to ambulance service staff

Training module name	April 2018 to January 2019

	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	49	50	98.0%	85.0%	Yes
Infection Prevention & Control Level 1	49	50	98.0%	85.0%	Yes
Load Handling	43	46	93.5%	85.0%	Yes
Health, Safety and Welfare	46	50	92.0%	85.0%	Yes
Hand Hygiene	43	47	91.5%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	42	50	84.0%	85.0%	No
Information Governance	41	50	82.0%	85.0%	No
People Handling	3	5	60.0%	85.0%	No
Adult Resuscitation - Non-Clinical	2	4	50.0%	85.0%	No
Infection Prevention & Control Level 2	21	47	44.7%	85.0%	No
Adult Resuscitation	18	46	39.1%	85.0%	No
Paediatric Resuscitation	12	44	27.3%	85.0%	No

In the emergency operations centre the 85.0% target was met for five of the 12 mandatory training modules for which support to ambulance service staff were eligible.

Support to doctors and nursing staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Hand Hygiene	1	1	100.0%	85.0%	Yes
Infection Prevention & Control Level 2	1	1	100.0%	85.0%	Yes
Fire Safety Part 1 - Theory	6	9	66.7%	85.0%	No
Health, Safety and Welfare	6	9	66.7%	85.0%	No
Load Handling	6	9	66.7%	85.0%	No
Information Governance	5	9	55.6%	85.0%	No
Infection Prevention & Control Level 1	4	9	44.4%	85.0%	No
Fire Safety Part 2 - Extinguishers	3	9	33.3%	85.0%	No
Adult Resuscitation - Non-Clinical	1	8	12.5%	85.0%	No
Adult Resuscitation	0	1	0.0%	85.0%	No
Paediatric Resuscitation	0	1	0.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for two of the 11 mandatory training modules for which support to doctors and nursing staff were eligible.

Qualified ambulance service staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Hand Hygiene	6	6	100.0%	85.0%	Yes
Health, Safety and Welfare	6	6	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	6	6	100.0%	85.0%	Yes
Fire Safety Part 1 - Theory	5	6	83.3%	85.0%	No
Fire Safety Part 2 - Extinguishers	5	6	83.3%	85.0%	No
Load Handling	5	6	83.3%	85.0%	No
Infection Prevention & Control Level 2	3	6	50.0%	85.0%	No
Information Governance	3	6	50.0%	85.0%	No
Adult Resuscitation	2	6	33.3%	85.0%	No
Paediatric Resuscitation	2	6	33.3%	85.0%	No

In the emergency operations centre the 85.0% target was met for three of the 10 mandatory training modules for which qualified ambulance service staff were eligible.

NHS infrastructure support staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	5	5	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	5	5	100.0%	85.0%	Yes
Health, Safety and Welfare	5	5	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	5	5	100.0%	85.0%	Yes
Information Governance	5	5	100.0%	85.0%	Yes
Load Handling	5	5	100.0%	85.0%	Yes
Hand Hygiene	3	5	60.0%	85.0%	No
Infection Prevention & Control Level 2	2	5	40.0%	85.0%	No
Adult Resuscitation	1	5	20.0%	85.0%	No
Paediatric Resuscitation	1	5	20.0%	85.0%	No
Adult Resuscitation	1	5	20.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for six of the 10 mandatory training modules for which NHS infrastructure support staff were eligible.

Nursing and Midwifery Staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Fire Safety Part 1 - Theory	2	2	100.0%	85.0%	Yes
Fire Safety Part 2 - Extinguishers	2	2	100.0%	85.0%	Yes
Hand Hygiene	2	2	100.0%	85.0%	Yes
Health, Safety and Welfare	2	2	100.0%	85.0%	Yes
Infection Prevention & Control Level 1	2	2	100.0%	85.0%	Yes
Infection Prevention & Control Level 2	2	2	100.0%	85.0%	Yes
Information Governance	2	2	100.0%	85.0%	Yes
Load Handling	2	2	100.0%	85.0%	Yes
Adult Resuscitation	1	2	50.0%	85.0%	No
Paediatric Resuscitation	1	2	50.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for eight of the 10 mandatory training modules for which nursing, and midwifery staff were eligible.

Since the inspection we received more up to date mandatory training figures and these showed as of 14 May 2019 the overall compliance rate was 85%. Dispatchers had achieved 90%, call handlers 88% and clinical hub staff 96%. Mandatory training rates for managers within EOC were 73% and non-clinical performance support officers (PSO) 71%.We saw dates of courses for those few those staff members who had not reached the compliance rate for mandatory training, had been booked within the next few months.

Staff told us they accessed mandatory training in a number of ways, such as online modules and by trainer delivered sessions. Staff received protected time to complete classroom training and staff were given the option of completing mandatory as part of their shift or as toil. Most staff said they completed on line modules during quieter periods during night time shifts.

There was good oversight from management for the monitoring of mandatory training. During the inspection a performance support officer (PSO) showed us a tracking sheet they kept to monitor mandatory training for their team of call handlers. The tracker sheet showed when staff had completed individual modules, and also showed future dates of mandatory training courses staff were booked on. The service lead monitored PSO's and clinical leads mandatory training. Most staff we spoke with found the mandatory training topics were relevant to their role within EOC. There was senior management oversight, where mandatory training was monitored through the ambulance divisional performance committee on a monthly basis.

(Source: Trust Provider Information Request – Mandatory training)

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 85.0% for completion of mandatory training.

A breakdown of compliance for safeguarding courses for April 2018 to January 2019 for all staff in emergency operations centre is below:

All Staff Groups

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children Lev 1	69	72	95.8%	85.0%	Yes
Safeguarding Adults Lev 1	64	72	88.9%	85.0%	Yes
Safeguarding Children Lev 3	13	15	86.7%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	59	72	81.9%	85.0%	No
Safeguarding Children Lev 2	35	60	58.3%	85.0%	No
Preventing Radicalisation Level 3	30	61	49.2%	85.0%	No
Safeguarding Adults Lev 2 Part 1	35	72	48.6%	85.0%	No
Safeguarding Adults Lev 2 Part 2	26	72	36.1%	85.0%	No

In the emergency operations centre the 85.0% target was met for three of the eight safeguarding training modules for which staff were eligible.

The trust also provided a breakdown of safeguarding training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in the emergency operations centre for April 2018 to January 2019 is shown below:

Support to ambulance service staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children Lev 1	49	50	98.0%	85.0%	Yes
Safeguarding Adults Lev 1	47	50	94.0%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	45	50	90.0%	85.0%	Yes
Safeguarding Children Lev 3	7	9	77.8%	85.0%	No

Safeguarding Children Lev 2	25	45	55.6%	85.0%	No
Safeguarding Adults Lev 2 Part 1	26	50	52.0%	85.0%	No
Preventing Radicalisation Level 3	22	47	46.8%	85.0%	No
Safeguarding Adults Lev 2 Part 2	17	50	34.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for three of the eight safeguarding training modules for which support to ambulance service staff were eligible.

Support to doctors and nursing staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 3	1	1	100.0%	85.0%	Yes
Safeguarding Children Lev 1	7	9	77.8%	85.0%	No
Safeguarding Children Lev 2	1	2	50.0%	85.0%	No
Safeguarding Adults Lev 1	4	9	44.4%	85.0%	No
Preventing Radicalisation Level 1 & 2	2	9	22.2%	85.0%	No
Safeguarding Adults Lev 2 Part 1	1	9	11.1%	85.0%	No
Safeguarding Adults Lev 2 Part 2	0	9	0.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for one of the seven safeguarding training modules for which support to doctors and nursing staff were eligible.

Qualified ambulance service staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Adults Lev 1	6	6	100.0%	85.0%	Yes
Safeguarding Children Lev 1	6	6	100.0%	85.0%	Yes
Safeguarding Children Lev 3	4	4	100.0%	85.0%	Yes
Preventing Radicalisation Level 1 & 2	5	6	83.3%	85.0%	No
Safeguarding Adults Lev 2 Part 1	5	6	83.3%	85.0%	No
Safeguarding Adults Lev 2 Part 2	5	6	83.3%	85.0%	No

Safeguarding Children Lev 2	5	6	83.3%	85.0%	No
Preventing Radicalisation Level 3	3	6	50.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for three of the eight safeguarding training modules for which qualified ambulance service staff were eligible.

NHS infrastructure service staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	5	5	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	5	5	100.0%	85.0%	Yes
Safeguarding Children Lev 1	5	5	100.0%	85.0%	Yes
Preventing Radicalisation Level 3	3	5	60.0%	85.0%	No
Safeguarding Adults Lev 2 Part 2	2	5	40.0%	85.0%	No
Safeguarding Children Lev 2	2	5	40.0%	85.0%	No
Safeguarding Adults Lev 2 Part 1	1	5	20.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for three of the seven safeguarding training modules for which NHS infrastructure support staff were eligible.

Nursing and Midwifery Staff

Training module name	April 2018 to January 2019				
	Number of staff trained	Number of eligible staff	Completion rate	Trust Target	Met (Yes/No)
Preventing Radicalisation Level 1 & 2	2	2	100.0%	85.0%	Yes
Safeguarding Adults Lev 1	2	2	100.0%	85.0%	Yes
Safeguarding Adults Lev 2 Part 1	2	2	100.0%	85.0%	Yes
Safeguarding Adults Lev 2 Part 2	2	2	100.0%	85.0%	Yes
Safeguarding Children Lev 1	2	2	100.0%	85.0%	Yes
Safeguarding Children Lev 2	2	2	100.0%	85.0%	Yes
Safeguarding Children Lev 3	2	2	100.0%	85.0%	Yes
Preventing Radicalisation Level 3	1	2	50.0%	85.0%	No

In the emergency operations centre the 85.0% target was met for seven of the eight safeguarding training modules for which nursing, and midwifery staff were eligible.

At our last inspection we raised concerns regarding the level of staff compliance with mandatory safeguarding training. During this inspection we reviewed up to date figures for all EOC staff and found, as of 14 May 2019 for Safeguarding Children levels 1, the compliance rate was above 85%. This was also the case for Preventing Radicalisation level 3. For Safeguarding Adults and Children level 2, where the compliance rate was below 85%, we were able to see that for all those staff who had yet to complete training had been booked on a course within the next three months. This was an improvement since the last inspection and staff fedback that there had been a drive from management to ensure staff were completing the relevant safeguarding training.

There were appropriate systems and processes in place for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. There was an embedded safeguarding team within the trust who provided advise and support to staff in respect of safeguarding matters. A number of staff were able to give examples of safeguarding concerns they had raised and all of the staff we spoke with were confident in explaining how they would recognise and escalate safeguarding issues. A staff member gave an example of a recent call they had taken where they had raised concerns of a child living in an environment exposed to possible domestic abuse. Call handlers passed safeguarding concerns to the clinical leads who completed a safeguarding form which was sent to the trusts safeguarding team. All staff we spoke with said the system worked well and were confident in the safeguarding teams' abilities to handle all concerns raised.

New guidance for safeguarding, the algorithm for escalating safeguarding concerns and the relevant contact details for the safeguarding team was displayed behind the clinician's desks.

(Source: Trust Provider Information Request – 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 EOC environments were visibly clean and well maintained. There were appropriate hand washing and drying facilities available for staff and visitors. Hand sanitizing gel dispensers were also available at the entrance of the centre.

Staff we spoke with were aware of infection prevention and control issues and passed information related to health care associated infections to the dispatch team before an ambulance was deployed. Ambulance crews were provided with as much information as possible about possible infection issues, so they could prepare themselves in terms of what personal protection equipment to use. Call handlers could seek advice from clinical leads on infection control matters if required. Any new guidance on infection control was discussed in the ambulance division quality committee and disseminated to staff through e-mails and updated information kept in a folder on staff members desks.

All staff within the EOC were up to date and had completed infection prevention control mandatory training.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The telephony system within the centre was old and required replacing. The risk of the old telephone system was compounded by the fact there was no seven days a week, 24-hour IT support cover in case of breakdowns. The service had an informal agreement with a local person, but there was no formal agreement in place.

At our last inspection in January 2018, we raised concerns regarding the old computer aided dispatch (CAD) system and how this was not allowing the trust to capture real time information. During this inspection we saw a new CAD system had been in place since October 2018. This meant the service was now able to have access to accurate real time information regarding the position of vehicles and ambulance crews and were now participating in the new Ambulance Response Programme (ARP), in line with all other NHS ambulance services. This was a significant improvement since the last inspection.

Staff we spoke with said the new CAD system was faster and provided more accurate information. Staff could now see where vehicles and ambulance crew were, with the better map system provided.

The EOC premises was spacious enough to accommodate the required staff to support the service. The premises were secure, and all areas were accessed with key cards. Staff checked our passes before we could gain entry to the centre.

Large screens displayed within the centre, provided live information, such as tracking of activity, CCTV coverage of the Island, and current national news. There was also a staff noticeboard, with information on lessons learnt from incidents, staff awards and latest clinical updates.

The satellite navigation systems were constantly updated by the ordnance survey. Staff told us they found the systems reliable to support the dispatch of ambulance services.

Employers must protect workers from the health risks of working with display screen equipment (DSE), such as PCs, laptops, tablets and smartphones. Staff completed display screen risk assessments as part of their mandatory training and were able to access occupational health if required.

Up to date business continuity plans were available on staff desks. The service lead told us how they conducted live tests and they tended to be scenario based. For example, if there was CAD system failure, staff would revert to paper-based records, and staff we spoke with were able to describe the process.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff used the NHS Pathways systems to assess risks, triage and offer advice to patients. The NHS Pathways systems is a triage software utilised by the NHS to triage public telephone calls for medical and emergency care. We observed call handlers taking emergency calls where a set first question of “Is the patient breathing” was asked, which enabled staff to assess the level of risk and dispatch appropriate resources as soon as possible.

Call handlers were able to forward calls to clinicians who had medical and clinical expertise. We observed calls such as, a child mistakenly taking medication and a patient with mental health issues being forwarded to clinicians for their clinical opinion on the correct patient pathway to

follow. Clinicians assessed the patients and offered their advice in terms of other alternative avenues the patient could follow or by making sure an emergency ambulance crew were dispatched.

Due to the relatively small size of the service clinicians were able to assess all NHS 111 and Cat 3 and 4 999 calls. Cat 3 calls are categorised as urgent but not immediately life-threatening calls and Cat 4 calls are categorised as less urgent calls. Therefore, clinicians had assessed the risk to the patient and spoken with callers before they were placed in a queue if an ambulance was not available. They were able to conduct welfare checks and because they had already assessed and spoken to the caller had a good general knowledge of the patient's condition. Clinicians conducted welfare calls on a half hourly basis, but more often if they felt the risk was higher. Clinicians worked well with dispatchers and we observed one call when the level of risk was escalated by the clinician and the dispatch team changed the level of response so the patient was seen quickly.

Clinicians were trained in the National Early Warning (NEWS) score, a set of scores used by medical professionals to determine the seriousness of an illness of a patient. The NEWS scores were used by carers or nurses in residential settings and clinicians were able to converse and understand the scores to assess the risk and respond to patients over the phone.

The computer alerted staff to any special notes which contained important information for those more vulnerable patients and this helped staff ascertain the level of assistance they required.

Staff we spoke with had a good awareness of the signs and symptoms of sepsis. Call handlers were able to seek support from clinicians and we found information on how to triage patients with suspected sepsis was displayed throughout the call centre. Updated screening tools on sepsis were available to all staff. We saw a 'Think Sepsis' poster displayed within the centre. The poster gave prompts on what to do if a patient described issues such as, infection, fever, confusion, and to contact the clinical desk if they did.

Dispatchers listened to 999 calls to assess the patient's condition and ensured the appropriate ambulance crew with the correct skill mix were sent. At busy times the trusts community crisis response team could be sent to Cat 3 and 4 calls (lower level of urgency) to assist patients. The crisis response team were based in the hub so there was a good communication flow between teams.

Staffing

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

Planned vs actual

The trust has reported their staffing numbers below for emergency operations centre as of April 2018 to March 2019.

Staff group	April 2018 to March 2019		
	Actual WTE staff	Planned WTE staff	Fill rate
NHS Infrastructure Support	4.8	3.7	127.9%
Support to Ambulance Service Staff	50.4	52.5	96.0%
Qualified Nursing and Health Visiting Staff	2.6	2.7	94.9%
Allied Health Professionals	11.0	14.0	78.5%

Total	**68.7**	**72.9**	**94.2%**

(Source: Trust Routine Provider Information Request– Total staffing)

Vacancy rates

From January to December 2018 the trust reported an annual vacancy rate of 4.7% for emergency operations centre. The trust did not set a target for vacancy. Negative vacancy rates have been reported for some staff groups and the trust have stated that this was due to an over establishment of staff in these groups.

Note that the vacancy rate of 134.8% for qualified allied health professionals is a result of a low number of WTE staff in some months in the period from January to December 2018.

A breakdown of vacancy rates by staff group is shown below:

- Qualified allied health professionals: 134.8%
- Support to ST&T staff: 100.0%
- Qualified Ambulance Staff: 17.0%
- Support to ambulance service staff: 3.6%
- Qualified Nursing and Health Visiting Staff: 2.8%
- NHS infrastructure support staff: -7.0%
- Support to Doctors and Nursing Staff: -56.9%

(Source: Trust Routine Provider Information Request– Vacancy)

Turnover

From January to December 2018 the trust reported an annual turnover rate of 6.4% for emergency operations centre. The trust target turnover rate was 5.0%.

A breakdown of turnover rates by staff group is shown below:

- Qualified ambulance staff: 18.8%
- NHS infrastructure support staff: 11.9%
- Support to ambulance service staff: 3.6%
- Qualified nursing midwifery Staff: 0.0%

(Source: Trust Routine Provider Information Request– Turnover)

Sickness

From January to December 2018 the trust reported an annual sickness rate of 5.8% for emergency operations centre. The trust target sickness rate was 4.5%.

A breakdown of sickness rates by staff group is shown below:

- NHS infrastructure support staff: 7.4%
- Support to ambulance service staff: 5.0%
- Support to Doctors and Nursing Staff: 4.0%
- Qualified Nursing Midwifery Staff: 0.6%

- Qualified allied health professionals: 0.5%
- Qualified Nursing and Health Visiting Staff: 0.0%

(Source: Trust Routine Provider Information Request– Sickness)

Nursing and medical bank and agency/locum staff usage

From January to December 2018, the trust reported that no bank or agency staff were used in the emergency operations centre to cover shifts for nursing and medical staff.

(Source: Trust Provider Information Request – Bank agency locum tab)

Temporary staff usage

This refers to staff that are not qualified nursing or medical and dental staff. It can apply to paramedics, operations centre staff or any other core service specific roles within the trust.

From January to December 2018, the trust reported a bank usage rate of 2.5% in the emergency operations centre for qualified ambulance service staff.

Team	Total shifts available	Bank Usage		Agency Usage	
		Shifts	%	Shifts	%
Integrated Care Hub	2,056	51	2.5%	0	0.0%

From January to December 2018, the trust reported a bank usage rate of 2.2% in the emergency operations centre for support to ambulance service staff.

Team	Total shifts available	Bank Usage		Agency Usage	
		Shifts	%	Shifts	%
Integrated Care Hub	5,338	115	2.2%	0	0.0%

(Source: Trust Provider Information Request – Temp staff tab)

At our last inspection we raised concerns regarding the staffing levels within the EOC, particularly for performance support officers (PSO), clinicians and dispatchers. During this inspection we saw an improvement had been made with an increase in the level of staffing.

In total there were six WTE PSO roles with coverage on a 24-hour seven day a week basis, with a minimum of one PSO per shift. This was an improvement since our last inspection. The 24-hour coverage had a positive impact on the support for dispatchers. There was now continual oversight and monitoring of the service on a day to day basis.

There were 13 WTE clinicians, two were rostered during the day shifts and one to cover the night shift from 11pm to 7am. During our last inspection we raised concerns regarding cover of sickness during the night shift. During this inspection we found no changes had been made to increase the level of clinicians on the night shift. Most staff we spoke with including the service lead said another clinician on the night shift was needed as a resilience measure and placed this as a high risk within their service. There were no effective backup plans should a staff member fall sick during the shift. The trust still relied heavily on the goodwill of their clinicians to cover sickness for the night shift.

At the time of our inspection there was a total of 25 call handlers in place with three vacancies. The three vacancies had been filled and the new recruits were due to start in June 2019. The three vacancies within the call handling team were having an impact on the service. At the time of our inspection there were three call handlers on the day shift as opposed to 4 to 5 and on the first day of our inspection the service experienced an upsurge demand in calls which affected the call pick up rate. However, for the rest of the inspection the demand fell, and the call handlers were able to handle calls within the expected time frames. At weekends there were 7 to 8 call handlers taking calls for each day time shift. The service had changed the way vacant shifts were covered. Bank staff were asked first to cover vacant shifts before overtime was offered. The services electronic system was able to highlight if staff has had worked excessive hours. Staff were also required to report late finishes, so their hours could be monitored. Call handlers no longer took switchboard calls and this was improvement since our last inspection.

Since the introduction of 24 hour seven days a week coverage for the PSO role, dispatchers no longer had to undertake additional tasks the PSO would had normally fulfilled. There had also been an increase in the dispatcher role to 6 WTE places. Dispatchers fedback this was an improvement to the operation and staff wellbeing.

The trust had recently introduced a new meal break policy and staff now received a paid meal break and two 10 minute breaks during their shift. Shifts usually were usually 11 hours and 30 minutes. Figures at the time of inspection showed 97.8% of staff had received a meal break since the new policy had been in place. However, the PSO and clinician covering the night duty did not always receive a planned break due to the fact there was nobody to cover for them. Although staff did say they were able to take a rest during quieter times, this was on an ad-hoc basis.

Three members of the audit team were trained to take NHS111 and 999 calls and during the inspection we saw this happen throughout one of the days when demand was high. However, the audit team did not have a CAD system in their department so had to come to the centre to take calls. A desk was set aside for their use.

Vacant roles for call handlers were usually filled quickly as the service had a high application rate.

All ambulance services across the UK work to a national framework, called the Resource Escalation Action Plan (REAP), which has four levels designed to maintain an effective and safe operational and clinical response for patients. REAP level 1 means an ambulance service is operating at a steady state and this can escalate to a REAP level 4 which means the service is under extreme pressure. The trust had an embedded REAP plan. We saw information displayed throughout the centre with the REAP level displayed for staff to see. During the inspection we saw the REAP level change from a level 2 to 3 which meant the service was experiencing higher demand. Staff were familiar with the different levels of REAP and the actions they needed to take when the levels changed. For example, informing patients that the ambulance may be longer than usual. We observed staff from the audit team were used to assist with taking calls when the REAP level had increased.

We found there was no effective long-term forecasting or solution to address staffing levels for the increased demand in the service. A new workforce strategy was still being finalised at the time of our inspection.

Records

Staff kept detailed records of patients' care and treatment.

Patient records were computer based and call handlers we spoke with found the system easy to use. The system allowed staff to record detailed patient information such as medical history, personal details, previous encounters, summary care record, case questions, and current consultation.

Patient records were initiated at the start of a 999 call and we observed staff record patient information following responses to set questions. Clinical leads and dispatchers had access to the same information, so the flow of patient information was quick and easily accessible by staff.

The service used special notes, which alerted staff to relevant information regarding a patient, for example, patients with complex or safety concerns. Special notes were highlighted if they contained information and this enabled the staff member to see that they needed to be opened.

Staff were able to use the software systems for both 111 and 999 services and records were kept secure via password entry and staff ensured their screens were locked if they left their desks.

The NHS pathways license required the service recorded all calls and calls were required to be audited for the purpose of service improvement and coaching. The audit team conducted monthly audits of calls and provided feedback and action plans with training for those staff who were not performing well. Staff also had the opportunity of asking the audit team to listen into call if they wanted support or guidance for future improvements.

Medicines

Staff gave advice on medicines in line with national guidance.

Staff followed NHS Pathways in relation to medicines. Call handlers were limited in the advice they could give and would forward more complex cases involving medication to the clinicians who had the medical and clinical expertise. The advice call handlers could give related to over the counter medicines such as paracetamol and ibuprofen.

Clinicians could access a database which gave advice on medication and what pathway to follow. We observed a call where staff were able to provide advice to a parent whose child had taken some medication. The clinical pathway followed was for accidental poisoning/inhalation. The toxic national database allowed the clinician to input the dose and patients weight and prompted the clinician to provide advice to the parent on the best course of action required to ensure the child's safety and wellbeing.

Clinicians also had access to the British National Formulary, a pharmaceutical reference book that contained a wide spectrum of information and advice on prescribing and pharmacology.

The service had recently employed a pharmacist as part of the clinical team who was able to give medicine advice to the team if they needed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

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 January to December 2018 the trust reported no incidents that were classified as a never event within the emergency operations centre.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no incidents which met the reporting criteria set by NHS England from January to December 2018 occurring within the emergency operations centre.

There was a good culture for the reporting and sharing of incidents. Staff knew how to report incidents either through the services electronic reporting system or by informing a performance support officer (PSO) on duty. Examples of incidents staff said they had reported included shortage of staff due to sickness and how this had impacted on the shift.

Feedback and lessons learnt from incidents was good. As the service was relatively small most staff were able to receive face-to-face verbal feedback on incidents from their line manager. A screen in the EOC hub called “wall board” displayed lessons learnt from incidents. For example, we saw on the wall board information displayed to staff on the importance of using the directory of services. This was in relation to an incident whereby a patient was sent to the wrong place

Incident information was shared on the staff noticeboard directly outside of the EOC hub office. Feedback was also shared in folders on each staff member’s desk and a lesson learnt letter was sent to staff.

We saw a good example of change made due to an incident which involved a child, where the service worked collaboratively with the family and external services to identify solutions. The changes resulted in a local school changing their practices for emergency incidents.

Incidents was a set agenda item in the quality committee monthly meetings and this fed into the ambulance divisional board monthly meeting.

There was an incident management policy which had recently been updated. The policy described roles and responsibilities with the handling of incidents and the level and degree of different types of risks. Staff were familiar with the Duty of Candour (DoC) and understood it related to being open and honest with people. Staff completed DoC training and as of the 14 May 2019 the compliance rate was 90%.

We reviewed a variety of incidents staff had reported through the electronic incident reporting system over a three month period. Incidents reported related to staff sickness and equipment failure. The incidents reported were graded as low harm and beside each incident the investigation actions were listed. We saw the actions taken demonstrated good oversight and management.

There had been a recent major incident at the trust and at the time of our inspection the trust was still conducting a full serious incident investigation and were at the stage of a de-briefing meeting. Staff we spoke with were able to describe the actions they had taken during the incident and how the training they had received was effective. All staff we spoke with regarding the incident said the incident was managed well and said the right people from the department were being involved in the investigation process.

The service had recently started to complete mortality reviews for cardiac arrest patients. The reviews were completed on a trust wide basis so there was a holistic approach with input from each service within the trust who had managed the patient.

(Source: Strategic Executive Information System (STEIS)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The service provided care and treatment based on national guidance. The NHS pathways system was used to triage calls and provide clinical advice. This was an accredited system for the management of 999 calls and we observed staff following the pathways correctly.

The trust had recognised the need to review policies and we saw updated standard operating procedures (SOP) related to EOC, such as ring back procedure for a lost call, had been reviewed and were all in date. The service had recently reviewed and updated all SOP's. Up to date policy guidance and SOP's were communicated to staff via the trust intranet, a 'wallboard' which was a big screen displayed in EOC and a folder on each staff members desk.

Clinical outcomes and effectiveness were monitored through the clinical quality and effectiveness group on a monthly basis. The group reviewed new NICE guidance. For example, from the meeting minutes of 7 May 2019 we, we saw the latest NICE guidance on initial management of suspected and confirmed transient ischaemic attack (mini stroke) was reviewed and actions to follow.

The clinical assessment team used systems based on the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines and National Institute of Care Excellence (NICE) guidelines. The software system gave clinical support to provide more detailed assessments and the relevant clinical advice to provide appropriate care and treatment. For example, access to websites such as Toxbase, the clinical toxicology database of the National Poisons Information Service. NICE compliance was now monitored via the ambulance quality subcommittee and disseminated through e-mails and updates placed in information folders on each staff members desk.

The quality assurance and audit team monitored consistency and quality of practice. From an NHS Pathways perspective, the team audited 5 calls for every call handler per month to ensure callers were correctly following NHS Pathways. Part of the auditing included five back to back triaged calls audited live using a checklist. A review was taken if the staff member was not consistent and this involved reflective practice as well as supporting documents and further training.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief advice in a timely way.

Staff used the clinical pathways to assess patients' pain and were able to seek advice from clinicians if required. We listened to approximately 15 calls and we heard staff ask patients if they were in pain, for example if they had any chest pain. This then enabled staff to offer advice and triage the patient the appropriate emergency response.

Response times

The service monitored agreed response times so that they could facilitate good outcomes for patients. However, the service were not always meeting the time to answer call targets.

The trust started on the new Ambulance Response Programme in April 2018.

All measures of ambulance systems performance were changed to reflect the new ways of working introduced.

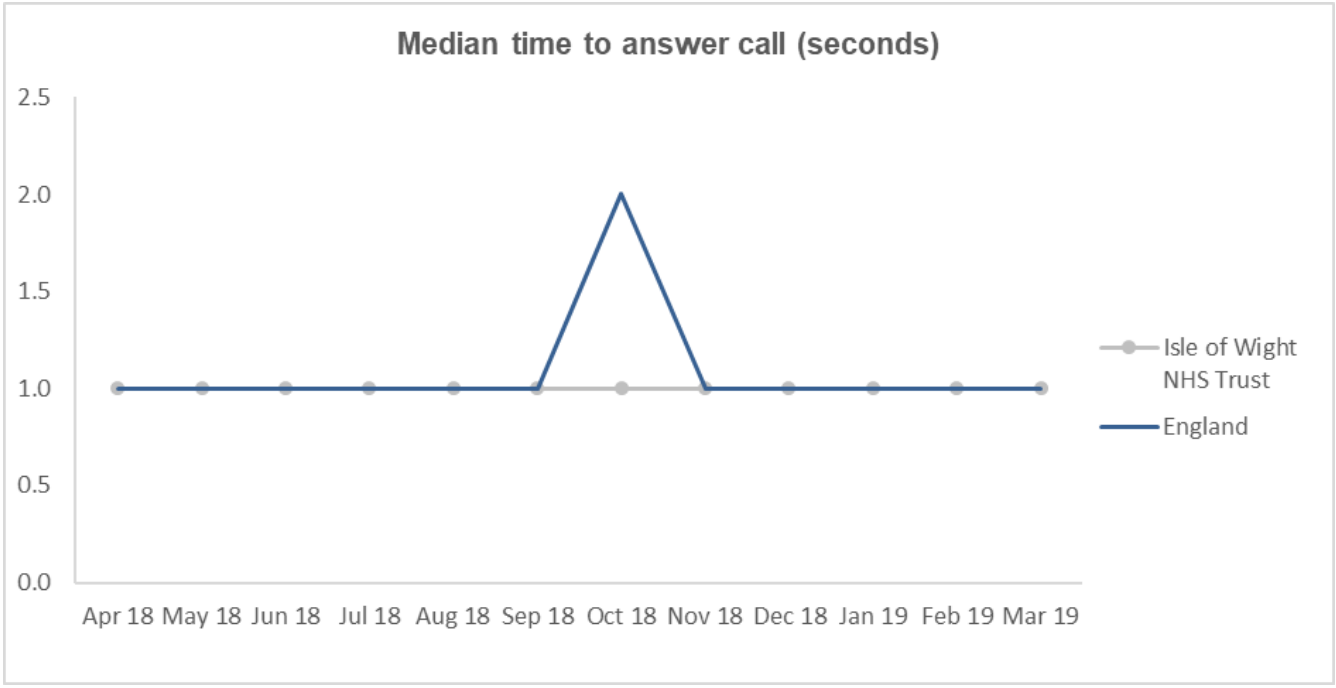
Ambulance systems (AmbSYS) indicators introduced under the NHS England Ambulance Response programme (ARP):

Time to answer call

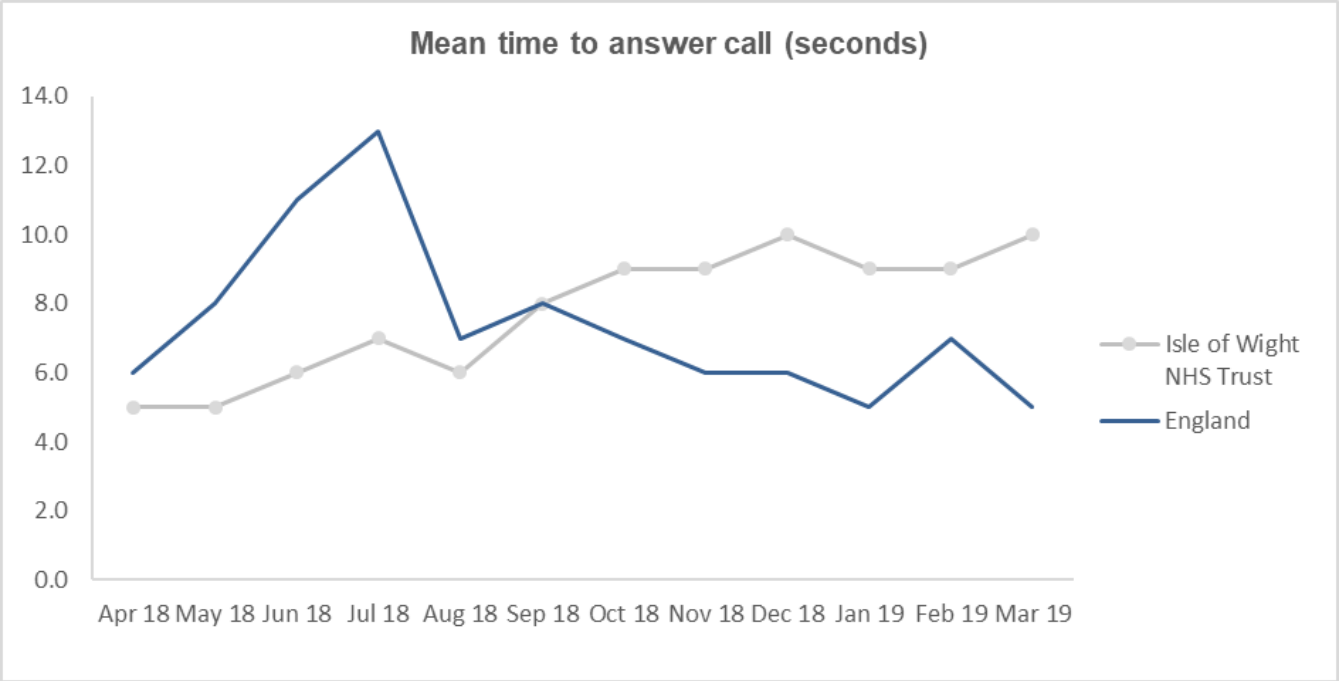
The time to answer each call is the time between call connect and call answer.

The four-metrics used to measure time to call answering are:

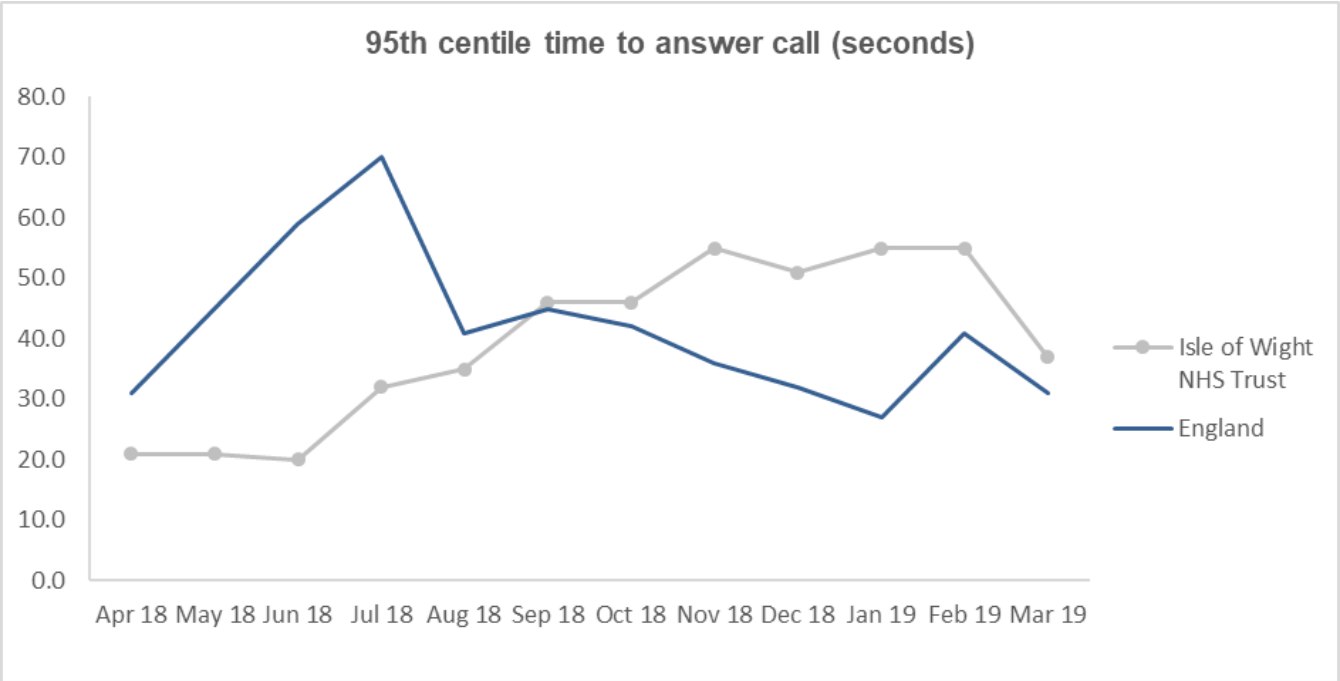
- Median time spent between call connect and call answer
- Mean time from call connect to call answer
- 95th percentile of times from call connect and call answer
- 99th percentile of times from call connect and call answer



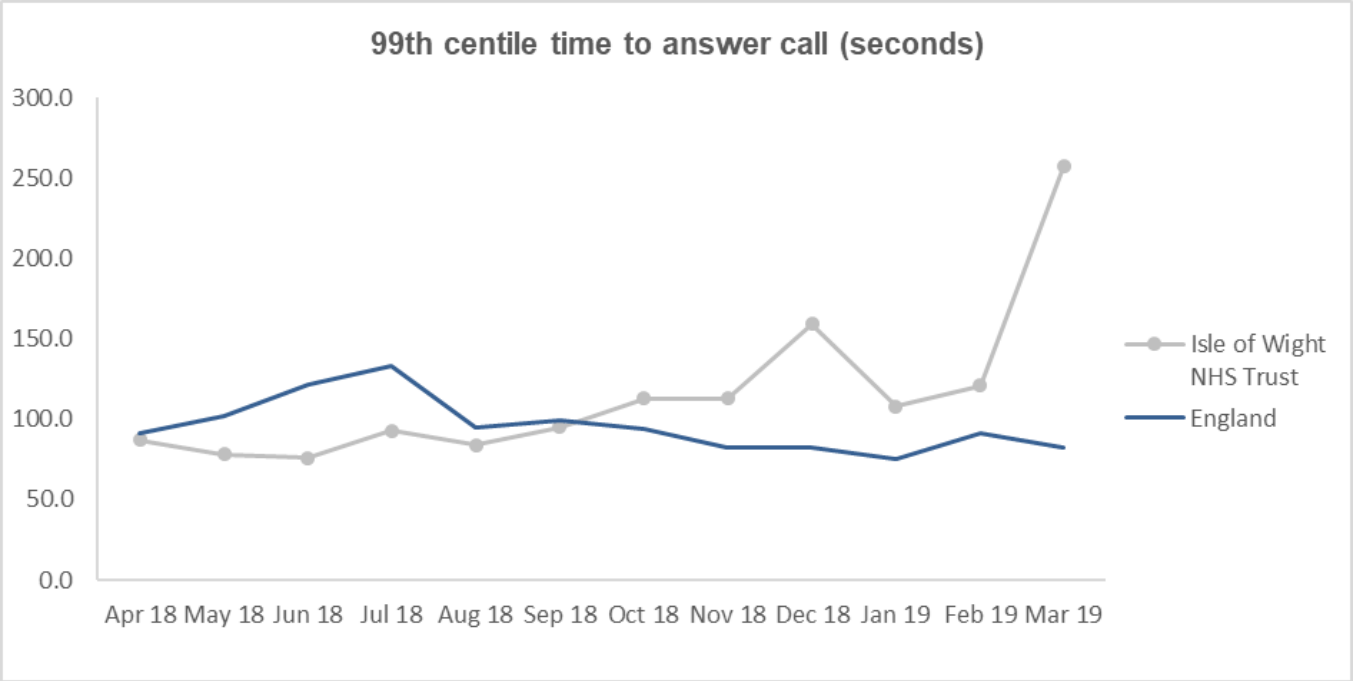
From April 2018 to March 2019 the trust median time to answer call was the same as the England average in all months other than October 2018, where the trust's performance was better than the England average.



From April 2018 to August 2018 the trust mean time to answer call was better than the England average. However, since September 2018 performance has deteriorated over time and performance was consistently worse than the England average in all months from October 2018 to March 2019.



From April 2018 to August 2018 the trust 95th centile time to answer call was better than the England average. However, since July 2018 performance has deteriorated over time and was consistently worse than the England average in all months from September 2018 to March 2019.



From April 2018 to September 2018 the trust 99th centile time to answer call was better than the England average. However, since August 2018 performance has deteriorated over time and from October 2018 to March 2019 performance was consistently worse than the England average. There was a particularly large deterioration in performance in March 2019.

Call performance was displayed on the main board within EOC. We viewed a selection of performance data for May 2019, for example on 5 May 2019 call performance displayed showed 93.24% of 999 calls were answered within the 5 second target. In total there were 74 calls and four call handlers. It should be noted that call handlers also took NHS 111 calls. On the May bank holiday of 4 May 2019, call performance achieved 90.48% of 999 calls answered within 5 seconds. This totalled 44 calls. Staff also answered 293 NHS 111 calls.

All ambulance services across the country work to a national framework, called the Resource Escalation Action Plan (REAP), which has four levels designed to maintain an effective and safe operational and clinical response for patients. Real time performance was monitored by the tactical commanders and activated REAP when performance dropped. We saw the service change the REAP level to 3 at the start of our inspection and this reflected the increased demand in calls received on that day. Members of staff from the audit team were asked to assist in covering calls to help with demand. At the end of our inspection the REAP level was 2 and again reflected the quieter period of time. Staff we spoke with understood the REAP levels and actions to take when the levels changed. For example, informing patients they may have wait longer than usual.

Recent changes of ringfencing 999 calls to a dedicated staff member, meant from March 2019, the wait times for calls being answered had gone down by up to 50%. Performance support officers (PSO) reviewed all missed CAT 1 and 3 calls and completed a review of how and why it occurred. They individually went through calls and since the implementation of the CAD system there was an improvement in documentation and oversight.

(Source: NHS England – Ambulance Quality Indicators – System Indicators)

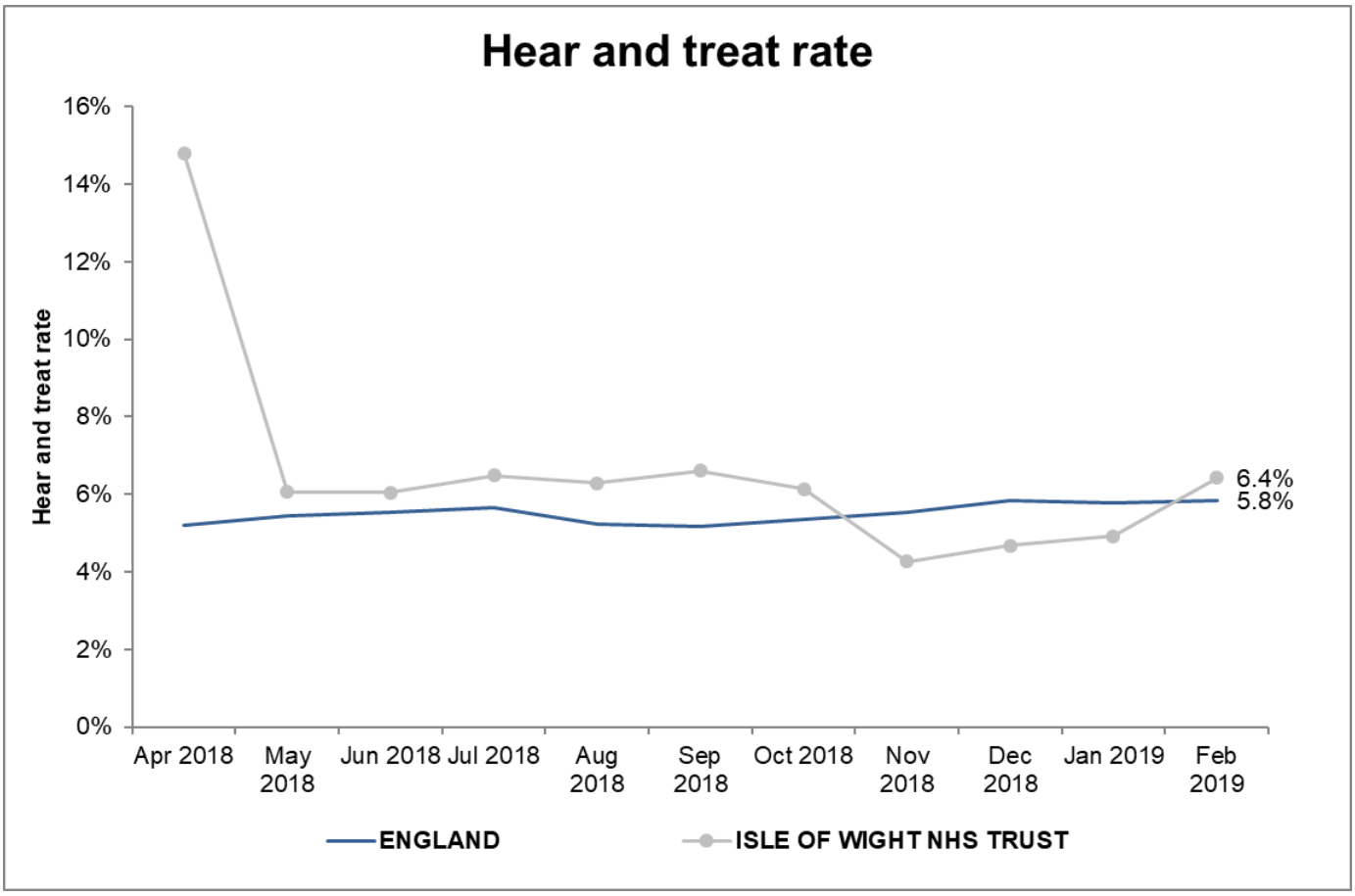
Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Calls closed with telephone advice / hear and treat

This measure relates to all calls to the emergency operations centre that are resolved through telephone advice or by referring to another service and where an ambulance is not dispatched.

The trust's performance against the metric for the period from April 2018 to February 2019 is shown below.



From May 2018 to October 2018 there was a fairly stable trend in the proportion of incidents resolved without face to face response. However, this proportion declined in the winter months from November 2018 to January 2019. In the most recent month (February 2019), the proportion of incidents resolved without face to face response increased to 6.4%.

The new CAD system meant better quality patient information could be gathered on a monthly basis, although this was still in the early stages. For example, clinical outcome figures from March 2019 found, 70% of CAT 3 and 4 calls that were validated, 56% of those calls found an alternative ambulance response. This was a positive national outcome. The audit also found that to date there was no evidence of patient harm as a result of the downgraded calls.

(Source: NHS England – Ambulance Quality Indicators – Systems indicators)

Competent staff

The service made sure staff were competent for their roles.

Appraisal rate

From April 2018 to February 2019, 77.6% of staff within the emergency operations centre at the trust received an appraisal compared to a trust target of 85.0%.

The breakdown by staff group is shown below:

Staff group	April 2018 to February 2019				
	Number of staff received appraisal	Number of required staff	Appraisal rate	Trust Target	Met (Yes/No)
Support to ST&T staff	1	1	100.0%	85.0%	Yes
NHS infrastructure support	5	5	100.0%	85.0%	Yes
Qualified ambulance service staff	6	6	100.0%	85.0%	Yes
Support to ambulance service staff	40	48	83.3%	85.0%	No
Qualified nursing & health visiting staff (Qualified nurses)	4	6	66.7%	85.0%	No
Support to doctors and nursing staff	3	10	30.0%	85.0%	No

(Source: Trust Provider Information Request – Appraisals)

At our last inspection, we identified gaps in management and support arrangements for staff and appraisal rates were low. At this inspection we saw significant improvements in the support structures now in place within EOC. As of May 2019, appraisal rates were 96%. Of the 57 staff within the centre, 55 had received an appraisal and the other two members were on long term sickness. Staff received an annual appraisal and staff told us appraisals were effective. Courses they had wanted to attend had been arranged, for example a challenging conversations course.

Call handlers now had an assigned performance support officers (PSO) as their line manager. PSO's each managed a team and had direct oversight of call handler's performance, development and conducted appraisals. Staff told us this was a better system as they felt they had more structure and stability and consistency with their performance and development. The PSO's were in the process of arranging one to one meetings. This was an improvement since our last inspection.

Development to a certain extent was restricted due to the size of the service, but several PSO had been promoted from clerical roles and four dispatchers had developed into the role from being a call handler. We were told the service was 'tapping' into the trusts development programme and had started funding for training within the whole trust. The service was also in discussion regarding offering staff shadowing with frontline ambulance crew.

All new staff attended an induction programme as well as training specific to their role. Staff we spoke with said the induction training was comprehensive and they felt they had been well informed. We spoke with a new clinician who was able to describe their training. They had completed three weeks of training for call handling, then completed one week as a call handler. They were then mentored by a clinical adviser for six to eight weeks. Call handler's induction involved two weeks training in NHS Pathways, training in systems and SOP's as well as receiving five weeks of coaching. During this time trainee call handlers were mentored and buddied during their induction.

The Performance Management framework set out the requirements of the NHS Pathways performance management. Performance was monitored monthly, through the audit process. Call audits were carried out using the call audit tools provided by NHS Pathways. There were two tiers of auditing. Tier One included three calls audited by the auditor plus one self-audit. Tier one consisted of three calls audited by the team and applied to new staff for the first three to six months after sign off during supervised practice, staff with persistent or significant performance issues and those staff taking 200 or less calls a month.

Tier Two involved five back to back triage calls audited live using a new checklist and applied to staff who were consistently performing well. If staff performed badly in audits they were provided with an action plan, which involved further training, such as reading materials and one to one training. Clinical audit information for March 2019 showed 120 audits achieved the 86% compliance rate with eight audits not achieving compliance. For clinicians, 46 audits achieved the compliance of 86% with 7 audits not doing so. Dispatchers were monitored by the PSO. Recent changes included monitoring throughout the day rather than at the end, so more real time information could be captured. However, the monitoring for dispatchers was not as well structured as it was for call handlers.

The audit team had devised ways to celebrate and promote good call handling. For example, if a call handler assisted with a successful cardiac arrest to discharge from hospital they were provided with a heart shaped pin they could wear on their uniform. We observed most call handlers wearing several pins which demonstrated they had handled difficult calls well. The audit team also sent messages titled ‘Don’t trip up’ to help provide tips and reminders of the NHS Pathways. For example, if a clinician was not available to take a CAT 2 validation call staff needed to continue as per the pathways and not to hold the call.

Staff were able to describe actions they had taken with a recent major incident. Staff were able to utilise an incident deployment matrix, whereby, the operational tactical commander told the centre how many casualties there were and the matrix worked out how many resources were available. For incident training, staff had received training and followed ETHANE protocols. Ethane stood for:

- Exact location
- Type of incident
- Hazards – both present and potential
- Access and egress – best route for the emergency services.
- Number of casualties
- Emergency services

Ethane dictated the form in which the receiving control station should get information from the first person or officer on the scene. Staff we spoke with said they understood their roles and responsibilities during a major incident and felt they had received good training.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked well with other teams and supported each other. The EOC hub consisted of other teams from the trust, for example, the community crisis response team, social services, a district

nurse, tele-health emergency pendant service, pharmacy support, frailty crisis team and the hospital switchboard. All teams worked well together, and the flow of communication was quick and effective.

Senior managers attended meetings with external bodies such as clinical commissioning groups. There was a good working relationship with another NHS ambulance trust. Several staff had visited their services to gain support with the implementation of the new CAD system. In turn, staff from the NHS ambulance trust had visited the trust and together that had worked as a team to achieve best response times for patients. The intention was to work more collaboratively together to share best practice.

The trust had good links and had forged strong working relationships with the police and fire services and other health organisations on the Island. The trust had a helicopter transfer service based next to the hub and staff interfaced with coastguards if there was an urgent response and people were in need of medical attention.

The PSO had daily handovers at the start of new shifts and a standard document was used which provided feedback on current performance and any issues.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Clinicians were able to provide health advice to those calls, that did not specifically require an ambulance response. Clinicians had access to software systems and a directory of services they could refer patients to. Within the hub there was a tele- health emergency pendant service. The service provided a community alarm and teleservice to enable Island residents to live independently in their own homes. Staff within the centre told us they often assisted and visited those more vulnerable patients, that did not require an ambulance.

Frequent callers were monitored by the clinical quality and effectiveness group and integrated locality services, whose aim was to improve the service users experience, focus on self-management and prevention, promote empowerment and improved sense of wellbeing. Frequent callers could be placed on a management plan, which was a care plan, incorporating local integrated services such as the callers GP. At the time of our inspection the service had one caller on a management plan and it was likely that this would be rescinded shortly, as the integrated locality service had been able to reduce call volumes from that caller.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA). There was a mental health crisis team staff were able to contact and mental health clinicians were contactable through another NHS ambulance trusts services. We observed a call where the call handler managed a patient with mental health concerns. The staff member was able to refer the patient to the clinical team to further support the patient. Staff were trained to follow the principle of the MCA 2005 in that they should assume all patients had capacity unless they found evidence to suggest otherwise.

The trust reported that from April 2018 to January 2019, (MCA) training was completed by 75.0% of staff in the emergency operations centre compared to the trust target of 85.0%. Since the inspection we received more up to date figures and as of May 2019 the compliance rate for MCA training was 90%.

The breakdown by staff group was as follows:

- NHS infrastructure support staff: 100.0%
- Qualified ambulance service staff: 100.0%
- Support to ambulance service staff: 80.0%
- Nursing and midwifery staff: 50.0%
- Support to doctors and nursing staff: 22.2%

The trust has reported that the Mental Capacity Act training module incorporates the Deprivation of Liberty Safeguard training.

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

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During the inspection we listed to calls taken by call handlers and clinical staff. All calls we listened into, we found staff were kind, respectful and caring. Staff spoke with a diverse range of patients and we found staff polite and respectful at all times. Staff were calm and provided reassurance during difficult and sometimes distressing situations. We observed a call where the staff member was calm and reassured a parent whose child had fallen and hurt themselves. The staff member was compassionate and kind to the relative.

Staff had completed people handling core modules as part of their mandatory training, several staff had completed challenging conversations courses, on how to learn new strategies for handling difficult conversations.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

We listened to a staff member calm and reassure a patient who became distressed. The call handler was able to lead the conversation, so the necessary details were obtained and then sought further support from the clinical team.

Staff demonstrated empathy and patience and treated people with sensitivity when dealing with callers who were upset or vulnerable. We observed a staff member handle a call from a patient with mental health issues. They were sensitive to the callers needs and were able to calm them when they became agitated. The staff member sought the appropriate help from the clinical team.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff treated people as individuals and demonstrated and involved patients and those close to them. Staff spoke clearly, slowly and did not use technical jargon. They often asked callers if they understood the information that had been given.

Staff recognised the importance of involving patients and their relatives and carers in their interactions of care. For example, we observed a caller speak with a relative of a patient who had fallen. The staff member was able to interact with both the relative and patient to get more details of the patient's condition and provide reassurance and support.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It did work with others in the wider system and local organisations to plan care.

The EOC was located in the one hub with all members of the teams in one location. This enabled together close communication between teams.

The service had been responsive to the changing demands of the service. For example in recognition of increased demand weekends extra call handlers were rostered on duty. During weekdays demand fluctuated however there was no set pattern as to why some days were busier than others. Therefore, the service had not been able to plan for these times in advance. However, on the first day of our inspection the centre experienced an increased demand in calls and the REAP level was changed to a level 3. In response to this surge in demand staff from the audit team, who were trained to take calls, assisted in the busier period. For the following two days of our inspection the REAP level was downgraded to a level 2, as the service experienced a quieter period. Dispatch staff we spoke with told us a key issue was access and flow. Staff told us delays were regularly experienced. Most staff we spoke with said the service was in need of more ambulance vehicles to meet demand.

An external review was conducted by the National Ambulance Resilience Unit (NARU) which recognised that the trust was not able to comply and respond in line with national standards, for example, chemical, biological, radiological, nuclear, and explosive materials. The trust were working together with NARU and NHS England to make changes and meet as many standards as possible. There was now an ambulance Emergency Preparedness, Resilience and. Response (EPRR) lead and ambulance staff had received training for specific EPRR competencies and more effective processes in place.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

EOC staff sought to meet people's individual needs. There was an emergency text service and staff had access to a translator service, for those people whose first language was not English. Staff told us both systems worked well.

There were facilities available for bariatric patients, such as a bariatric wheelchair and staff made the necessary arrangements and liaised with ambulance crew when required.

There were systems to manage frequent callers and all staff we spoke with understood what protocols to follow. Call handlers said they would triage the call to assess whether the patient required an immediate urgent response and then pass the call to the clinician who assessed the patient. The service worked closely with frequent callers GP's and the local district nursing team.

Staff were able to contact a mental health crisis team, who were able to provide support for those patients with mental health issues.

Access and flow

People could access the service when they needed it, in line with national standards, but did not always receive the right care in a timely way.

Calls were monitored by the on duty PSO to make sure people got the response they required. Information on the number of calls, calls waiting, and staff availability were displayed on screens within the centre. The call handlers managed both 999 calls and NHS 111 calls. A bell rang within the call centre for 999 calls and was a distinct sound which was recognised by all staff. The service had recently introduced a ring-fenced member of staff to take 999 calls only. This meant there was a dedicated member of staff assigned to just take 999 calls. Clinicians and dispatch staff assisted and could take 999 calls if no call handler was available.

Calls were prioritised by category in line with the Ambulance Response Programme Indicators. Ambulance cases were created following the use of a triage system by either call handlers or clinicians. Dispatchers told us there were frequent delays in dispatching ambulance vehicles as the resources were used on a continual basis. Most staff said there were not enough ambulance vehicles to cope with demand. For those CAT 3 and CAT 4 calls where an ambulance crew could not be dispatched within the allocated time frame, clinicians monitored cases and offered call backs. Clinicians called patients back to establish if a patient's condition had deteriorated, and, if so whether a more urgent response was required.

As part of the dispatch process, dispatchers could send community first responders to patients in rural areas on the Island where they may be a delay with the ambulance. There were set protocols for community first responders and who they could attend. For example, they could not attend patients with gynaecological difficulties. The new CAD system meant there was 99.9% coverage of the Island which meant all ambulance vehicles were could be tracked.

There was now a weekly clinical review of all patients who had a long wait as defined by the national long wait criteria. The audit showed what call category, location of call, whether treatment was in line with JRCALC guidelines and whether the long wait negatively impacted on the patient's condition. If the answer was yes this was escalated and reviewed by the clinical quality lead.

For March 2019, long waits for CAT 1 calls, totalled three and for CAT 2, this totalled 36. The re-attendance rate was 8.3%, a total of 42 calls out of 504 calls.

As the ambulance service was based in and part of the hospital trust, clinicians were able to contact the emergency department to forewarn them if they had directed a patient to attend. They

were able to provide the necessary information to the department, so emergency department were aware and could make the necessary preparations if required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations. The service had made improvements and were now responding to complaints in a timely way.

Summary of complaints

From January to December 2018, there were five complaints about the emergency operations centre. The trust took an average of 34.8 days to investigate and close the complaint, and 20.0% were closed within 30 working days. This is not in line with their complaints policy, which states that 75% of complaints should be closed within 30 working days. The service had recently changed their complaints handling procedure and processes. There was better oversight and monitoring of complaints. Each complaint was discussed in the ambulance quality committee monthly meetings, by the senior management team and the quality lead now tracked and chased on the timeline of complaints. The EOC service lead would receive an e-mail if the complaint related to EOC and would investigate the complaint and feedback to the quality lead. From February to May 2019, all complaints within EOC had been managed within the agreed timescales.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Values and Behaviours (Staff)	3	60.0%
Clinical Treatment - General Medicine group	1	20.0%
Communication	1	20.0%
Total	**5**	**100.0%**

(Source: Trust Provider Information Request – complaints)

Number of compliments made to the trust

From January to December 2018 there were 28 compliments about the emergency operations centre at the trust. The trust stated compliments often acknowledge staff as being caring, informative, compassionate and polite.

People were able to provide feedback or contact the service via a website link. We saw a good example, where a complaint relating to an incident with a young person, led to face to face engagement meetings with the family. The service invited the young person and family to visit the ambulance station and the family were involved in discussions to improve the service. Changes were made as a result of the complaint, for example, the service worked together with a local school to improve emergency practices.

(Source: Trust Provider Information Request – compliments)

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

At our last inspection in January 2018, we found there was a lack of a stable leadership team for the ambulance service, and little representation of ambulance services at board level. At this inspection we found changes had been made to the overall structure of the leadership team.

The ambulance service had recently been incorporated into the new integrated urgent and emergency care division and there was now a head of the ambulance service. The integrated urgent and emergency care division had been operational for five months and was described as undergoing ‘proof of concept’. This comprised of the ambulance service and the emergency department with one over-arching executive management team. The executive management team reported directly to the trust board, giving the ambulance service direct access to the board.

Managers reported that the pilot was working well and gave the service stability. Leaders in the service told us the pilot would be evaluated once completed in July 2019. Senior staff in the service told us they were not aware of what the future plans for the integrated urgent care division were. Therefore, it was not clear what the ongoing leadership and support arrangements would be.

The service had made changes at a local level to the leadership structure within EOC. The majority of interim roles had now been made permanent, which included the service delivery manager of EOC, a new emergency preparedness, resilience and response (EPRR) manager, a quality and clinical lead and business manager. The service had recruited more PSO’s and each PSO now directly managed a team of call handlers. The PSO’s no longer undertook frontline duties within the dispatching role. Their role purely focused on managing the control room and line management of their team of call handlers. Call handlers we spoke with, said this was an improvement, as they now had more consistency with performance appraisals, one to one meetings and had a direct line manager they could speak with.

Staff we spoke with, found senior leaders supportive, visible and had an open-door approach. Staff said they felt the service now had a ‘voice’ at an executive level and did not work in silo separate from the rest of the trust. They could see managers had made efforts to raise the profile of the service within the trust as a whole.

The head of the ambulance service held an informal one to one meeting with the service delivery manager and met regularly (usually on a weekly basis). The service delivery manager had received and appraisal which had set agreed objectives and goals. The managers and leaders had attended a leadership conference earlier in the year and all of them were being supported to take part in the compassionate leadership program.

Leaders in the service told us the pilot would be evaluated once completed in July 2019. Senior staff in the service told us they were not aware of what the future plans for the integrated urgent and emergency care division were. Therefore, it was not clear what the ongoing leadership and support arrangements would be.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. However at the time of our inspection strategies were not yet fully embedded into the service.

At the last inspection of January 2018, we found there was no clear vision or strategy for the service. During this inspection we found the service had developed an ambulance service strategy with involvement from staff, which had been approved by the division board and trust board. Although the service had made strides in developing strategic vision for the service, this was very much in its infancy and therefore, it was too early to establish whether the overall strategy for the ambulance service was embedded or working effectively.

Due to the implementation of the new CAD system the service now had access to business intelligence and were able to action plan ahead. Managers told us for the past year they had been fully invested in implementing the CAD service, and this had taken most of their resources and time to do so. They called this ‘Phase One’ and were now just starting ‘Phase Two’ of the process which was to collect all the business intelligence coming through to start planning and driving quality improvements. This was aligned with their service strategy, but again was still in its early stages.

The patient engagement strategy had been built on the foundation of the trust’s purpose and values. The trust’s purpose was to care for people on the Isle of Wight - saving lives, providing care and making sure they get the help they need.

The values of the service stated that by caring, working as a team and innovating and improving services they will:

- Provide the right service for every individual, every time, delivered locally wherever clinically appropriate and cost effective.
- Be an excellent, trusted provider of care, central to the health and wellbeing of Island residents and visitors.
- Provide the best integrated care in the country – services integrated with each other and with those of our partners – and as a result we will be locally and globally admired.
- Fully realise for our patients and our commissioners the potential of our integrated organisational form and deliver an Isle of Wight system-wide strategy for integrated care.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Since our last inspection of January 2018, staff within EOC told us there had been a change in the culture and staff felt the service now embraced new change and development. There was more focus on the future, more accountability and staff said the services profile had been raised

throughout the trust. There had been many changes within EOC in the past year and staff felt the service was on a ‘journey of improvement’ and recognised there was still a way to go, but fundamental changes had been made.

The new CAD system had been the biggest change within EOC this had impacted positively the everyday functions for staff within EOC. The majority of staff we spoke with, said the new CAD system had a positive impact on their working day, due to the updated and reliable information compared to the older system they had been using. Staff said this meant they were able to provide better patient care. It had taken the service the best part of a year to fully implement the CAD system into the centre. The service had involved staff with the changes, for example a performance support officer (PSO) was able to describe how they had been seconded to the IOW ambulance CAD project working alongside another NHS ambulance trust to implement the new CAD.

The trust had a Freedom to Speak Up Guardian, and local champions were based within each service. Information was displayed on the hub notice board and staff knew who to contact.

The service were in the early stages of implementing better career development opportunities for staff, through utilising the trusts development scheme. Staff we spoke with did not say there were any concerns with being treated unfairly. Staff said they were treated on an equal basis to other staff within the centre, and were confident they could raise concerns to the senior team, if they were not.

There was more focus and emphasis on the safety and wellbeing of staff within EOC, and there were systems in place to protect staff from abuse. For example, a staff member was able to describe the support they had received when a caller had been verbally abusive to them. A zero tolerance letter was sent out by the service to the caller, and the staff member said this made them feel supported and appreciated as an individual by the service.

There were trauma risk, manager (TRiM) practitioners available for staff who experienced traumatic calls. Some staff were able to describe the support they had received when they had experienced an upsetting call. Call handlers said they were able to have time away from their desks taking calls if they had taken an upsetting call and had received support from the PSO on a supervisory level. Staff were able to use occupational health services within the hospital and the new post of a mental health worker had made a positive impact. The service had developed mental health first aiders. There were six to eight champions for mental health first aiders and they were given four hours of protected time each month, so they were available to help support those staff that required help. The staff members had received training in counselling courses.

The clinical auditing team were able to help rewrite the interview and mentoring processes for call handlers and said this made them feel empowered and valued.

Governance

Leaders operated governance processes, throughout the service and with partner organisations, however the governance structures and processes were in their infancy and it was too early to establish whether they were effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At our last inspection, we found the governance structures were complex and ineffective. Since then, the governance structures had been redefined and there was a now a more streamlined system. However, the systems were new and had yet to be fully embedded into the service.

Therefore, we were unable to establish whether the new arrangements were impacting on the service in driving through consistent positive change.

There had been an interim ambulance advisor to the board, which had led to the trial of the integrated urgent and emergency care division, which had an executive lead and care group director, and was the division in which the ambulance service sat.

The ambulance division had a meeting structure which provided oversight of both operational performance and quality. The ambulance divisional board met on a monthly basis and received input reports from two subcommittees; from the ambulance performance and ambulance quality committees. The divisional board also reviewed: risks which scored over 15; a quality strategy update; EPRR update; a workforce up date from their business partners including mandatory training, appraisal rate and sickness rate; and a finance up date from their finance partner.

The quality committee reviewed serious incidents, complaints, review of clinical national guidance, audit outcomes and patient experience. The performance committee focused on operational performance, human resources issues and finance.

The ambulance performance committee received operational performance information from the weekly operational team meeting which comprised of PSO's, clinical support staff and the service delivery manager. PSO's fedback that the meetings were more structured and less time consuming than before. There were set agenda items under the headings of safe, effective, caring, responsive and well led domains.

We reviewed meeting minutes from the ambulance division quality committee meeting of 18 March. There was a set agenda and we found discussion took place on a patient's story of how there was a good incident follow up with NHS Pathways regarding an incident of a young child.

Meeting minutes from the ambulance divisional performance committee of 18 March 2019 showed set agenda items included strategy and planning, performance and assurance, finance and workforce performance. For example, we saw the current mandatory rates and appraisal rates for March 2019 were highlighted and updates on training courses and recruitment.

Staff were able to access policies and up to date guidance on the staff intranet. Staff also received updates on guidance and clinical pathways via a folder kept on each staff members desk.

The ambulance divisional board signed off the ambulance division board summary which reported into the trust leadership committee. The ambulance service worked independently of the rest of the division. There was not one board for the urgent and emergency care division however each service under the division was presented to the trust board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, the systems were new and still needed to be embedded into the service. The service identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Risks were reviewed monthly through the risk review meeting, which included the senior management team of the ambulance service. Updates to risks were completed before the meeting, so discussion during the meeting centred on the risks themselves.

Risks were rated in accordance to severity and those rated above 15 were discussed at the ambulance divisional board. Those risks above 12 were discussed in the sub committees to the board. We reviewed the integrated urgent and emergency care division ambulance services risk

register as of 13 May 2019 and found one risk directly related to EOC. The risk was in relation to no overnight night time shift resilience in clinical advisors. We were able to corroborate this with what staff within EOC said was the top risk within the centre. We were able to review the historical detail relating to this risk and the progress and action plans in place. The risk had regularly been reviewed by the ambulance operational manger and the latest progress update showed a business case had been completed and submitted to the executive team to make a decision on employing additional clinical service staff. Of concerns was the information indicted there was an increasing demand on the system but there were no plans in place as to how this would be managed by the service and it had not been recognised as a risk.

Staff we spoke with were able to identify the risks which were on the risk register. For example, we asked staff what the top risks were and they said the lack of resilience for the overnight shift on the clinical desk and the replacement of the telephony system. We saw both risks were on the ambulance risk register. There was an approved case for the replacement of the telephony system, however there was no specific date as to when this was happening.

Since the installation of the new CAD system, there was better quality data collection related to performance. However, this was still in the early stages, and the capturing of data to identify themes and trends and the drive quality improvements and performance had yet to be fully embedded into the organisation. There was a monthly ambulance service operational dashboard which shared details of initial performance of call answered, current programme of works and key risks. This report was shared to the ambulance divisional board.

PSO's monitored operational performance at various times throughout the day and night and were able to escalate any problems to the service delivery lead. The PSO's fedback that the quality of real time data and information on the service had vastly improved since the introduction of the new CAD system. Although the system was new and was still being embedded into the service they were able to gather more performance data than previously. The service was working with another NHS ambulance service to share quality and performance data.

The service had an up to date Resource Escalation Action Plan (REAP) and contact numbers of the commanders, tactical advisers and strategic commander were displayed in the hub. Staff were clear on the escalation process. The service had recently recruited to the post for Emergency Preparedness Resilience and Response (EPRR). The trust was working together with NARU and NHS England to improve and meet as many of NARU's standards as possible. Staff had received training for specific EPRR competencies. A recent major incident identified staff followed the trusts escalation protocols and processes when dealing with the incident. At the time of our inspection, the trust was still investigating the incident.

Information management

The service collected reliable data and analysed it, however this was in its early stages and not fully established. Staff were in the early processes of finding the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Since the implementation of the new CAD system, the service now received more in-depth reliable information. However, as the system had recently been installed, utilisation and effectiveness of this information was still in its infancy. The service recognised, now they had implemented the system they needed to collect and use the information to drive service improvement. This was part of the services Phase two CAD process, and the service had just started to enter this phase in more depth.

Staff completed information governance modules as part of their mandatory training. At the time of our inspection staff were compliant and had completed training.

We observed staff lock and secure their computer screens when they were not using them.

Engagement

Leaders actively engaged with staff and were in the process of developing engagement with patients, equality groups, the public and local organisations to plan and manage services. They were developing processes to collaborate with partner organisations to help improve services for patients.

The service had recently introduced a patient engagement strategy and there were actions underway to deliver the strategy based on patient feedback. This was still in the very early stages of implementation. The strategy outlined the commitment to patient and public engagement over the next two years.

There was an action plan as part of the strategy and this involved producing an annual report, engaging with community groups to offer ambulance representations and patient representations on assurance committees. The ambulance quality committee monthly meeting had a set agenda on patient experience, which involved a patient story and updates on the patient strategy. For example, from the meeting minutes of March 18, 2019, we saw the service engaged with visits to a local beaver's group and a future engagement with a local school.

Discussion was taking place on having patient representation within the hub, to offer follow up calls to those CAT 3 and CAT 4 callers to get patient feedback on the service. Currently patients could provide feedback via the Patients Advice Liaison service (PALS) and the services communication team.

There was an ambulance staff engagement strategy, and this was aimed at improving the way the trust engaged with staff and increasing staff response rates to staff surveys. An initiative to gain more staff engagement in surveys included asking short questions displayed on the centres wall board and noticeboards. The short questions included 'I have had sufficient rest periods to perform my job effectively.' Staff were given the opportunity to respond and this enabled the service to gain staff views on proposals of changes, such as start times for shifts and meal break changes. Staff participated in the national ambulance staff survey and results showed the trust was one of the better performers.

There were now hub staff meetings with staff representation and staff received information in a variety of ways, through the centres wall board, e-mails, hub newsletters and noticeboards within the hub. The service recognised and celebrated success. Thank you, cards, and certificates were sent to staff who achieved good audit compliance and staff who had dealt with difficult calls which had resulted in good outcomes for the patient.

Currently patients were able to provide feedback via the Patients Advice Liaison service (PALS) and the communication team.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

An ambulance quality strategy had been implemented and quality improvements were being driven through the ambulance improvements plan with weekly progress reporting via the divisional board to the trust leadership committees. We had sight of an ambulance improvement programme which was produced monthly. The programme provided a snap shot of delivery plans under the heading's programmes, leadership, governance, quality, resilience, issues and risks. Key performance indicators tracked improvement and performance. For example, the 15 March 2019 report showed under the governance heading, the percentage of standard operating procedures reviewed in November 2018 was 68% against a plan of 70%.

The service had developed ways to celebrate success within EOC. Staff pin badges were presented to staff for the following:

- Heart Badges **–** for call handlers who have started CPR on a call and the patient survived to be discharged from Hospital ROSC (Return of spontaneous circulation). Four badges were issued between June 18 and November 2018
- Telephone badge (and flowers) **–** For call handlers who have achieved an average 95% or above audit score for 12 consecutive months
- Baby born badge - For call handlers who deliver a baby before the crew arrives and call ends. One badge had been awarded in the last eight months
- Gold Star badges - for call handers who get 100% on all audits in a month

NHS Pathways had recently started to use five of EOC calls as part of their training package for Cardiopulmonary resuscitation (CPR) pathway.

On the NHS 111patient survey, callers had left comments about being left on hold too long, or multiple times. The service carried out a review of volume of calls and call lengths when a patient was put on hold. Results showed that there was room for improvement, so the service challenged the call handlers in a competition. to develop an acronym to use to make the transfer of information better whilst a patient was on hold. As a result, the development of 'Keep It Brief – RASH' Rash stood for:

- R – reason for speaking to clinician
- A – Age of patient
- S - Symptoms
- H – Help given

Information was posted on each computer terminal and monitored through the audit team. Following the introduction there had been a significant decrease in internal calls and call lengths and a reduction in NHS 111 feedback comments about being on hold.