

Isle of Wight NHS Trust

St Mary's Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Requires improvement



Accident and emergency

Good



Medical care

Requires improvement



Surgery

Good



Critical care

Good



Maternity and family planning

Good



Services for children and young people

Good



End of life care

Requires improvement



Outpatients

Good



Ambulance services

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Isle of Wight NHS Trust is an integrated trust that includes acute, ambulance, community and mental health services. St Mary's Hospital in Newport is the trust's main base for delivering acute services for the Island's population. The hospital has 246 beds and handles 22,685 admissions each year. Services include A&E, the Beacon Centre (providing walk-in access to GP services), emergency medicine and surgery, planned surgery, intensive care, maternity services, services for children and young people, neonatal intensive care unit and outpatient services, including planned care such as chemotherapy.

We carried out this comprehensive inspection because the Isle of Wight NHS Trust is an aspirant foundation trust, prioritised by Monitor. The Care Quality Commission's (CQC) latest intelligent monitoring tool identified the trust as being in band 5 (band 1 is the highest priority for inspection, band 6 is the lowest priority).

The team of 41 included CQC inspectors and analysts, doctors, nurses, patients and public representatives, Experts by Experience and senior NHS managers. The inspection took place from 4 June to 6 June 2014, with an unannounced visit on 21 June between 4pm and 11pm.

We inspected A&E, medical care (including older people's care), surgery, critical care, maternity and family planning, services for children and young people, end of life care, outpatients and the ambulance service.

Overall, we rated this hospital as 'requires improvement'. We rated it 'good' for providing caring services, but it required improvement for the services to be safe, effective, responsive and well-led.

We rated medical care and end of life care as 'requires improvement'. A&E, surgery, critical care, maternity and family planning, children and young people's services, outpatient services and ambulance services were 'good'.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- Staff followed good infection control practices. The hospital was clean and well maintained and infection control rates in the hospital were within an acceptable range.
- The hospital monitored harm-free care in all inpatient areas and had taken action to reduce avoidable harms, such as pressure sores and falls.
- Incidents were reported but staff did not always receive feedback and the lessons learned were not widely shared.
- Serious incidents were investigated and there was evidence of changes, but these were sometimes not implemented in a timely manner.
- The trust had considered guidance from the National Institute for Health and Care Excellence (NICE), but these were not consistently implemented, monitored or adhered to.
- Nurse staffing levels had been reviewed and in some areas the need for a change in staff number and skill mix had been identified. In some areas of the hospital, the right number of staff with the right skills and knowledge to meet patients' specific needs were not present. For example, there were insufficient numbers of nurses trained to care for sick children in the A&E department and insufficient numbers of medical and nursing staff trained to care for patients who had had a stroke.
- Some patients were being placed at risk by the hospital's bed management system. Patients were being moved from wards where staff had the appropriate skills and knowledge to one where staff did not have such skills and knowledge.
- The hospital had a named consultant for each ward and if a patient moved wards then they were allocated to a new consultant. Patients did not have one named consultant for the duration of their stay and did not necessarily have the specialist they required.

Summary of findings

- There was a palliative care team to support patients who were coming to the end of their life. However, patients were not always being identified as being on an end of life care pathway in a timely manner, and did not always receive the care and support they required.
- Do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions were not clearly documented, reviewed and were not always discussed with the individual or their family.
- There were clear processes for taking people's wishes into account and seeking their consent where they had capacity to do so. People who did not have the capacity to consent did not always have their needs considered in a safe and proportionate way, as not all staff were informed about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- There was a good service for children in the inpatient wards, day care, outpatients and neonatal intensive care unit (NICU) areas. There was, however, a lack of clarity over where sick children should be taken in an emergency when resuscitation might be required, as they could be taken to the ward, A&E, or, if very young babies, to the NICU. This had caused uncertainty and children's care and treatment had been delayed. At the unannounced visit on we founded the Trust had had changed the pathway for all children to be taken to A&E, but this was without fully considering the opinions and concerns of the paediatric staff. Risks to care were still being identified.
- The ambulance service provided flexible and responsive services to meet the needs of people on the island.
- There were good medicine management systems in the hospital, but the system in the ambulance service did not ensure the safe handling, storage and management of medication at all times. The trust had made improvements during our unannounced inspection.
- Staff were supported through mandatory training and appraisals.

We saw several areas of outstanding practice including:

- There was evidence-based care for orthopaedic patients having hip and knee operations.
- A wide, shared-care network for managing children with the most complex and rare conditions had enabled families to be supported and children treated closer to their homes. It also enabled them to access the best possible advice. For example, the children's ward was a level 1 paediatric oncology shared-care unit, and the hospital could also offer care to visitors to the island with oncological problems.
- The pharmacy service was operational seven days a week. The service was innovative and worked effectively within multidisciplinary teams to improve patient care. For example, electronic prescribing had reduced medication errors and was being used when venous thromboembolism risk assessments occurred. The service offered an advice line and was involved in the preadmissions initiation of antibiotics with ambulance services.
- An integrated call centre (Integrated Care Hub), opened in 2013 and provided access to the 999 emergency calls service, the NHS 111 service, the GP out-of-hours service, district nursing, adult social care, telecare services, non-emergency patient transport services and mental health services. Key services were accessed out of hours through the Hub.
- Ambulance staff used electronic tablets to enable operational staff to complete their e-learning.
- The ambulance service was participating in a trial in early intervention in sepsis. The aim was to identify patients who might have sepsis, and to reduce their mortality through early intervention prior to admission to hospital.
- The Individual Learning Plan (ILP) had been developed and implemented to support the development of staff competency in the ambulance service. This was introduced in 2014 and staff were given learning objectives and were required to demonstrate learning as part of their continuous professional development.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure that:

- Staff receive training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The principles must then be applied to ensure that where people do not have capacity to consent the correct procedures are followed.
- The leadership of end of life care services is supported to improve across the trust. A strategy for the service needs to be implemented and the quality and risks to the service need to be appropriately monitored.

Summary of findings

- Staff are competent in being able to recognise a patient who is on an end of life journey, so that decisions are made and their care managed appropriately. The trust must also ensure that staff have received the appropriate training and understand the tools available to them. This includes the use of the 'AMBER care bundle' and the use of syringe drivers.
- DNACPR orders are completed in their entirety, in a timely manner, for all patients where this decision has been made. There must be clear documentation as to how this decision was reached. Discussion with patients and their relatives should happen and be appropriately documented.
- Risk assessments in relation to patient care are completed and used to inform the patients' plans of care.
- All patients have a named consultant for the duration of their stay, with clear referral and an acceptance criteria when there is change in their consultant for clinical need.
- The provision of care for patients who have had a stroke is reviewed to ensure that the pathway is fully reflective of national guidance.
- National guidance is reviewed, gap analysis completed, and improvement plans put in place and monitored, where required, to ensure that practices are in line with national recognised guidance.
- There is a lead nurse qualified in the care of children (RN children) and sufficient registered children's nurses are employed to provide one per shift in the A&E departments receiving children, as per the Standards for Children and Young People in Emergency Care Settings 2012.
- There is a single point of access for children in an emergency situation where resuscitation may be required. There should be joint working with the A&E and paediatric teams to ensure that any changes are safely implemented.
- Nursing staffing levels are reviewed in the A&E department and the stroke ward to ensure that they are staffed to the agreed establishment and skills mix in line with current guidance.
- There is an effective and safe procedure for the obtaining, recording, handling, using, safe keeping and the dispensing of medicines used by the ambulance service.

In addition, the trust should ensure that:

- The use of bed rails is risk assessed and the patients' consent acquired for them to be used. In cases where patients are unable to consent, then there should be clear assessment of their capacity and a clear reason for the use of the bed rails.
- There is effective working with specialists and expertise in multi-disciplinary teams, particularly where clinical expertise is unavailable or limited in the trust.
- The environment of the eye clinic is reviewed to ensure that it is fit for purpose and safely meets the need of the patients visiting the department.
- Consultants have protected time for outpatient clinics so they are not cancelled at short notice when they are called to attend to emergencies.
- Nursing staff are not disturbed while undertaking a medication round.
- Patients have protected meal times.
- All medication and intravenous fluids are stored in line with current guidance in all areas.
- The number of patient bed moves for non-clinical reasons and out of hours is reviewed and action is taken to minimise this.
- In all outpatient areas where children are seen, there is a dedicated children's waiting area.
- All resuscitation equipment is checked on a daily basis, unless an area is closed.
- The provision of a separate children's area in the A&E department is considered in line with current building guidance.
- The process for implementing change following an investigation into an incident is reviewed to ensure that it occurs in a timely manner.
- The provision of controlled drugs in the resuscitation area in the A&E department is reviewed.
- The process for streaming patients in the A&E department is reviewed to ensure the decisions are being made by staff who have the knowledge and skill required to do so.

Summary of findings

- Seven-day services continue to develop, particularly for patients requiring emergency care.
- Patient information held by the ambulance service is securely stored at all times.
- There is a clear and current system in place to red flag addresses where there are concerns about safety for ambulance crews to use to make informed choices and manage risk when attending these locations.
- There is a review of the specialist medical care that is available for patients who have had a stroke.

Professor Sir Mike Richards

Chief Inspector of Hospitals

August 2014

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Rating

Good



Why have we given this rating?

The A&E department had been redesigned and was clean and welcoming with appropriate levels of well-maintained equipment. Medical and nursing care in the department was good and there were effective interventions to appropriately treat emergency patients. Patients and relatives reported positively about the service, treatment and care they had received.

The safety of the department was compromised by the level of nurse staffing, which did not always reflect the requirements of the patients seen there. Also, there were too few children's nurses. The island had limited numbers of registered staff at its disposal, and this had impacted on the department. There was a system of non-clinical streaming of patients by reception staff, but this had been changed so that initial assessment was done by nursing staff. This, however, was causing longer waiting times because of the pressures on nursing staff.

There was no clear pathway for the children attending the hospital. This meant that children being brought by ambulance to the hospital were not always allocated to the correct emergency area. This was potentially unsafe and we asked the trust to address this. In our unannounced inspection, we found that the trust had made changes, but these had not been agreed by the paediatric team and risks were still identified.

Medical leadership was strong and medical trainees felt well-supported. However, nursing staff told us they had raised concerns about staffing levels, but this had not been dealt with effectively by the trust. National guidance was used to inform treatment and specific care pathways and care bundles were followed. There was good multidisciplinary team working and provision of specialist knowledge. Seven-day working was developing. Staff were well supported with training and development. Staff were passionate and positive about their department, and were proud of some its recent

Summary of findings

initiatives in relation to sepsis management, internal training and team building. Governance arrangements monitored quality and risks, but concerns were not always acted upon by the trust.

Medical care

Requires improvement



Standards of cleanliness and hygiene on the wards we visited were good. Medicines were stored appropriately and there was a good system of electronic prescribing. Where patients had capacity to consent, consent was taken appropriately and correctly. However, patients assessed on admission as suffering from memory loss, confusion, or who were diagnosed with dementia, did not have mental capacity assessments.

National Institute for Health and Care Excellence (NICE) guidelines and other professional guidelines were identified for use where relevant, but were not always implemented or monitored to ensure compliance and patient outcomes varied. Staff were compassionate and caring, and had good access to training and worked effectively in multi-disciplinary teams but not all services were available across seven days.

The hospital was meeting national waiting time targets. However, we found that bed management was not well organised across the hospital, which meant that, although patients often felt well looked after, they were not always placed on the most appropriate ward for their needs. Medical and surgical patients were often mixed on both medical and surgical wards. Of particular concern, was the safety of the trust's acute stroke services. There was a mix of stroke, gastroenterology, respiratory, and surgical patients on the acute stroke ward. Many of these patients required treatment from doctors and nurses with knowledge of their specific types of conditions. Patients did not always receive the care they needed because there was an insufficient number of suitably trained medical and nursing staff to provide care for patients on this ward. There was no clear medical leadership on the ward and there were instances where the ward did not have any medical cover.

Lessons from complaints, incidents, audits and quality improvement projects were discussed at clinical governance meetings, but the lessons learned were not routinely cascaded to staff within

Summary of findings

the directorate or across the organisation. Risks were not always identified and flagged on risk registers at ward-level, or at divisional-level. Where concerns about the safety or quality of services were identified, they were not always adequately addressed.

Surgery

Good



Overall, surgical services were good. The use of the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist – was monitored and the way staff were completing this checklist was improving across all specialties, except ophthalmology, and actions were being taken to address this. Information about the quality of care was displayed on the wards. Staff provided compassionate care to patients. Patients and relatives told us nursing care was good. Patients who needed help in eating were provided with the necessary support. Patients who were seen by a GP in the A&E department were, if they required surgery, referred for appropriate clinical colleagues. Data from national audits and databases showed surgical outcomes were at, or close to, the national average. There was support available for patients living with dementia and patients with learning disabilities. The trust vision was well recognised by staff. However, concerns raised by clinical staff were not always heard, or acted upon, by the trust leadership team. The surgical services team had a 'can do' culture. There was a sense of energy and purpose in the divisional leadership team that they could improve the service and make a positive impact on the patient experience.

Critical care

Good



The service followed procedures that ensured patients received safe and effective care. Clinical outcomes were monitored and this showed good outcomes for patients. Patients and relatives expressed a high degree of satisfaction about the care they received. Care was provided in a caring, dignified and compassionate way. The departments were well led and demonstrated positive leadership and culture. A business plan had been submitted to the trust board and this included a review of ICU and CCU and a proposal to include dedicated high

Summary of findings

Maternity and family planning

Good



dependency beds in order to improve care. This would also improve the responsiveness for pre-planned admissions following surgery, and effective use of ICU beds.

Maternity services at St Mary's hospital and in the community were well planned and organised. Midwifery staffing levels were below national recommendations but staff were working flexibly to ensure there were adequate numbers. There was recruitment to improve medical staffing level. Safety standards were followed and the environment was clean and the service was fully equipped. Women's care and treatment followed national evidenced based guidelines and staff were appropriately trained and worked well in multi-disciplinary teams. Women told us they received compassionate and supportive and supportive care and had choices and were involved in decisions about their care. Governance arrangement and risk management were effective and there was a leadership culture that promoted learning and continuous improvement.

Services for children and young people

Good



Services for children and young people were good throughout. Most parents told us the staff were caring, and we saw that children and their parents and carers were treated with dignity, respect and compassion. Ward areas and equipment were clean. There were enough trained staff on duty to ensure that safe care could be delivered. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs. The services were responsive to the needs of children and young people and their families and carers. The ward managers communicated well with staff and staff were positive about the service and quality. Children's experiences were seen as the main priority. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements.

End of life care

Requires improvement



The specialist palliative care team had effective procedures to provide safe, effective and responsive services. However, end of life care was not consistent across the hospital ward areas and national guidance was not followed. Ward staff were not

Summary of findings

appropriately trained in end of life care and care was not always delivered appropriately. Patients were monitored to identify if their condition deteriorated, but staff were monitoring patients at a level that was not always required. There was a failure to recognise patients as being at the end of their life until they were in the final stages of the process. When it was recognised, a do not attempt cardio-pulmonary resuscitation (DNA CPR) order was not always used or the documentation was not appropriately completed, which put patients at risk of inappropriate care. Assessments of a patient's mental capacity to make decisions were not consistently completed or documented before decisions about the care that was in their best interests were made.

Staff were caring and compassionate, but this varied, particularly on busy wards and there was less time to respond to patient needs. Some patients receiving end of life care had moved wards several times while they were in hospital and patients, or their relatives, were not consistently involved or informed about resuscitation decisions. The leadership of the service had recently been strengthened by the trust, but the services required a clear strategy and staff identified the need for more resources. Arrangements to monitor the quality of the services were not developed.

Outpatients

Good



There were effective procedures to support a safe service for patients. Staff were caring and treated patients with dignity and respect. Patients were seen within national waiting times and told us they were happy with the care they had received while attending their appointments within the outpatient department.

Most of the patients we spoke with felt they were seen promptly and were kept informed if clinics were running late. Each clinic had a board that displayed the length of time patients might expect to wait to be seen. The service was undertaking a review to improve its efficiency and responsiveness to the needs of the local population. The leadership of the service was good and there were examples of innovative practice to support people and improve treatment and diagnosis on the island.

Summary of findings

Ambulance services

Good



The ambulance service had a very low occurrence of untoward incidents and clear ownership of risk. The ambulance station and vehicles were clean, and equipment was well stocked and maintained.

Medicines management was not appropriate, as there was poor stock control and storage arrangements for medicines although this had improved during our inspection process. Staff were well trained and supported by some examples of innovative practice. Planning for major incidents was fully in place in conjunction with partner organisations.

The service used evidence-based guidelines for treatment and was innovative in developments to support best practice. The early intervention in sepsis trial was an example of innovations and initiatives, which were used to support evidence-based care and treatment. The Individual Learning Plan was used to support the development of staff competency. The Hub, which coordinated access to care for the Island, was a good example of multidisciplinary working.

Patient satisfaction comments were consistently positive in surveys. Patients were treated with compassion, dignity and respect by ambulance staff. Ambulance crews listened carefully to patients and involved and supported them in understanding their care and treatment. Staff provided emotional support for patients and their relatives throughout their contact with the service.

The ambulance service had clear operational and clinical leadership. Ambulance staff told us that the level of integration of the ambulance service and being part of the trust allowed them to respond quickly for the benefit of patients. The ambulance service monitored the operation of the service against key performance indicators and consistently met its response time standards.

St Mary's Hospital

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients; Ambulance services

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Background to St Mary's Hospital

St Mary's Hospital in Newport is the trust's main base for delivering acute services for the island's population. The hospital has 246 beds and there are 22,685 admissions each year. Services include A&E, the Beacon Centre (providing walk-in access to GP services), emergency medicine and surgery, planned surgery, intensive care, comprehensive maternity, neonatal intensive care unit and services for children and young people. They also provide a number of planned care services, where admission is not required, including chemotherapy and orthopaedic provision.

The Isle of Wight ambulance service is located at St Mary's Hospital. The service provides a range of ambulance services to residents and visitors, including emergency ambulance response, an NHS 111 service and patient and non-patient transport services. The trust reported that the number of ambulance calls presented to the switchboard in 2013-14 was 23,071. During the year,

around 8% of emergency calls were resolved by telephone advice and of those incidents attended, around 46% were managed without the need for transport to A&E.

St Mary's Hospital has been inspected twice since registration, in March 2012 and January 2013 and on the most recent inspection was found to be compliant for all outcomes inspected.

We carried out this comprehensive inspection because Isle of Wight NHS Trust is an aspirant foundation trust, prioritised by Monitor. Care Quality Commission's latest intelligent monitoring tool identified the trust in band 5 (band 1 being highest priority for inspection, band 6 being lowest priority).

We inspected A&E, medical care (including older people's care), surgery, critical care, maternity and family planning, services for children and young people, end of life care, outpatients and the ambulance service.

Our inspection team

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

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team of 41 included CQC inspectors and a variety of specialists: a midwife, an obstetrician, an emergency

department consultant, an anaesthetist, a crucial care nurse, a consultant surgeon, a theatre coordinator, a junior doctor, a student nurse, a physiotherapist, two medical consultants, a paediatrician, a nurse qualified in the care of sick children, the head of clinical quality, a critical care nurse, a general nurse, a medical director, an emergency department nurse, an expert by experience, a paramedic and an ambulance service director.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

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

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

Detailed findings

Emergency Medicine, Royal College of Anaesthetists, NHS Litigation Authority, Parliamentary and Health Service Ombudsman, Royal College of Radiologists and the local Healthwatch.

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

We carried out an announced inspection visit from 4 to 6 June 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pathology department staff, pharmacy technicians, pharmacists and ambulance crews. We spoke with the local authority, the coastguard and the fire service.

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

We carried out unannounced inspections from 4pm to 11pm on Saturday 21 June 2014. We looked at how the hospital ran at weekend, the levels and type of staff available, and how they cared for patients.

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

Facts and data about St Mary's Hospital

Isle of Wight NHS Trust: Key facts and figures

Isle of Wight NHS provides an integrated acute, community, mental health and ambulance healthcare provider to the population of the Isle of Wight. It was established in April 2012 following the separation of the provider and commissioner functions within the Isle of Wight. The health services provided by the trust include:

- **Acute Care Services.** Included A&E, the Beacon Centre (providing walk-in access to GP services), emergency medicine and surgery, planned surgery, intensive care, comprehensive maternity, NICU and paediatric services. A number of planned care services, including chemotherapy and orthopaedics, are also delivered.
- **Ambulance Service.** The island's ambulance service delivers all emergency and non-emergency ambulance transport for the island's population. The service operates from a single base across the island. The service is also responsible for transporting patients to mainland hospitals.

1. Context

- The hospital had around 246 beds.
- The island population is around 138,265 of which 20% is urban, 80% rural.

- Deprivation is lower than average, but varies (126 out of 326 local authorities). About 4,900 children live in poverty.
- The proportion of people aged over 50 years is greater than that of England and the proportion of people between 0–49 is less than that of England.
- Life expectancy for men is not significantly different from the England average, but is significantly better for women.
- The number of staff was 3,038.
- The annual turnover (total income) for the trust was £169 million in 2012/2013).
- The trust surplus (deficit) was £509,000 for 2012/2013.

2. Activity

- Inpatient admissions: 26,899 (2012–13)
- Outpatient attendances: 135,688 (2012–13)
- A&E attendances: 47,183 (2012–13)
- Births: 1,415 (October 2012 – November 2013)
- Deaths in St Mary's Hospital: 672 (December 2012 – November 2013)

3. Bed occupancy

- General and acute: 79.4% (October–December 2013). This was below both the England average of 87.5%, and

Detailed findings

the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital

- Maternity was at 19.9% bed occupancy – lower than England average of 58.6%.
- Adult critical care was at 77.8% bed occupancy – lower than England average of 85.7%.
- Neonatal Intensive Care Unit was at 0.0% – lower than England average of 71.0%.

4. Intelligent Monitoring

Acute Safe

- Risk: 0
- Elevated: 1 (domain risk is 2)
- **Domain score: 2**

Effective

- Risk: 1
- Elevated: 0
- **Domain score: 1**

Caring

- Risk: 1
- Elevated: 0
- **Domain score: 1**

Responsive

- Risk: 0
- Elevated: 0
- **Domain score: 0**

Well led

- Risk: 1
- Elevated: 0
- **Domain score: 1**

Total

- Risk: 3
- Elevated: 2
- **Domain score: 5**

Individual risks/elevated risks:

- Elevated risk: Proportion of patients risk assessed for venous thromboembolism
- Risk: Dermatological conditions
- Risk: CQC survey – pain control in hospital

- Risk: MC National Training Survey – Trainees overall satisfaction

5. Safe

'Never events' in past year: 1 (January 2013 to March 2014). No evidence of risk

Serious incidents (STEIS): 78 (April 2013 to March 2014) - 39 Acute; 29 Community; 10 Mental Health Services: 56% of these were for pressure ulcers.

National reporting and learning system (NRLS) March 2013-February 2014; No evidence of risk.

Death

- Acute: 11
- **Total: 18**

Severe Harm

- Acute: 48
- **Total: 80**

Moderate Harm

- Acute: 83
- **Total: 120**

Total

- Acute: 102
- **Total: 218**

Safety thermometer (March 2013 – February 2014)

- Pressure ulcers – lower than England average
- VTE – Lower than England average
- Catheter UTIs – Lower than England average
- Falls – Lower than England average

Infection control (April 2013 – March 2014)

- 6 cases of Clostridium Difficile – No evidence of risk
- 3 cases of MRSA – No evidence of risk

6. Effective

- Hospital Standardised Mortality Ratio (HSMR): No evidence of risk (Intelligent Monitoring)
- Summary Hospital-level Mortality Indicator (SHMI): No evidence of risk (Intelligent Monitoring)
- Mortality Outlier: Composite indicator: In-hospital mortality – Dermatological conditions

Detailed findings

7. Caring

- CQC inpatient survey (10 areas): Within expected range all areas.
- FFT inpatient (March 2014): Below the England average
- FFT A&E (March 2014): Above the England average
- Cancer patient experience survey (68 questions)
Highest scoring 20% of Trusts for 19 questions; average for 28 questions; and lowest scoring 20% of trusts for 21 questions

8. Responsive

- A&E 4 hour standard – Mostly Better than England average during the course of the year (2013/14).
- Emergency admissions waiting 4–12 hours in A&E from decision to admit to admission: Worse than England average
- A&E left without being seen: below the average.
- Cancelled operations: Similar to expected
- Delayed discharges: Similar to expected
- 18 week RTT 95.6% (Better than the NHS operating standard of 90%)
- Ambulance response times (January 2014 – March 2014): Targets met.

No evidence of risk for indicators above.

9. Well led

- NHS Staff survey (28 questions) Better than expected (in top 20% of Trusts) for 4 questions; tending towards better for 5 questions; average for 5 questions; tending towards worse 5 questions; worse than expected (in bottom 20% of Trusts) for 9 questions;
- Sickness rate 3.7 %. Below 4.1 % which is the England average

No evidence of risk for indicators above.

- GMC National Training Scheme Survey (2013) The Trust was worse than expected in one or more section of the GMC survey for Endocrinology and diabetes mellitus; gastroenterology; General surgery; Obstetrics and gynaecology and Trauma and orthopaedic surgery. The Trust was better than expected for local teaching in acute internal medicine. Overall satisfaction – risk

10. CQC inspection history

- Four inspections had taken place at the trust since its registration in April 2012.
- St Mary's Hospital was inspected in March 2012 and January 2013. The trust was compliant on the most recent inspection.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Requires improvement	Inadequate	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Good	Good	Good
Ambulance services	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Accident and emergency

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The accident and emergency (A&E) department serves a population of approximately 138,250 people. The department treated approximately 37,000 patients during 2013/2014 and one third of these patients were admitted to hospital. On average, 90-120 people were treated each day, although this could rise to 150 during the summer (holiday) months. On average, approximately 17% of people seen in the department were children.

The department had a Minors area with eight cubicles, which included one for eye patients and a plastering room. The Majors area had ten monitored cubicles. There were also two cubicles designed to be used as a clinical decision unit (CDU), which provided closed door single-sex accommodation for overnight stays. This was a new area, following recent refurbishment. Though this area was not fully operational and was being used as host GP admissions/assessment pilot. There were three beds within the resuscitation area, one of which could be used for children or adults. There was a dedicated waiting area with chairs, and a small children's waiting area. There was one cubicle designated for children. Children could access the department as 'walk in' patients or via the ambulance service. In these cases, trauma patients were admitted through A&E and medical care direct to the children's ward. There was a helipad with close access to the A&E department.

We spoke with 12 patients, eight relatives, and 19 members of staff of different disciplines. We observed daily practice, reviewed paper and electronic records and documentation and reviewed information provided prior to our inspection.

Accident and emergency

Summary of findings

The A&E department had been redesigned and was clean and welcoming, with appropriate levels of well-maintained equipment. Medical and nursing care in the department was good and there were effective interventions to appropriately treat emergency patients. Patients and relatives reported positively about the service, treatment and care they had received.

The safety of the department was compromised by the level of nurse staffing, which did not always reflect the requirements of the patients seen there, and there were too few children's nurses. The island had limited numbers of registered staff at its disposal, and this had impacted the department.

There was a system of non-clinical streaming of patients by reception staff but this had been changed so that initial assessment was done by nursing staff. This, however, was causing longer waiting times because of the pressures on nursing staff.

There was no clear pathway for the children attending the hospital. This meant that children being brought by ambulance to the hospital were not always allocated to the correct emergency area. This was potentially unsafe and we asked the trust to address this. In our unannounced inspection, we found that the trust had made changes, but these had not been agreed by the paediatric team and risks were still identified.

Medical leadership was strong and medical trainees felt well supported. However, nursing staff told us they had raised concerns about staffing levels, but this had not been dealt with effectively by the trust. National guidance was used to inform treatment and specific care pathways and care bundles were followed. There was good multidisciplinary team working and provision of specialist knowledge. Seven day working was developing. Staff were well supported with training and development.

Staff were passionate and positive about their department, and were proud of some its recent initiatives in relation to sepsis management, internal training and team building. Governance arrangements monitored quality and risks, but concerns were not always acted upon by the trust.

Are accident and emergency services safe?

Requires improvement



There were procedures in the department to ensure safe care for patients. Safety standards, for example, for infection control, equipment and medicines management were being met, although access to controlled drugs in the resuscitation area needed to improve. The children's waiting area was too small and therefore children and adults shared a waiting area.

Patients who were acutely ill were assessed and treated appropriately, but safety was compromised because of the three high risk issues: The department used a system of non-clinical streaming to enable access to the department. This meant that the reception staff were making judgements about people's emergency health requirements, based on a list of health complaints. This was potentially unsafe practice, and we asked the department to review this practice. In our unannounced inspection, we found that nursing staff were undertaking the initial assessment of patients but patients were waiting a long time to be seen.

The level of nurse staffing did not always reflect the requirements of the patients seen there, particularly in the resuscitation area of the department. There were also too few children's nurses and this did not reflect the needs of the department.

There was not a clear pathway for the children attending the hospital. This meant that children being brought by ambulance to the hospital were not always allocated to the correct emergency area. This was potentially unsafe and we asked the trust to address this. In our unannounced inspection, we found that the trust had made changes, but these had not been agreed by the paediatric team and risks were still identified.

Incidents

- 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There had been no recent Never

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Events in the A&E department, and the number of incidents reported from the department were in line with expectations for the size of the department and the trust.

- Incident reporting was managed in line with the trust policy. Staff were encouraged to report fully, appropriately and in a timely manner. Feedback was provided to the staff and to the senior sister and matron. Where learning could take place, incidents were made anonymous and the actions taken included in staff meetings and in staff information sheets. Any themes emerging were also discussed in staff meetings. An example given was that all pressure ulcers noted in the department had digital photography, which was attached to the incident form as a clear record of the ulcer, so that it could be compared when reviewed again therefore providing an audit trail.
- Staff reported feeling confident in incident reporting, and in the feedback they received.

Cleanliness, infection control and hygiene

- The department was clean and there was regular adherence to cleaning schedules. We observed equipment being cleaned after use, before the next patient entered the cubicle.
- Staff of all grades were seen to adhere to the trust policies of hand-washing and wearing clothing that was 'bare below the elbow' in clinical areas.
- Preadmission screening for MRSA was carried out in accordance with national guidelines. This was consistent and in line with the trust policy.
- Patients in isolation were treated in accordance with good principles of hygiene, and staff used personal protective equipment, such as gloves and aprons, appropriately.

Environment and Environment

- The environment on the unit was safe and well laid out for the patients and staff.
- Equipment was regularly cleaned, electrical tested and serviced, and there were adequate stocks of equipment.
- The department had two new high specification beds. These enabled a quick and comfortable transfer to and from the helicopter.
- Resuscitation equipment was checked and signed for daily and after each episode of use.

- There was child-appropriate equipment in the children's waiting area, children's cubicle, and in the resuscitation area. This specialised equipment was labelled by age and size to ensure the correct equipment was used in an emergency.
- In addition to the resuscitation bay equipped for children, there was only one cubicle dedicated for children. This meant that children would be seen in areas of the department where they would not be separated from adults.
- While there was a children's waiting area, it was small and could only comfortably accommodate one family. This meant that children were waiting in the same area as adults.
- During our unannounced visit on 21 June 2014, we identified that the paediatric resuscitator for neonates was now available in ED and there were plans to have a fold down equipment for warming babies. There were plans to move the paediatric resuscitation bed from the middle of three beds to the corner as a solid wall was needed for new equipment.

Medicines

- Medicines were stored correctly in locked cupboards or fridges, as necessary. Fridge temperatures were monitored and were within recognised normal temperature ranges.
- Controlled drugs were stored appropriately. However, this medication was stored in an area away from the resuscitation area. This meant that when controlled drugs were required for patients, staff had to leave the area. For this to be done safely, another nurse had to be called to look after the patients while the medications were checked. Nurses told us it could take "quite some time" before a nurse was available and this impacted on the number of staff in the department. Controlled drugs were thus reported as "not always being able to be given as soon as they were prescribed".
- The trust had put in place a small stock of non-controlled medications within the Resuscitation area. Nurses described this as "helpful, but still gave no urgent access to controlled drugs".
- Medications were delivered in a format that suited the person, for example, liquid rather than tablets was given on request.

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Records

- Records were in both paper and electronic format. Electronic format documents had to be printed out for transfer to the ward, as not all areas were able to support the same IT system.
- All staff had access to current and comprehensive information on each patient. We saw that notes were detailed and written in a timely manner.
- Electronic records were password protected and an audit trail for all information input was available.
- Staff demonstrated compliance with their 'need to view' policies, and correctly logged out of their screens before leaving the area.
- Risk assessment documentation was used and most were completed. Nursing and medical notes were dated, timed and signed.
- We noted three instances where paper records were inappropriately displayed. These papers contained personal data, and had been displayed facing outwards in Observation Room 3 and CDU 1 and 2. This information was able to be read by passers-by. We alerted the medical and nursing staff to this and noted that it was then turned around, so that it was no longer visible.

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

- Patients were consented appropriately and correctly. Children and parents we spoke with told us they were well informed about potential procedures and the likely outcome. We heard verbal consent being obtained before care was delivered. Where children were over the age of 16, appropriate guidelines were used to ensure they could give their own consent. Where children were under the age of 16, consent was sought from the parent or nominated adult where a child was too young to have capacity to give consent.
- Training records and conversations with staff noted that all clinical staff had attended Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. All staff we spoke with demonstrated clear understanding of the Mental Capacity Act 2005, the Deprivation of Liberty Safeguards and of their responsibilities. We did not see any patients who did not have capacity to consent during our inspection, so we were unable to comment on appropriate provision for this.

Safeguarding

- The department had systems in place to safeguard vulnerable adults. Staff were fully aware of their responsibilities and used safeguarding pathways in the department.
- Vulnerable adults were identified by staff who had undergone safeguarding training. Where concerns were identified, staff were aware of the correct escalation process, and provided examples of where this procedure had taken place. A copy of the escalation process was held within the department.
- Social services staff were described by medical and nursing staff as having "excellent relationships" within the department.
- Information provided by the trust indicated the 68% were up to date with their adult safeguarding training, 86 were up to date with children's safeguarding level 1 and 82% with level 2 and only 10% were up to date with safeguarding level 3.

Mandatory training

- Staff mandatory training records were displayed in the department. Records confirmed that 92% of staff were up to date with their mandatory training.
- The department had instigated an initiative where staff were split into two groups and each spent a full week undergoing mandatory training together, while the other group covered the departmental staffing for that week. This had the added benefit of delivering close working relationships with people training together.
- Specialist training such as adult and child life support courses had been undertaken by registered staff. Care support staff also undertook adult intermediate life support training.

Assessing and responding to patient risk

- The unit used the modified early warning score (MEWS) system for adults. This provided a consistent and appropriate approach to monitoring patients, using frequent observations and assessing the need for specific interventions when scores changed.
- Clear directions for escalation were used when patients scored more highly than expected. Staff we spoke with were aware of the actions to be taken and had escalated appropriately in the notes we checked. Repeat observations or other necessary interventions had taken place in the correct time frames.
- Patients who would normally score highly on the national early warning score system had 'personalised'

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scores set to demonstrate their escalation. This was evidence of good practice, as it meant that people would require treatment and intervention at a level specific to them.

- The Sepsis Six bundle was available and used by staff, and this ensured that appropriate screening was in place. Urgent antibiotics were given promptly, within 30 minutes.

Nursing staffing

- Nurse staffing levels had been assessed using the national Safer Nursing Care Tool. The daily staffing numbers were displayed on a board in the department, alongside the stated required establishment numbers. This included the skills mix on the shift, for example, the number of registered staff to non registered staff on duty. There were five registered to one non-registered staff on a day shift and four registered with one non-registered staff on at night. With one registered twilight shift from 2pm to 2am.
- The nursing rosters for three months from March to May 2014 indicated that that only 16% (14 out of 83) of day shifts had had five registered nurses. There had only been two registered staff on 10 shifts, three on 24 shifts, four on 35 shifts and five of the agreed establishment on 14 shifts. For the night shift, there had only been 43% (36 out of 85 shifts) that had four qualified staff. There had been two qualified staff on six shifts, three on 43 shifts and four for the agreed establishment on 36 shifts.
- The trust provided further information for the period and indicated that out of 92 day shifts only one was not covered by five registered staff which was the required staffing levels. Out of 92 shifts 13 night shifts (12%) were not covered by four registered staff which was the required standard.
- There was minimal use of bank staff, due to a shortage of registered and skilled staff on the island. There were three regular bank staff that regularly worked in the department and other additional shifts were covered by the department's own staff. For the 92 day period mentioned above, 125 shifts were covered by these regular bank staff or the department's own staff doing extra hours. This indicated that many of the department's own staff were working longer hours to keep staffing to an appropriate level.
- The skills mix was, at times, inappropriate. Nurses told us there were insufficient non-registered staff, and that because of this, nurses struggled to look after the

number of Majors patients they had been allocated. They told us it took considerable time to undress and prepare some patients for tests, and that another non-registered member of staff was necessary to allow the registered nurses to provide a high standard of care in a timely manner. They said this was made worse on night duty when one nurse was allocated to the whole of the Majors area (10 beds), when the twilight shift nurse went home.

- Nurses said the resuscitation area “felt unsafe” with one nurse looking after up to three patients. This was exacerbated if the nurse had to leave the area to obtain controlled medications in a next door area.
- One nurse commented that the senior sister did not usually work clinically, even if the department was short of registered nurses. Another nurse said that the matron and the senior sister were often absent from the department at the same time and were therefore not able to be used as a resource within the department during busy periods. The trust submitted evidence following the inspection to note that the senior sister had a clinically supervisory role. She worked five days a week 8:30 – 4.30 pm and was not part of the rostered numbers. However, the senior sister had worked at least six rostered shifts when staffing was reduced.
- Two nursing staff said the lack of a departmental porter during the morning could impact on the timeliness of care given, as general hospital porters had to be requested to undertake patient transfers “and this could take up to half an hour”.
- Nursing staff told us that handovers from ambulance staff sometimes had to wait until a nurse became available, but noted that 80% of ambulance handovers take place within the 15 minute time frame.
- Nursing handovers took place at shift changeover times. All patients and their current management were discussed, including if a referral had taken place or was awaited.
- Staffing for the shift, allocation of specific areas and bed management also took place within this handover. This meant that the person in charge of the department was made fully aware of the arrangements in place and was therefore able to lead the shift in a safe manner.
- Information disseminated in the handovers when people were transferred included, medical and nursing management while in the department, further investigations ordered, planned future management and personal information, such as next of kin details.

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Medical staffing

- There were four full time whole time equivalent consultants employed in the department. They worked in the department between 8am to 8pm Monday to Friday. Staff informed us the consultant visibility was consistently high.
- Weekend consultant presence was limited from 8am to 11am, although they stayed later, if clinically necessary. Consultants were then contactable by phone, if required, over the weekend. They always attended trauma calls.
- The consultant in charge told us they were hoping to recruit another consultant to the department with an interest in elderly care.
- There was no robust process for consultant sign-off of certain conditions, as required by clinical quality indicators (CQIs).
- There were eight middle-grade doctors and one long-term locum. The department was covered by middle-grade doctors 24 hours a day, seven days a week.
- The junior doctor rota had one vacancy covered by internal locum. The junior staff covered shifts in the department throughout the 24-hour period.
- Medical handover took place twice a day and was led by the senior doctor in the unit. This was of good quality and was informative, with informal training.

Initial assessment of patients

- Walk-in patients were initially assessed by non-clinical receptionists who streamed them either to the GP service or to the A&E department. This was undertaken by using a list of clinical illnesses/presentation symptoms, such as backache or indigestion. This practice was potentially unsafe as there was no distinction between age or underlying illnesses. The trust took immediate action and the process was changed to have a nurse at reception to do the initial assessment.
- When our unannounced inspection took place, we found that the reception would ask the patients if they wanted to see the GP or the A&E staff. If they wanted to see the A&E staff, they then waited to be triaged by a member of the nursing staff. We observed four patients, including one child, who were screened by nursing staff

for triage. Patients were waiting over an hour to be seen. One patient was crying out in pain in the waiting room, but triage staff were seeing patients in the order they came into the department.

- All patients with chest pain were transferred to the Majors area immediately to have serial electrocardiogram (ECG) heart tests and for the assessment of these. This was good practice, as clarification of diagnosis was more immediate and appropriate emergency treatment could be started without delay, where necessary.

Children in the A&E department

- There were only two registered children's nurses in the departmental staff. Nurses told us that even when a children's nurse was on duty, they may not always be allocated to look after a child coming into the department, as they may already have a full case load allocated at the beginning of the shift. Therefore, a child may not be cared for by the person with the specialist skill and knowledge.
- Every child attending the department was checked to see if they had a child protection plan in place. If there was one in place, this triggered a referral to the appropriate Specialist Registrar.
- Any concerns regarding the welfare of an attending child were discussed with the departmental staff and their paediatric staff equivalents. Where specific or significant concerns were noted, this triggered the input by a children's consultant for review.
- Child ward transfer handover information referred specifically to the input of social services and that they had been alerted to the child's admission.
- Staff were aware of their responsibilities. However, information provided by the trust indicated 86% of staff were up to date with children's safeguarding level 1, 82% with level 2 but only 60% that required level 3 children's safeguarding training were up to date.
- A paediatric early warning score (PEWS) was used to ensure the early detection of a deteriorating child. This provided a consistent and appropriate approach to monitoring a child, using frequent observations and assessing the need for specific interventions when scores changed.
- There was an inconsistency within the children and young person's pathway. There was more than one clinical area children could be admitted to in the hospital in an emergency, either through the A&E

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department for trauma patients, the children's ward for medical patients, or the neonatal unit. Ambulance crews had had to call while in transit for confirmation on where to take the child. This had the potential to be unsafe and to impact on outcomes for the acutely sick child. The ambulance service informed us that, on one occasion, they had been redirected three times and the A&E consultants told us that there had been times when the children's ward had not been able to take children so they had been directed to A&E. There had been a serious incident, because of these issues, which were still being investigated, and the trust had requested an external review of services.

- This had been identified by the trust as an issue during the investigation of an incident when it was discovered that this process was not in line with the Four Local Safeguarding Children's Boards policy about admitting a child at risk of death to A&E. In practice, this meant that all blue light ambulances carrying a child should go to the A&E department.
- At an unannounced inspection, which was part of this review, the trust had taken action and all ambulances transporting children subsequently went to the A&E department and medical and nursing staff from the children's service were called to attend. This practice had already been in place for trauma patients. Feedback from the medical staff from the children's service was that the final decision to implement the change in service delivery had occurred without final discussion with the paediatric team. Therefore, they felt that there had been no consideration taken of any impact the new pathway would have for the rest of the children's service. The change had put an extra strain on the children's ward, particularly at night and was a risk for patients who were frequent attenders to the children's ward who had until now been given direct access to the wards. There had been an incident, one weekend, where a child who had a condition that caused regular, prolonged seizures was admitted via ambulance to A&E. The mother was extremely unhappy that her child had to be admitted into A&E, rather than directly to the children's ward where the child would have received instant treatment. When the paediatric team were called, they found that the patient had not had any input from staff in the A&E department.
- The resuscitation space in the A&E, for children, was in a central bay. The resuscitation space in the A&E for children was in a central bay. During the unannounced

inspection, the consultant in A&E told us this bed space was being moved as they needed a solid wall for some equipment. A resuscitaire was available as part of the new arrangement for paediatric admission via A&E. They were waiting for a child to be retrieved to Southampton and waiting for ferry which had to be booked. However this child was receiving all appropriate care while awaiting transfer. An adult was occupying the paediatric bed space and the area may not be ready for a paediatric emergency.

Security

- Security was provided by staff employed in a flexible capacity by the trust. This meant that they covered more than one area and were called to the department, as required. The car parking attendant was called to the department as security when required.
- If the situation required additional support, the police were called to attend the department.

Major incident awareness and training

- All clinical departmental staff had annual training in major incident planning.
- Trust-wide plans were reviewed and updated by senior departmental staff and their colleagues in other departments in the hospital.
- Staff were clear about helicopter transfer procedures and how this may be affected by adverse weather, as the helicopter was used to transfer patients to and from the mainland during 'severe weather'. Plans were in place for when this transport was not able to be safely used. All staff we spoke with were aware of the 'severe weather' transfer plans.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate



We are not currently confident, overall, that it is possible to collect enough evidence to give a rating for effectiveness of A&E departments.

National guidance was used to inform treatment and specific care pathways and care bundles were followed.

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There was good multidisciplinary team working and provision of specialist knowledge. Seven day working was developing. Staff were well supported with training and development.

Evidence-based care and treatment

- The department used National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to ensure the treatment they provided was correct.
- A clinical handbook had recently been updated for in-house staff by the lead consultant in the department, to ensure a consistent approach to current treatment. The consultant also provided expertise and advice to staff.
- There were specific pathways for certain conditions. These included the onset of stroke, sepsis and acute coronary syndrome (ACS). These were regularly audited by senior staff to ensure compliance.
- Integrated care pathways for those patients who had suffered a stroke were in place and this information was handed over to the receiving ward. The pathways were linked to the relevant NICE guidelines.
- The department used a new resource for the Sepsis Six pathway. This pathway was designed to save lives by taking six clear steps for all patients presenting with signs of sepsis. All staff in the department had access to up-to-date information, via a resource board and departmental teaching and updates.
- Junior medical staff were encouraged to partake in national clinical audits.
- All clinical audit activity was reviewed and action plans had been amended, as a direct result of audit results.

Pain relief

- Pain relief was usually given within a 30 minute time frame, although we saw two notes indicating high pain scores where pain relief had not been given within this time frame.
- Patients we spoke with confirmed that nursing staff had returned after the administration of pain relief to check on its effectiveness.
- In the national pain in children audit, the trust scored below the national mean for the promptness of the giving of pain relief. The trust scored better than the mean for assessment of pain and pain relief given in line with national guidance.

Nutrition and hydration

- All patients who were allowed to drink had water jugs and clean glasses within reach.
- Nursing staff kept accurate fluid charts recording the fluids taken by the patient.
- The department did not routinely have meals delivered from the hospital kitchen, but these were provided for those who had a medical need or had been delayed within the department.
- There was a small servery kitchen in the department. Staff made small snacks of tea and toast if the patient required it during their short stay in the department.
- Patient relatives were encouraged to bring food in for their relatives to eat, if it was allowed to be eaten or drunk.
- Hot and cold drinks were available from vending machines in the waiting room.

Patient outcomes

- The unit contributed to some CEM audit activity, including sepsis, stroke and fractured neck of femur. Data from February 2014, which was provided by the trust, showed that 100% of patients with suspected stroke were admitted directly to an acute stroke unit within four hours of arriving at the hospital.
- We observed the stroke pathway in action with one patient. The pathway was followed as per the official guidelines and the patient was seen by medical staff in resuscitation within five minutes.
- There was a clear pathway for stroke patients admitted to A&E which was followed. Those who met the criteria for thrombolysis (clot busting), treatment was initiated in A&E and patients were admitted to the coronary care unit for close monitoring and management.
- Unplanned reattendances were recently slightly above the planned target of 5% set by the College of Emergency Medicine (CEM), although these rates remained consistently lower than the England average between February 2013 and January 2014.
- The trust performed better than the national average for ensuring that a patient displaying signs of myocardial infarct (heart attack) was seen by a cardiologist (heart doctor) or a member of that team.
- The department had participated in the College of Emergency Medicine Severe Sepsis and Septic Shock 2011 to 2012 audit and was below the national average in all areas. We did not find any evidence of re-audit to determine current levels.

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- The department contributed to the Trauma Audit and Research Network (TARN).

Competent staff

- Nursing and medical staff told us they felt supported by their managers, and had received regular clinical supervision and appraisals.
- There was a new clinical supervision booklet in which reflections on work practice were made and were able to be used at supervision meetings. This was an example of good practice recently implemented.
- The department had tried to respond to the national shortage of paediatric nurses and island shortage of registered general nurses. They had advertised and interviewed staff, although they were still under their preferred staffing numbers. They had ameliorated this by 'upskilling' the care support workers in the department. This was seen as a valuable resource within the department.
- An advanced nurse practitioner and emergency nurse practitioners supported other nursing staff to develop specific skills and review practice.
- The trust score was as expected for the General Medical Council national training scheme survey 2013 for trauma and orthopaedics except for adequate experience, in which they scored worse than expected. Emergency medicine was not included in the survey.

Multidisciplinary working

- Strong multidisciplinary teamwork was in place. Pharmacy staff regularly attended the department, and the physiotherapy, occupational therapy and social services staff were well-regarded by the department staff.
- Where necessary, multidisciplinary staff were requested to visit the department in order to provide specialist knowledge for admission or discharge.
- Out-of-hours specialist provision of physiotherapy was available.
- Provision of a pain specialist nurse and a palliative care team were available on request, although this was only within normal working hours.
- Children's specialist provision was available at all times in that medical staff would attend the department to see a child if requested to do so and a member of the medical staff and a nurse from the children's service would attend in an emergency.

- There was a strongly positive team working culture between the medical care unit and the A&E unit. This was encouraged by senior nursing and medical staff, as they felt this demonstrably contributed to the delivery of good patient pathways and excellent communications.

Seven-day services

- Consultants worked limited hours over the weekend. They worked an on-call rota of one in four. They attended the department on Saturday and Sunday from 8am to 11am, and then were on-call from home for telephone advice. They attended all trauma calls.
- During the unannounced inspection the consultant was on site and worked from 9am to 4pm. They were on call and attended the department as required and also provided telephone advice. Following the emergency admission of the child, the consultant was in attendance and remained in A&E waiting for the child to be transferred to support the staff.
- Specialist head scanning services were available at all times. This meant that people requiring urgent diagnosis of a head injury or illness had access to the appropriate tests.
- Pharmacy provided a seven-day service, with an on-call system in place for out-of-hours services.
- Radiology reporting was not a 24-hour service. However, there was 24 hour access to Radiology reporting for CT images out of hours through a contract with private providers. Out of hours services were provided through an call service.
- Pathology services were provided seven days a week with an on-call system in place out of hours.

Are accident and emergency services caring?

Good



Accident and emergency services provided a caring service. This was clearly evidenced by the interactions observed between staff, patients and relatives. Handovers to admission wards provided appropriate information, delivered with compassion and expertise.

Compassionate care

- The trust's score for the A&E NHS Friends and Family Test was above the England average between December 2013 and March 2014.

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- In the Care Quality Commission (CQC) inpatient survey 2013, the trust score was similar to other trusts for being given enough information on their condition and treatment in A&E and for being given enough privacy when being examined or treated in A&E.
- During our inspection, we noted patients and relatives being treated with dignity, respect and compassion.
- All patients were cared for in privacy, with doors closed and screens fully drawn.
- Patients were asked how they would like to be addressed and that term was noted and then used.
- Patients were offered help with undressing. Any patient wearing a gown had it fastened fully to prevent loss of dignity.
- Patients were informed appropriately before any test or investigation was undertaken.
- Consent was actively requested for procedures such as ECG recordings, where clothing needed to be removed.
- Time was taken to ensure the patient and relatives experienced good care. This was strongly evident, even where the staff were busy.

Patient understanding and involvement

- Patients and relatives were involved in the planning of their care and treatment. They told us they had been consulted “at all points”.
- Patients’ understanding of procedures and information given was comprehensively and regularly checked by staff. This was particularly evident in the resuscitation area.
- We observed staff ensuring a patient’s point of view was requested and noted.

Emotional support

- We observed staff providing emotional support to patients and to relatives.
- We observed a handover from A&E staff to the children’s ward and noted the sensitivity and compassion displayed by the nurse to distressed relatives.

Are accident and emergency services responsive to people’s needs? (for example, to feedback?)

Good



A&E services were redesigned to increase capacity.

Overall patients were seen and assessed within national waiting time targets but emergency patients could experience long waiting times for admission. Some services were not always organised in a responsive way and there were delays for some patients. Some patients had waited for over an hour to be seen for initial assessment. While the admission pathway for children in an emergency was amended during the inspection period, there was no evidence the trust had considered the potential impact on quality and safety on other areas of the children’s services and the impact the changes may have on outcomes for some children. The department provided specific support to people with mental health conditions and people living with dementia. Translation services were available and information leaflets were printed in various languages. A new helipad was in use for the urgent transfer of patients in and out of the hospital. This also enabled swift transfers to and from the mainland. Complaints were handled in accordance with trust policy and guidelines.

Service planning and delivery to meet the needs of local people

- A new helipad was in use for the urgent transfer of patients in and out of the hospital. This also enabled swift transfers to and from the mainland.
- The A&E department included the Beacon Centre, which was run by GPs for non-urgent admissions. There was effective joint working and conversations took place between GP staff and A&E medical staff regarding the pathway some patients would take and patients’ treatment plans. Admission avoidance measures were in place and included a pilot system to assess all acute GP referrals.
- The A&E department had been refurbished and the layout redesigned. This had enabled an increase in major beds to 10, which now had a solid divide for greater privacy for patients. The number of beds in the resuscitation area had been increased from two to

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three. One resuscitation bed was available for children. Two rooms had been identified as rooms to be used for observation similar to a clinical decision unit and one room had been identified as a room where children were to be seen. The lead consultant informed us that there were hopes of another phase to build a dedicated children's area in the dormant quadrangle, but there was no confirmation that this would happen.

- There was more than one clinical area children could be admitted to in the hospital in an emergency either through the A&E department for trauma patients, the children's ward for medical patients or the neonatal unit. Following our announced inspection, this had been identified as a risk because ambulance crews were uncertain of where to take children for treatment. The trust had taken action for all ambulance transporting children to attend the A&E department and medical and nursing staff from the children's service were called to attend. The trust however, had not clarified the arrangements for children who had previously had direct access to the children's ward and this was required to prevent treatment delays.

Access and flow

- Ambulance waiting times were usually within normal parameters, and ambulance staff reported that nursing staff were usually able to take handover with 10 minutes of arrival.
- Overall, during April 2013 and March 2014, the trust achieved the four-hour waiting time target from arrival to admission, transfer or discharge and was above the England average in this respect.
- From April 2013 to March 2014, the trust performed worse than the England average for the percentage of emergency admission via A&E waiting four to 12 hours from decision to admit to being admitted. The trust was lower than the England average in only five out of the 12 months in the year. March 2014 saw a spike of 25% of emergency admissions having to wait four to 12 hours from the decision to admit until being admitted. This was said to be due to bed capacity issues in the hospital, as some wards were under reconfiguration and bed numbers were reduced.
- The unplanned reattendance rate within seven days at A&E was consistently higher than the England average (7%) between February 2013 and January 2014, at approximately 10%.

- The percentage of patients who leave A&E without being seen was between 1% and 2%, which was better than the England average at around 3%. The figure was slightly higher (at around the England average) during the summer holiday months.
- On day one of the inspection, five patients stayed over four hours in the department. This occurred for non-clinical reasons (due to the lack of beds). On days two and three, there were no reported breaches. We observed good flow through the department, despite bed pressures in the hospital.
- Screening and assessment procedures had changed during our inspection. At our unannounced inspection, the department was very busy and there were patients waiting over an hour to be seen for initial assessment. One child had waited for 25 minutes to be assessed and triaged by a nurse.

Meeting people's individual needs

- Translation services were said to be "adequate" by staff, and available either in person, on request, or via a dial in telephone service. Leaflets about common conditions were held in a variety of languages within the department.
- There was an efficient liaison service with a learning disability nurse. We read a comment from the parents of a patient with learning disability, where they positively described the care, time and understanding shown to their relative and themselves on a recent departmental admission.
- There was good liaison between the departmental staff and the community psychiatric nurses (CPNs). However, access to the CPNs was described as "intermittently challenging" due to delays in them attending to work with the patient. This delayed psychiatric assessments.
- There was a high level of dementia awareness amongst the staff we spoke with. Nursing staff described a mechanism where patients identified as living with dementia had "icons" put above the bed to alert visiting professionals that extra care and time may be required when requesting information from the patient. This was also said to be helpful if patients living with dementia displayed challenging behaviour.
- Multidisciplinary meetings were held prior to complex discharges. These often incorporated physiotherapists, occupational therapists, social workers and nursing staff. This ensured that people's needs were discussed by those people able to provide specialist input.

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Learning from complaints and concerns

- Complaints leaflets were available in the department. These described a first line response from the matron or senior sister. Where this was deemed insufficient by the complainant, the next step was for them to contact the patient experience officers based within the quality team. A contact number was given.
- Patients and relatives we spoke with felt confident in raising a concern or complaint if they needed to.
- There was a Patient Advice and Liaison Service (PALS) available within the hospital, and this was clearly signposted.
- Complaints were handled in line with trust policy, and within trust time frames. There were few complaints in the department. Where these had occurred, the matron had taken a clear and well-defined approach to their management.
- Where lessons could be learned, this was fed back to staff via newsletters and staff meetings. Actions taken were clearly documented for learning purposes.
- There were many cards and letters from patients and relatives, complimenting the staff on the service they had delivered.

Are accident and emergency services well-led?

Good



Staff we spoke with told us they were proud to work in the department. They described their workplace as a supportive and knowledgeable team, and this ensured high standards of patient care.

Medical staff told us they felt well supported by their consultant leads. Nursing staff told us that, while the senior nursing staff were pleasant and helpful, the staff did not always feel their concerns were adequately managed. They said they had expressed concerns around staffing issues, particularly in the resuscitation area, but that little had changed. The matron came from a non-A&E background, but was said to be supportive of the staff. Ongoing recruitment was continuing to nursing posts, but this had proven difficult to fill appropriately.

The governance processes in the department were well-developed and there was a culture of assurance about actions taken following audit and incidents. The

department did have a culture of innovation and learning, and this was evidenced by ongoing projects, such as Sepsis Six management and new clinical supervision strategy. Staff told us they were engaged with changes, and were usually kept abreast of changes in the department and the rest of the hospital.

Vision and strategy for this service

- The clinical lead had their strategic vision for maintaining this service, which was to further develop good relationships with the medical unit and safely embed the children's pathway into practice.
- Staff were mainly positive about the strategy for the service, but had reservations about "running low on nursing staff". Some medical staff expressed concern about the low level of paediatric nurses in the department. They said that "further change should not take place without appropriate staffing to maintain the service safely".

Governance, risk management and quality measurement

- The department held regular governance meetings, and led these, alongside the medical unit. The lead clinician told us that this resulted in excellent cooperative working between the two departments. This was a demonstrable opportunity to raise concerns, share good practice and keep up with the latest news from the medical unit.
- Senior staff were clear about quality initiatives and all clinical audits being undertaken in their unit and in the medical unit. This learning was cascaded down to the rest of the departmental staff in a timely and effective manner.
- Feedback from incidents was robust, clear and timely, with dates, action plans and learning attached.
- Risk of not achieving the four-hour target for A&E was on the acute directorates risk register, as were the staffing issues identified.

Leadership of service

- The matron, clinical services manager and clinical lead consultant worked closely together. This ensured shared knowledge, robust planning and a cohesive framework for strategic change.
- The medical lead was reported to be highly visible, highly supportive and engaged with medical and nursing staff.

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- The matron had been in post approximately 18 months and did not have A&E experience. Staff told us they found her approachable, but that continuing concerns raised about staffing had not resulted in the specific changes they had hoped for. The matron had previously interviewed staff for posts, but had been unable to fill these with appropriate staff. The nursing staff felt strongly that the lack of staffing in the resuscitation area, and the Majors cubicles overnight (when the trained twilight nurse had left at 2am) was sometimes inadequate to the needs of the presenting patients.

Culture within the service

- Staff were generally positive about their department and the service they provided for patients.
- Staff told us of the departmental team-building exercise that had recently been introduced by the senior sister. They told us it had been beneficial to “get to know” people they worked with.
- Staff confirmed that they felt supported and enabled to raise concerns with their matron and senior sister. They said their concerns were usually responded to in a timely manner, although staffing concerns were still outstanding.

Public and staff engagement







- The department engaged with the public via the NHS Friends and Family Test and this was above the England average.
- Sickness levels within the department were within national requirements. However, the department was small, and one person on long-term sick leave did make a significant difference to staffing levels in the department. Sickness was actively managed by senior nursing staff and with the HR department.

- At the time of our inspection, the trust had recently finished consulting with staff about a proposed merger of its acute and planned directorates.
- Although staff at unit-level felt they were part of a supportive team, they did not always feel there were sufficient opportunities for engagement with trust management. Some nursing staff described executive team members visiting the department, but “only talking with the navy blues”. This was a description of senior staff, and demonstrated that junior staff felt their opinions were not asked for, or listened to, by these visiting executive team members.
- Results from the NHS staff survey showed that staff at the trust were less likely to recommend the trust as a place to work or receive treatment, and reported lower levels of satisfaction with the quality of work and patient care that they were able to deliver.

Innovation, improvement and sustainability

- Staff were involved with innovation in the department. For example, the senior sister was working on a new project, implementing clinical supervision records for each member of nursing staff.
- Nursing staff told us of the work of one new member of staff who had introduced a comprehensive training package and noticeboard around Sepsis Six and this was supporting staff to work to the same standard.
- Staff reported that, while their training programme was excellent, the department would really benefit and become more sustainable in the long-term, if a care support worker was supported to start nurse training. This had apparently been previously requested, but turned down on financial grounds. However, several nursing and medical staff told us this was a “flawed decision and they were concerned the department may lose a highly skilled, highly valued, member of staff”.

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

Information about the service

The Isle of Wight NHS Trust is an integrated trust that provides inpatient medical services. The acute medical division at the trust had four permanent medical wards, although one of these was closed for refurbishment during our visit. The division also included a 23-bed medical assessment unit (MAU) and a number of medical beds on surgical wards.

We visited three of the hospital's medical admissions wards, including the medical assessment unit (MAU), acute stroke unit and the cardiac care unit. We also visited Colwell Ward, which is a dedicated medical ward as well as St Helen's Ward and Whippingham Ward, which are surgical wards where medical patients were treated. We also spoke with patients and staff in the trust's discharge lounge, where some people waited for transport to take them home.

We talked with 18 patients, two relatives, 37 members of staff, and three volunteers. These included all grades of nursing staff, healthcare assistants, domestic staff, consultants, doctors, junior doctors, pharmacists, Allied Healthcare professionals and management. We observed care and treatment and looked at nine sets of patient records, including medical notes, nursing notes, and drug charts. We received comments from people at our listening events and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Standards of cleanliness and hygiene on the wards we visited were good. Medicines were stored appropriately and there was a good system of electronic prescribing. Where patients had capacity to consent, consent was taken appropriately and correctly. However, patients assessed on admission as suffering from memory loss, confusion, or who were diagnosed as living with dementia, did not have mental capacity assessments.

National Institute for Health and Care Excellence (NICE) guidelines and other professional guidelines were identified for use where relevant, but were not always implemented or monitored to ensure compliance and patient outcomes varied. Staff were compassionate and caring, and had good access to training and worked effectively in multi-disciplinary teams but not all services were available across seven days.

The hospital was meeting national waiting time targets. However, we found that bed management was not well organised across the hospital, which meant that, although patients often felt well looked after, they were not always placed on the most appropriate ward for their needs. Medical and surgical patients were often mixed on both medical and surgical wards. Of particular concern, was the safety of the trust's acute stroke services. There was a mix of stroke, gastroenterology, respiratory, and surgical patients on the acute stroke ward. Many of these patients required treatment from doctors and nurses with knowledge of their specific types of conditions. Patients did not always receive the

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care they needed because there was an insufficient number of suitably trained medical and nursing staff to provide care for patients on this ward. There was no clear medical leadership on the ward and there were instances where the ward did not have any medical cover.

Lessons from complaints, incidents, audits and quality improvement projects were discussed at clinical governance meetings, but the lessons learned were not routinely cascaded to staff within the directorate or across the organisation. Risks were not always identified and flagged on risk registers at ward-level, or at divisional-level. Where concerns about the safety or quality of services were identified, they were not always adequately addressed.

Are medical care services safe?

Requires improvement



Overall, medical services had effective procedures to provide safe care but there were concerns about safety on the stroke unit. Across the division, there was an open and supportive incident reporting culture. The trust had a lower number of patients suffering from falls, pressure ulcers, new urinary tract infections (UTIs), and new venous thromboembolism (VTE) than the England average. Standards of cleanliness and hygiene on the wards we visited were good. Medicines were stored appropriately and there was a good system of electronic prescribing.

Patient records were well maintained on all wards except the acute stroke, although risk assessments were not always completed to for patient safety risks such as VTEs, falls, malnutrition and pressure sores unit. Where patients had capacity to consent, consent was taken appropriately and correctly. However, where patients did not have capacity to consent, formal 'best interest' decisions were not held in deciding the treatment and care patients required.

Staffing levels were adequate during the day, although there were concerns about medical staffing levels out of hours and at weekends. There were not suitable numbers of trained medical and nursing staff on the acute stroke unit. This was a particular concern, as there was a mix of stroke, gastroenterology, respiratory, and surgical patients on the acute stroke ward, all of whom required input from doctors with knowledge of their specific types of conditions. There was no clear medical leadership on the ward and there were instances where the ward did not have any medical cover.

Incidents

- 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There was one Never Event in the acute medical division that occurred in March 2014. This was a drug-related incident involving Methotrexate, which was given daily, instead of weekly. As a result of the investigation, a training programme was run on the wards and there was an electronic staff bulletin

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reminding staff about the safe use of methotrexate, compulsory training was provided for prescribers. Staff we spoke with were able to tell us what had changed, as a result of the Never Event.

- Between April 2013 and March 2014 the medical division reported 68 incidents to the National Reporting and Learning System (NRLS). All but three of these incidents resulted in moderate or severe harm and three resulted in death. Of these incidents, grade 3 and 4 pressure ulcers accounted for the highest number of incidents.
- Staff we spoke with stated they were encouraged to report incidents, but said they did not always receive feedback from investigation findings.
- Themes from incidents were discussed at ward meetings and staff were able to give us examples of where practice had changed as a result of incident reporting. Staff on MAU told us of an incident where a nurse failed to alert other ward staff that a patient's medical condition had deteriorated. The staff on the ward described revised monitoring procedures, which were put in place as a result in order to detect deteriorating patients earlier.
- When we looked at patient records and cross-checked them against the trust's incident management system, we found incidents were reported.
- There was good reporting of pressure ulcer incidents.
- Staff were open to learning from incidents and complaints and making changes as a result. They were able to give us examples of changes they had made as a result of incidents and complaints.
- Root cause investigation analyses were not always shared with staff. This was a particular concern regarding pressure ulcers. This meant staff across the organisation were not always able to learn from incidents in order to improve patient care.

Safety Thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, VTEs and falls.
- Safety Thermometer information was clearly displayed at the entrance to each ward. This included information about falls, new VTEs, and new pressure ulcers.
- All wards had information displayed about the quality of the service. This included information about infection control measures, results of the NHS Friends and Family Tests, numbers of complaints, levels of staff

absenteeism, mandatory training updates, numbers of patient falls, new pressure ulcers, new UTIs and new blood clots. Staff said that some of this information was relatively new and had been introduced a month prior to our inspection.

- The trust had a lower number of patients suffering from falls, pressure ulcers, new UTIs and new VTEs than the England average.

Cleanliness, infection control and hygiene

- Overall, standards of cleanliness and hygiene on the wards we visited were good.
- Staff told us they had infection control training and were supported by infection control champions.
- We saw staff regularly wash their hands and they wore gloves and aprons, when appropriate. The trust's 'bare below the elbow' policy was adhered to and audited.
- Hand sanitising gel was available at the entrance to every ward, along corridors, and at the bottom of each patient's bed.
- Hand hygiene audits from March 2013, indicated medical wards achieved at least a 90% compliance rate with the trust's hand hygiene standards. Compliance was at or above the trust target of 90%.
- There were side rooms available for patients who may pose a risk for cross infection.
- The trust's infection rates for MRSA and C. difficile were within expected limits when compared to trusts of similar size and complexity.

Environment and equipment

- The ward environment was safe on all the wards we visited, except for Colwell.
- On Colwell, we found there was no door to the ward's treatment room. This meant equipment and waste medicines could be accessible to patients, visitors, staff and volunteers.
- The lock on one of the toilets on Colwell was broken. We observed an incident where a patient was trapped in a toilet as a result of the broken lock. Staff responded quickly, but told us similar incidents had happened. Although they had asked for the lock to be fixed, staff told us the issue had not been addressed.
- There was a refurbishment programme underway at the time of our visit on Appley and Colwell wards. Staff told us the wards were being redesigned so they could better meet the needs of people living with dementia.
- Equipment was checked and cleaned regularly. There were daily checks of resuscitation equipment on all the

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medical wards, except the stroke unit and this was documented. Checks of resuscitation equipment on the stroke unit were often undertaken daily, but there were repeated gaps where checks were not completed for one or two days at a time.

- There was 24-hour access to pressure-relieving equipment, including specialist beds.
- Staff told us there was sufficient equipment to meet their needs and additional equipment was made available, when needed.

Medicines

- Medicines were mostly stored correctly, including in locked cupboards or fridges, when necessary. However, needles and IV fluids on Colwell were accessible to the public, because the treatment room in which they were kept did not have a door. We were told by the lead sister that there was a plan in place for a new treatment room as part of the ongoing refurbishment
- Checks on the temperature of refrigerators used to hold medicines were done on all the wards we visited, except Colwell.
- There was a very good system of using electronic prescribing, with the admissions pharmacists initiative reducing the reconciliation error rate from 70% to 3% on admission
- Pharmacists we spoke with could describe recent medication errors and explained to us what they had learned from these errors. Ward sisters were aware of medication incidents that happened on their wards and the learning they took from these incidents.
- Patients told us they were usually given their medication on time. They also said medicines were explained to them and they were told about the risks associated with taking medication.
- We observed staff giving patients medication only after correct checks were made.
- Drugs rounds were not protected and we observed nurses on Colwell were interrupted while doing drugs rounds. This posed a risk that nurses would make a mistake while administering medication.

Assessing and responding to patient risks

- Risk assessment documentation was available to manage risks to patient safety, such as VTEs, falls, malnutrition and pressure sores.

- Risk assessments, however, were not always completed and, where risks were identified, they were not always appropriately addressed. This was a particular concern on the stroke ward.
- Where patients were assessed on the stroke ward as being at risk of developing a pressure ulcer, they were not always turned every two hours, as required by the trust's procedures.
- For example, on one occasion on the stroke ward, we found that it took 25 days for a patient who was assessed as being depressed to have a mental health assessment. The same patient, who was diagnosed as having an eating disorder, was not seen by a dietician until 15 days after being admitted to the ward. The patient was at risk of developing hospital-acquired pneumonia and her clinical records showed she was supposed to be assessed for this two times a day. We found the patient had not been assessed for this since 27 May 2014.
- There were clear strategies for minimising the risk of patient falls, particularly on Colwell. Staff on Colwell demonstrated a good understanding of the causes of falls and how to avoid these. Intentional rounding was used across the trust. Intentional rounding is a structured process where nurses on wards in acute and community hospitals and care home staff carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks.
- Staff on all the medical wards we visited, except the stroke unit, told us intentional rounding was used to monitor and review all patients.
- Intentional rounding was used inconsistently on the stroke unit. Staff told us intentional rounding was only used for high risk patients, or those patients who had intentional rounding on a previous ward. There was no documented tool to determine which patients were high risk and therefore required intentional rounding. Staff told us they would assess the need to use the tool, based on a visual assessment of the patient. We checked patient records and found intentional rounding was done only for very high risk patients.
- Patients across all wards were often kept on pressure-relieving mattresses when they no longer needed them. The risk is that this delays their recovery.
- Medical wards used the modified early warning score (MEWS) system to identify deteriorating patients.

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- Staff could tell us the protocol they followed when a patient deteriorated. Patient records we looked at showed the protocol was followed.
- Staff felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency.
- There was a critical care outreach team, which supported ward staff in managing deteriorating patients. Staff across all wards praised this service highly for its responsiveness and support.

Records

- Patient records were organised and easy to follow in all but one case. There were standardised care plans and these were used.
- Risk assessments were documented, although they were not always fully completed. Nursing and medical notes were almost always dated, timed and signed.
- Patient information and records were stored securely on all wards, except Colwell. We observed two instances on Colwell where patient records were left unattended and unsupervised.
- Where side rooms were in use, patient records were stored on a wall mounted bracket placed just outside the door to the room. These were not supervised or locked and the records could be taken and viewed by anyone walking by.
- Patient records on the acute stroke unit were not always well maintained. We looked at seven sets of patient records and five of them were poorly organised, difficult to follow, and information about patient care was sometimes missing. For example, we saw patient records that were not always bound together and clinical notes that were at risk of falling out of patient records. On one occasion, we found one patient's clinical records in another patient's medical records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where patients had the capacity to consent, they were consented appropriately and correctly.
- Where patients were assessed on admission as suffering from memory loss, confusion or diagnosed as living with dementia, mental capacity assessments were not undertaken.
- Where patients did not have capacity to consent, formal best interest decisions were not held in deciding treatment and care that patients required.
- Staff told us patients were assessed for mental capacity if they were being discharged to a nursing or care home

and there was a question about their capacity to consent to such an arrangement. Staff told us patients with memory loss or suspected dementia were referred to the outpatient memory clinic on discharge, where their mental capacity would be assessed. This meant patients in hospital who did not have capacity to consent were at risk of receiving care and treatment to which they may not have agreed.

- Ward staff we spoke with had little or no knowledge of the Mental Capacity Act 2005. When we asked them, there was little understanding of best interest decisions, or how and when these should be made.
- Training records provided to us by the trust showed 19 members of staff were trained in the Mental Capacity Act 2005 between April 2011 and March 2013. Most staff had been trained in the Mental Capacity Act 2005 between April 2007 and March 2011 had not had any updated training.
- We observed one instance on Colwell, where a mental capacity assessment of a patient was not undertaken when it would have been appropriate to do so.

Safeguarding

- There were safeguarding procedures and protocols and staff were aware of these.
- Staff told us they had training in adult and child safeguarding. Information provided by the trust indicated that 84% of staff working on the medical wards were up to date with their adult safeguarding training and 87% with level 1 children's safeguarding.
- They were able to describe the kinds of situations in which they would raise a safeguarding concern and how they would escalate any concerns.
- There was a low take up of safeguarding training on the stroke ward. At the time of our visit, 31% of staff on the ward had had adult safeguarding training. The matron for the ward told us staff were booked on training, which was scheduled for later in the year and that there had been difficulties accessing training venues.

Mandatory training

- There was an induction programme for new staff, which included mandatory training.
- Staff we spoke with told us they were up to date with their mandatory and statutory training.
- Data provided by the trust in its February 2014 performance report showed high levels of completed

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mandatory training on all wards except the stroke unit. The report showed 78% of staff on the stroke unit had completed mandatory training against a trust target of 80%.

Nursing staffing

- Nursing numbers were assessed using the National Safer Nursing Care Tool and there were identified minimum staffing levels. Two of the wards we visited, the acute stroke unit and Colwell, had recently identified a need to increase staffing levels in response to patient acuity on the wards.
- We spoke to staff about staffing levels and looked at rotas. We found there were adequate numbers of staff on all the medical wards we visited except the acute stroke unit.
- Patients told us they had sufficient numbers of nursing staff looking after them and they did not have to wait long for help or care.
- Staff on the acute stroke unit told us there were often too few qualified staff on duty. During one of our visits to the ward, there were three qualified nurses and five healthcare assistants on duty to care for 26 patients. According to staffing numbers set by the trust, there should have been four nurses and four healthcare assistants.
- There were occasions where patients who were assessed by ward staff as needing dedicated, one-to-one care from a nurse, did not receive it. This occurred on two occasions during the inspection.
- There were a high number of vacancies on the acute stroke unit and 18.6% of staff working on the unit were bank staff compared to a trust target of 5.7%. These were internal bank staff, some, but not all of whom, regularly worked on the ward. Staff told us healthcare assistants were often substituted for nurses when nurses were not available.
- Staff told us the trust had tried to recruit nurses to work on the ward, but there were few applicants and those who applied did not have the skills needed to work on a stroke unit.
- Staff told us the trust did not use agency staff. Where nursing cover was required, managers used bank staff.
- The nursing handovers that we observed were very good. There was a thorough discussion of each patient, which included information about their progress and potential concerns.

Medical staffing

- There was a consultant presence on the medical assessment unit (MAU) from 8am to 8pm, five days a week. Patients who were admitted at night were seen by consultants the next morning. Other medical consultants were on call out of hours and during weekends.
- Staff told us there were sufficient consultants and doctors on the wards during the week day, but there was a shortage of medical staff out of hours and at weekends. Night staff said this left them feeling stretched.
- During one of our visits to the trust, which was at night, we met with the hospital 'at night' team. There was one surgical senior house officer (SHO), one medical SHO, one medical registrar, an advanced nurse practitioner, and a clinical site coordinator on duty that night.
- Once patients were transferred from the MAU to a specialist ward, they were seen by a consultant during the following consultant ward round. If patients moved wards, then they were seen by a different consultant. The patients did not have a named consultant for the length of their stay.
- Consultant ward rounds on all wards took place twice a day on MAU and at least once a day on other wards.
- The consultant ward rounds we observed on wards, other than acute stroke, were well managed and thorough. Junior doctors felt well supported by senior doctors and told us that consultants were contactable by phone if they needed support out of hours.
- Medical patients who were on surgical wards were seen by medical consultants and medical doctors. This was managed by there being a dedicated team for medical outlier (patients not on a medical ward) patients.
- The one exception was on the acute stroke ward. There was no dedicated acute stroke consultant.
- There were two registrar vacancies on the ward and there was a locum registrar filling in for one of the vacancies. The acute stroke ward and rehabilitation ward shared one junior doctor, who was newly qualified.
- Doctors raised concerns about the lack of senior medical support they received on the stroke unit.
- The consultants, registrar, and junior doctor provided medical cover for acute stroke patients and for patients with respiratory and gastrointestinal conditions, who

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were also on the ward. This posed a risk that the medical staff would not have the necessary skills or experience to care for patients who required specialist care and treatment.

- During our inspection, on one of our visits, we found that there was no specialist medical cover for either the acute stroke unit or the rehabilitation ward until the start of the morning shift at 10am. We also found there was one registrar covering both wards and staff told us this registrar had been “borrowed” from elsewhere in the hospital.
- Medical and nursing staff raised concerns with us about the safety of the stroke unit. They felt the lack of sufficient medical cover put patients at risk of harm.
- The medical handovers that we observed were very good. There was a thorough discussion of each patient, which included information about their progress and potential concerns.

Major incident awareness and training

- The bed management system was not ensuring that patients' needs were met in a safe way, or in an area most suited to meet their needs at a time when there was increased demand on beds. The hospital was undertaking some refurbishment. This meant that one medical ward was closed. Medical patients were being cared for on surgical wards. On occasion, the trust was using more beds than normal on the private ward, beds on the rehabilitation wards were being used as acute beds with medical and surgical patients in these areas. Patients were also being moved, sometimes late at night, to wards that may not have been able to meet their needs effectively, while other patients were waiting for beds on the rehabilitation wards.
- Emergency plans and procedures were in place. Staff were able to describe how they would respond to specific emergencies, for example, a major incident. There was staff training in how to respond to major incidents and staff told us they had this training.

Are medical care services effective?

Requires improvement



National Institute for Health and Care Excellence (NICE) guidelines and other professional guidelines were identified for use where relevant, but were not always

implemented or monitored to ensure compliance. Patient outcomes varied, for example, national audit showed the trust was similar to other trusts for acute myocardial infarction and bowel cancer care but was in the bottom 20% of trusts for stroke care. The Sepsis Six care bundle had not been rolled out across the trust.

There were good arrangements for ensuring patients had timely pain relief. Patients at risk of malnutrition or dehydration were risk assessed, although referrals to, and assessments by, dietitians or speech and language therapists was not always made within expected timescales. Staff had mandatory training and were competent for their roles. There was good multidisciplinary team working and there was a good consultant presence on all but the stroke ward. Not all services were available seven days a week.

Evidence-based care and treatment

- Integrated care pathways for those patients who had suffered a stroke were in place and performance was monitored to improve the service being provided. The pathways were linked to relevant National Institute for Health and Care Excellence (NICE) guidelines.
- The Sepsis Six care bundle is recognised as a recommended approach to the management of sepsis. This was reported to have been rolled out across the trust, but this was not supported as there was a lack of staff knowledge and understanding of the pathway.
- Treatment protocols did not always reflect NICE and other clinical guidelines. For example, staff were unaware of the NICE guidelines for treating kidney injuries, even though the trust had been previously identified as a mortality outlier for acute and unspecified renal failure.
- Where NICE guidelines were identified as being relevant to the directorate, there was no programme in place to ensure the implementation of the guidelines.
- The use of NICE guidelines was not systematically audited to ensure compliance.
- Local audits were undertaken and had included the use of the Malnutrition Universal Screening Tool (MUST), concerns had been identified with regards to the effective use of the tool action had been taken and outcomes were being monitored through an ongoing audit.

Medical care (including older people's care)

Pain relief

- Ward staff monitored and treated patients who were in pain and could access support from the trust's pain team, when needed.
- Patients told us they were given pain relief when they needed it.
- Acute medical wards used the essence of care benchmarking tool for the prevention and management of pain in order to identify areas for improvement and promote best practice.
- Results from the national pain database showed that the trust performed within expected limits.
- The 2012/2013 Cancer Patient Experience Survey found the trust performed better than similar trusts for staff controlling patients' pain, all of the time.

Nutrition and hydration

- Patients were weighed and screened for malnutrition using MUST on admission.
- Where concerns were identified, a referral to a dietician was made, although patients were not always assessed by a dietician in a timely way. On the stroke ward, we found two instances where patients were not seen by a dietician when they should have.
- Special diets and pureed meals were available to patients who needed it.
- The MAU operated a red tray system to identify patients who needed help with eating and drinking and used red lidded jugs to signify patients who needed fluid intake monitoring. The red tray system was not used on all wards.
- Staff on the Colwell ward told us that, while they had tried, it had not been possible to introduce protected meal times. This meant that staff and patients could be disturbed at this time. This had the potential to impact on staff's availability to support patients with eating.
- Stroke patients' swallowing was assessed to ensure that nutrition and hydration was provided through an appropriate route.

Patient outcomes

- The trust's mortality rates were within the expected range.
- Medical mortality reviews were completed but not for all patients and the process to include all patients was still developing.
- The trust was an outlier for dermatological conditions. At the time of our visit, the trust had undertaken a 'rapid review' of dermatological conditions. The review

suggested that patients were not dying from skin conditions. Instead, patients who were admitted with leg ulcers also had comorbidities, which led to mortality. However, the review was incomplete at the time of our inspection, as some of the relevant case notes could not be found. Where the review identified improvements could be made, no action had been taken in response.

- The trust had had a mortality alert for acute and unspecified renal failure, which was received from Dr Foster Intelligence (a provider of healthcare information), in December 2012. The trust investigated the reasons for its high mortality rates in this area and identified required improvements. The trust produced an action plan but, during our visit, we found limited progress had been made in implementing it. For example, the Sepsis Six care bundle had not been rolled out across the trust and NICE guidelines for treating acute kidney injury were not used. One particular issue arose around inserting nephrostomy tubes (inserting a tube into kidney tissue so that liquid could be drained away). The tube should be inserted within 24 hours of diagnosis but it was happening closer to 48 hours. The delay occurred because there was only one practitioner available to do nephrostomies and this one practitioner only worked one day a week. Patients coming in when the practitioner was not there were not always seen.
- Emergency readmissions were within expected parameters and the standardised readmission rates compared favourably with national rates.
- National clinical audits were completed and results showed the trust's performance was similar to that of other trusts.
- Data from audits in acute myocardial infarction (MINAP) and the national bowel cancer audit project (April 2011 to March 2012) showed outcomes for patients at this trust were within expected limits.
- The sentinel stroke national audit programme (SSNAP) from October to December 2013 showed the trust performed well against some indicators and worse than expected against others. Overall, the trust was in the second lowest quartile when compared with national audit results. The trust required improvement in the organization of acute care, for example, the time taken to provide patients with physiotherapy and occupational therapy assessments, to administer thrombolysis and for patients to be seen by a multidisciplinary team.

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- Data collected by the trust since December 2013 showed improvement in these areas, although performance against two audit standards continued to require improvement. The standards included, providing thrombolysis to patients with suspected stroke within 60 minutes of arrival at hospital (i.e. giving them medication to break down blood clots) and providing swallowing assessments to stroke patients within 72 hours of admission.
- Data from February 2014, which was provided by the trust, showed that 100% of patients with suspected stroke were admitted directly to an acute stroke unit within four hours of arriving at the hospital.
- The trust performed better than the national average for ensuring that patients showing signs of a heart attack were seen by a cardiologist, or a member of their team.
- The medical division participated in all but one national clinical audit in which it was eligible to participate. It did not participate in the Parkinson's disease audit.

Competent staff

- Clinical staff told us they had regular supervision and appraisals.
- On all the wards almost all staff (96.8%) had received an appraisal.
- The General Medical Council's (GMC) national training scheme survey 2013, found that the trust performed similarly to expected for acute internal medicine, with a score of 'better than expected' for local learning. The trust performed worse than expected in gastroenterology. According to the survey, junior doctors in gastroenterology were dissatisfied with arrangements for clinical supervision, handover, induction, experience, local and regional teaching and study leave.
- We spoke with junior doctors and, aside from those on the acute stroke unit, they felt well supported. Junior doctors specialising in gastroenterology told us they were busy, but there were sufficient staff and a supportive environment.
- Most staff told us they had online training in dementia care, but many did not feel the training was effective. Three members of staff told us they had attended a classroom-based training session in dementia care and found it to be "excellent".
- Most staff told us they had completed an internet-based training programme in dementia care.

Multidisciplinary working

- Care on all the wards we visited was planned and provided by multidisciplinary teams, although there multidisciplinary ward rounds did not take place on every ward.
- We observed multidisciplinary ward rounds and these were well attended by staff from different disciplines.
- Patient records we saw showed patients were usually assessed and reviewed by physiotherapists and dietitians when they needed to be. When required, patients were referred to the pain team.
- There was good involvement of the critical care outreach team in providing advice and support for deteriorating patients on medical wards.
- There was dedicated pharmacy support on all the wards we visited.

Seven-day services

- There was a consultant presence on the MAU from 8am to 8pm, seven days a week.
- On all the other wards we visited, except the stroke unit, there was good consultant presence during normal working hours, but there was limited consultant availability at night and at weekends.
- Staff told us there was no consultant for stroke patients on call, out of hours, or on weekends. During these hours, staff had access to the one registrar on duty for the whole of the hospital. There were no junior doctors to cover the acute stroke unit out of hours, or at weekends.
- Staff told us consultants were on call out of hours and were accessible, when required.
- Pharmacy services were available seven days a week.
- Physiotherapy and occupational therapy services were not available at the weekends.
- Support from the mental health liaison team was not provided during the weekend.
- Staff praised the radiology service, but felt it should be available during weekends so patients did not have to stay in hospital over weekends waiting for x-rays or imaging.
- Junior doctors expressed frustration at the lack of ultrasounds at weekends and told us this sometimes resulted in patients needlessly staying in hospital.

Are medical care services caring?

Medical care (including older people's care)

Good



Overall, staff on medical wards were compassionate and caring. Staff were focused on the needs of patients and improving services for patients. People we spoke with praised ward staff for being kind and responsive to their needs. Most patients we spoke with felt involved in their care. There were rooms on some wards where private conversations could be held with families and relatives. Information from national patient experience data showed good patient experiences in some areas, but improvements were required in others. Some improvements should be made to ensure patients' privacy and that the confidentiality of their personal information was improved.

Compassionate care

- Information from the CQC adult inpatient survey 2013 showed the trust performed similar to other trusts for all 10 areas of questioning.
- The results from the inpatient NHS Friends and Family Test, demonstrated that the trust performed slightly below the England average. In March 2014, two of the trust's four medical wards, Appley and Colwell, were the least likely to be recommended by patients to their friends and family. Against a trust average NHS Friends and Family Test score of 71, Appley received a score of 56 and Colwell received a score of 43. The acute stroke unit achieved an NHS Friends and Family Test score of 100%, which is the highest score possible.
- The majority of patients and relatives we spoke with were pleased with the care provided at the hospital. They told us nurses and healthcare assistants were caring, compassionate, and responded quickly to their needs.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect.
- There were, however, some concerns about privacy on Colwell. We observed a multidisciplinary ward round was held in the middle of the ward. Patients, visitors, porters, cleaners, and volunteers could overhear discussions about patients, which should have been confidential. We saw two phlebotomists, one porter, one patient and two ward staff walk through the group having the ward round in order to cross from one side of the ward to another.

- We noted large television-like screens on two of the wards we visited, which had patients' names on them. The screens were publicly situated and included confidential patient information that could be seen by anyone visiting or staying on the ward. Staff told us the use of the screens had been approved by the trust's information governance team.
- Almost all the patients we spoke with said the food and menu choices were adequate.

Patient understanding and involvement

- Patients said they were regularly seen by doctors and felt well informed about issues relating to their care.
- Patients and relatives from almost all the wards we visited told us they felt involved in their care. They said they were given the opportunity to speak with the consultant looking after them and they were provided with explanations in a way they could understand. They felt they were able to ask questions if they had any and these were answered.

Emotional support

- The hospital chaplaincy had a visual presence around the hospital and were happy to meet people to offer them support.
- There was a bereavement service to support families who had lost a loved one.

Are medical care services responsive?

Requires improvement



Overall, medical services were responsive. Patients waiting times were within national targets. However, we found bed management was not well organised across the hospital, which meant that, although patients often felt well looked after, they were not always placed on the most appropriate ward for their needs. Medical and surgical patients were often mixed on both medical and surgical wards. Patients who had an acute stroke were mixed with patients who were in hospital for gastrointestinal or respiratory conditions, or who were recovering from surgery. Acute medical patients were mixed with patients receiving end of life care.

Patients' individual needs were usually met although there were some exceptions. There was support available for patients who were living with dementia or had a learning

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disability, and for staff caring for these patient groups. The trust used the 'Butterfly Scheme' system to identify people living with dementia, but staff did not consistently use it. Refurbishment was in progress to update some of the wards and make them more responsive to the needs of people living with dementia. Some patients told us they had been moved from one ward to another multiple times. They found this confusing and frustrating. Patients were sometimes moved from one ward to another late at night which staff said caused confusion and could increase the risk of falls. Action was taken to improve patient experiences of care and ward staff were able to describe changes they had made as a result of suggestions or complaints from patients or relatives.

Service planning and delivery to meet the needs of local people

- There was a 23-bed medical assessment unit for medical emergency admissions, which was staffed 24 hours a day, seven days a week. Staff told us the unit was always busy and was instrumental in alleviating pressures in the A&E department.
- There was a refurbishment programme underway at the time of our visit on Appley and Colwell wards. The wards were being redesigned so they could better meet the needs of people living with dementia. The ward changes, however, had also meant a reduction in the number of beds which was affecting the flow of patients in the hospital and increasing the number of medical outliers.
- Bed management was not well organised across the trust, which meant that, although patients often felt well looked after, they were not always placed on the most appropriate ward for their needs. Medical and surgical patients were often mixed on both medical and surgical wards. Patients who had an acute stroke were mixed with patients who were in hospital for gastrointestinal or respiratory conditions, or who were recovering from surgery. Acute medical patients were mixed with patients receiving end of life care.
- Patient waiting times for diagnostic tests for patients waiting over six weeks for a diagnostic test (November 2013) were within expected ranges.
- All cancers had a 31-day wait from diagnosis to treatment (over the months from July 2013 to September 2013) within expected ranges. Information provided by the trust indicated that, as of February 2014 for the year to date, that in 99% of cases the trust met the 31-day diagnosis to treatment target for all cancers.
- During our inspection, we found that bed management was not well organised and there were many medical outliers across the wards. Patients often felt well looked after, but they were not always placed on the most appropriate ward for their needs. Medical and surgical patients were often mixed on both medical and surgical wards. Patients who had an acute stroke were mixed with patients who were in hospital for gastrointestinal or respiratory conditions, or who were recovering from surgery. Acute medical patients were mixed with patients receiving end of life care.
- Staff on the acute stroke unit and rehabilitation ward told us there were often long waits out of hours for patients to be seen by a doctor, often patients were waiting between one to two hours. Staff told us they often had to page doctors several times because doctors did not respond to their calls. Staff told us they frequently called the critical care outreach team, or the clinical site coordinator for help in getting a doctor to come to the ward at night.
- Some patients told us they had been moved from one ward to another multiple times. They found this confusing and frustrating. Staff confirmed patients were sometimes moved between wards numerous times during busy periods. Moving patients multiple times is a risk because it can lead to inconsistencies in patient care.
- We found patients were sometimes moved from one ward to another late at night. One set of patient records we looked at showed a patient was moved at midnight. Staff told us patients were occasionally moved at night, but also said such moves were discouraged by managers. Staff were able to talk us through the risks of moving patients at night. For example, it can lead to patient confusion and result in an increase in falls.
- There was a hospital 'at night' team that was made up of two senior house officers (SHOs), a medical registrar, an

Access to services

- The hospital's bed occupancy rate of 76.4% between October and December 2013 was lower than the England average of 85.9%.
- The trust performed as expected or better than expected against waiting time targets.

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advanced nurse practitioner and a clinical site manager. This team identified and escalated patients appropriately to ensure they received safe and effective care.

- There was a dedicated care manager on the MAU and on Colwell to help facilitate patient discharges. They acted as a link between the hospital and the local authority to find care home places and ensure appropriate care packages were available to patients when they were discharged from hospital.
- Staff told us discharge summaries were usually completed before patients were discharged. They said discharge letters were sometimes delayed when patients were sent to the mainland for treatment or care.
- Discharge summaries were sent out electronically to patients' GPs. Staff told us they were usually sent out within 72 hours of patients being discharged.

Meeting people's individual needs

- There was support available for patients living with dementia or who had a learning disability, and for staff caring for these patient groups.
- The wards we visited had a named dementia and learning disability champion.
- Staff told us patients that were confused and/or living with dementia were referred to the trust's mental health liaison team and this team supported them in caring for people living with dementia or other mental health needs. The team was highly regarded by staff with whom we spoke.
- However, we found that the care of people living with dementia could be inconsistent. The trust used the 'Butterfly Scheme' system to identify people living with dementia, but staff did not consistently use it. This resulted in staff not knowing which patients had dementia and, therefore, might need additional support.
- Patient records showed patients were referred to the mental health liaison team. However, there were no documented records demonstrating that patients were seen by a mental health liaison nurse.
- There were a number of instances where patients were described to us as having dementia. When we checked these patient records, we found many patients had not been assessed as having dementia. Their medical notes stated they were confused, as a result of a UTI.

- There was limited support for patients and staff who were caring for patients with drug and alcohol addictions. We observed staff on Colwell Ward managing a very challenging patient with a history of alcohol abuse. In the absence of support from the mental health liaison team, ward staff contacted the mental health crisis management team, who offered telephone support.
- Ward staff told us they valued the advice given to them by the mental health crisis management team. They also said one-to-one support for the patient from a drug and alcohol specialist might have improved communication with the patient and relieved some of the patient's anxieties.
- There were no drug or alcohol support services on the main hospital site for staff to contact for support or intervention.
- Interpretation services were available and staff knew how to access the service when needed. Some staff we spoke to described a recent influx of Polish patients and how the interpreting service had been useful in communicating with this group of patients.
- There were rooms on some wards where private conversations could be held with families and relatives. In others areas, where there was not a dedicated room, we were told that an office would have to be used.

Learning from complaints and concerns

- The trust had a complaints policy and written information about how to make a complaint was on every ward except the MAU. Staff on MAU told us they did not provide written information on making a complaint, because they preferred patients coming directly to them with their concerns, so they could resolve them immediately. This meant patients who did not wish to make a complaint directly to ward staff did not always have information about how to make a complaint to the trust.
- There was a poster on the MAU promoting the use of the trust's Patient Advice and Liaison Service, but the poster did not contain contact details, such as a phone number, on which to call the service. This was a concern, because patients who might not be able to walk to Patient Advice and Liaison Service, for example, those with limited mobility, might not be able to access the service.
- Where patient experiences were identified as being poor, action was taken to improve their experiences. For

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example, staff on the MAU were able to tell us about measures they had put in place to reduce pressure ulcer incidents. Colwell staff explained how they had responded to a higher than expected number of patient falls. For example, patients assessed as being at high risk of falls were placed closer to the nursing station, electronic pressure mats were given to patients at risk of falls and an alarm went off when these patients left their bed.

- Ward staff were able to describe changes they had made as result of suggestions or complaints from patients or relatives. For example, staff on MAU told us of a complaint from a patient who did not feel they were given sufficient pain relief. There is now a link nurse on MAU who works with a pain nurse specialist to ensure patients are adequately assessed for pain.
- Staff told us ward sisters investigated complaints and gave them feedback about complaints in which they were involved.

Are medical care services well-led?

Requires improvement



Overall, medical services were not well led. The trust had a vision of “providing quality of care for everyone, every time” and this was well recognised by staff. Staff were able to repeat the vision to us at focus groups and in individual conversations. The division had a quality dashboard for each service and ward area and this showed performances against quality and performance targets.

Lessons from complaints, incidents, audits and quality improvement projects were discussed at clinical governance meetings, but the lessons learned were not routinely cascaded to staff within the directorate or across the organisation. Risks were not always identified and flagged on risk registers at ward-level, or at divisional-level. Where concerns about the safety or quality of services were identified, they were not always adequately addressed. For example, the action plan in response to a Dr. Foster Intelligence mortality alert from December 2012 for acute and unspecified renal failure was not implemented appropriately.

Matrons were visible and had a regular presence on their wards. Staff spoke positively about the services they provided for patients and were proud to work for the trust.

They described the trust as a good place to work and as having an ‘open’ culture. However, staff told us the visibility and responsiveness of divisional managers of the acute medical wards was poor. Clinical leads were not always aware of the risks and challenges faced by staff and patients on their wards. Medical and nursing staff did not feel their concerns were acknowledged or addressed by trust management.

Vision and strategy for this service

- There was not a specific strategy for medical care services.
- The trust had a vision of “providing quality of care for everyone, every time” and this was well recognised by staff. Staff were able to repeat the vision to us at focus groups and in individual conversations.
- Staff took clear ownership of the vision and took pride in the patient-focused ethos it represented.
- Matrons and ward sisters were passionate about improving services for patients and providing a high quality service.
- However, staff across the division felt trust managers were not always receptive to the concerns they raised and this sometimes put patient care at risk.

Governance, risk management and quality measurement

- The wards we visited had regular team meetings in which performance issues, concerns, complaints and general communications were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The division had a quality dashboard for each service and ward area and this showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings. Where performance fell below what was expected, ward staff were informed and action was taken in response.
- Lessons from complaints, incidents, audits and quality improvement projects were discussed at clinical governance meetings, but the lessons learned were not routinely cascaded to staff within the directorate or across the organisation.
- Risks were not always identified and flagged on risk registers at ward-level or at divisional-level. For example, the environmental risks on the newly

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refurbished Colwell were not identified to ensure its suitability for patients. Where concerns about the safety or quality of services were identified, they were not always adequately addressed.

- The trust failed to implement its action plan in response to a Dr Foster Intelligence mortality alert from December 2012 for acute and unspecified renal failure. We found a number of actions from the trust's action plan were not implemented and clinical leads were not aware of this. The trust's action plan included the use of a Sepsis Six care bundle across the trust and the implementation of NICE guidelines for nephrostomy. We found the Sepsis Six care bundle was used only in A&E and nowhere else in the hospital. The NICE guidelines were not in use.

Leadership of service

- There was good leadership on all the medical wards we visited, except the acute stroke unit where medical and nursing leadership was poor.
- Ward staff and ward sisters felt well supported by their managers and told us they could raise concerns with them.
- Staff across medical wards told us matrons were visible and had a regular presence on their wards.
- With the exception of the acute stroke unit, junior doctors felt well supported by consultants and senior colleagues. They told us consultants were accessible and approachable.
- However, staff told us the visibility and responsiveness of divisional managers was poor.
- Clinical leads were not always aware of the risks and challenges faced by staff and patients on their wards.
- Medical and nursing staff did not feel their concerns were acknowledged or addressed by trust management.

Culture within the service

- Staff spoke positively about the services they provided for patients and were proud to work for the trust. They described the trust as a good place to work and as having an open culture.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.
- Staff survey results from the 2013 NHS Staff survey showed the trust's performance was rated as 'worse than expected', or 'tending towards worse than expected' for 14 out of 28 indicators. Areas in which staff did not feel the trust performed well included,

communication between senior management and staff, staff feeling satisfied with the quality of work and patient care they were able to deliver, experiences of harassment, bullying and abuse from other staff and the trust as a place to work or receive treatment.

- Staff were committed to their work and to providing high quality care for patients. We observed many examples of caring and compassionate care, which was provided even when staff were stressed and under pressure. There was a culture of caring.
- We observed a number of medical and nursing handovers and multidisciplinary ward rounds. Staff were well informed about patients in their care and showed a genuine interest in the welfare of their patients.

Public and staff engagement

- There were good links with the local Healthwatch, who provided feedback on services and with patient participation groups. For example, on diabetes care.
- Clinical governance meetings showed patient experience data was reviewed and monitored.
- At the time of our visit, the trust was consulting with staff about a proposed merger of its acute and planned directorates.
- Although staff at ward-level felt they were part of a team, they did not feel there were sufficient opportunities for engagement with trust management.
- The results of the 2013 NHS Staff Survey were organised into 28 key findings. The trust performed better than expected for the percentage of staff receiving job-relevant training, learning or development over the previous 12 months and the percentage of staff saying hand washing materials were always available. The trust's performance was rated as 'worse than expected' or 'tending towards worse than expected' for 14 of the 28 key findings in the NHS 2013 staff survey. These included staff at the trust being less likely to recommend the trust as a place to work or receive treatment. Staff reported lower levels of satisfaction with the quality of work and patient care that they were able to deliver and communication between senior management and other staff.

Innovation, improvement and sustainability

- There were examples of innovative service delivery and clinical practice. This included the trust's use of electronic prescribing, ward-based pharmacists, and ward-based care managers.

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- Although there were examples of innovative practices, innovation and improvement were not embedded across the medical division. Examples of this included the trust's failure to fully respond to, and implement, changes in response to its mortality outlier alerts.

Surgery

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

Information about the service

The Isle of Wight NHS Trust is an integrated trust that provides inpatient and day surgery. There are two surgical wards, a day surgical unit, a preadmission assessment unit, four main theatres and two day surgery theatres. It also has two trauma and orthopaedic wards. The hospital provides emergency and elective surgery for a range of specialties including: general surgery, trauma and orthopaedic surgery, ophthalmology and oral surgery. There were 15 elective surgical beds, 21 emergency surgical beds, and 41 trauma and orthopaedic beds

We visited four wards in the hospital. We spoke with 19 patients, four relatives and 20 members of staff. These included nursing staff, junior and senior doctors and managers. We observed care and treatment and looked at ten care records. We received comments from people at our listening events, as well as from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Overall, surgical services were good. The use of the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist – was monitored and the way staff were completing this checklist was improving across all specialties, except ophthalmology. Actions were being taken to address this. Information about the quality of care was displayed on the wards.

Staff provided compassionate care to patients. Patients and relatives told us nursing care was good. Patients who needed help in eating were provided with the necessary support. Patients who were seen by a GP in the A&E department were, if they required surgery, referred for appropriate clinical colleagues. Data from national audits and databases showed surgical outcomes were at, or close to, the national average. There was support available for patients living with dementia and patients with learning disabilities.

The trust vision was well recognised by staff. However, concerns raised by clinical staff were not always heard or acted upon by the trust leadership team. The team had a 'can do' culture. There was a sense of energy and purpose in the divisional leadership team that they could improve the service and make a positive impact on the patient experience.

Surgery

Are surgery services safe?

Good



Surgery services were following procedures to provide safe care. Surgery staff told us they were encouraged to report incidents and these were discussed at ward meetings and monthly quality meetings. However, reporting of themes at ward-level was not consistent with some wards sharing learning from incidents and some not. The use of the 'five steps to safer surgery' checklist was monitored and was improving across all specialties, except ophthalmology where there was an action plan. Equipment was not appropriately tested but action was being taken to ensure all equipment was safe to use.

Incidents, reporting and learning

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There were no Never Events in surgery from January 2013 to March 2014.
- Between April 2013 and March 2014 there were 16 incidents in surgery were reported to the National Reporting and Learning System (NRLS). The majority were classed as 'moderate' harm, two as 'severe' harm and two resulted in death. These reports were for avoidable harms, such as pressure sores and falls. We were shown examples of change that had taken place as a result of incident reporting. For example, the wards have since ensured that patients who were likely to fall were kept under closer observation near the nursing station.
- Incidents were addressed in a timely manner and the results of investigations were shared with staff.
- Staff were encouraged to report incidents and incidents were discussed at team meetings. However, not all staff always attended these meetings. In response, the results of investigations were placed on staff bulletin boards for staff to see and take note.
- Where trends and patterns from incidents were identified, these were not shared with staff at ward-level. This meant staff were not always aware of actions they could take to prevent incidents from recurring.

Safety Thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls.
- NHS Safety Thermometer information was displayed on all the wards we visited. The NHS Safety Thermometer provides a 'temperature check' on harm that be used alongside other measures of harm to measure improvement in patient care. Safety Thermometer results varied between wards, which suggested inconsistencies in the quality of care provided to patients. This issue had been identified by the trust and was now being addressed by the team.
- All wards had information displayed about the quality of the service. This included information about infection control measures, results of NHS Friends and Family Tests, numbers of complaints, levels of staff absenteeism, mandatory training update, and numbers of patient falls, new pressure ulcers, new urinary tract infections (UTIs) and new blood clots. Staff said that some of this information was relatively new and had been introduced a month prior to our inspection.
- The wards had met trust targets to reduce and prevent falls. There was a staff nurse on every ward who championed falls on the wards.
- Overall, the services in surgical were meeting the trust's target to reduce the number of pressure ulcers. The trust had introduced a new system of ensuring risk assessments for patients with a potential blood clot. Records provided to us by the trust showed 98% of patients had received an assessment and appropriate therapy to prevent blood clots.

Cleanliness, infection control and hygiene

- The ward areas were clean and cleaning schedules were clearly displayed on the wards.
- Staff followed trust policy on infection control. Staff regularly washed their hands and used hand sanitising gels between patients, and the 'bare below elbow' policy was adhered to.
- Ward curtains and mattresses were regularly checked for cleanliness. A mattress audit was undertaken in November 2013 and all soiled and old mattresses were discarded. Staff who made the beds each day checked the cleanliness of mattresses. This ensured all mattresses were clean.

Surgery

- After patients were discharged, a total clean of beds and bedside lockers was undertaken.
- Hand hygiene audit indicated it was performing at 95%, which was above the trust target of 90%.
- Rates for MRSA and C. difficile for the trust were within an acceptable range.

Environment and equipment

- The environment on the wards was safe.
- Equipment was appropriately checked and regularly cleaned. The resuscitation trollies on Luccombe Ward and St Helen's Ward were checked daily. However, on Alverstone and Whippingham, resuscitation trolley checks were done irregularly, with several checks a month missed. The resuscitation equipment in the day surgery unit and theatres was checked daily.
- There was adequate equipment on the wards and staff told us there were no problems in accessing medical equipment on the wards.
- We checked six blood pressure machines and found they were last tested more than two years ago. This was highlighted to the wards, who took steps to get the equipment checked. The trust was aware of this time lag in the testing of the equipment. Managers told us the reason for the delay was that the medical equipment department was short-staffed. The trust had completed a risk assessment of testing arrangements for blood pressure machines and found current arrangements presented little clinical risk to patients.
- At the time of our visit, the medical equipment department had recruited a new member of staff. We were assured that all equipment across the hospital would be tested by the end of July 2014.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges, when necessary.
- The temperature of medication fridges was monitored in all wards but one. We found that there was no monitoring taking place on Alverstone Ward. This meant staff were not aware when the fridge temperature was either above or below the normal range. This could reduce the efficacy of medication given to patients.

Records

- Nursing documentation was kept at the end of each patient's bed and were fully completed. Records included an assessment of nutrition, risk of falls and hydration.

- The wards had care plans for patients and these were routinely used. Patient notes were available, when required and nursing records were within the patient notes.
- There were regular audits of patient records to ensure they met professional standards. These audits highlighted some gaps in patient record keeping and there was an action plan in place to address this. Ward sisters told us that improving patient record keeping was a priority for them and would be part of their quality monitoring processes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguarding

- Patients were asked for their consent to care and treatment. We saw examples of patients who did not have capacity to consent and the Mental Capacity Act 2005 was adhered to.
- Staff across surgery had completed their training on consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We were shown percentage figures that showed over 80% had completed this training and the rest were scheduled to complete the training in the next few months (July and August 2014). Each ward had a champion for this area who was responsible for raising awareness with staff on issues of consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff told us confused patients, or those living with dementia were referred to the trust's mental health liaison team. They told us there were good links between the ward and the trust's mental health liaison team.

Safeguarding

- There were safeguarding procedures and protocols and staff were aware of these. Staff we spoke with had received training in adult and children safeguarding. They were able to describe the kinds of situations in which they would raise a safeguarding concern and how they would escalate any concerns.
- Training records we inspected showed almost all staff on the surgical and trauma and orthopaedic wards were up to date with safeguarding training. Information provided by the trust showed that 78% of staff working in surgery and orthopaedics had completed their adult safeguarding training and 80% had completed level 1 children's safeguarding training and 47% at level 2.

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Mandatory training

- Staff mandatory training records and performance reports for all the wards we visited, for April 2013 to February 2014, showed 95% of the staff were up to date in mandatory training.
- Where staff had not yet had mandatory training, the ward managers had assigned them to a training session. Performance reports for Luccombe Ward and Alverstone Ward showed the percentage of staff who had mandatory training was less than 75%. The matron was aware of this and had an action plan to ensure all staff completed their mandatory training by September 2014.

Management of deteriorating patients

- Surgical wards used the modified early warning score (MEWS) to identify deteriorating patients. There were clear instructions for staff about how to respond to deteriorating patients and members of staff were aware of these.
- We looked at six completed NEWS tools and saw that staff had escalated concerns in line with established protocols. Repeat observations were taken within necessary time frames. This meant patients were treated safely, according to the protocols.

Assessing and responding to patient risks

- The Five Steps to Safer Surgery checklist should be used at each stage of the surgical pathway from the time a patient is transferred to theatre until their return to a ward. The trust monitored the use of steps 1 to 4, which included a team briefing and the WHO safe site surgery check list on a monthly basis.
- There was no evidence that stage 5, about debriefing at the end of the operating list, consistently took place. An audit from March 2014 showed compliance with the checklist was improving and was 90% across all types of surgeries except in ophthalmology where it was 52%. There was an action plan in place to improve compliance in ophthalmology.

Nursing staffing

- Nursing numbers were assessed using the national Safer Nursing Care Tool and there were identified minimum staffing levels. The use of the tool began in March 2014. Required and actual staffing numbers were displayed on every ward.

- We spoke with staff about staffing levels and inspected rotas to confirm staffing numbers. We found there were adequate numbers of staff on all the surgical and trauma and orthopaedic wards we visited.
- We spoke with patients, who told us they were sufficient numbers of staff on the wards looking after them. They told us they did not have to wait long for help or care. Relatives we spoke with told us that there were always staff to help with care.
- Staff reported when they were understaffed, vacancies were filled with bank staff. The wards did not use any agency staff.
- Nursing handovers occurred three times a day. We observed an evening handover. Staffing for the shift was discussed, as well as any high-risk patients or potential issues. There was a handover of each patient, which was done at their bedside. This meant there was direct patient contact with staff during these handovers, which gave patient the opportunity to raise concerns or comments about their care.

Surgical staffing

- There was consultant presence Monday to Friday on the wards. Consultants reviewed emergency patients at weekends, but not all patients. There was emergency surgery cover. Emergency surgery was always undertaken under the direction of a consultant.
- Surgical consultants from all specialties were on call 24 hours a day, seven days a week. Each patient had a named consultant who was the overall person in charge of their care.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed any support.
- Medical handovers took place at 8am and were led by a senior doctor. Any concerns raised by junior doctors were escalated to a consultant, who was available on call.
- Handovers were informal and unstructured. They covered care of patients based on the severity of their condition. Handovers were not documented.
- In general surgery, there was an informal handover from one consultant to another at the end of an on call week.

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Major incident awareness and training

- There was regular major incident awareness taking place at the trust. We spoke with ward sisters, who were aware of their role in this and had received the necessary training and support.
- There were plans for winter pressure. Winter pressures are times where there is a demand for urgent and emergency care. This meant non-urgent services would be cancelled. The trust had plans in place for this, which included patients being seen by their relevant specialty doctors.

Are surgery services effective?

Good



The surgical division part of the planned directorate contributed to all national audits. Surgical mortality reviews were completed in a timely manner. Outcomes in surgery were good and improving. For example, patients were operated on quickly after sustaining a fractured neck of femur.

Patients were provided with appropriate pain relief and patients who needed help were supported to eat and drink. Medical and nursing staff undertook daily ward rounds five days a week, but these were not attended by therapy staff to support multidisciplinary care. Clinical supervision was available for all clinical staff and most staff had received an annual appraisal.

Evidence-based care and treatment

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations. We found the Royal College of Surgeons' standards were used for emergency surgery. Surgery out of hours was consultant-led and delivered.
- The clinical lead for surgery informed us that there was a pathway in place for the rehabilitation of patients after a critical illness and that this was monitored as part of the clinical audit program. There was an established monitoring system in place to aid the early detection of a deteriorating patient.
- The surgical division contributed to all national audits it was eligible for.

- The directorate contributed to the National Joint Registry. The Registry collects information on all hip, knee, ankle, elbow and shoulder replacement operations and monitors the performance of joint replacement implants. The completion rate was 98%.
- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, orthopaedics and ear nose and throat (ENT) areas. This approach prioritized, thorough pre-assessment, less invasive surgical techniques, pain relief and the management of fluids and diet in order to help patients recover quickly post-operatively.
- Local audits were undertaken. These had included, for example, the use of the 'five steps to safer surgery' checklist, for patients undergoing surgery. Information provided by the trust indicated that nursing staff took part in saving lives audits relating to reducing the risk of infection. One of these relating to 'surgical site infections'.

Pain relief

- The trust performed similar to other trusts for questions relating to pain relief in the CQC adult inpatient survey 2013. During our inspection, we found staff ensured that patients who required pain relief were given this in a timely manner. Patients who needed pain relief were routinely checked to make sure they had adequate pain relief.
- Patients were assessed pre-operatively for their preferred pain relief post-operatively.
- Patients told us they were provided with pain relief as and when they were required.
- We checked the records of five patients and found pain assessments were undertaken and patients were provided with necessary pain relief.

Nutrition and hydration

- The trust did not use a 'red trays' system, which is a way of alerting healthcare staff that a patient requires help with eating. Instead, the trust used red napkins to identify people who required assistance. We observed that patients who used red napkins were helped to eat and drink.
- Patients who required nutritional supplements were provided with the same. Some patients required these supplements as part of their surgery. These supplements aided the recovery process and could shorten the patients' length of stay in the hospital. We

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found these supplements readily available on the wards. We found patients were given these nutritional supplements and there was monitoring in place to ensure they had taken these.

Patient outcomes

- The division had a performance dashboard that it used to monitor the quality of care provided.
- Surgical mortality reviews were completed. There were no mortality outliers and, overall, mortality rates were within an expected range.
- Outcomes in surgery were good and improving, for example, 60% of patients with fractured neck of femur were operated on within 24 hours and 90% within 48 hours in 2012/13. This was an improvement compared to previous years.
- Overall, day case surgery rates performed below national expectations. The British Association of Day Surgery recommends that 90% of certain operations are completed as day cases. The trust rates were at 65%.

Competent staff

- Clinical supervision was available for all clinical staff and staff told us they received regular clinical supervision. Across the service, 94% of staff had received appraisal. This was below the trust target of 100%.
- The General Medical Council National Training Scheme Survey (2013) indicated the training given to junior doctors in general surgery was similar to other trusts, but was worse than expected for local teaching. Overall, in trauma and orthopaedic surgery, the trust was similar to other trusts, but was worse than expected for junior doctors having an adequate experience. Junior doctors told us there had been improvements since the survey.
- A deanery visit had been undertaken in May 2014 and the trust was awaiting the deanery's report.

Multidisciplinary working

- There was input into patient care from physiotherapy and occupational therapy staff. Daily ward rounds were undertaken five days a week on all surgical wards. Medical and nursing staff were involved in these. We did not observe any physiotherapists or occupational therapists attending these rounds. This meant the expertise of these professionals was not readily available to doctors and nurses when decisions about treatment and care for patients were discussed.

- Wards had access to specialist nurses for conditions such as: diabetes, nutrition and others. We found there were good links with these nurses and input was sought on a regular basis.
- Each ward had a ward pharmacist who was responsible for ensuring the safety of medicines on the wards. The trust's antibiotic prescribing policy was closely monitored.

Seven-day services

- Orthopaedic consultants did weekend ward rounds and saw all patients. General surgery consultants saw emergency admissions at weekends.
- Access to medical advice at night came from the hospital 'at night' team. Staff told us they were responsive. There was an advanced nurse practitioner who was on the hospital 'at night' team and who was accessible for advice.
- There was no physiotherapy and occupational therapy support out of hours and at weekends. On weekends, nurses helped patients to improve their mobility. This was based on the care plan identified by the physiotherapist and occupational therapists.
- Radiology services were led by a consultant. They were not routinely available after 5.30pm and on weekends. However, radiology staff could be called out of hours, in the event of an emergency.
- The pharmacy service was operational seven days a week. Patients discharged during weekends had medicines available to take home.

Are surgery services caring?

Good



Staff provided compassionate care to patients. Patients were treated with dignity and respect. However, feedback from the patient surveys identified that some wards needed to improve. Patients and relatives told us nursing care was good, staff regularly came to speak with them and they felt that they were involved in their care.

Compassionate care

- The results from NHS inpatient Friends and Family Test demonstrated that the trust performed slightly below the England average. In March 2014, two of the trust's four surgical wards, Alverstone Ward and Whippingham Ward, were the least likely to be recommended by

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patients to their friends and family. Against a trust average NHS Friends and Family Test score of 71, Alverstone Ward received a score of 60 and Whippingham Ward received a score of 40.

- Comfort rounds or intentional rounding (where nursing staff regularly check on patients every few hours), were undertaken every two hours. We observed these during our inspection. We also spoke with relatives, who confirmed that staff came regularly to check on patients. We inspected the records of five patients and found that information on these rounds was recorded.
- There was protected time for visitors and we observed staff ensuring that they left as soon as visiting times were over. This meant patients were able to rest during their stay in the hospital.
- We observed staff treated patients with kindness and compassion.

Patient understanding and involvement

- Patients and relatives we spoke with said they felt involved in their care. Each patient had a named nurse. Patients and relatives we spoke with were aware of them and their role.
- Patients and relatives were given the opportunity to speak with the consultant looking after them.
- The CQC adult inpatient survey (2013) demonstrated the trust was similar to other trusts for the quality of care and treatment and the hospital and ward operations and procedures.

Emotional support

- We spoke with a chaplain, who said that they were regularly informed of patients who required emotional support, including those wanting to receive Holy Communion. They told us the ward staff were diligent in ensuring the necessary support for patients and relatives.
- On the day of our inspection, we observed a chaplain providing support to patients. One patient who received the support told us how much they appreciated these visits. They told us they felt very lonely and emotionally vulnerable during their stay and the visits by the chaplains lifted their spirits. They told us, "It felt good to have the chaplain visit me. I don't have family on the island and their visit boosts my spirits."

Are surgery services responsive?

Good



Overall, surgery services were responsive. Patients who were seen by a GP in the A&E department were, if they required surgery, referred to appropriate clinical colleagues. There was a one-stop clinic for patients with suspected breast cancer. Patients were treated within national waiting times and had access to diagnostic services, when needed. Support was available for patients living with dementia and patients with learning disabilities. Complaints were handled according to trust policy and there was information about how to make a complaint.

Service planning and delivery to meet the needs of local people

- There were plans in place to meet the needs of local people. The service had arrangements in place to ensure all complex surgery was undertaken with a trust on the mainland.
- Patients who required treatment for major trauma and complex paediatric cases were sent to Southampton General Hospital. Patients could either be transferred via ambulance on a ferry or in an emergency, by helicopter. There were transfer protocols in place and staff we spoke with were confident that these were safe.
- The service had plans to ensure patient access to relevant local surgical services, for example, surgery for hip fractures were going to be undertaken locally. However, the future of some services, such as breast surgery, were at risk, as consultant vacancies had not been filled.

Access to services

- Bed occupancy was 76.4%, which was lower than the England average of 85%. Occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally.
- There were referral processes in place to ensure patients who required surgery were assessed by surgical doctors. When a patient was seen by a GP in the clinical decision making unit (CDU), part of the A&E department, they arranged for required diagnostic tests. If tests indicated patients required surgery, GPs contacted the surgical registrar for follow up. If a registrar was not available, a consultant was called instead.

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- Patients were treated within national waiting time standard of 18 weeks; 95.6% of patients were treated within the target which was above the NHS operating standard of 90%.
- The directorate had a pre-admission assessment unit, to ensure that elective cases were assessed prior to surgery in a timely way.
- There was a one-stop clinic for patients with suspected breast cancer. This meant patients were treated on time and had access to other services, such as diagnostics, if required.
- The trust scored similarly to expected when compared with other trusts for cancelled operations.
- The average length of stay for patients at the hospital for the period between 2013 and 2014 was five days.
- Discharge summaries were sent out to GPs electronically. We checked the five sets of patient records and found discharge summaries were sent out within 72 hours of discharge.

Meeting people's individual needs

- There was support available for patients living with dementia and for patients with a learning disability. Nurses were aware of the procedure for accessing support for these patients. All wards we visited had a named dementia and learning disability champion.
- The 'Butterfly Scheme' was used on the wards to identify patients with dementia and this involved the use of a blue butterfly symbol on a patient's bed. The butterfly was used to help support people to give them more time for care or arrange specific support. Most staff were aware of the significance of the blue butterfly, although a few members of staff were not.
- There was a discharge coordinator, who ensured that discharge planning started as soon as a patient was admitted onto a ward.
- Patients and relatives had access to written information regarding the different operations. The information was available on the wards for patients and relatives to access. One patient told us that the information was made available to them when they had come in for their pre-admission assessment. There was also a DVD available to patients and relatives about their post-operative care after knee and hip replacement.
- The wards had access to translation services. We spoke with staff who knew how to access it and they told us that it was available when required.

- There was a room where more sensitive conversations could be had with patients or their relatives. This room was a multipurpose room that was used as and when necessary.

Complaints

- Complaints were handled in line with trust policy. Staff told us they would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. Staff also said patients would be advised to make a formal complaint if they were unhappy with how ward staff had handled their concerns. All patients who complained were given an opportunity to speak directly to the ward staff.
- We found one ward (St Helen's Ward) had invited a patient who had complained about their care to their ward meeting in order to share their experiences. A ward sister told us that this would help staff learn from patient experience and make the necessary changes to the care provided.
- There was information on the wards about how to complain.

Are surgery services well-led?

Good



Surgical services were well-led. The trust vision was well recognised by staff and there was strong clinical leadership in the division. Governance arrangements had improved because of the appointment of senior staff and risks were appropriately managed. Staff said their concerns were not always heard or acted upon by the trust leadership team and they hoped that the investment of staff as quality champions to raise concerns would improve this. Patient engagement was limited, but had started to improve. Staff felt engaged, empowered and supported in their work and the team had a 'can do' culture. There was a sense of energy and purpose in the divisional leadership team that they could improve the service and make an impact on the patient experience. The division undertook projects that promoted innovation and ensured patients were treated safely and effectively.

Vision and strategy for this service

- There was a trust-wide quality strategy and the trust vision of 'providing quality of care for everyone, every time' was well recognised by staff.

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- The trust vision of ‘providing quality of care for everyone, every time’ was well recognised by staff. For example, staff were engaged in the design of the trust’s new computer system and they felt that this had improved patient care.
- There was also a local vision and strategy for the surgical division to use enhanced recovery pathways and increase day surgery.
- The division team had an overall understanding of their role in this vision.
- Staff told us that they felt the trust leadership had “listened but not heard” their concerns. This affected staff morale. Staff told us that, in spite of this, they retained a sense of commitment, purpose and direction at the division-level, to continue to improve the quality of patient care.
- Staff were concerned about the provision of local surgical services, particularly as steps were not being taken to improve the recruitment processes. This was affecting the recruitment of consultants in key services.

Governance, risk management and quality measurement

- In May 2014, the division began to hold monthly quality meetings where quality issues, such as complaints, incidents and audits were discussed. Matrons met with the acting head of clinical services to monitor progress on actions that were taken to improve the quality of the service.
- The division had a quality dashboard for each of its services and ward areas. Dashboard data included performance information against quality and performance targets. Members of staff told us these were discussed at team meetings. We found orthopaedic wards had consistently poor results on mandatory training and these results were not followed up. We spoke with the acting clinical service lead, who was aware of the issue, and had plans to improve performance monitoring across the service.
- Staff were encouraged to raise concerns about quality, but we found concerns raised by the division were not always heard or acted upon by trust management. For example, the trust had launched a capital development programme to improve the quality of access. Clinicians in the division had raised concerns that the programme would have an adverse impact on the quality of patient experience. Staff perception was that the concerns were not taken seriously and action was not taken in

response until after the capital programme had started. A consultant told us that they had informed the medical director about concerns regarding post-operative infection rates but no action had been taken.

- However, the trust has learned from this experience. It has now asked the acting division clinical lead to assess all capital programmes and identify strategies to minimise the negative impact on the patient experience.
- There were divisional risk registers that identified key risks to the service. Risks were reviewed and monitored at both division and board-levels. For example, the concerns about poor patient experience as a result of the capital development programme had been placed on the risk register. As a result, the trust leadership team had taken actions that had been previously identified.

Leadership of service

- We found there was strong clinical leadership from clinicians in the division. There were engaged and felt supported in their work, although they did not always feel their concerns were addressed.
- There was a sense of energy and purpose in the divisional leadership team. They wanted to improve the service and make a positive impact on the patient experience.
- Ward managers we spoke with felt engaged and supported by matrons. They told us they were given a high level of autonomy and flexibility to improve patient experience. For example, they were empowered to fill vacancies on their wards.
- The matrons we spoke with told us that the quality of patient care was paramount. For example, in response to concerns about inappropriate transfers of patients, a new protocol was due to be implemented. Matrons told us that all decisions about transferring patients from one ward to another would be undertaken by matrons. Previously, decisions about patient transfers had been made by less clinically experienced staff and had resulted in some inappropriate patient transfers.

The appointment of the head of clinical services was welcomed by staff as an improvement of clinical governance arrangements.

Culture within the service

- The culture in the division could best be described as a ‘can do’ culture. On the wards, we found staff engaged

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on quality of patient care and experience. For example, the wards had quality champions who met trust directors monthly in order to raise concerns about staff morale, care provided to patients and any other issues.

- We spoke with five quality champions in the division and they told us the culture in the division was improving. They said there was greater visibility of the trust board on the wards. The non-executive directors undertook ward rounds and their feedback was shared with staff at monthly staff meetings.
- In theatres, we found two separate teams had been merged into one team in order to ensure the workforce was suitably skilled. This was a good example of the division's commitment to ensuring high quality care for patients.
- The divisional leadership team recognised the importance of promoting a positive culture on the wards. For example, the trust had a leadership development programme for all ward sisters. However, because ward sisters had clinical duties, which were additional to their managerial responsibilities, they were sometimes unable to attend these programmes. As a result, matrons redefined the role of the ward sister and limited it to clinical leadership at ward-level.
- Matrons told us that the culture within the division of improving patient care made them feel empowered to make such changes.

Public and staff engagement

- The division did not undertake any formal public engagement. Most formal engagements with the public were undertaken by the trust as a whole. However, we did find examples where the public had shared their experiences with wards. For example, patients who complained were given an opportunity to share their complaints with the staff, so as to enable greater learning. Staff we spoke with told us that a patient was going to come to their staff meeting in July 2014 to share their experience on the ward. This meant staff would hear about the impact the care had on patient experience.

- The division engaged staff in various ways. The wards had quality champions who shared concerns from staff about issues affecting the quality of care with the trust board leadership. Quality champions we spoke with told us the communication with the board was improving through this mechanism. They felt they could raise matters and get their voices heard. However, it was too early to judge whether this initiative will make a difference. Ward sisters encouraged staff to share their concerns. We were given an example of how staff concerns about patient transfers onto the wards resulted in ward specific protocols on patient transfers. At our inspection, the protocols were in draft and had yet to be approved.
- Staff we spoke with felt proud of their wards and the work they undertook. They told us that there were mechanisms in place to engage and be part of the overall vision of the division. However, we were concerned that the division had not examined the recent 2013 staff survey results of their staff. This meant the divisional leadership team were not aware of how staff morale was within their division. While they had anecdotal evidence of this, they were no division-specific action plans to improve the results of the staff survey.

Innovation, improvement and sustainability

- There were initiatives in place to improve quality.
- Junior doctors undertook clinical audits and the results were shared with clinical staff. Ward sisters undertook leadership development programmes where they developed projects to improve the quality of services. For example, on St Helen's ward, the ward sister who attended this programme initiated a pilot project on ensuring nutritional supplements for patients were placed on the wards for easy access and use. Nutritional support drinks helped patients recover after their surgery and this intervention should help reduce hospital stays.
- There was a pilot in theatres involving the use of a new electronic stock management system, which was intended to ensure cost effectiveness.

Critical care

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

Information about the service

The Isle of Wight NHS Trust intensive care unit (ICU) at St Mary's Hospital had six beds. The critical care unit did not have a high dependency unit. However the unit provided level 3 care that is for patients requiring one-to-one support, such as those ventilated. Level 2 contained intensive care beds, such as those used for high dependency care. The outreach team provided support with the care of critically ill patients who were on other wards. The critical care service had consultant cover 24 hours a day, seven days a week. The critical care department included the adult intensive care unit (ITU) six beds, the coronary care unit (CCU) with six acute care beds and 12 other beds.

As part of our inspection, we visited the ICU and CCU. We talked with seven patients, three relatives and 18 staff. These included nursing staff, junior and senior doctors, a pharmacist, domestic staff and managers. We observed care and the treatment patients were receiving and viewed four care records. We sought feedback from staff and patients at our focus groups and listening events.

Before our inspection, we reviewed performance information from, and about, the trust and data from the Intensive Care National Audit & Research Centre (ICNARC). This showed that between July and December 2013, there were 156 patients admitted to ICU.

Summary of findings

The service followed procedures that ensured patients received safe and effective care. Clinical outcomes were monitored and this showed good outcomes for patients. Patients and relatives expressed a high degree of satisfaction about the care they received. Care was provided in a caring, dignified and compassionate way. The departments were well-led and demonstrated positive leadership and culture. A business plan had been submitted to the trust board and this included a review of ICU and CCU and a proposal to include dedicated high dependency beds in order to improve care. This would also improve the responsiveness for pre-planned admissions following surgery, and effective use of ICU beds.

Critical care

Are critical care services safe?

Good



Critical care services followed procedures to provide safe care. Staffing levels followed national guidelines about caring for critically ill patients and risks to patients whose condition may deteriorate were escalated appropriately. All the staff we spoke with said they were encouraged to report incidents and received direct feedback and outcomes from incidents that were discussed at daily meetings.

The environment was clean and hygienic. Staff followed their procedures for infection control and clear information was displayed on the prevention of infection.

Multidisciplinary handovers occurred twice a day and were well managed. All professionals involved with a patient during their admission to the unit added their notes to the same records and this ensured continuity and a team approach to delivering care.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. The trust had reported they had no Never Events on the intensive care unit between January and December 2013.
- Between June 2013 and December 2013 there had been one serious incident in critical care which was related to transfer from the medical unit to critical care. The incident was investigated and lessons were learned about the need to use the integrated outreach team more effectively in assessment and transfers of critically ill patients.
- All staff we spoke with said they were encouraged to report incidents and received direct feedback from their matron. These incidents were discussed at staff meetings, action plans developed and learning was taken from incidents.
- Staff told us of one serious incident that had impacted on a patient, which had not been reported. The unit manager said this had been missed and would be addressed.

- Incidents of cardiac arrests were monitored. A root cause analysis followed each cardiac arrest and feedback provided to lead clinicians and ward managers.
- Mortality and Morbidity meetings were held monthly. These were attended by medical staff and nursing staff. All incidents of death and poor outcomes for patients were reviewed and where appropriate action was planned and implemented to improve outcomes for patients.

Safety Thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections (UTIs), venous thromboembolism (VTE) and falls.
- The NHS Safety Thermometer information was displayed at the entrance to the intensive care unit. This included any new pressure ulcers or whether a patient had a blood clot, known as venous thromboembolism (VTE) or catheter urinary tract infection (UTI). The unit was performing as expected in these areas.
- Risk assessments for patients for pressure ulcers and VTE were completed on admission and prophylactic therapy instigated for VTE prevention.
- The ventilation care bundle was used for all patients requiring invasive treatment such as mechanical ventilation.
- The trust's prevalence of patients with a new VTE was lower than the England average for the last 12 months from March 2013 to February 2014 with no new VTEs reported in nine of those months.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Staff followed the trust policy on infection control. The 'bare below the elbow' policy was adhered to and hygienic hand-washing facilities and protective personal equipment (PPE), such as gloves and aprons, were readily available, used and changed by staff between patients.
- There were effective arrangements for the safe disposal of sharp and contaminated items.
- The unit contributed their patient data and outcomes to the Intensive Care National Audit & Research Centre

Critical care

(ICNARC) and so was evaluated against similar departments nationally. ICNARC data showed infection rates. For example, MRSA rates were below the national average.

- The latest hand hygiene audits in ICU and CCU showed they had achieved 100% compliance.

Environment and equipment

- The environment on the unit was safe and the restricted access to some clinical areas was well managed.
- Their equipment was fit for purpose, modern and up to date. The resuscitation equipment was checked daily and recorded. All equipment was clean and safety checks were completed.
- The emergency equipment used for the transfer of patients had not been checked as per the trust procedure. This was resolved on the second day of our inspection. An action plan and monitoring process was being developed to prevent recurrence when the unit was busy.
- The unit environment was bright, bed space was spacious and the unit was in good decorative order.
- There was direct access to the operating theatre from the unit.
- There was a day room with a sofa bed for relatives. There were no facilities for hot drinks in this area, although staff said they did offer refreshments to people who may spend long hours in this room.

Medicines

- All medicines were stored safely and securely, including in locked cupboards or fridges, as required. This included intravenous (IV) fluids, as per recent guidelines.
- Fridge temperatures were monitored daily, this ensured medicines were maintained at the recommended temperature and that they were safe for use.
- There were arrangements for the effective access to medicines out of hours. The pharmacist was allocated to the intensive care unit and reviewed all medical prescriptions daily to ensure sufficient stocks were available. They provided advice and support to the staff on all aspects of medicine management for the patients' benefit.

Records

- There was standardised nursing documentation kept at the end of each patient's bed. Observations were recorded clearly. The timing and frequency of observations were determined by the acuity of patients.

- All records were in paper format. They followed the same format, which meant information could be found easily.
- All professionals involved with a patient during their admission to the unit added their notes to the same records. This ensured continuity and a team approach to care delivery.
- The unit used a daily ward round pro forma, which was completed during the morning ward round. There were clear records of the treatment patients had received and any further treatment or follow-up they required.
- Records were transferred with the patients to the coronary care unit, which provided continuity of care.
- Patients were reviewed on a daily basis and detailed records of these were completed. These also demonstrated patients and relatives were kept informed of ongoing treatment.
- Records were comprehensive and included a weekend plan and information of when bloods were checked and any further investigations required. This was to assure continuity of care for the patients.
- There was no formalised recording system in use for withdrawal of patients' treatment and the involvement of the palliative care team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients, or their relatives, were asked for their consent to procedures appropriately and this was recorded.
- The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and to report on what we found. The unit manager told us there was no one who was receiving care under this safeguard. Staff were aware of Mental Capacity Act 2005 and how this related to the patients they cared for.
- Although relatives were informed of procedures such as a percutaneous tracheostomy, staff did not always follow their procedure for recording consent from relatives. However, discussions with staff and our observations of care being provided showed that, while not well recorded, consent was sought actively for any intervention.
- Patients who were undergoing elective surgery had their consent sought and recorded. Staff told us for those

Critical care

patients who were unable to consent, their relatives were consulted. The trust had documentation to be completed when involving relatives in providing consent, this was not always completed.

Safeguarding

- All staff we spoke with confirmed they completed training about safeguarding vulnerable adults and children as part of mandatory training and updates. Information provided by the trust indicated that 92% had completed adult safeguarding training, 98% had completed children safeguarding training at level 1 and 76% at level 2.
- Staff demonstrated a good understanding about safeguarding procedures and the reporting process.

Mandatory training

- The unit had a training plan for all nursing staff to ensure they met their mandatory training targets. Staff confirmed mandatory training was completed annually.
- There was a preceptorship programme for new staff and 77% of staff working in the unit had the necessary intensive care qualification.
- Resuscitation officers provided training in basic life support, intermediate life support, paediatric and advanced life support for clinical staff. Records showed 40% of clinical staff had completed basic life support (trust-wide). Although doctors were compliant with basic life support. There was no breakdown for ICU/CCU staff.

Assessing and responding to patient risks

- Nursing handovers occurred at the beginning of each shift. There was a short handover where all nursing staff were updated on the patients' condition. This was followed by an individual handover at the bedside, which staff said was effective and ensured vital information was not missed.
- The modified early warning score (MEWS) escalation process for the management of acutely unwell adult patients was used to identify patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- The outreach team was an integrated team and provided vital support available seven days a week for the management of critically ill patients.
- There was arrangement for the transfer of certain critically ill patients to two hospitals on the mainland.

- All stroke patients admitted to hospital and assessed, as appropriate for thrombolysis, were admitted to the CCU for management and close monitoring. This procedure was often carried out by the outreach team in A&E to assure patients received this treatment within the optimum time frame and as per the stroke pathway.
- There was no facility for the care of critically ill children. They were managed and stabilised in the paediatric resuscitation room, prior to transfer.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patients' illness. Alarms were set on monitoring equipment to alert of any changes in the patients' condition. This meant deteriorating patients would be identified and action or escalation by the appropriate team was initiated without delay.
- The unit manager/lead person for the shift also attended handover for medical staff to ensure communication remained effective.
- Staff were supported by a multidisciplinary team, such as physiotherapy, occupational therapy and pharmacy, for advice and support in the management of patients.
- Staff demonstrated a good understanding of people's social and cultural needs and how these could be met in the intensive care unit.

Nursing staffing

- The staffing roster was planned and staff worked on a rotational basis on days and nights. This consisted of three teams working four weeks on day duty and two weeks rotation on nights. This provided continuity for patients and achieved the appropriate skills mix. All level 3 patients were nursed one to one, and level 2 patients one to two and, often, they also had one-to-one care. There was also a unit manager or lead nurse who had overall responsibility for the unit. They were supported by an administration person and healthcare assistants.
- The unit manager and other staff spoken with told us they had adequate staff to meet the patients' needs.
- Shortfalls in staffing levels were covered by permanent staff, which meant extra hours/overtime, and a cohort of bank staff.
- There was a supernumerary senior nurse who led each shift. However, on night duty in the last month, the supernumerary nurse was allocated a patient on about five occasions, due to staff shortages.

Critical care

- The critical care outreach team was available and provided support in resuscitation rooms.
- The unit manager looked at the staff's skills mix as part of duty roster planning to ensure there were always adequate staff, with the right skills, providing patient care.

Medical staffing

- Care in the ICU was consultant-led. There were four consultants in intensive care providing cover five days a week from 8am to 5pm and were available on call at other times and at the weekend. A consultant was able to attend the unit within 30 minutes, if required. There were eight specialty and Associate Specialist (SAS) doctors and one foundation year 2 (FY2) doctor.
- The consultants worked in ICU in consecutive five day blocks, as recommended in national guidelines for intensive care. All admissions to the unit were discussed and admitted under a consultant.
- The SAS doctors worked a 24-hour shift and provided cover for obstetrics. We discussed the impact of the unit not having adequate cover if the SAS doctor was called out for obstetrics and we were told the on-call consultant would provide cover, as needed. Consultants were supported by the SAS team.
- There was good support from other teams of doctors, such as surgery and obstetrics in the management of the critically ill patients. There were difficulties in getting support from the medicines division of the acute directorate. ICU staff also had difficulties in discharging patients to the medicines division, as they had to ring a consultant to accept the patient.

Major incident awareness and training

- The staff worked with the trust policy and procedure for major incidents.
- There were some procedures which were specific to the intensive care unit, such as the management of critically ill patients if transfer was not possible due to adverse weather conditions.
- Staff told us the lead or unit manager would take responsibility and coordinate for all major incidents.
- There was a clear procedure instructing staff what to do, for example, in the event of a fire. This meant staff working in the unit were clear of their responsibility in the event of a major incident.
- The fire evacuation procedure was kept at the end of each bed, which provided information for the staff in an emergency.

Are critical care services effective?

Good



The unit followed national guidance in the care and treatment of patients. There was good multidisciplinary team working and support for the patients and relatives. Appropriate care pathways were followed to ensure patients received safe and effective care and treatment. There were a variety of audits completed looking at the effectiveness of the service provision and remedial actions taken. Training and staff induction were undertaken and practices monitored.

Evidence-based care and treatment

- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society and the Faculty of Intensive Care Medicine guidelines to determine the treatment they provided.
- There were clear care pathways such as the ventilator care bundle which was used to ensure appropriate and timely care for ventilated patients.
- In the CCU, the stroke pathway was followed and thrombolysis initiated for stroke patients, this was according to NICE guidelines. Patients presenting with a stroke received a scan within an hour.
- The integrated outreach team initiated the stroke pathway on admission to the emergency department and thrombolysis therapy commenced as appropriate, prior to transfer to CCU.
- The unit took part in the **National Confidential Enquiry into Patient Outcome and Death (NCEPOD)** for tracheostomy. This looked at the quality of care to improve outcome for patients who had to undergo a tracheostomy. This was ongoing and no results were available.
- All patients were screened and received prophylactic treatment for venous thromboembolism.

Pain relief

- In ICU, staff followed their protocol on pain control for ventilated patients.
- Patients in ICU told us they received pain control as needed and they were not in pain.
- In CCU, patients had their pain monitored and patients told us they received pain control medicine accordingly.

Critical care

- Staff said pain was also discussed at ward rounds. Pain relief was also available at any time according to a patient's needs.

Nutrition and hydration

- The unit used the Malnutrition Universal Screening Tool (MUST) to assess the nutritional needs of patients.
- In ICU, staff followed their protocol for hydration and nutrition for ventilated patients and enteral tube nutrition was initiated.
- Patients' nutritional and hydration needs were assessed daily, as part of their overall treatment. Appropriate action was taken to ensure their needs were met. Records showed nutritional and fluid intake was monitored.
- A dietician's advice was sought to ensure patients received the appropriate enteral feed to meet their dietary requirements.

Patient outcomes

- The unit contributed to the Intensive Care National Audit & Research Centre (ICNARC) database. This demonstrated that mortality was below the national average and unplanned readmissions were lower to those in other trusts.
- ICNARC data showed the unit was performing well in managing VTE risk and was above the trust's target of 95% compliance.
- The ICNARC data for delayed discharges (hour delay) showed that the trust's rate of delayed discharges (hour delay) lies within the units 95% confidence interval (CI). A confidence interval is a range of values whose width gives an indication of the uncertainty or precision of an estimate.

Competent staff

- In ICU, 77% of the nursing staff had achieved a post-registration award in critical care nursing.
- All staff received group and one-to-one supervision and appraisals. This process covered training and development needs and practices. Information provided by the trust indicated that, as of January 2014, 91% of staff in this directorate had completed their appraisal.
- An induction programme took place for all new staff and they confirmed it was informative and sufficient at the start of their critical care role. There was a competency programme for new nurses and this included observation of care being provided.

- The unit managers were supportive of staff's personal development and further training needs were assessed and opportunities made available to them for further training. Staff were positive about the support they received from the lead person on the shifts and the multidisciplinary team.
- There was a planned teaching programme and specialist nurses were invited to share practices. Recent teaching programmes included how to deal with blood transfusion for Jehovah's Witnesses and blood cultures. Staff shortages had impacted on the daily teaching programme and this was being looked at.
- Senior nurses provided further support, which included a preceptorship programme for new and existing staff. An education lead nurse was available and told us that sufficient support and resources were available to ensure training and support was provided to all new staff.
- There were no trainee doctors in ICU. This was a deanery decision. The lack of trainees was viewed as a negative aspect of the development and ethos in ICU as there was no contact with the royal colleges or networks to develop and maintain professional standards.
- All new medical staff were given a consultant to support their induction into working in the NHS and this complemented the trust induction training. All medical staff were assessed for competency and to check that they had completed target training prior to working independently.
- Meetings and training for medical staff on the mainland was actively promoted by the trust.
- Advanced life support (ALS), paediatric advanced life support and advanced trauma life support (ATLS) courses were available locally and funded.

Multidisciplinary working

- There was a multidisciplinary team who supported patients and staff in the unit.
- There was a dedicated critical care pharmacist to provide advice and support to those who visited the unit and they were available daily and at other times. The team included physiotherapists, a dietician, tissue viability nurses, infection control nurses, dementia care and learning disability specialists.
- There was a twice daily ward round, which had input from nursing, microbiology, pharmacy and physiotherapy.

Critical care

- The outreach team was fully integrated and provided valuable support in the care of the critically ill patients.
- There were good multidisciplinary team working with surgery and obstetrics. However, this was not the case for medicine which was not well represented and staff experienced a lack of support in ICU and such, as when transferring patients back to the ward.
- There were clear procedures and service-level agreements with hospitals in Southampton and Portsmouth for the transfer of patients.
- The unit had good links with the organ donor team in Portsmouth. They worked closely and had daily contact with the team at the unit. The staff were aware of the procedures to follow and the access to contact information for transplant services. Referrals were made appropriately and donor packs were available. The outreach team was also involved in the management of support for potential donors and for their families.

Seven-day services

- There was consultant cover for patients in the unit, during the day 8am to 6pm and an on call service out of hours. This ensured that there was seven day cover.
- There was 24-hour consultant cover and they carried out daily ward rounds and were available for advice and support at other times.
- A multidisciplinary team, including: physiotherapy, pharmacy, biochemistry and radiology was available, either on site or on call, which meant patients continued to receive care and treatment, as required.
- At the weekends, support was available on site from the multidisciplinary team, including microbiology, physiotherapy and pharmacy.

Are critical care services caring?

Good



Patients and the relatives we spoke with were highly complimentary about the staff, the care and treatment they had received. Patients told us they were involved in their care and relatives told us the staff had explained to them what was happening at each stage and treated the patients with the utmost dignity and respect. We observed staff supporting patients and relatives with compassion and in a calm and supportive manner.

Compassionate care

- During our inspection, we observed patients were treated with the utmost compassion, dignity and respect. Patients and relatives we spoke with were highly complimentary about all the staff and the respectful and sensitive care their relatives had received in the unit.
- Patients told us the care “has been fantastic, they (the staff) look after you very well”. Another patient said they had been “very poorly when I came” and the staff “did a very good job”.
- Relatives told us the staff were “very busy”, but that they “always have time for you”. They described the care as “very good” and said the staff were caring and treated their relatives with compassion.
- Another relative said the staff maintained good communication with family and explained the care and treatment plan to them.
- The use of effective screening meant that patients had their privacy protected at all times and the use of stickers on the outside of screens alerted staff. We observed blinds were closed when patients were receiving care in the side rooms.
- A local Healthwatch survey result in April 2014 showed 84% of patients were satisfied with the care and treatment they had received and would recommend the unit. The trust received positive feedback from Healthwatch and patients described care in the CCU as “outstanding in all respects”.

Patient understanding and involvement

- On admittance to the unit, many people were not able to be involved directly in their own care and treatment, as they may be sedated or unconscious. However, their relatives told us they were consulted and felt very involved in the decision-making process.
- A patient told us that they were able to participate in their care and nursing and medical staff had fully involved them. Information provided was clear and, for example, reasons for tests were fully explained to patients.
- Patients who were undergoing elective surgery had their consent sought and recorded. Staff told us that, for those patients who were unable to consent, their relatives were consulted. The trust had documentation to be completed when involving relatives in providing consent, this was not always completed.

Critical care

Emotional support

- Staff had a good understanding of the needs and support for patients and relatives who were faced with an often unexpected and life-threatening illness. Emotional support was provided both during admission and after discharge from the critical care units.
- Clinical nurse specialists and donor teams provided support to relatives and patients, as needed.
- The hospital's chaplain visited the unit to offer emotional support to patients, their relatives and the staff, as requested. There was no guidance on how to access this service for people from other religious denominations and ethnic minorities. A senior staff member told us this would be discussed at trust level.
- Relatives told us they felt "very well supported" when they had arrived at the unit and were grateful for the support they had received.
- Information about counselling services were provided, as needed, to patients.

Are critical care services responsive?

Good



The critical care services were responsive to the needs of patients and there was support for patients with physical and learning disabilities, if needed. Staff demonstrated a good understanding of people's social and cultural needs. Patients who were discharged from the unit were aware of their discharge plans and there were appropriate records to those receiving them into their care. There was pressure on beds and patients were transferred to the mainland at least once a month. The unit had plans to increase bed capacity to respond to the needs of the population. Complaints and concerns were managed effectively and staff followed the trust procedures.

Service planning and delivery to meet the needs of local people

- There were clear protocols and procedures for the safe transfer of patients to hospitals in Southampton and Portsmouth, which was part of their service-level agreements. This included support from the critical care outreach team.

- A business plan had been discussed to increase bed capacity from six to eight beds in ICU. This was a medium to long-term proposal for resolving the shortage of critical care bed capacity. The plan was also looking at having a dedicated high dependency unit.
- There was also a proposal to build an equipment storage facility next to ICU to free up more space for more beds.

Access and flow

- For the period from January 2014 to March 2014, the ICU had a bed occupancy rate of 77%, which was below the national average of 85.7%. However, there were a number of breaches (of the rule that stipulated that no patient should be kept in the unit) due to delayed discharges from the unit because of the lack of bed availability on the wards.
- ICNARC data showed that transfers for reasons that were not about clinical care and treatment were similar to the national average.
- Overspills (where there were insufficient beds for ICU patients) were managed in recovery or the A&E department.
- There was at least one non-clinical transfer per month to a hospital on the mainland, due to bed capacity.
- The number of operations cancelled by the trust was similar to the rate in other trusts. There had been one cancelled, planned operation, due to the lack of ICU beds, during 2013/2014.
- The average length of stay for patients was six days. Sometimes, patients remained in the unit longer due to the lack of beds on the wards.
- Patients requiring thrombolysis were cared for in the CCU for close monitoring. Once treatment was completed and the patients no longer needed such intensive treatment, they were transferred to beds in the ward next door, which was effective in freeing CCU beds.
- Staff were looking at how to improve the availability of beds when cleaning the rooms used for patients who were to be 'barrier nursed' was delayed and not effective. The term 'barrier nursing' is given to a method of nursing care used when caring for a patient known or thought to be suffering from a contagious disease such as open pulmonary tuberculosis. This, we were told, sometimes impacted on admission to these beds.

Critical care

- Patients who were discharged from the unit were involved in their discharge plans. An appropriate discharge summary was completed on transfer to maintain continuity in care.
- The critical care outreach team was involved in discharge planning and visited patients after discharge from the ITU to offer continued support.
- The ICNARC data for delayed discharges shows that the trust's rate of delayed discharges is within the expected range.

Meeting people's individual needs

- There was good multidisciplinary working and support to meet the needs of patients.
- Support for patients with learning disabilities and/or people living with dementia was available, as required, from specialist nurses. Staff sought advice when needed.
- Patients with complex needs were referred to the specialist teams for advice and treatment plans.

Learning from complaints and concerns

- Complaints policies and procedures were available. The patients and relatives we spoke with confirmed they were confident when it came to raising any concerns with the unit manager/staff in charge and this would be dealt with.
- The patients we spoke with told us they had "no complaints" and "nothing but praise for the staff, who had a difficult job to do".
- Complaints were handled in line with trust policy. Complaints were dealt with by the team leader/unit manager, as appropriate.
- Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- Records were kept of a recent complaint and an action plan developed following completion of the investigation. Action included staff revisiting policy and procedures on confidentiality and data protection.
- The unit also sought patients and relatives views via their own questionnaires. Feedback was reviewed and an action plan developed to effect any changes, as needed. For example, keeping relatives informed and updated during busy periods.

Good



Staff were clear about the trust vision for the future, in particular, in relation to increasing bed capacity and effective use of the current facilities. Staff felt well supported and information from trust board meetings was shared with them. There was a strong and supportive leadership within the unit. They were passionate about the work they did and the support they received. They felt proud of the multidisciplinary team and worked well together and there was obvious respect for each other. Risks were being managed appropriately and staff were involved in quality improvement projects.

Vision and strategy for this service

- A business plan had been discussed to increase bed capacity from six to eight in ICU. This was a medium to long-term proposal for resolving the shortage of critical care bed capacity.
- Currently, there was no high dependency facility (HDU), which meant level 2 patients who were fit for discharge continued to occupy ICU beds. Staff told us there were proposals being looked at for developing HDU service and using capacity in CCU.
- A strategy for relocating CCU and ICU had been proposed and was being discussed, increasing overall bed capacity.

Governance, risk management and quality measurement

- The unit had monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were cascaded to staff during regular unit meetings and the minutes of the meetings were available to the staff.
- Doctors attended monthly clinical governance meetings for morbidity/mortality. Minutes from these meetings demonstrated that individual cases were discussed and outcomes and alternative options considered.
- ICNARC data was displayed in the unit so that patients, their relatives/carers and staff could see the quality of care on the unit.
- Managers from the unit attended the trust governance meetings and information was cascaded to staff on the

Are critical care services well-led?

Critical care

unit. Staff were part of the Thames Valley & Wessex Critical Care Network, which enabled them to share their experiences and learn from good practices in similar care services.

- Risks around the delivery of safe care were clearly identified on the trust's risk register. There was a risk of insufficient critical care capacity to meet fluctuations in demand. Supporting actions were identified and discussed at governance and board meetings and linked to the business plan.

Leadership of service

- The ICU and CCU units were led by a consultant clinical lead, unit managers and senior nurses. There was strong local leadership of the units.
- Staff teams from the critical care department were well-led and staff said they felt well supported and there were good multidisciplinary working.
- Staff told us that they felt supported by all of the experienced staff on the units and were able to ask for support or help at any time.
- There was a flexible workforce that eliminated the use of agency nurses and sustained continuity in patient care.
- Management staff told us they felt listened to and involved in decisions about the service.

Culture within the service

- Staff we spoke with were passionate about the care they provided for patients.
- There was an open culture, in which staff were encouraged to raise their concerns.
- Good working relationships and respect were fostered between medical and nursing staff.
- Staff told us that providing high quality and safe care were their priorities. We observed how shift and unit leaders were compassionate, supportive and led by example. We saw a supernumerary senior nurse who led each shift by providing support to relatives in a calm and compassionate manner. Visitors told us the nurses were "marvellous" and felt "very reassured" when their relative was admitted on the previous day.
- Staff were encouraged to complete incident forms or raise concerns.
- Staff were engaged and worked well with the multidisciplinary teams and departments within the hospital, such as the integrated outreach team.

Public and staff engagement

- Information about the intensive care service was available on the trust website. This meant that the public were informed about the service provided by the unit. The website also provided links so patients could give feedback about their experience of receiving care and treatment.
- There were links to assist people to learn more about the trust performance, including a Dr Foster Intelligence report and ICNARC data.
- Staff told us that the use of staff meetings and handover sessions meant they were fully informed and involved in the running of the service.
- The results of the 2013 NHS Staff Survey were organised into 28 key findings. The trust performed better than expected for the percentage of staff receiving job-relevant training, learning or development in last 12 months and the percentage of staff saying that hand washing materials were always available. The trust's performance was rated as 'worse than expected' or 'tending towards worse than expected' for 14 of the 28 key findings in the NHS 2013 staff survey. These included staff at the trust being less likely to recommend trust as a place to work or receive treatment, staff reported lower levels of satisfaction with the quality of work and patient care that they were able to deliver and communication between senior management and staff.
- There was support for staff and debriefing sessions on a regular basis and after each resuscitation episode. They had looked at their staffing and the hours. Staff in ICU reported a high degree of satisfaction in their work and all said it was a great place to work and were very well supported.

Innovation, improvement and sustainability

- Staff said they felt encouraged within their department to be innovative. They were able to attend training and used external speakers for development and learning. These included, for example, a blood transfusion specialist and a Jehovah's Witness representative.
- There was a business development plan for increased ICU beds and an HDU facility, which would give greater sustainability. Medical cover was currently shared with maternity.

Maternity and family planning

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

Information about the service

Maternity services were an integrated service, which included an acute setting at St Mary's Hospital and community clinics across children's centres and medical practices. There were approximately 1300 babies born each year, or about three to four births a day.

There are 18 inpatient beds on the maternity ward area, with a three bed triage room on one ward area (not overnight beds) and five labour room beds in a consultant and midwife-led service at St Mary's Hospital. There was a maternity assessment unit and antenatal screening. There was a maternity theatre and antenatal, labour and postnatal wards.

Some babies were identified as requiring additional or 'transitional' support, but remained with their mothers on the ward. Babies who were unwell were admitted to the neonatal intensive care unit. This unit was adjacent to the maternity services. Babies and mothers requiring more specialist care were transferred to a hospital on the mainland.

We visited the wards and units and talked with 25 members of staff, including midwives and consultants, about the maternity services available in the community and in the hospital. We also spoke with eight mothers about their experiences through pregnancy and labour and the time they spent on the postnatal ward.

Summary of findings

Maternity services at St Mary's Hospital and in the community were well planned and organised. Midwifery staffing levels were below national recommendations, but staff were working flexibly to ensure there were adequate numbers. There was recruitment to improve medical staffing levels. Safety standards were followed and the environment was clean and the service was fully equipped.

Women's care and treatment followed national evidence-based guidelines and staff were appropriately trained and worked well in multidisciplinary teams. Women told us they received compassionate and supportive care, had choices and were involved in decisions about their care. Governance arrangement and risk management were effective and there was a leadership culture that promoted learning and continuous improvement.

Maternity and family planning

Are maternity and family planning services safe?

Good



The service reported incidents and had an open and trusting culture that encouraged staff to learn from incidents to improve the safety of services offered. There was a high level of awareness about avoiding infections and the behaviours adopted by staff reflecting good practice. In the main, medicines were stored safely and appropriately and patients' records were informative, well planned and maintained. The environment was clean and the service was fully equipped.

Mandatory training was thorough and a new competency framework was being introduced, so that midwives could practice safely in all settings. Staffing levels were adequate on the ward, but were described as "stretched" in antenatal screening and in the maternity assessment unit. There were plans to improve the flexibility of staffing following further integration with community services. There were medical staff vacancies, but recruitment was taking place. Risks to women were appropriately managed and documented and staff were knowledgeable about safeguarding procedures.

Incidents

- 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There had been no Never Events reported for maternity.
- A consultant obstetrician for maternity services took the lead on the recording, monitoring and analysis of incidents. Incidents were taken very seriously within the department so that lessons could be learnt. Information about incidents was shared and the unit leads were involved in the analysis.
- There was one incident classified as serious reported for the maternity services between April 2013 and March 2014. This was an unexpected neonatal death.
- On average, over the last six months, 11 incidents were reported in maternity services each month. The number of incidents reported indicated that midwives were using the reporting system consistently to record and monitor the number and pattern of incidents.

- The incidents reported included several cases of shoulder dystocia and postpartum haemorrhage (loss of blood). There were also several unplanned home births recorded, third degree tears and a number of transfers from the island to receive treatment in Southampton. The number of incidents reported were consistent with the national average.
- Monthly mortality and morbidity meetings were held. These meetings were attended by the lead consultant obstetrician, head of midwifery and other midwives including those with specialist or lead roles within the service. All midwives were invited to attend and it was planned that all midwives should attend a minimum of two meetings annually.
- The notes of a recent mortality and morbidity meeting, which were not dated, included a review of all clinical incidents reported and the activity taking place during the month. The cases were examined and any patterns of learning identified. For example, we saw from the notes that colleagues were reminded to contact the on-call community midwife to provide cover if the ward was busy and staff were struggling to undertake observations and offer pain relief. The notes of this meeting were circulated to everyone working in the service and one member of staff told us, "The notes are useful and they keep us informed."
- The midwife leading on risk told us that, in 2013, it had been noticed that many of the incidents reported were for postpartum haemorrhage. As a result, the service provided additional training and this had improved the awareness and promptness of action taken by midwives and clinicians. This resulted in a reduction of the number of cases.

Safety Thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections (UTIs), venous thromboembolism (VTE), and falls.
- The NHS Safety Thermometer was a local improvement tool for measuring, monitoring, and analysing patient harms and 'harm free' care. There was a report published nationally each month.

Maternity and family planning

- We did not see the Safety Thermometer data displayed on the notice boards, but we saw that the information was collected and submitted monthly to a central point in the trust. Staff we spoke with were aware of the results.
- The clinical consultant lead informed us that the service was 100% compliant in taking action to prevent deep vein thrombosis and pulmonary embolism (VTE). This was particularly important for women with diabetes and/or a raised BMI. This demonstrated a good awareness, and use, of the Safety Thermometer.

Cleanliness, infection control and hygiene

- All the ward areas we saw were clean and so were the individual rooms. We saw cleaning in progress.
- We saw staff using hand sanitising gel and encouraging visitors to use it as well. We also saw staff wearing protective equipment including gloves and aprons.
- We noted that the service was vigilant in taking action to reduce the risk of infection by restricting access to the kitchen areas for visitors and the room for making up baby feeds.
- There was a degree of caution about the addition of decorative soft furnishings and, although tours of the units were permitted, they were not encouraged and the service was planning to offer a virtual tour on the website.
- A room, adjacent to the maternity theatre, for setting up theatre equipment had not been used because of an inadequate airflow. This had been identified as a potential infection control risk. In the meantime, the equipment was being set up in the theatre itself. This issue had been added to the corporate risk register and the trust was considering what action to take to resolve the problem.
- Two of the consultants told us about the audits they had conducted on wound infections post-caesarean section and the work they were conducting on the use of antibiotics. The lead obstetrician reported that they had not found evidence of higher levels of wound infection than expected.
- Between October 2012 and October 2013, there were 25 incidences of puerperal sepsis and/or other puerperal infections, which was within the expected number.

Environment and equipment

- The ward environment was bright and cheerful and the facilities were well positioned and clustered together. There was a dedicated theatre for maternity and other theatres were just minutes away. The maternity services were also alongside the neonatal intensive care unit.
- The airflow issue in the theatre setting up room had been entered on the risk register at the end of April 2014. The clinical team were mitigating risks with short term plans by preparing patients in theatre, and there was risk assessment and monitoring. However, this was still unresolved some six weeks later.
- We saw resuscitation equipment was freely available on the labour ward; however, when we looked, we found that the maintenance record showed that one of the trolleys had not been checked for several weeks.
- The paediatric trolley on the postnatal ward had not been checked for about four weeks.
- We noticed that there were new modern pumps available for expressing breast milk. This meant that mothers who wanted to use their breast milk to feed could do so, even if they were unable to breastfeed immediately.
- There was a general lack of facilities for partners on the wards and for partners who wanted to stay overnight. Though we were told that camp beds could be provided. Partners did not have access to the kitchen areas. Staff told us that this was in order to reduce the risk of infection.
- The room for families who had experienced a loss of a baby or a still birth was located slightly away from the main labour and postnatal wards. It was adequate, but the midwives said that they would like to improve the furnishings to create a more sensitive environment.
- There was a birthing pool on the labour ward and staff us it was used regularly. However, data on usage rates were not readily available. We observed that there was no hoist or net to assist with the removal of a mother from the pool in an emergency. While it had not been a problem to date, the head of midwifery agreed it was a risk that should be attended to.
- There was a chair specifically designed for labour in the room with the birthing pool and a mattress that would facilitate mobility in labour. We also saw other equipment such as a birthing ball and bean bags to assist mothers in labour.

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- One midwife said it would be helpful to have an equipment store, so that they could borrow items as they were needed to promote greater safety.
- We were told by several members of staff that the lack of electronic systems in the community was a major obstacle to effective communication. Community midwives had to telephone the hospital for patient results, for example, and this had the potential to cause a delay in providing appropriate support.

Medicines

- Medicines were stored securely in locked cupboards and in fridges at the right temperatures.
- We found that one drug on the adult resuscitation trolley had just expired.
- The contents of the obstetrics emergency trolley had not been checked for four weeks and one of the drugs (Syntocinon) was found on the trolley rather than in the fridge. This drug was normally kept in a locked fridge, but staff told us it had been removed from the fridge and placed on the trolley, so that it was available in an emergency. However, this drug lost potency after 30 days if it was removed from the fridge and no date of removal was displayed.
- Community midwives carried a small amount of Syntocinon to use in an emergency and we were informed that it was discarded after 30 days if it was not used.

Records

- The patient notes for mothers and their babies were unique to the trust and had been developed by staff and the risk manager. One of the consultants we spoke with said, "They are good once you get used to them."
- The notes were clearly set out and in a logical order. There were separate notes for antenatal care, labour and postnatal care for mothers and their babies.
- The antenatal care records included information about the risks of smoking, details on diet and nutrition and a pregnancy care pathway for women with a raised BMI. There was also a VTE risk assessment and assessments for mental health and information around 'safeguarding your baby'.
- A batch of 10 sets of notes, selected randomly, was audited each month for completeness and quality. We saw this at the labour ward meeting and all were found to be complete and in order.

- The use of the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist was inconsistent for both emergency and elective caesarean sections.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We examined three sets of postnatal case notes for women who had emergency or elective caesarean sections. Consent had been given for the elective procedure, but there were no consent forms in the notes for the two emergency caesareans. It was not clear from the medical notes that the reasons for caesarean section had been explained to the women nor that verbal consent had been obtained.
- Staff said that they had had training in the Mental Capacity Act 2005 and those we spoke with had a good understanding of their responsibilities. They said that they would also access support from colleagues in the mental health services.

Safeguarding

- There was a named midwife lead for safeguarding and there was training for staff in safeguarding. Information provided by the trust showed that 88% of staff had completed their adult safeguarding training and 95% had completed children safeguarding training at level 1 and 88% at level 2.
- There was a specialist midwife for drugs liaison and for mental health and bereavement, but the specialist midwife role for teenage pregnancy had been withdrawn.
- Staff told us that it was difficult to have specialist midwives in all areas, because it was a relatively small team.
- Community midwives reported that they conducted a risk assessment during an appointment with the mother at 16 weeks of pregnancy and this covered safeguarding issues, including the risk of domestic abuse. One midwife explained that this was a better time to have these conversations because the first appointment was "already quite full of important information and the 16th week was further into the relationship".
- The Isle of Wight Healthwatch maternity services report for 2014 stated, "Comments were made to us that women were not screened for domestic violence." The head of midwifery said that, "We are not as good at this as we should be and we need to get better."

Maternity and family planning

- The teenage pregnancy rate was in line with the national average. When a teenager was pregnant, if there were any concerns, the community midwife would make a referral to social services and the health visitor.
- Community midwives ran clinics in the nine children's centres across the island. Women we spoke with said that this was convenient.
- All safeguarding referrals were considered by the multiagency safeguarding Hub.

Mandatory training

- The head of midwifery said that compliance with mandatory training was about 76% and that there was some delay in some areas because of the availability of training sessions, across the trust.
- There was compulsory e-learning on health and safety, fire safety, drug administration and information governance.
- Manual-handling training was a little delayed because midwives needed a specialist update and the training required a significant number of midwives to be available at the same time. This was difficult to achieve, due to workload pressures, but we were told it was being prioritised.
- Other mandatory training included the care of women with an epidural, identification and care of severely ill women and breech delivery.
- We saw the programmes for the maternity clinical study days and they included sessions on neonatal and maternal resuscitation, antenatal screening, sepsis, handover of care, severe pre-eclampsia, fetal monitoring and safeguarding.

Assessing and responding to patient risk

- The service was using the modified early obstetric warning score (MEOWS) to enable recognition or deterioration of an acutely ill women.
- This system was included as part of the clinical notes and was to be used for all antenatal women and all postnatal women, until discharge from the hospital.
- There was also a high dependency chart for women requiring high dependency care.
- The MEOWS chart provided information about the frequency of observations for women with different degrees of dependency.
- The service also used the 'fresh eyes' approach to ensure that a patient was seen by another midwife or clinician to give an independent opinion of the care and treatment. This was good practice.

- The midwives we spoke with in the focus group said, "There is always somebody to ask and colleagues are very supportive." We were also told that there was an opportunity for a "debrief to ensure that there was learning for next time".
- The postnatal clinical lead shared some work they were completing on an escalation alert to guide colleagues on the ward as to when to call for assistance. This alert listed the combination of factors that might demonstrate that the service was safe, such as, that "a supervisor of midwives was on call but not working clinically". Circumstance that might indicate that safety was at risk would be "reduced staff with no extra staffing on call".

Midwifery staffing

- There was information about safe staffing levels displayed on notice boards on the wards.
- The total midwifery establishment was 66.84 whole time equivalents. This number included the head of midwifery, 41.81 whole time equivalent midwives, 2.63 whole time equivalent midwife sonographers, 19.73 whole time equivalent healthcare assistants and some part-time administrative staff.
- The trust's birth to midwife ratio, calculated according to the Birthrate Plus tool, was 1:32. The ratio was lower before and had been actively increased, as part of a cost-improvement programme. The national guidance was for a minimum ratio of 1:28.
- The head of midwifery reported that there was 1:1 care in labour for all women. Other staff and the women we spoke with on the postnatal ward confirmed this. One woman we spoke with said, "The staff have been available, I have only had to ask and they have responded quickly."
- However, the 2014 Healthwatch report into the maternity services at St Mary's Hospital said that some mothers had said that "midwives were rushed off their feet".
- The majority view from staff was that there were enough midwives and healthcare assistants to provide the appropriate level of care for women. If a ward or unit became very busy, staff from other units could help out, or the 'on-call' midwives could be brought in.
- Staff told us that the service could become very busy from time to time and additional support was called upon in this way.

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- The midwife to supervisor ratio was 1:12 and this was better than Nursing and Midwifery Council recommendation that ratios should not normally exceed 1:15. Midwives were able to choose their supervisor. There was always a supervisor of midwives on-call.
- The service did not use agency staff and only had a very small bank of midwives available. When the service needed additional staff they would contact their own staff to see who was available and the midwives responded to that.
- The head of midwifery and lead for education and development said that they had an ageing midwifery workforce and that there could be a succession issues in the near future.
- The head of midwifery said that the challenge was to ensure that midwives were deployed in the right place and in the right numbers in the hospital and across the community. Several midwives told us that community midwives “need to have a base at the hospital so that we can be more fluid”.
- We spoke with the antenatal screening coordinator who said that the volume of work in this role was too large for one person and that there was no deputy or cover for absence. One midwife we spoke with said, “Everything goes on hold when she is not here.” The midwife leading on risk management agreed that this service was overstretched and needed additional resources.
- There was not always a dedicated midwife for the maternity assessment unit and this also needed to be resolved.
- The head of midwifery was introducing a new approach to the deployment of midwives that would enable them to rotate, on a six monthly basis, between a role in the community and a role in the hospital. This would make better use of resources and help midwives regain and retain the skills needed to practice in both settings.
- The more integrated approach was set out in a new competency framework that was being distributed to midwives and it had become the basis for recruitment and selection of new midwives. Existing midwives were supported in regaining and maintaining their skills.
- There were three midwives who were also trained sonographers involved in screening and midwives were being trained to take blood and examine babies, and carry out the detailed neonatal examination required by the National Screening Committee.

Medical staffing

- The trust had 40 hours of consultant obstetrician over available to attend between the hours of 9.00 am to 17.00 pm with no other clinical commitments
- Outside of these hours, there was a consultant on call and living within 30 minutes of the hospital. Each of the consultant's on call had not usually been called to attend more than about once a month.
- There were four consultants working cooperatively to deliver the consultant-led service and one an associate specialist . Three of the consultants were working on obstetrics and gynaecology. One predominately covered gynaecology as there specialty did not have an antenatal caseload. However they took part in the 40 hours and call consultant rota There were awaiting the appointment of an additional consultant.
- The clinical lead informed us that it was more difficult filling the posts that made up the ‘middle-grade’ or specialist doctors on the rota. There were currently five in post with recruitment taking place to fill an additional post. The service had been using a locum for some time, but we were told that this was expensive.
- One doctor told us that having too few doctors in post in the middle grades, the grades between consultants and junior doctors could be a problem. There were six posts at present with one vacancy. However, the doctor said that it was not a problem at the moment because “the doctors were motivated to help”.
- Anaesthetic cover was provided for eight hours with the anaesthetist having no other commitments during the hours of 9.00am to 5.00pm Monday to Friday. Out of hours an anaesthetist provided maternity cover alongside ITU cover. The consultant anaesthetist on call was also available from home
- The consultant team offered a number of clinics, including clinics for women with diabetes, those with a raised BMI and for women having twins.
- The consultants we spoke with said that they had time available for training and study leave.

Major incident awareness and training

- Isle of Wight NHS Trust is a ‘category one’ emergency responder to major incidents. This covers both the ambulance service and St. Mary's Hospital.
- Staff said that closing the labour ward was never an option, as it would involve women in labour crossing over to give birth on the mainland.

Maternity and family planning

Are maternity and family planning services effective?

Good



The service used national evidence-based care, treatment and guidelines and was working towards accreditation through the United Nations Children's Fund, UNICEF UK's, Baby Friendly Initiative, designed to improve support for breastfeeding. Women's outcomes were good and improving, as the service emphasised normal birth and reduced its rates for caesarean sections and the induction of labour. A choice of pain relief was available at all times and the care and treatment was provided by highly competent staff working in multidisciplinary teams.

Evidence-based care and treatment

- Care was provided in line with the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including the Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour report). For example, a consultant had to be present to deal with complex conditions, such as placenta accreta (where the placenta does not detach from the uterus).
- Clinical guidelines were up to date and accurate on the intranet. In addition, when guidelines were updated they were sent to all staff in the service by email and a hard copy was made available in several places.
- We examined several guidelines, including one for the management of postpartum haemorrhage. We noted that these guidelines were based on RCOG guidelines and included a pro forma, risk factors and courses of action for prevention.
- There was a section of each of the guidelines setting out the process for 'continuous audit' and there was an audit programme overseen by the clinical lead for obstetrics.
- We saw evidence of audits to check that there was follow up for women who did not attend an appointment. There were signed consent forms for new-born bloodspot and screening was taking place for infectious diseases.
- The Healthwatch report on the maternity services at St Mary's Hospital included a section on the prevalence of

tongue ties or ankyloglossia. The head of midwifery said that the trust was following a 'middle way', as reflected in the guidance from the National Institute for Health and Care Excellence (NICE).

- The service had registered its intention to work towards accreditation by following the steps set out in the UNICEF UK Baby Friendly Initiative to improve support for breastfeeding.

Pain relief

- Women could use a TENS machine for pain relief (a TENS machine is a small, battery-operated device that has leads connected to electrodes) and ENTONOX® (often called gas and air), was available.
- Midwives reported that diamorphine was being used now instead of Pethidine, as they found it more effective.
- An anaesthetist was always available. From the time an anaesthetist was called the standard was that the epidural would be sited within one hour. The service was also using epidurals with a mixture of medication that would allow women to remain mobile during labour. Staff told us that this had been a great improvement for women.

Nutrition and hydration

- Women could eat and drink during labour. Snack packs were available, as well as toast and cereal.
- One woman we spoke with said that she missed breakfast on the postnatal ward, as she had not been told it was there and available.
- Another woman said that she was a vegetarian and was pleased to be offered at least two vegetarian choices on the menu. However, she did add that there were "some strange combinations like pizza and mashed potato".

Patient outcomes

- There were approximately 1,300 babies born in the trust each year, or a little over 300 a quarter. The profile of delivery methods at the trust was slightly better than the national average. Between October 2012 and November 2013, 7.6% of deliveries were by elective caesarean (compared with 10.7% for England overall), 14.6% were emergency caesarean sections (compared with 14.1%) and 65.7% of women had normal deliveries (compared with 60.7%).
- There was an emphasis within the service of promoting normal delivery. Caesarean section rates have been steadily falling with the yearly average now around 20%

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and some months having just 16 or 18 %. The overall average rate has been reduced by effective use of the NHS Institute for Innovation and Improvement caesarean section toolkit: Pathways to Success – a self-improvement toolkit.

- The admission of full-term babies to the neonatal intensive care unit had been high, with 20 babies admitted in one month in 2013. This had meant that mothers were being separated from their babies. This number had been reduced by changing the threshold for medical intervention, but the number of babies categorised as requiring transitional care had increased. However, these babies were able to remain with their mothers on the postnatal ward.
- The maternity service was currently investigating concerns about the number of babies being categorised as requiring transitional care. There were 27 babies categorised as requiring transitional care in February 2014 and 20 in March 2014 out of a total population of about 100 babies born each month.
- Maternal readmission from October 2012 to September 2013 was higher than expected numbers (27.8) at 40. Neonatal readmissions from October 2012 to October 2013 was 48 which was lower than expected (62) compared to standardized ratios.

Competent staff

- The new competency framework for midwives made extensive reference to the Nursing and Midwifery Council codes and guidance. This included guidance on record keeping and on professional conduct. For example, each midwife “works with honesty and integrity, upholding the reputation of the profession”.
- The head of midwifery had begun the phased introduction of integration and rotation so that community and hospital midwives could practice in both settings. This programme required some midwives to update their skills through a six-monthly rotation from community to hospital. There was a competency framework setting out the skills required and support for midwives throughout the programme. This programme was designed to make the workforce more adaptable and flexible.
- Appraisals were taking place with a target of 100% compliance for all staff, which was expected to be achieved. In February 2014, 92% of staff in the planned directorate had completed an appraisal.

- The head of midwifery reported that she had had an annual appraisal and quarterly one-to-one meetings with her manager. There was also a ‘back to the floor’ day once a month for managers.
- Some midwives received additional training, so that they could take blood, conduct an examination to discharge newborn babies and offer support to families facing bereavement.
- Staff would also be receiving two additional days training, as part of the UNICEF UK Baby Friendly Initiative.
- The doctors we spoke with were all receiving annual appraisals and mandatory training and they said that there were opportunities for study leave. We spoke to a new consultant, who was receiving induction.
- One consultant said that the low caesarean rate at the hospital was due in part to the “seniority of the middle-grade and staff-grade doctors”.

Multidisciplinary working

- There was effective multidisciplinary working on the labour ward and the mortality and morbidity meetings were a good example of where midwives and clinicians worked well together.
- The integrated approach would enable midwives to work in the hospital, the community and the home and so transfer between sites would be facilitated by the new integrated approach in midwifery.
- There was evidence of a joint team approach in areas involving safeguarding with the local authority social care team and health visitors, GPs and midwives.
- There was also an integrated approach when transferring patients to mainland hospitals, involving the hospital, community and ambulance teams. Staff worked together to transfer mothers and babies to specialist hospitals on the mainland when there was an emergency.
- In responding to complaints and incidents, we saw evidence of managers, doctors and midwives taking an ‘open forum’ approach and learning from these experiences.
- The paediatric consultants and the team on the neonatal intensive care unit took a joint problem-solving approach and shared the workload, particularly at busy times. For example, these consultants would provide cover for babies in the transitional care unit when there was a high volume of activity on the labour ward.

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- There was a labour ward technician who offered assistance with caesarean sections and helped with washing women post-delivery and cleaning of the theatre. The doctors we spoke with said that this post was very helpful.

Seven-day services

- Clinics were available only during week days, but community and hospital midwives were available seven days a week.
- Consultants conducted ward rounds at weekends and were available on-call, out of hours.
- Elective caesareans were only performed during the working week, but services were available seven days a week in the case of an emergency.

Are maternity and family planning services caring?

Good



Women we spoke with said that they received compassionate care and support before, during and after the birth for their babies. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in planning and making decisions about their care. There was a high level of emotional support for women. For example, help was offered to help women cope with possible depression or to deal with the unexpected loss of a baby.

Compassionate care

- The results of the NHS Friends and Family Test were displayed on the wall in the postnatal ward. The results were based on only a small number of respondents. The results indicated that 50% of respondents on the antenatal unit were extremely likely to recommend the hospital to friends and family, 79% of respondents on the postnatal ward and 64% of respondents in the community. Even though the numbers were small, they were similar or slightly better than the England averages.
- The CQC maternity survey, conducted in 2013, found that the Isle of Wight maternity services performed better than other trusts for care in the hospital after

birth. This survey also found that the Isle of Wight performed about the same as other trusts for care during labour and birth, and for staff during labour and birth.

- Women and their partners we spoke with on the wards were generally positive about the care they received. One woman said, "I could not fault the service, staff were very kind and caring."
- Unfortunately, the antenatal clinic area had a single waiting area for women who were pregnant and those who may have recently lost a baby, or who were having difficulty becoming pregnant. It was planned that the refurbishment of this area would provide separate waiting areas for these women.

Patient understanding and involvement

- The women we spoke with said that they felt informed about, and involved in, their own care and treatment.
- One woman had come into the hospital with early contractions and she had been monitored and reassured and was going back home. She said, "It was all explained and I know that everything is OK."
- Another woman, who had booked an elective caesarean, said, "It had to be delayed because of an emergency and the theatre was busy." But she added, "They informed me, so that I knew what was happening."

Emotional support

- There was a lead midwife for bereavement and a bereavement room.
- The bereavement midwives had training from the stillbirth and neonatal death charity (SANDS).
- Memory boxes were available for parents of stillborn babies, along with photographers and facilities for making foot and hand imprints and wallets for keeping hair.
- Patients' antenatal notes included questions about wellbeing and depression and, where these were a concern, there were options to refer to the GP.
- The midwife leading on risk management was offering sensitive support to a family facing the loss of a newborn baby. The midwife had attended several meetings and was providing ongoing contact with the family. In this case, counselling was made available alongside the emotional support.

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Are maternity and family planning services responsive?

Good



The service experienced peaks and troughs of activity and was able to rely on a flexible workforce to provide responsive services. Clinics were delivered locally by midwives working in the local community. Clinics were held every week day in children's centres and GP practices.

This small service could respond well to local needs and offer individualised care. There was an active response to complaints and concerns and genuine commitment to learn lessons from experience.

Service planning and delivery to meet the needs of local people

- The service was planned as much as possible around those areas that could be planned primarily for elective caesareans and the induction of labour. However, the service was subject to peaks and troughs of activity and so staffing was required to respond flexibly and quickly to the changing needs.
- We attended the labour ward meeting, at which the obstetric consultant went through the more complex cases with a view to plan ahead for any bloods or specific medication that would be needed and to ensure that there was sufficient capacity available.
- Some attempts were being made to plan for future bookings of women in the maternity services and to manage the induction of labour and elective caesareans in line with capacity and resources.
- At busy times, the service was able to cancel clinics, delay elective work and inductions, and bring in additional staff from the community, children's services and from on call staff.
- As the service was on an island, it was unable to divert cases or close the service. Only complex, high risk or high dependency cases would be transferred to facilities on the mainland.
- Clinics were held every day in the community and were accessible in children's centres.

Access and flow

- We attended a labour ward meeting and saw how the caseload was discussed and preparations were made for the new intake and any complex cases.

- There were 24 beds available in the maternity services with an average annual occupancy rate of 19.9%. This was low, when compared with an overall average for England of 58.6%.
- However, despite a low occupancy rate, the service experienced unpredictable peaks when the service was very busy and periods when it was very quiet.
- Staffing levels were set at 'safe levels' and could be increased, should the service become busy. During the quieter periods, the staff could catch up with on-line training and any administrative duties.
- The normal length of stay in the hospital was between 24 and 48 hours, although some mothers could leave as early as two hours after a normal, uncomplicated birth.
- During labour, 100% of women were seen by a midwife within 30 minutes.

Meeting people's individual needs

- Interpreters were available for any non-English speaking mothers.
- Clinics were held locally in children's centres or medical practices.
- Where possible, there was continuity of care with the same midwife attending to a mother during pregnancy and then in labour and this would be improved in the future with greater integration.
- A named midwife would deal with cases where there had been a previous complexity or trauma.
- Support was available for smoking cessation, diabetes for women with a raised BMI. This support was made available through local clinics and was in the form of advice and information and monitoring women's progress throughout pregnancy, labour and postnatally.
- There was breastfeeding support with advice from a counsellor on the benefits of breastfeeding and how to overcome some of the early difficulties.
- Home births were available for women who were anticipating a low risk birth.
- There was targeted support for vulnerable women, with a system to identify cases early and track them through the transfer from the community into the hospital.

Learning from complaints and concerns

- The midwife leading on risk management informed us that 12 complaints were received in 2012/2013 and three were logged as formal complaints. They said that a root cause analysis was conducted for all formal complaints and the learning from these complaints was shared across the service.

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- The head of midwifery and the lead for risk management informed us about a particular complaint that had been received recently. This complaint had led to some changes in practice around communication and transferring patients to the mainland. In addition, a paediatric consultant had given a presentation to update colleagues on a rare hereditary condition in young babies. The issue had been discussed with a London hospital and an 'open forum' had been held at the trust to ensure that colleagues were able to learn from the case.
- A concern had been raised internally about the number of babies delivered at full term and admitted to the neonatal intensive care unit. The rates appeared high, with 20 babies admitted in one month in 2013 from a total of about 100 babies delivered in total. This issue was the subject of review by a neonatal network team from the mainland and they concluded that there was too much medical intervention and that babies were kept in the neonatal intensive care unit for too long. This led to a number of changes in practice and the numbers of full-term babies admitted to intensive care dropped significantly.

Are maternity and family planning services well-led?

Good



The service had a clear vision and strategy that was well communicated and understood. The culture was open and staff said that they were supported by effective leaders at all levels within the trust. Governance and risk management were appropriate to overseeing standards of care. Levels of patient and public engagement with the service, and staff engagement with the leadership team needed to improve. Innovation was welcomed and the service had been making improvements with normalising birth and reducing rates of clinical intervention.

Vision and strategy for this service

- We were given a copy of the vision and strategy for the services entitled Birth the Wight Way. This set out five objectives for the service, including the integration of the team, normalising birth and the UNICEF UK Baby Friendly Initiative. The strategy was set out clearly and was available to staff in the service.

- Midwives we spoke with in the focus group and on a one-to-one basis were aware of, and understood, the strategy. The clinicians were also aware, and supportive, of the strategy for the service.

Governance, risk management and quality measurement

- At the monthly mortality and morbidity meetings, all incidents, complaints and audits were reviewed.
- The department had a risk management strategy. We spoke with the midwife with a lead responsibility for risk management. There was a trigger list for adverse incidents in the risk management strategy and a diagram setting out the risk management structure. This was managed consistently well through a clear governance structure.
- There was a maternity dashboard for 2013/2014. This had been laminated and displayed on noticeboards. The dashboard was also the first item at the labour ward meeting we attended and was used across the department.
- The risk register included the air flow risk that existed in the laying up room adjacent to the maternity theatre. Mitigating actions were taken and the trust was seeking to resolve the issue but this remained unresolved.
- The consultant lead for obstetrics was fully engaged in the risk and audit process and was taking a lead role in the measurement of quality and patient outcomes. He chaired the labour ward meeting and the mortality and morbidity meeting.
- Attendance at the labour ward and the mortality and morbidity meetings was poor from midwives who were not also holding a specialist responsibility in the department.

Leadership of service

- We heard from several members of staff that the chief executive of the trust had attended a meeting to support the staff in responding to a recent complaint. The staff were appreciative of this and said, "We felt supported and valued by the chief executive."
- A consultant informed us that the chief executive was putting an emphasis on clinical leadership and on improving staff engagement with a Listening into Action™ group. This consultant said that "leadership was evolving for the better".
- The head of midwifery spoke to us about the strategy and the overall direction of the service. She fully understood some of the challenges facing the service,

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including the ageing workforce and some reluctance to engage in the integration of community and hospital-based midwives from a small minority of the workforce.

- We found that the leadership of the service was well respected and appreciated. There was enthusiasm and expertise within the team that was being well directed across the service and particularly in risk management, education and development and the leadership of wards and units.
- Communication was good and was via a service newsletter, e-mail and face to face.
- Staff told us that communication across the community was made more difficult because information technology was under developed.

Culture within the service

- We observed an open culture within the service. We saw evidence of a willingness to share experiences and learn from incidents and complaints.
- One of the consultants informed us that, when they reviewed an incident or a case, they removed the names of the staff involved, as this helped colleagues to have a discussion that was objective and less defensive.

Public and staff engagement







- The local maternity services liaison committee had been disbanded recently, as this was not well attended. There was no similar forum in place through which the public could engage, but patients were invited to give their views on the service through the NHS Friends and Family Test, or through Healthwatch. There was also an opportunity for women to talk to a midwife about their birth experiences on the postnatal ward.

- The antenatal clinic was due to be refurbished and one of the midwives expressed their concern that staff and patients may not be invited to engage with this process.
- Some concern was expressed about the opportunities for staff to be involved in planning for the refurbishments of the antenatal unit.

Innovation, improvement and sustainability

- Colleagues from the service were keen to visit trusts on the mainland to compare their practices and to obtain ideas for innovation and improvement. For example, the head of midwifery had taken ideas about the integrated service from the Chief Nursing Officer for England and from the NHS Quality, Innovation, Productivity and Prevention (QIPP) programme.
- The head of midwifery said that she was happy to consider secondments to trusts on the mainland so that midwives could “enrich their practice”, although this had not started yet.
- Improvements had been made in lowering rates on caesarean section, admissions to the neonatal intensive care unit and improving rates of skin-to-skin contact at birth. The service had a strategy that included further improvements in length of stay, rates of home birth, the UNICEF UK Baby Friendly Initiative and safeguarding practices. Improvements in lowering caesarean sections had been achieved through using the NHS toolkit and focusing on achieving a normal birth for women who had a previous caesarean section.

Services for children and young people

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

Information about the service

The services for children and young people at St Mary's Hospital included a 13-bed paediatric ward accepting children aged up to 18. The ward provides emergency care, a resuscitation room and a high dependency bed for stabilising patients prior to transfer to the tertiary centre on the mainland. The ward also accepts direct medical emergency admissions rather than them going to the A&E department.

There was a day surgery unit, paediatric outreach service and an 11-bed neonatal intensive care unit (NICU).

We visited all children's wards and outpatient areas. We spoke with five children and their parents and 16 members of staff including nurses, student nurses, medical staff, healthcare assistants, a ward clerk, domestic staff, managers and play specialist. We observed care and treatment and the environment, and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Services for children and young people were good. Most parents told us the staff were caring, and we saw that children and their parents and carers were treated with dignity, respect and compassion. Ward areas and equipment were clean. There were enough trained staff on duty to ensure that safe care could be delivered. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs.

The services were responsive to the needs of children and young people and their families and carers. The ward managers communicated well with staff and staff were positive about the service and quality. Children's experiences were seen as the main priority. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements.

Services for children and young people

Are services for children and young people safe?

Good



There were procedures in place for children and young people to have safe care. Ward areas and equipment were clean. Patients at risk of, or suffering from, an infective illness were cared for in single rooms to reduce the risk of spreading infection. There were enough trained staff on duty to ensure that safe care could be delivered. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs. Children's, or their parent's or other appropriate adult consent to treatment was obtained appropriately.

Incidents

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There had been no Never Events reported that related to children's services.
- Serious incidents were reported and managed appropriately. One serious incident had been reported in the past 12 months. As a result of this, learning had taken place and changes had been made to practices within the children's service, which included revising the detail in the paediatric early warning score (PEWS) charts.
- Mortality and morbidity meetings were not held. However, issues that would be discussed at such meetings (such as reviewing cases to highlight where changes could be made to the care and treatment provided to children with similar conditions) were discussed at regular multidisciplinary meetings. These were well attended with detailed minutes of discussions that took place and action points recorded. There was a plan to implement formal mortality and morbidity meetings.
- All staff we spoke with said they were supported and encouraged to report incidents. Themes from incidents were discussed at staff meetings.

Cleanliness, infection control and hygiene

- Ward areas and equipment were clean. Parents of children on the children's ward and NICU ward told us that the wards were always clean and tidy.
- Staff followed the trust policy on infection control. Staff used hand sanitising gel and personal protective equipment (PPE), such as aprons and gloves, appropriately.
- Patients at risk of, or suffering from, an infectious illness were cared for in single rooms to reduce the risk of spreading infection. Designated cubicles were available for children having chemotherapy, to protect them from infections.
- Feeding equipment, such as babies' bottles, were single use. Where sterilising fluid was used, for babies' dummies, this was changed daily.
- Each service within paediatrics had a nurse with a special interest and training in infection control who was responsible for coordinating and performing audits. Audits of cleanliness were regularly performed and feedback was provided.
- No incidence of hospital-acquired infections had been recorded on the children's ward.

Environment and equipment

- There was sufficient equipment on the wards to ensure safe care.
- In the outpatient department the emergency equipment was checked daily. However these checks were not consistently recorded, so the department was unable to evidence they were carried out. During the course of the inspection, staff told us the process for checking emergency equipment was being revised and a second member of staff was being trained to have the responsibility for checking the emergency equipment in the outpatient department.
- Other equipment was regularly checked and well maintained. Broken equipment was replaced in a timely manner. However, on the NICU ward the process for ordering a new washing machine to wash the woollen cot blankets was a complicated procedure. This was because the equipment was not classed as vital piece of medical equipment and there were several authorisations that had to be obtained before the washing machine could be ordered. This meant that woollen cot blankets were having to be thrown away rather than washed and reused.

Services for children and young people

- Access to the children's areas was secure and staff were wearing appropriate identification. Entrance ways were monitored through a camera so that staff could see who requesting entrance to the area.
- The areas were bright and colourful. There was a dedicated play area on the ward and the outpatient area.
- On the children's ward there was a room with facilities to care for adolescents with mental health concerns. This dedicated area which could be locked to prevent access to the ward but with access to the room from the outside which would help to protect the children on the ward.

Medicines

- Medicines were stored appropriately. Fridge temperatures were monitored and identified risks were dealt with appropriately to ensure that medicines remained effective.
- There was a pharmacist allocated to the ward and the neonatal unit. They supported the correct prescribing of medicines.
- We observed medicines being administered following trust and local protocols, which included two members of staff checking that the correct medicine and dosage was administered to the correct patient.
- Medication prescribing errors were investigated and appropriate actions were taken to reduce the risk of similar occurrences happening. Recording of changes to care and treatment were now made contemporaneously, during ward rounds, to reduce the risk of incorrect information being remembered, which would result in incorrect medicines being prescribed for children.
- The stock level of controlled drugs in the control drug cabinet was checked but daily in line with best practice.

Records

- The children's ward, day surgery unit and NICU all used standard pathways or multidisciplinary notes. All staff wrote in the same set of notes. This ensured that all disciplines had access to current and comprehensive information on each patient. We saw that notes were detailed and written in a timely way.
- Notes were kept in a trolley in a supervised environment to maintain confidentiality.
- Medicines record sheets were well completed and reviewed daily by the ward pharmacist.

- All patients had a care plan that identified specific care needs.
- Audits of the quality of record keeping were performed and identified issues actioned for improvement.

Consent

- All children admitted for surgery had a correctly completed consent form that detailed the procedure and the potential risks or complications. This was signed and dated by the surgeon.
- Children who were competent to give consent were included in the process and there was space for older children to sign to say they had given consent. Staff had a good understanding of the Fraser guidelines. (These are guidelines to assess whether a child under the age of 16 has sufficient maturity and capacity to consent to treatment).
- Records of post-operative children showed that the correct checks had been made prior to surgery, using the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist – to ensure informed consent had been obtained.
- Children and parents we spoke with felt very well informed about the procedure and the likely outcome. We heard verbal consent being obtained before care was delivered.

Safeguarding

- Information received showed that the take up of safeguarding children (SGC) training for all levels (levels 1, 2 and 3) had steadily increased during the first three months of 2014. As of 14 May 2014, 87% of all staff had completed training in safeguarding children level 1, 61% level 2 and 60% level 3. Action, in the form of increased numbers of training sessions, was being taken to increase the numbers of staff completing training.
- The department had systems in place to safeguard children. There were clear policies and procedures for handling potential safeguarding concerns. The trust worked in partnership with the local safeguarding children boards (LSCBs).
- Children identified as a potential safeguarding concern had a specific care plan. Birth plans included details of child protection issues and any prenatal child

Services for children and young people

safeguarding plans were shared with the relevant staff. All children with a safeguarding concern, or with a child protection plan, were seen by a consultant paediatrician on admission and prior to their discharge.

- Any children who failed to attend an appointment were followed up using the trust protocol.
- Any child who presented with self harm or drug/medication overdose was automatically referred to the Child and Adolescent Mental Health Services (CAMHS). All such children were admitted and not discharged from the inpatient ward until they had been seen by CAMHS. There was a separate pathway referred to as 'Get Sorted' that was followed for children admitted with alcohol and recreational drug misuse.

Mandatory training

- Records showed that 82% of staff working in the children's service had completed all their annual mandatory training. Subject areas where there were reduced numbers of staff completing training included people handling and level 3 safeguarding children. Some staff working on the children's ward told us that the moving and handling mandatory training was aimed at the care of adults and did not fully meet the moving and handling needs of children. However, each of trained their staff in the appropriate moving and handling methods for the type of children they were looking after and the patient-specific equipment that was being used.
- Some staff felt there was a delay in being able to access courses because of insufficient number of course being arranged.
- All nurses on the children's unit had completed both paediatric and adult life support.
- The neonatal unit staff (nursing and medical) linked with staff from across the neonatal network and attended clinical days to share best practice.

Assessing and responding to patient risk

- The trust had a paediatric early warning score (PEWS) and tool. This provided guidance to staff on the use of the tool to help identify children who were at risk of a sudden deterioration in their condition. The tool had been revised as a result of learning from a serious incident, with PEWS charts now being available for different ages and developmental stages for children. This meant there was a reduced risk of failure to identify a deteriorating child. We saw the tool was used effectively to identify changes in a child's condition.

- The children's ward had a resuscitation room and a one-bed room that could be used for high dependency care, although the area was not a designated a high dependency unit (HDU). This room had included children who needed non-invasive ventilation and very close monitoring of their condition. Children requiring stabilisation prior to transfer to an intensive care unit were cared for in the resuscitation room and the high dependency room on the children's ward.
- The hospital had a good relationship with the local retrieval service. This service managed the transfer of sick children to intensive care units in other hospitals.
- The neonatal unit used an early warning tool specifically designed for newborn and preterm babies and we did not identify any problems with the use of this tool.

Nursing staffing

- In winter 2013, the manager, as part of the trust's safe staffing levels, had submitted a review of safe staffing levels on the children's ward. As a result of this review, they had requested that staffing numbers on the ward were increased to ensure they were consistently in line with Royal College of Nursing recommendations. The request included increasing the number of registered nurses available at night, day-to-day support and an additional whole time equivalent deputy sister. In the event of a child being admitted elsewhere in the hospital, we were told that, if these staffing levels were achieved, support and advice would be readily available from the paediatric nursing staff. At the time of our inspection, if such support was provided, it was at the risk of depleting staff on the ward to a level that did not meet best practice guidelines. This was an identified risk, and occurred, when children were admitted to the A&E department.
- The Royal College of Nursing (2013) guidelines identified a minimum of 70:30% registered to unregistered staff with a higher proportion of registered nurses in areas such as children's intensive care, specialist wards. There should be a ratio of (registered nurse : infant) 1:4 in special care; 1:2 in high dependency care 1:2; and 1to1 in intensive care 1:1 (increasing to patients with higher acuity levels). There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas and access to a senior children's nurse for advice at all times throughout the 24 hour period.

Services for children and young people

- At the time of our visit, there was no action for increasing the nursing staff levels. However, staff told us that levels were achieved due to the commitment and good will of staff working extra hours. There were at least two nurses trained in the care of children on duty with an identified shift coordinator on duty on the children's in patient ward. The present staffing levels had had no adverse impact on the care and treatment of patients.
- No agency staff were used on the children's ward. At busy times, or if there was a shortage of nursing staff due to sickness, the shortfall of staff was filled by permanent staff from the children's ward. The ward also operated a nurse on-call system. This meant that if a child needed to be transferred to the mainland for treatment the ward staffing did not have to be depleted.
- If needed, staff on the children's ward and NICU worked across both wards to ensure staffing levels were safe for the number of patients in each ward area.
- The Department of Health report on the staffing of neonatal units was used to calculate the staffing needs of the unit. Adjustments were made as demand for the service changed, but remained at a safe level at all times.
- Comprehensive medical and nursing handovers took place between shifts and ensured that all pertinent information was passed on.
- Staff from the children's ward also offered support and advice to the A&E department when a child was admitted there and responded to any emergency children's calls.
- A nursery nurse was on duty on each shift on the children's and NICU ward. A play specialist was employed by the trust and worked across the ward, day surgery unit and the outreach team.
- The outreach team, who provided a service to the children being cared for or treated in the community, consisted of four whole time equivalent nurses, which included senior and junior nurses. There were also two whole time equivalent nursery nurses working in the outreach team.
- Advanced nurse practitioners supported nursing and medical staff and reduced the impact of difficulties recruiting junior doctors onto the island.

Medical staffing

- There were five paediatric consultants employed at the hospital, who had designated specialties and interests.

This included, but was not exclusive to, consultants who had special interests and experience in the management of diabetes, community care, asthma and respiratory disease, and neurological disabilities. This meant children received treatment from consultants who had knowledge and experience about treating their conditions or illnesses.

- A consultant was present in the neonatal unit and on the children's ward from 9am to 5pm, Monday to Friday and 8.30am to 2pm at weekends, or until they were not needed. At night and at weekends after 2pm, there were consultants on call. We were told that consultants would come in at the "drop of a hat", if they were needed.
- There were 5 middle grade doctors, the rota being two tier only. We were told recruitment was difficult to the junior tier as the post was not considered to be a training post told. We were told the main area of recruitment of junior doctors was by employing overseas doctors who would work on the Isle of Wight before moving onto the mainland.
- There was a medical staff rota that ensured all areas of the children's service had medical cover 24 hours a day. Where needed, consultants would cover for middle-grade doctors. This was confirmed in conversations with medical staff.
- In response to the difficulties in employing junior grade doctors, paediatric advanced nurse practitioners were employed to fulfill some parts of the role of junior doctors. We received no information to indicate the lack of junior doctors was having an adverse impact of the safety of children receiving treatment at the hospital.
- Children were seen by a paediatric consultant within the first 24 hours of their admission to the hospital.
- Ward rounds were completed twice a day, with daily handover meetings between medical staff, to ensure continuity of care.
- Visiting consultants from tertiary centres provided specialist input for children with complex or rare conditions at outpatient sessions.

Major incident awareness and training

- The trust had a major incident plan and all staff working in children's services were aware of, and understood, their role.
- Staff told us about mock major incidents that had taken place that ensured staff understood their roles in such an event.

Services for children and young people

Are services for children and young people effective?

Good



Children were treated according to national guidance. At departmental meetings, any changes to guidance and their impact on current practice were discussed and agreed. The services had an annual clinical audit programme to monitor that guidelines were being adhered to. All patients had an initial assessment that involved discussion with both the child and their parent or carer. Daily ward rounds were performed to ensure ongoing needs were assessed.

Evidence-based care and treatment

- Children were treated according to national guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics and Child Health (RCPCH). Most local policies and procedures used within the department were based on national guidelines and were up to date.
- Children's protocols were developed that were specific to the needs of children when trust-level documents were not appropriate.
- There were no paediatric surgeons employed by the trust. This meant that elective paediatric surgery was undertaken by surgeons who had an interest and experience in paediatric surgery. A 'children's surgical user group' had been set up to meet four times a year. As part of that group, a protocol for children's surgery at the trust had been developed and was adhered to. This meant that there were strict guidelines set that experienced surgeons and anaesthetists must adhere to before treating a child. These guideline also related to the age ranges of the children for whom elective surgery could be carried out. Where it was anticipated a child would require high dependency nursing following surgery, the surgery care and treatment was carried out at the tertiary centre on the mainland. This was in line with the report, The acutely or critically ill child in the district general hospital: A team response (Department of Health, 2006).
- Paediatric palliative care was usually provided by the outreach paediatric team. There was no paediatric hospice provision on the Isle of Wight. However, the paediatric unit had worked with the local adult hospice

to provide care for a child who wished to die in a hospice. The children's service supported parents and siblings to access counselling services provided by a local organisation on the island.

- Screening of neonates for congenital conditions, such as phenylketonuria and cystic fibrosis, was carried out routinely.

Pain relief

- A pain assessment tool was incorporated into the children's services pathways tools and was completed, as needed. Older children that we spoke with assured us that they were given pain relief medication frequently. Medication charts seen showed that analgesia was prescribed and administered regularly. Pain levels were checked later to measure the effectiveness of the analgesia.
- The play specialist understood the value of adequate preparation and distraction techniques when managing children's pain during procedures. Nursing staff recognised the analgesic effect of a parent's presence for babies and young children.

Nutrition and hydration

- Breastfeeding was actively encouraged on both the neonatal and children's ward.
- Separate rooms were not always available but privacy could be afforded for mothers who wanted to feed their baby discreetly.
- Storage facilities and pumps were available for mothers who wanted to express milk. On the neonatal unit, mothers were encouraged to express beside their baby to stimulate milk production.
- On the children's ward, a designated milk kitchen was used to prepare all babies' feeds.
- Simple food, such as sandwiches and toast, were available on request.
- A paediatric dietician was available to offer advice to staff and parents.
- When necessary, fluid and food intake was monitored and recorded.

Patient outcomes

- The trust reported participation in the Epilepsy12 audit (childhood epilepsy), neonatal intensive and special care 2012/2013 quality report. The trust also

Services for children and young people

participated in the British Thoracic Society audit of paediatric asthma and pneumonia during the same period. This showed that the trust participated in all the national audits that it was eligible for.

- A peer review of paediatric diabetes care had been completed in March 2014. At the time of our inspection, the service had received a draft copy of the report of this peer review, which had identified 14 areas of good practice and five areas that needed some improvement. The service had met the criteria for the nationally recognised Best Practice Tariff for Paediatric Diabetes.
- Children requiring intensive care were transferred promptly, to optimise the chances of a positive outcome. There were no concerns arising from either the Dr Foster Intelligence Hospital Standardised Mortality Ratio, or the paediatric/neonatal mortality rates monitored by the CQC surveillance programme.
- All children or young people with an acute medical problem who were referred for a paediatric opinion were seen by, or had the case discussed with, a paediatrician on the consultant rota, or a paediatrician on the middle-grade rota.
- The neonatal ward had participated in a national survey run by Bliss titled the Bliss Baby Charter Audit tool, which helped the ward assess how well they were delivering family-centred care.

Competent staff

- Senior nurses provided supervision to student nurses, nursery nurses and healthcare assistants.
- Staff told us they felt supported and had attended clinical supervision where they could discuss and reflect on work practices.
- The hospital was responding to the national shortage of paediatric nurses by planning to 'grow their own'. This included supporting recently qualified staff to develop their skills.
- An advanced neonatal nurse practitioner supported other nursing staff on the neonatal unit to develop skills and review practice.
- Medical staff adhered to the protocols of the specialist tertiary hospitals and had good access to specialist advice when providing care to children with complex or rare conditions.
- Membership of local and regional networks, such as the Neonatal Network and Oncology Network allowed for the sharing of best practice and the updating of knowledge.

- In February 2014, 91% staff in the planned directorate, which includes children services, had completed their appraisal.

Multidisciplinary working

- The paediatric ward had specialist paediatric physiotherapists and occupational therapists, and there was a dedicated pharmacist. All staff participated in multidisciplinary ward rounds.
- A hospital teaching service was not available. This was because, due to the nature of the care provided at the hospital, children rarely stayed in hospital for a lengthy period of time. However, it was reported that the children's ward had effective working relationships with the local schools, who offered educational support to children, if it was required. We were provided with an example where one child admitted was supported by their school and the hospital to complete school exams while they were a patient on the ward.
- The service employed a Paediatric Diabetes Nurse Specialist to support patients, parents, local authority and ward staff, required to meet the Best Practice Tariff for Diabetes.
- Multidisciplinary meetings were held for case reviews and discharge planning.

Seven-day services

- The children's ward and the NICU ward were open seven days a week. The outpatient department and day surgery ward were open Monday to Friday only.
- Consultant-led Radiology was not available at weekends and bank holidays except in exceptional circumstances.
- The pharmacy was open on Saturday and Sunday. Out of hours, there was an on-call pharmacist to dispense urgent medications.
- The child and adolescent mental health services (CAMHS team) only operated Monday to Friday. There was no access to child mental health support during the weekend. This was provided, where needed, by the adult mental health service.
- The outreach team only provided a five-day service, but had identified a need to expand to have a seven-day service to provide more care and support for children, as well as support and advice for GPs who were treating children. A business case was being prepared to seek funding for a seven-day service.

Services for children and young people

Are services for children and young people caring?

Good



Most parents told us the staff were caring and we saw many cards displayed that expressed thanks to ward staff. Children and their parents/carers were treated with dignity, respect and compassion. Patient records were completed sensitively and detailed the discussions with children and their parents. The ward had open visiting times for family. Parents could stay overnight and there were facilities for making refreshments. This helped parents to support their child in adapting to the hospital setting. There was a Saturday Club for children who were being admitted to the hospital for elective surgery for the purpose of a pre-admission assessment and introducing the child to the ward and staff.

Compassionate care

- The children's and young people's service did not participate in the NHS Friends and Family Test. However, results from the trust's own children's inpatient survey for 2013/2014 showed a high level of satisfaction with service provided. 94% of people expressed that they would recommend the service to family and friends.
- Most parents told us the staff were caring and we saw many cards displayed that expressed thanks to ward staff.
- We observed that children and their parents or carers were treated with compassion. We saw a nurse encouraging parents to support their child's needs and to overcome their fear of "getting it wrong".
- Children and parents or carers were treated with dignity and respect. Records were completed sensitively and detailed the discussions with children and their parents.

Patient understanding and involvement

- Children and their parents were involved in decisions about their care and treatment.
- Staff had a sound understanding of the Fraser guidance in relation to consent by children and ensured competent children were offered the opportunity to make decisions relating to their care.
- The play specialist was used to support children to understand their illness and any procedures they might have to undergo. For children who were scheduled to

have elective surgery, a Saturday Club was held every two weeks. Children and their parents or guardians visited the ward and the operating theatre, if appropriate. The play specialist and nursing staff supported the children to understand what to expect when they came into hospital. Feedback from one parent was that the Saturday Club was very well organised, with all paperwork being done. They said that their child was able to visit the theatre suite. The same person told us that everything was explained in a child-friendly manner, so that both they and their child understood what was happening.

- A second parent told us that all staff had good communication skills, approaching the parent and child at the right level so they could both understand what was happening.
- Patients had an initial assessment, which involved discussion with both the child and their parent. Daily ward rounds were performed to ensure ongoing needs were assessed.
- Staff on the neonatal unit encouraged parents to be present for the ward round each morning. Where this was not possible, staff ensured that the nurse caring for the child provided feedback.
- Routines on NICU had been changed to include parents in the care and important events in their baby's life. This included having the parents present when the baby was being weighed and when their baby was being transferred out of an incubator into a cot.

Emotional support

- The play specialist worked with children to help them adapting to the new environment and to the hospital experience.
- Children presenting with mental health problems were referred to the CAMHS team and not discharged until they have been seen.
- Parents on the neonatal unit were able to access support via a local Facebook support group that had been set up by a parent.
- Mothers of babies on the neonatal unit were encouraged to have skin-to-skin contact, to promote bonding.
- A practice of maintaining parenting diaries on NICU helped staff identify specific support that parents needed to help them bond and care for their baby.
- The ward and NICU supported parents and siblings to access counselling services.

Services for children and young people

Are services for children and young people responsive?

Good



The services were generally responsive to the needs of children and young people and their families and carers. Access was good, and the needs of all different kinds of child patients were met appropriately. There were multidisciplinary networks that supported the early discharge for children. These included links to community nursing and children's outreach services.

Service planning and delivery to meet the needs of local people

- The ward catered for children up to the age of 18.
- During episodes of increased patient admissions, the location of the day unit meant that beds in the day unit could be used as ward beds. Extra nursing staff to care for patients in this situation would be sourced from the children's ward with staff working extra hours.
- There were potential risks associated with the access to children's services in the event of a child being admitted in an emergency. This was because there was not a single point of access process to the hospital. Medical emergencies were admitted directly, via ambulance, to the children's ward, whereas surgical and trauma emergencies were admitted via ambulance to A&E. This meant that ambulance staff had to make the decisions as to whether a child had a medical or surgical condition. It was reported to us that there had been incidents where children were transferred from A&E to the children's ward because medical staff in A&E declined to attend to them. This practice meant there was a potential risk that children would not be attended to in a timely manner. Staff told us there was a plan to have a single door access to the hospital policy, which would mean all emergency admissions were admitted via A&E. However, discussions had been ongoing for seven months and this had yet to be fully agreed and implemented.
- This had been identified by the trust as an issue during the investigation of an incident where it was discovered that this process was not in line with four Local

Safeguarding Children's Boards policy about admitting a child at risk of death to A&E. This meant that all blue light ambulances carrying a child should go to the A&E department.

- At an unannounced inspection, which was part of this review, the trust had taken action to ensure that all ambulances transporting children went to the A&E department and that medical and nursing staff from the children's service were called to attend. This practice was already in place for trauma patients.

Access and flow

- The children's ward acted as an assessment unit and GPs could refer children directly to the ward.
- Some patients had access to the children's ward directly, via an open-door policy. This policy applied to those with long-term illnesses such as cystic fibrosis. Some patients had a 24 to 48-hour open-door policy after discharge. This policy enabled parents to obtain advice directly by phoning the ward.
- There were a total of 13 beds on the inpatient ward. Accommodation on the ward was flexible, so that babies, younger children and adolescents were not nursed in the same areas. The day surgery unit only admitted children over two years of age for day surgery, closing overnight and at weekends. There were side rooms that could be used for children receiving chemotherapy.
- One bed was used as a high dependency bed.
- The neonatal unit had 11 cots and was a level 2 unit for babies born before 35 weeks who required specialist care. Those born before 27 weeks, or who required complex specialist treatment, were transferred to another hospital with a larger specialist neonatal unit. The regional neonatal centre was at the Queen Alexandra Hospital, Portsmouth.
- Children who presented with injuries and a history that might indicate a non-accidental cause were always referred to a consultant paediatrician and admitted for further consideration.
- The outreach service provided a service to children in the community, including follow-up service for surgery, care for the terminally-ill child, continuing care and chronic care advice for GPs. It was reported that there were effective processes for ensuring children received the care at home they required, which also included close liaison with community nursing teams and other agencies involved in the child's care. The outreach team

Services for children and young people

only provided a five-day service, but had identified a need to expand to have a seven-day service to provide more care and support for children and support and advice for GPs who were treating children. A business case was being prepared to seek funding for a seven-day service.

Meeting people's individual needs

- Children with special needs were assessed on admission and a nursing care plan developed to address their needs. Staff told us parents or carers tended to stay with the patient. Staff also said that there were good working links with the local schools for children with special needs. Some outpatient clinics were held in "nominated" schools, rather than the child having to attend the hospital.
- Translation services were available if needed. However, generally, a member of staff or the parents were able to help translate.
- Educational needs of the children were met by support of the individual child's school.
- Transition to adult services was usually at 18 years of age. Transition arrangements for children whose care was shared with a tertiary centre was dependent on the protocol of the other hospital. This had the potential to be confusing for patients within the 16 to 18 age range, if the tertiary centres only treated children up to the ages of 16.
- The team had contact with the CAMHS team and referred all children who were admitted with self-harm, alcohol-related illness or drug misuse. However, the CAMHS team only operated Monday to Friday. There was no access to child mental health support during the weekend. This was provided, where needed, by the adult mental health service. Children with acute illness due to eating disorders were admitted to the ward where they needed physical intervention, but were referred for care elsewhere in the longer term.
- There were multidisciplinary networks that supported the early discharge for children. These included links to community nursing and the children's outreach service that was run from the hospital.
- Multidisciplinary meetings were used for more complex discharges requiring ongoing support in the community.
- A discharge letter was sent to the patient's GP and these included details of the reason for admission, investigation and treatment. A copy of the letter was also given to the patient. Staff told us that some medical

staff did not use the computerised process for discharge summaries, which sometimes led to delays in GPs receiving them. This meant there was a risk that there would be a delay for some GPs in receiving information about what treatment their patient had received.

- Private rooms were available for sensitive discussions.
- The ward had open visiting times for family. Parents could stay overnight. There was a lounge room for their use and facilities for making refreshments. This helped parents to support their child in adapting to the hospital setting.

Learning from complaints and concerns

- Children's services received very few complaints and most were resolved locally.
- All formal complaints were responded to by a senior nurse. They were investigated and the investigations were timely and appropriate. Complainants were invited to face-to-face meetings or received a phone call to discuss their issues. The lessons learned from complaints were communicated to the department via team meetings and notice boards, and incorporated into training modules if necessary.
- The Patient Advice and Liaison Service monitored and responded to formal complaints made to the trust.
- We saw good examples of changes made as a result of complaints received. These included improving the documenting of conversations had with parents, so there was a clear record to refer to when parents were unable to remember the conversation details. Also improvements had been made to the recording of decisions made during ward rounds to reduce the risk of wrong care and treatment being given to children.

Are services for children and young people well-led?

Good



The ward managers communicated well with staff and staff were positive about the service and quality. Children's experiences were seen as the main priority. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements. The service had many examples of innovative practices. There was learning from incidents audits and complaints. This

Services for children and young people

was incorporated into training, where required. However, risks to the services and with working with other departments were not appropriately identified on risks registers.

Vision and strategy for this service

- All the staff we spoke with had a very clear, shared vision and aspirational ideas of where they wanted to take children's services. All levels and disciplines of staff were enthusiastic about where their directorate wanted to be and all reported similar changes that had already happened, which had taken the service towards achieving the vision.
- There was ongoing work to achieve the vision for a one-door emergency access to children's services and a dedicated adolescent unit.

Governance, risk management and quality measurement

- Monthly clinical governance meetings were held to assess the outcome of any audits, complaints or incidents.
- A ward dashboard showing the current status of a variety of indicators was available online.
- There was a wide range of audit and governance activities, including serious injury reviews, complaints reviews, infection control audits and isolation precaution audits. This included national audits such as the Bliss Baby Charter Audit tool and diabetic audits.
- Learning from events, incidents and complaints was incorporated into training, if required.
- There were no risks associated with the children's service on the trust-wide risk register. However, the trust had requested an external review of paediatric services following two serious incidents in the children's emergency care pathway, which included the A&E department.

Leadership of service

- There was a matron responsible for the overall service and each area had a ward sister in charge.
- A clinical lead was responsible for managing the medical staff, including those in training posts.
- Staff reported to us that the leadership within the children services was good. However, there was a general lack of confidence among staff that information from the ward-level to the trust board was always fully considered. This was because staff did not always receive feedback from the trust board about issues or

concerns they had raised. One example given was that feedback from incidents reported to the board did not always detail the action that was being taken, just a 'thank you' for the information.

Culture within the service

- The ward sisters were fully aware of their service and communicated well with staff.
- Staff were positive about the quality of the service and children's experiences were seen as the main priority.
- Staff worked well together in multidisciplinary teams to provide holistic care to children. Staff told us that the ward and unit team was wider than the nursing staff and included: housekeeping staff, medical staff, play staff and administrative staff. Medical staff respected the views and professional opinions of the nursing staff.

Public and staff engagement

- The children's service engaged with the public with the use of surveys, which showed a high level of satisfaction with the service provided.
- Regular, recorded staff meetings showed that the trust engaged with staff. This meant there was a process for feeding information from the trust to staff working in the children's services and for staff to voice concerns and issues to the trust board. However, staff on the wards did not always feel that mechanisms for the trust to feedback information were consistently effective.
- On the children's ward, staff did not know who the non-executive director, who had special interest in children's services, was.
- The results of the 2013 NHS Staff Survey were organised into 28 key findings. The trust performed better than expected for the percentage of staff receiving job-relevant training, learning or development in the previous 12 months and the percentage of staff saying hand-washing materials were always available. The trust's performance was rated as 'worse than expected' or 'tending towards worse than expected' for 14 of the 28 key findings in the NHS 2013 staff survey. These included staff at the trust being less likely to recommend the trust as a place to work, or receive treatment. Staff reported lower levels of satisfaction with the quality of work and patient care that they were able to deliver and communication between senior management and staff.

Services for children and young people







Innovation, improvement and sustainability

- Innovation and ideas from staff were actively encouraged. We were given several examples of small changes that had been made as a result of staff ideas. A member of the clerical staff had initiated the development of the garden for the use of children and their parents.
- Because of the location of the trust, there were difficulties in appointing junior doctors. To overcome this problem, advanced nurse practitioners for both NICU and the children's ward had been appointed to fulfil some of that role.
- A wide, shared care network for managing children with the most complex and rare conditions had enabled

families to be supported and treated closer to their homes. It also enabled access to the best possible advice for these families. For example, the children's ward was a level 1 paediatric oncology shared care unit and could also offer care to visitors to the island who had oncological problems.

- To sustain the service and ensure there were sufficient numbers of paediatric trained nurses on the ward, the service was planning to adopt the accepted practice of 'growing their own' specialist nursing staff. This was where healthcare assistants or general nurses were supported to gain additional qualifications and become registered as children's nurses.

End of life care

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

Information about the service

Patients receiving end of life care were distributed throughout the wards within the hospital. The palliative care team comprised a consultant, clinical nurse specialists, an occupational therapist and a clinical psychologist. The service did not keep figures for the number of deaths in hospital. The team received 287 referrals between January and December 2013 (an average of 24 referrals per month) and in the first quarter of 2014 received 111 referrals (an average of 37 per month).

We visited nine wards at St Mary's Hospital. We talked with 33 members of staff, including nurses, healthcare assistants, consultants, doctors, Allied Healthcare professionals, support staff and senior managers. We visited the mortuary, bereavement suite and the multifunction centre. We talked with three patients and one relative of a patient receiving end of life care. It was not possible to speak to more patients, due to the small numbers with whom end of life issues had been discussed and the condition of the patients. We observed care and treatment and looked at care records. We reviewed performance information about the trust's end of life care.

Summary of findings

The specialist palliative care team had effective procedures to provide safe, effective and responsive services. However, end of life care was not consistent across the hospital ward areas and national guidance was not followed. Ward staff were not appropriately trained in end of life care and care was not always delivered appropriately. Patients were monitored to identify if their condition deteriorated, but staff were monitoring patients at a level that was not always required. There was a failure to recognise patients as being at the end of their life until they were in the final stages of the process. When it was recognised, a do not attempt cardio-pulmonary resuscitation (DNA CPR) order was not always used or the documentation was not appropriately completed, which put patients at risk of inappropriate care. Assessments of a patient's mental capacity to make decisions were not consistently completed or documented before decisions about the care that was in their best interests were made.

Staff were caring and compassionate, but this varied, particularly on busy wards and there was less time to respond to patient needs. Some patients receiving end of life care had moved wards several times while they were in hospital and patients, or their relatives, were not consistently involved or informed about resuscitation decisions. The leadership of the service had recently

End of life care

been strengthened by the trust, but the services required a clear strategy and staff identified the need for more resources. Arrangements to monitor the quality of the services were not developed.

Are end of life care services safe?

Requires Improvement



Incidents were reported and staff were learning from these. Most medicines were appropriately prescribed and administered, but this varied and was incorrect for some patients. There was inconsistent use of the documentation to record decisions about whether resuscitation should be attempted for patients in the event of a cardiac arrest. This resulted in a lack of clarity and the potential for the incorrect action to be taken. In addition, assessments of a patient's mental capacity to make decisions were not consistently completed or documented before decisions about their care were made. Patients were monitored to identify if their condition deteriorated, but staff were monitoring some patients at a level that was not always required. Staffing levels had been reviewed and were planned to increase.

Incidents

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There were no Never Events reported between January 2013 and December 2014 that related to end of life care.
- One incident was identified in the six months prior to our inspection relating to end of life care. This was a safeguarding alert and subsequent investigations did not reveal any concerns or inappropriate practice.
- Staff we spoke with stated that they were encouraged to report incidents and received direct feedback from their matron. We were told, and saw examples, of staff bulletins produced by the trust to ensure lessons learned from incidents were disseminated more widely.

Cleanliness, infection control and hygiene

- The mortuary was clean.

Environment and equipment

- The mortuary was fit for purpose and had sufficient capacity to deal with fluctuations in requirements. There was appropriate equipment available for safe moving and handling. Bariatric equipment necessary to manage obese patients was also available.

End of life care

Medicines

- There were appropriate procedures for the administration of medicines. However, the electronic prescribing system adopted by the trust did not currently allow for variable dosages of medicines to be prescribed. To manage this, we were told by staff that information relating to variable doses should be written in the note section of the note sheet. This system had resulted in one patient receiving the highest, and not the ideal, dose of morphine.
- Guidance on anticipatory medicines was available with the AMBER care bundle' documentation on the trust intranet. We saw the records of one patient being discharged home on the day of the inspection and there were appropriate arrangements in place for the supply and administration of these medicines.
- On one ward, the use of a syringe driver for the administration of pain-relieving medicines had been considered, but a lack of staff who were competent to manage syringe drivers resulted in a decision not to administer the medicines in this way.

Records

- An audit to examine completion of the DNA CPR documentation had been undertaken during February 2014. This found that only 52% of forms were correctly and fully completed and were, therefore, valid. Although the most common reason for invalidity was a missing NHS number, 22% had not been countersigned by a consultant.
- During the inspection, we found that very few do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were in use on the wards we visited. The ward staff on Luccombe Ward told us the Orthopaedic consultants were reluctant to discuss end of life issues. We observed three patients where it would have been appropriate to have had a DNA CPR form. They would be receiving palliative care and were in the last 12 months of life.
- We looked at seven DNA CPR forms on medical wards. In four forms the DNA CPR decisions were not always recorded. Where they were recorded, they were not always signed by a doctor and there was no evidence of a review.
- We checked seven DNA CPR forms on other wards. Most of the forms we checked were signed by an appropriately senior member of staff, but in one case there had been a delay of a week between the form

being completed and the consultant countersigning the form. As a result, the form was not valid for an extended period and could have led to uncertainty if resuscitation had been required.

- During the inspection, we found that the majority of DNA CPR forms we examined did not indicate the review date, or whether the decision was to continue indefinitely. In one instance, the documentation stated the DNA CPR had been brought in with the patient, but it was not present within any of the patients' documentation at the time. A valid DNA CPR form must be seen at the time of a cardiac arrest, otherwise a patient must be resuscitated.
- Bed rails, considered a form of restraint, were commonly used and checks they were in place were included in the intentional rounding checklist. However, there was no evidence of an individual risk assessment being undertaken for patients when bed rails were in place, or documentation of discussion about their use with the patient, or relatives.
- There was little nursing documentation relating to patients' end of life care and nurses relied on verbal handover to provide information about patients' end of life care needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was no record of mental capacity assessments being undertaken to assess patients' capacity to make decisions about their end of life care in instances when we would have expected this to be necessary. This meant that decisions about care at end of life had been made without a record showing that consideration had been made for their ability to be involved, or that decisions had been taken in line with the legal requirements of the Mental Capacity Act 2005.
- Staff we talked with had not received training on the Deprivation of Liberty Safeguards and were unsure about the implications for their practice.
- In children's services DNA CPR processes and advance directives documentation were in place. These were printed in lilac for ease of identification and were transferred with the patient.

Safeguarding

- Information on adult safeguarding was widely available within the hospital.

End of life care

- Staff were aware of the action they should take if they were concerned about the possible abuse of a patient and the referral process.
- There were appropriate procedures in place for the management of patients' property following death. Property was collected from the ward by the bereavement officers and appropriate signatures obtained at each stage of the process. There were secure facilities within the bereavement office for the safe storage of patients' property and valuables.

Mandatory training

- Staff reported that e-learning was available for some mandatory training.

Management of deteriorating patients

- A modified early warning score (MEWS) was in use to identify the early signs of patient deterioration. When a decision was taken that resuscitation was not to be attempted, we saw that the medical staff made the decision to discontinue using MEWS. However, there were several instances when the patient's vital signs continued to be recorded on a regular basis. When staff were asked why they continued to monitor the patient's vital signs, they told us the trust policy was to record vital signs at least twice daily.
- We observed there were a number of patients on the wards we visited who were in the later stages of a terminal illness, but in whom there was no documentation of any decision making or discussion about whether a DNA CPR order would be appropriate. This meant that, in the case of a cardiac arrest, attempts would be made to resuscitate the patient, which may not have been appropriate.

Nursing staffing

- A review of nurse staffing had been undertaken by the trust and, as a result, it had been agreed that some wards required an increase in nurse staffing. However, the increase was not due to be implemented immediately.
- There was no evidence of a recent review of the nurse staffing levels required within the palliative care team. Three clinical nurse specialists covering a total of two full time nurse's hours were in post and we were told there was a half-time vacancy. In addition, a community matron had responsibility for providing education and training across acute and community services.

Medical staffing

- A palliative care consultant had been recently appointed to an integrated post across acute, community and hospice services and the appointment of a second consultant was imminent.

Are end of life care services effective?

Requires Improvement



End of life care was not provided in line with national guidance. The trust had discontinued the use of the Liverpool Care Pathway, in line with national recommendations. The trust had commenced the implementation of the AMBER care bundle. This was introduced to ensure optimal care in the last year of life. However, care was not always effective, because decision making did not occur until very near the end of life and there were misconceptions about the use of the AMBER care bundle. Resources and information were available to staff, but most staff we talked with had not had training in its use, or in end of life care at all.

There was good multidisciplinary support from the palliative care team when patients were referred. Progress towards achieving the best practice outlined in the National Care of the Dying Audit had been limited due to a lack of resources and vacancies within the palliative care team. There was no evidence that action following audit had been taken, or that care or guidelines were regularly monitored. Arrangements to monitor the quality of the services were not well developed.

Evidence-based care and treatment

- The trust had followed national guidelines to phase out the use of the Liverpool Care Pathway by July 2014 and had taken the decision to implement the AMBER care bundle.
- A pilot had been carried out on one ward initially and it had recently been rolled out across the trust. However, one member of staff expressed a concern that it had been implemented without consultation and it was clear from our observations and discussions with staff there were issues with its implementation. Initially, there was no consultant lead for the implementation, but a consultant had recently been identified and implementation on their ward was being progressed. A

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resource folder had been developed by the team and placed on every ward to provide information on the AMBER care bundle. Staff however, told us they were not fully consulted or engaged with the process.

- We only found the AMBER care bundle documentation in one patient's records. There was poor understanding amongst the senior nurses we talked with about the period of time that was defined as end of life and when the care bundle should be initiated. In at least two instances, when patients had clearly been identified as being at the end of their life, we were told they were not using the AMBER care bundle because "the patient is not at that stage yet". This meant that adherence to evidence-based practice was not assured.
- One patient, who was on an accelerated discharge home plan, had a range of anticipatory drugs prescribed. However, in another patient they had documented distress and agitation overnight, but this did not seem to have been related this to possible pain or discomfort. It had been documented that there was no pain and the agitation was not being managed.
- In the National Care of the Dying Audit of Hospitals 2013/2014 the trust achieved the key performance indicator for clinical protocols for the prescription of medications for the five key symptoms at the end of life.

Care plans and pathway

- During the inspection, staff identified very few patients as being at the end of their life, but when we talked to them in more depth and examined some patients' notes, it was clear there was a failure to recognise end of life patients. As a result, appropriate planning was not in place.
- The National Care of the Dying Audit 2013/2014 identified that the trust was below the England average for the multidisciplinary recognition that the patient was dying.
- It was suggested by some staff we talked with that there was such a strong focus on saving lives, and that decisions to allow a natural death and not actively resuscitate patients were not made until the patient was very close to death.
- In the absence of the AMBER care bundle documentation, there was no end of life care plan in use and little individualised care planning for these patients.

Pain relief

- The National Care of the Dying Audit 2013/2014 identified that the trust had the clinical protocols but was below the England average for prescribing medication, as and when needed, for the five key symptoms that may develop when people die.
- There was a lack of recognition with some staff about potential pain. When pain had been identified as an issue, analgesia was prescribed and administered.

Nutrition and hydration

- Fluid charts were found in most of the patient records we examined, but were not fully completed. For example, two charts had records of the patient's urinary output only. There was no record of fluid intake. Food charts were also used to record the food eaten but were also poorly completed. It was not clearly stated that these patients had required regular review of their hydration and nutrition requirements. If food charts were necessary, they should have been completed.

Patient outcomes

- The trust had participated in The National Care of the Dying Audit of Hospitals for 2013/2014. This audit evaluated the standards of care of people dying in hospital.
- The trust achieved only two of the seven organisational audit measures assessed in the audit. These were: access to specialist support for care in the last hours or days of life and clinical protocols for the prescription of medications for the five key symptoms at the end of life.
- In the case review, the audit indicated that the trust achieved lower scores than the national average in all 10 of the key performance indicators measured. Standards covered communication, spiritual support, interventions, nutritional and hydration requirements, assessment and care. We asked about progress against these standards since the audit and were told progress had been limited due to the lack of a palliative care consultant. A new consultant had been appointed recently to an integrated hospital, hospice and community post and another appointment was imminent.

Competent staff

- At the time of the inspection, some patients at the end of their life had multiple comorbidities and complex

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care needs. Staff did not always have the knowledge to provide optimal care to these patients, particularly when medical patients were being cared for on surgical wards.

- The palliative care team had developed a competency framework for healthcare assistants in December 2012 and we were told they were hoping to implement it, but it had not been possible to take it forward previously.
- Children and young people's services were part of the palliative care forum and network and training opportunities were shared. Funding was often difficult, so charitable funding was accessed.
- Most staff had not attended any training in the use of the AMBER care bundle. We were told some training sessions had been held, but staff could not be released to attend, resulting in low attendance. Formal training for medical staff had not been provided, due to a lack of capacity within the palliative care team to provide training.
- Staff from the children and young people's service had attended a variety of training and conferences in end of life care.
- Syringe driver training had been provided on a 'Train the Trainer' basis. However, we were told there was a poor uptake of training by hospital staff. The staff we spoke with said they had not received any training and were not confident in the use of syringe drivers. Information provided by the trust showed that 32 members of trust staff had been trained in the use of these devices between June 2012 and February 2014.

Multidisciplinary working

- The palliative care team comprised a palliative care consultant, three clinical nurse specialists, the equivalent of two whole time posts, a clinical psychologist and an occupational therapist. The clinical nurse specialists were managed by a community nurse manager and this facilitated integrated working with community colleagues.
- Multidisciplinary palliative care ward rounds were held weekly and were attended by the chaplaincy team.
- The palliative care team were core members of the lung and upper gastro-intestinal multidisciplinary team meetings.

Seven-day services

- The palliative care team were available 9pm to 5pm, Monday to Friday. In addition, there was an on-call service at weekends.

- Support was also available from the hospice and community teams out of hours and at the weekend. The staff we spoke with knew they could contact someone out of hours and said they were able to obtain advice.

Are end of life care services caring?

Requires Improvement



Many patients were not well enough for us to talk to, but patient who could, told us about the care and compassion they received and that staff treated patients with dignity and respect, although this was not consistent for all patients and some said care was variable. Patients or their relatives were not always involved in conversations about their care with some staff were identified as reluctant to engage in conversation. Patients had good emotional support from the specialist palliative care team and chaplaincy services, but the specialist palliative team said this could be difficult when they had high workloads.

Compassionate care

- Most patients we talked with also told us they felt staff were caring and gave them the help and support they needed. However, there were some examples given by patients of waits for nurses to attend to their daily activities and delays in answering the call bells. One patient said care was variable, depending on which staff were on duty.
- Delays to responding to call bells were reported by two patients we talked with on Colwell Ward, where the staff admitted that medicines and meals were given late, due to staff shortages.
- The palliative care team and the chaplains said they felt staff were caring and supportive of patients at the end of their life on the wards.
- During the inspection, we observed staff interacting sensitively with patients and treating them with dignity and respect.

Patient understanding and involvement

- There were some examples of good communication with patients and families when decisions were made about end of life care, but these were not always documented adequately. There were also some examples where conversations had not taken place and staff told us some consultants were reluctant to initiate these conversations.

End of life care

- We were unable to speak to many patients, or their relatives about their involvement in decisions about end of life care, due to availability of relatives and the condition of the patients.

Emotional support

- The palliative care nurse specialists provided emotional support whenever possible, but sometimes their workload prevented this.
- The chaplain services provided emotional support to people, when requested.
- The bereavement officers provided a sensitive and caring service and the staff had built good relationships with staff across the trust and with the registrar. They had the time to spend with families and provided emotional support. There were links with counselling services in the community, so that referrals could be made if people wished. This meant they could provide an individualised service that met people's needs.

Are end of life care services responsive?

Inadequate



Patients referred to the palliative care team were seen within 48 hours and within 24 hours, if urgent.

There were good level of support from the specialist palliative care team, but staff on the wards did not always recognise people who required end of life care. Some patients had several bed moves while in hospital, which was disruptive the continuity of their care. There were procedures in place to enable rapid discharge to allow patients to die in their place of choice and this was facilitated by the paliative care team. However, there were constraints outside of the hospital that delayed this, on occasion.

Patients' notes did not record that 'do not resuscitate' decisions had been discussed with them. When patients died in hospital they could not always be accommodated in side rooms to facilitate their own and their relative's privacy and dignity. There was support for vulnerable people, but this was not always implemented. For example, there was no written information on end of life care and

people living with dementia did not always have their wishes or preferences identified. The mortuary service had recently been refurbished and had facilities that were sensitive to people's needs.

Service planning and delivery to meet the needs of local people

- Recently, the service had focused on resolving operational issues and recruitment and it had not been possible to progress further service planning.
- There was membership of the southern network for paediatric palliative care, which enabled an integrated approach to be taken for children and young people

Access and flow

- Urgent referrals to the palliative care team were normally seen within 24 hours and others were seen within 48 hours.
- Referrals could be made via a range of routes to aid the ease of referral. The number of referrals had increased over the first quarter of 2014, which the palliative care team attributed to an increased awareness of patients in need of end of life care and the contribution the team could make to patient management. Decisions about end of life were often made late, which limited the impact the palliative care team could have.
- Staff told us they received a prompt response from the team when a referral was made and that they felt well supported by the team.
- Ward staff did not always recognise that patients required end of life care to refer to the specialist team.
- There were occasional delays reported in the response of some of the other clinical nurse specialists, such as the haematology nurse specialist, to requests for review of patients on the wards, due to other commitments. This had the potential to impact on the patient care.
- It would be normal for the use of side rooms to be prioritised for patients approaching the end of their life, in order to provide privacy for the patient and their family. Staff told us that the limited number of side rooms and the need to isolate patients with infections resulted in patients frequently dying in shared bays.
- There were examples of patients who had had several ward moves for non-clinical reasons. During the visit, we saw patients who were being cared for on wards where the understanding of their condition was limited. With each move, the consultant caring for them was changed and continuity of care was reduced. This led to delays to decisions about their care and treatment.

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Discharge arrangements

- One type of DNA CPR form was used across the hospital and community services and this helped to ensure that when a decision was made not to attempt resuscitation, the transfer of a patient did not require additional documentation and reviews were not necessary.
- There were procedures in place for the rapid discharge of patients whose preferred place of care was not an acute hospital. The hospital and community services worked closely together to manage this. However, when social care was required, a lack of availability in some areas of the island frequently resulted in a delay to discharge. This was the case with one patient in the hospital at the time of the inspection.
- According to the National Council for Palliative Care Minimum Data Set for hospitals during 2012/2013, of the 287 patient referrals to the palliative care team, 102 patients died in hospital and 26% were discharged to home. This was better than the England average of 24%.

Meeting people's individual needs

- Multifaith chaplaincy was available 24 hours a day, seven days a week. Arrangements were in place to ensure that, where necessary for religious reasons, deceased patients could be released from the mortuary promptly.
- Documentation was available in the form of This is me booklets, to identify the preferences and wishes of people living with dementia. However, these were not always completed.
- A learning disabilities liaison nurse was available to support people with a learning disability when they came into hospital.
- When patients had received care at hospitals on the mainland, there were difficulties in accessing the scans and reports that were needed to aid decisions about their care.
- A comprehensive information booklet was also given to families to provide practical information and support they might need, following the death of someone close to them. It also provided information to signpost people to other agencies.
- There was no written information available on the wards on end of life care or the DNA CPR policy.
- Although the DNA CPR forms had often been ticked to indicate discussion about the decision to allow a natural death and not to attempt resuscitation, staff had

not recorded the content of these conversations with patients or their families. This meant that there wasn't a clear record of the information given to patients and their families and there was no clear evidence that they had been involved in the decision-making process.

- We looked at seven sets of records and the DNA CPR decisions. We found patients and their relatives had not had a discussion about the DNA CPR decisions in four cases.
- Interpreters were available, when necessary.
- There was a concern about the care of a patient on St Helens Ward. The patient had multiple myeloma and spinal cord compression. The patient had moved through several different consultants and staff were not appropriately trained to deal with the patient's condition or to recognise deterioration in what is a complex disease. To address these concerns the patient was moved to a mixed medical and surgical ward and advice was sought from professional who were more informed. The issues identified were that the trust did not have dedicated Haematological or Oncology beds there was only locum Haematologist. It was not clear how the MDT link worked with Southampton to organise care

Facilities for relatives

- There were flexible visiting arrangements for relative of patients at the end of their life and arrangements could be made for a reclining chair at the bedside for relatives, if they wished to stay overnight.
- There was not a relative's room on every ward to allow privacy when more sensitive conversations needed to occur. To manage this, staff told us they would use an office.
- The mortuary and chapel of rest had been recently refurbished to a good standard and was supplied with fresh flowers donated by a local supermarket and arranged by a volunteer. A Moses basket was available, if required. The children's ward assisted with clothing and blankets when there was an infant death. This meant that the deceased person was treated with dignity and respect and environment was sensitive to the needs of relatives.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy.

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- The information booklet provided to relatives following a death contained a page that could be removed and returned to the bereavement office to provide feedback on the bereavement service.
- A 'thank you' book in the mortuary contained many positive comments from people who had experienced the service.

Are end of life care services well-led?

Requires Improvement



The trust strategy for adult palliative and end of life care was developing and its leadership had been strengthened, but this was at an early stage and there were significant challenges. The specialist palliative team were passionate about the service they offered and were working to develop the service, but identified the need for more resources. Governance arrangements for end of life care were weak. Risks were not appropriately recorded and end of life care standards were not monitored across the hospital. Patients were able to feedback on the service, but this and other sorts of engagement were not supported. Staff had not been effectively engaged to support the implementation of best practice pathways.

Vision and strategy for this service

- A paper was produced for the trust at the beginning of the year identifying steps needed to implement the Department of Health strategy and guidance on end of life care.
- The palliative care team and the newly appointed consultant were passionate about improving the care at the end of life and had some clear ideas about how this could be achieved. However, the team's ability to deliver against these was dependent on additional resources being made available within the team and the appointment of the second consultant.

Governance, risk management and quality measurement

- There were few audits or quality measures in place to measure the effectiveness of end of life care. There had been little progress towards achievement of the National Care of the Dying Audit measures.

- DNACPR forms were inadequately completed and, although a small improvement had been shown at the last audit in February 2014, there did not appear to be a clear action plan to address the issues raised.
- There were no items relating to end of life care on the trust's risk register.

Leadership of service

- The medical director was the executive lead for end of life care.
- The staff we talked with told us the trust now recognised the importance of end of life care and saw it as a priority.
- There had been difficulties in recruiting palliative care consultants and there had been a period of time when no consultants were in post. A new consultant with responsibilities across the hospital, community and hospice services had been appointed and it was hoped that the appointment of a second consultant would be confirmed shortly.
- Although the integrated approach across hospital, community and hospice services should bring benefits, the appointments were perceived by some staff as 'hospice' staff and this led to some uncertainty about their role.
- There was no clear understanding within the trust of the definition of 'end of life' and the palliative care team required support to develop this further.

Culture within the service

- Staff were open and honest about the challenges they experienced and the constraints they perceived to be affecting their ability to provide the service they strived for.
- Staff were proud to work at the trust and many commented on the fact that the hospital was their own local hospital and they wanted to ensure they provided a high quality service to everyone.
- Staff worked well together and there was obvious respect across disciplines and between specialties.

Public and staff engagement

- Bereaved families were invited to leave their comments in the 'thank you' book in the mortuary.
- The booklet Helpful information following a death at St Mary's Hospital, contained a detachable page inviting

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feedback about the bereavement services. We were not told of any other mechanisms in place to obtain feedback from patients or engage them in decisions about end of life care.





- There was a lack of effective engagement in the trust with staff on decisions about end of life care. There was a general lack of knowledge amongst the staff we spoke with of end of life issues and the work being progressed with the AMBER Care Bundle. The decision to implement the AMBER care bundle had been made at a

senior level and not discussed with staff prior to implementation. One ward had identified an end of life link nurse, but the other wards we visited did not have an identified lead for end of life.

Innovation, improvement and sustainability

- There was a willingness to improve and take new ideas forward within the palliative care team.
- The team felt the appointment of a second consultant was necessary to implement many of the improvements they had identified.

Outpatients

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The trust's main outpatient clinics were located at St Mary's Hospital, with satellite clinics in different departments within the hospital and at the Ryde Clinic. During 2013/2014 there were 135,688 outpatient attendances.

We visited the main outpatient department, fracture clinic and clinics in six other locations at St Mary's Hospital. We talked with 12 patients and their relatives and 18 members of staff, including nurses, student nurses, healthcare assistants, consultants, doctors, Allied Healthcare professionals, support staff and senior managers. We also talked with two volunteers. We observed the clinics themselves, the care being provided and looked at care records. We reviewed management and performance information.

Summary of findings

There were effective procedures to support a safe service for patients. Staff were caring and treated patients with dignity and respect. Patients were seen within national waiting times and told us they were happy with the care they had received while attending their appointments within the outpatient department.

Most of the patients we spoke with felt they were seen promptly and were kept informed if clinics were running late. Each clinic had a board that displayed the length of time patients might expect to wait to be seen. The service was undertaking a review to improve its efficiency and responsiveness to the needs of the local population. The leadership of the service was good and there were examples of innovative practice to support people and improve treatment and diagnosis on the island.

Outpatients

Are outpatients services safe?

Good



There were procedures to ensure the delivery of a safe service. Medicines and prescription pads were securely stored. The outpatient areas we visited were clean but the eye clinic was an unsuitable environment for the number of patients seen. Resuscitation equipment, including a defibrillator, were available in each clinic and were well maintained. Patients were appropriately asked for consent to procedures and staff were aware of their responsibilities to safeguard people from harm. Staff reported and learned from incidents.

Incidents

- 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. No Never Events were reported during 2013/2014 that related to outpatients.
- Incidents were discussed at the monthly directorate quality meetings to identify themes and agree actions.
- Staff we spoke with stated that they were encouraged to report incidents and received direct feedback from their matron. We were told, and saw examples, of staff bulletins produced by the trust to ensure lessons learned from incidents were disseminated more widely.

Cleanliness, infection control and hygiene

- All the outpatient clinics we visited were visibly clean. We looked at the treatment rooms, where minor procedures were carried out and the rooms and equipment were visibly clean.
- Cleaning schedules were completed appropriately. Labels to identify equipment had been cleaned were in place and single use disposable items were used appropriately and whenever possible.
- Toilet facilities were clean and had a chart to indicate the last time they had been cleaned.
- The staff we observed were adhering to the trust's 'bare below the elbow' policy and used hand sanitising gel between patients. Hand sanitising gel was available in the reception area and the consulting rooms.

Environment and equipment

- The environment within the main outpatient clinic and fracture clinic was fit for purpose and necessary equipment was available. However, there were constraints caused by the age and layout of the building for some of the clinics within the specialist departments.
- The eye clinic was very busy and the environment was cramped. Demand had increased significantly over the previous eight years. There were double doors at the entrance to the clinic with the reception desk just inside the entrance. Patients queuing for the reception desk blocked the entrance. Inside the clinic, there were narrow corridors between the consulting rooms and a main thoroughfare for the hospital ran through the middle. The floors sloped and this caused an unsafe environment for patients with poor eyesight. Staff were constantly advising patients to be careful of the sloping floor. A mixture of seating was used for patients waiting in narrow corridors at various points in the clinic. There were problems with damp in some rooms and the décor needed refurbishment. One patient said, "The waiting facilities are archaic."
- The endoscopy unit was also small and crowded.
- The diagnostic imaging department, where patients attended for a range of diagnostic procedures, was pleasant and well maintained.
- Resuscitation equipment and a defibrillator were available in each outpatient area. Weekly checks were completed and a signed record was kept with each set of equipment.

Medicines

- Medicines were stored appropriately in locked cupboards and within rooms with restricted access.
- Prescription forms were locked away each evening. All outpatient prescriptions were only valid for dispensing at the hospital pharmacy. No external prescription forms (FP10s) were used.

Records

- Staff told us patient records sometimes were missing and had to be found prior to the start of clinic, but the number was small and this was usually resolved without causing major delays to appointments.
- High quality x-ray images were available electronically in consulting rooms in the fracture clinic and were uploaded immediately. This meant that doctors in the clinic had immediate access to x-rays carried out while the patient was in clinic.

Outpatients

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us the options for their treatment were discussed with them to enable them to make informed decisions. In the case of a young person, their parent told us, “They always talk to [the young person] and involve them in the discussion. We make the decision together.”
- Patients also told us staff checked with them before giving care, to ensure they understood what was going to happen.
- The staff we talked with said they always explained what they were going to do before giving care. Nurses said that when written consent was required this was normally obtained by doctors. They were able to describe the action they would take if a patient was unable to give informed consent to treatment and understood the principles of the Mental Capacity Act 2005.

Safeguarding

- Adult safeguarding was included in the mandatory training programme and all the staff we spoke with were up to date with their mandatory training. 87.5% of staff in the outpatient department were up to date with their adult and children level 1 safeguarding training. Only 20% were up to date with children safeguarding training at level 2, as of April 2014.
- Staff were aware of the action to be taken if they were concerned about the potential abuse of a vulnerable person. Two of the staff we talked with told us they had reported a concern and this had been acted on and reported to the local adult safeguarding team. One person, who had reported a concern relating to a member of staff, said the matron had been very supportive and they had been offered counselling. They had received feedback on the outcome.
- We saw posters and leaflets in all the outpatient areas giving information about the abuse of vulnerable adults and the way to report concerns.
- All the staff we talked with said they would be confident to use the whistleblowing policy, if necessary. They felt their concerns would be listened to and acted upon.

Mandatory training

- In February 2014, 75.49% of staff in the planned directorate that includes outpatient services had completed their mandatory training.

Nursing staffing

- The nurse staffing levels for the outpatient department had not been reviewed in the last year and, as a result of discussions about the possible centralisation of clinics, current vacancies had been frozen. This resulted in significant numbers of bank staff being used.
- The bank staff tended to work regularly in the department and knew the area very well. This reduced any negative impact.
- Clinics we visited were allocated a nurse or healthcare assistant and medical staff told us their clinic nurse was normally available to act as a chaperone, when required.

Medical staffing

- When medical staff were on leave, locum cover was provided where possible. In other circumstances, clinic dates were moved.
- In larger specialties, such as trauma and orthopaedics, other consultant colleagues covered clinics during absences.
- In specialities such as ophthalmology, there were occasions when an emergency admission that required urgent surgery resulted in the clinic being cancelled to allow the consultant to be released to attend theatre.

Major incident awareness and training

- The outpatient department had been allocated a specific role in the case of a major incident and this was identified in the major incident plan. The role played by the outpatient department was modified following a recent exercise, to reduce the pressure on the A&E department.
- The staff we talked with were all aware of the role of the department and there was an action card displayed on the notice board in the sister's office.

Are outpatients services effective?

Not sufficient evidence to rate



We report on effectiveness for outpatient services below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatient department.

Outpatients

Evidence-based guidelines were adhered to where they were available and the quality of the service was monitored and assessed through local and national audit programmes. Staff had completed the training required to provide effective care.

Evidence-based care and treatment

- The outpatient services used relevant National Institute for Health and Care Excellence (NICE) guidelines and other national recommendations to treat patients. We looked at the clinical guidelines for diabetes and respiratory services and saw the guidelines referred to NICE guidance.
- The specialist nurses were able to confirm these guidelines were adhered to by the team. One of the diabetes consultants was a member of the national group of clinicians who review NICE guidelines.
- The trust had implemented the lung cancer pathway and carried out audits of compliance.
- One-stop clinics had been introduced for breast screening to enable patients to be screened and have an appointment with the consultant with their results on the same day.

Patient outcomes

- We saw the trust participated in a wide range of audits relevant to the service and action plans were developed to improve the department, based on the results of the audits.
- The diabetes service participated in the National Diabetes Audit.

Competent staff

- Staff had undertaken appropriate specialist training and competency assessment to carry out their roles. For example, the respiratory physiologists were registered with the Registration Council for Clinical Physiologists and a healthcare assistant who was undertaking spirometry had attended external training and competency assessment for this role.
- Medical staff revalidation was established and surveys were used to obtain patient feedback for this.
- According to the trust's records, 79% of staff in the outpatient department had had an appraisal within the previous 12 months. We were told that this was slightly lower than normal, as a change was being introduced to the schedule for appraisals, to bring them all in line with specific timescales and cascade objectives down through the trust.

- Staff spoke positively about the appraisal process, but identified that there were sometimes difficulties in releasing staff to attend training. For example, a new camera had been purchased, which required training, but the number of staff able to use it was limited, as they could not be released for training.
- The bank staff we talked with had not had an appraisal. Outpatient managers told us appraisals of bank staff were undertaken centrally.

Multidisciplinary working

- We saw examples of good communication and liaison between different professionals across acute and community services. For example, the diabetes doctors and specialist nurses worked closely with the dieticians and podiatrists. The pain management team consisted of an anaesthetist, nurse, physiotherapist and clinical psychologist.

Seven-day services

- Managers told us the possibility of seven day working for outpatient services was currently being explored. There are already a small number of evening clinics for some specialties. However, the lack of available public transport availability on the island made out of hours clinics unsuitable for some patients.

Are outpatients services caring?

Good



Patients uniformly praised the staff in the outpatient services for their caring, compassionate and professional approach. They told us they were always involved in decisions about their care and treatment and staff listened to what they had to say.

Patients were being helped and guided through the departments to give them reassurance and ensure they had a smooth journey through a range of tests and treatments. In the eye clinic, staff had been employed to provide specialist emotional support for people with eyesight problems.

Compassionate care

- We observed people being treated with dignity and respect. Staff were friendly and welcoming to patients and gave reassurance where it was needed.

Outpatients

- All the patients and relatives we talked with praised the attitude and commitment of the staff. One patient said, “They are magic. They are good with everyone.” Another said, “Care is excellent, staff are polite, professional and helpful.”
- A parent told us how staff took the time with their child to calm them down before carrying out a procedure as they were “panicky”.
- We saw volunteers in some of the outpatient clinics and observed them helping patients with directions and accompanying them to other departments, as necessary.
- Patients told us they had confidence in the staff. They said the doctors knew about them and their previous treatment.
- The facilities in the diagnostic screening department were not conducive to maintaining patient dignity when they had to change into a gown for diagnostic procedure. There were curtained cubicles for patients required to undress for their procedure. It was recognised that it was not ideal for these patients to wait in hospital gowns in the same area as other patients of both sexes. Managers had worked with the patients’ council to improve privacy and dignity issues in this area. An attempt had been made to provide a separate waiting area for those patients wearing gowns, but as there was no member of staff to oversee the area, segregation was not always maintained.

Patient understanding and involvement

- Patients said they were always involved in decisions about their care and treatment. They said staff listened to what they had to say and they felt able to ask questions if they were unsure.
- One patient described the support and information given to them by the specialist nurses to help them in making decisions about their care and treatment. They told us the different options were discussed fully with them and time given to them to fully consider the best way forward.

Emotional support

- The eye clinic had introduced eye care liaison officers (ECLOs) who were available five days a week to provide emotional support to patients who were experiencing problems with their eyesight. The ECLOs were visually impaired and had first-hand experience of the issues patients were facing.

- Two patients told us of the input of specialist nurses who had given them support through their care and treatment.

Are outpatients services responsive?

Good



The outpatient service was responsive to people’s individual needs and the hospital was reviewing how services could be developed further. Patients were seen within national waiting timescales and delays in clinics were explained to the patients. Action was being taken to reduce ‘did not attend’ (DNA) rates and clinics that were being cancelled at short notice. There was support for people with a learning disability and volunteers helped to guide people around the department. Translation services were available for people who did not speak English. Complaints were handled appropriately and action was being taken to improve the service.

Service planning and delivery to meet the needs of local people

- A review of the provision of outpatient services was being undertaken to maximise use of the space and improve access for patients. Centralisation of the clinics was seen as being advantageous and there was a desire to improve the environment for patients, particularly in the eye clinic and other clinics in the older parts of the building. However, this work was in an initial scoping stage of development and no clear plans had been developed.

Access and flow

- The percentage of patients who did not attend (DNAs) their outpatient services appointment was 7.4%, which is slightly lower than the national average of 8%. The trust had a procedure for the management of DNAs to ensure appropriate steps were taken to discharge the patient back to their GP, if necessary.
- Overall, the trust met the 18-week referral-to-treatment time targets in 2013/2014. Based on December 2013 figures. A few services were not meeting this target in neurosurgery, general medicine, gastroenterology and cardiology.
- Targets for diagnostic treatment times within six weeks and urgent referrals for appointments for patients with

Outpatients

suspected cancer within two weeks were met. The trust regularly scrutinised patient level data and performance dashboards to manage waiting times. Additional clinics were scheduled, where necessary.

- Nurses ensured patients were kept informed when clinics ran late through announcements and updating information boards in waiting areas. Staff told us most patients were seen within 15 minutes of their appointment time. However, oncology clinics often ran late with waits of up to an hour.
- Patients we talked with told us waiting times were variable, but they understood that sometimes people needed extra time with the doctor and did not have an issue with this. In a clinic such as the eye clinic, there were a number of different tests and examinations performed during the visit and this meant delays were exacerbated. One patient said, "It is quick at the first stage, but then it falls apart." Patients said they were offered tea or coffee if there were long delays.
- For the financial year 2013 to 2014, approximately 16% of outpatient appointments were cancelled by the hospital. The highest reason for cancellation was for staff being on annual leave without giving sufficient notice or when locum cover was unavailable. The trust had a target to reduced cancellation rates by 10% in 2014/15.

Meeting people's individual needs

- There was a memory clinic to support people living with dementia and to assess people with memory loss or suspected dementia.
- Staff had access to a learning disability liaison nurse and, where possible, obtained information about patients before they attended the department to identify their specific needs.
- There was access to an interpretation service, as required.
- Volunteers were available to provide extra support to patients and were seen guiding them through their journey through the departments.
- Bariatric equipment for the care of obese patients had been purchased and hand-held equipment was available in ophthalmology there were issues with access. Specialist chairs were available in all waiting rooms and trolleys were available as needed. The door width in the ear, nose and throat (ENT) clinic had been increased to enable access to the treatment room with a wider wheelchair.

- There was a separate area for children within the eye clinic and this was decorated in a 'child friendly' manner, with a range of toys for younger children. However, two consulting rooms used for adults could only be accessed from this area and this occasionally resulted in adults waiting in the children's area. There was no formal system in place of the regular cleaning of toys in this area. We saw very few children's areas within other clinics.

Learning from complaints and concerns

- Outpatient services had had only two complaints within the last year. A proactive approach to managing complaints was taken and the manager called the complainants within 48 hours of the complaint to discuss how they wished it to be dealt with.
- We saw leaflets in all the clinics providing information for patients on how to raise a concern or complaint.
- The staff we talked with were familiar with the complaints process and said they received feedback on complaints and were able to give an example of the action that had been taken as a result of a complaint. There had been an issue with the attitude/interpersonal skills of staff and this had been raised and discussed at a staff meeting.

Are outpatients services well-led?

Good



The outpatient services lead was reviewing how the service could be developed to improve efficiency while meeting the needs of the local population. There was good local leadership of clinics and staff who were committed to providing optimal care to patients. Governance arrangements were developed, but the service needed to ensure risks were appropriately recorded. Patient feedback was not used to improve the service, but there was patient and public consultation on services. The department was innovative in its use of technology to meet the needs of an island population.

Vision and strategy for this service

- The trust mission statement and quality priorities were displayed in a number of outpatient areas.

Outpatients

- A review and scoping exercise was being carried out to consider optimal use of the facilities and the future placement of clinics. Weekend and evening clinics were being considered.

Governance, risk management and quality measurement

- There was an established governance structure, which included directorate quality boards. Quality meetings were held at subspecialty level.
- Performance data, such as the DNA rates was displayed in the sister's office for staff to see.
- Monthly quality meetings took place, chaired by the Head of Clinical Services. Complaints, concerns, incidents, infection control and risk assessments were discussed at the meetings.
- There were a number of department audits which were carried out on a regular basis. These included audits of case notes, infection control, medicines and decontamination procedures.
- The trust's risk register included concerns with the environment in the eye clinic and the waiting area in the diagnostic and screening area.
- There were systems to monitor performance and address risks to performance. There were weekly management meeting to manage waiting times, track patients, examine theatre capacity and schedule additional clinics, as necessary.

Leadership and culture of the service

- There were clear lines of accountability and staff felt well supported by senior management.
- There was appropriate clinical leadership within the clinics. The clinical leaders were enthusiastic and passionate about the provision of a high quality service and this was evident to junior staff.
- Staff meetings were held every month and staff had the opportunity to raise issues and concerns. They felt they were listened to and when it was possible to address the concerns raised, this was followed through.

- Staff told us that outpatient services was a good place to work and several told us they all worked together well, as an effective team.







Public and staff engagement

- There were no surveys or formal mechanisms in place to obtain regular feedback from patients using the service.
- A form of the NHS Friends and Family Test had been used previously, but this was not used currently. The quality manager was looking at options for the use of electronic tablets to obtain feedback from patients in the future. This would include, but not be confined to, the NHS Friends and Family Test.
- There was a patients' council and members of the council had been consulted in relation to the environment within the diagnostic and screening department. There were plans to obtain patients' views on the potential centralisation of clinics and extension of clinics into the evenings and weekends.
- The NHS staff survey in 2013 indicated that staff felt communication between senior management and staff could be improved. While there was no service-level data available this view was not supported by staff in the outpatient department.

Innovation, improvement and sustainability

- The outpatient review to centralise clinics and provide seven day and evening services was being developed to improve service.
- The department was innovative and used technology because of the need to serve an island population. For example, a non-invasive ventilation service had been brought to the island to improve outcomes for people with long-term conditions, such as muscular dystrophy and motor neurone disease. The eye clinic offered a range of services, usually only available in regional centres, avoiding the need for patients to travel to the mainland for treatment.

Ambulance services

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

Information about the service

The Isle of Wight ambulance service is located at St Mary's Hospital. The service provides a range of ambulance services to residents and visitors, including emergency ambulance response, an NHS 111 service and patient and non-patient transport services.

The ambulance headquarters and station at St Mary's Hospital provides a base for 11 management and administrative staff and 102 operational emergency service staff. Operational staff included paramedics, emergency vehicle operatives and operational and clinical managers. Non-emergency patient transport services consist of 17 staff within a separate base at St Mary's Hospital.

An integrated call centre (Integrated Care Hub), opened in 2013, provided access to the 999 emergency calls service, the NHS 111 service, the GP out-of-hours service, district nursing, adult social care, telecare services, non-emergency patient transport services and mental health services. The Integrated Care Hub coordinated access to emergency, urgent and unscheduled care for the Isle of Wight. 64 staff are located at the Integrated Care Hub, including switchboard, call handlers, dispatchers, clinical advisers and operational and clinical managers. Key services are accessed out of hours, through the Hub.

The ambulance service had 13 frontline emergency vehicles, including two multipurpose vehicles and seven rapid response vehicles (RRVs). The maximum number of frontline vehicles at any one time is eight. One vehicle is

equipped with chemical, biological, radiological and nuclear (CBRN) protective equipment and one vehicle is equipped for major incidents carried supplies for multiple casualties. The service also has one 'Jumbulance', which carries four stretchers and is available for transfers to the mainland.

The trust reported that the number of ambulance calls presented to the switchboard in 2013-14 was 23,071. During the year, around 8% of emergency calls were resolved by telephone advice and of those incidents attended, around 46% were managed without the need for transport to A&E.

During our inspection, we visited the ambulance service locations and spoke with 37 managers and operational staff, as well as a further nine representatives of partner organisations and volunteer staff. We observed operational staff engaged in providing transport services and care for 15 patients. We observed the care that patients received.

Ambulance services

Summary of findings

The ambulance service had a very low occurrence of untoward incidents and clear ownership of risk. The ambulance station and vehicles were clean, and equipment was well stocked and maintained. Medicines management was not appropriate, as there were poor stock control and storage arrangements for medicines although this improved during the inspection process. Staff were well trained and supported by some examples of innovative practice. Planning for major incidents was fully in place, in conjunction with partner organisations.

The services used evidence-based guidelines for treatment and were innovative in developments to support best practice. The early intervention in a sepsis trial was an example of innovations and initiatives, which were used to support evidence-based care and treatment. The Individual Learning Plan was used to support the development of staff competency. The Hub, which coordinated access to care for the island, was a good example of multidisciplinary working.

Patient satisfaction comments were consistently positive in surveys. Patients were treated with compassion, dignity and respect by ambulance staff. Ambulance crews listened carefully to patients and involved and supported them in understanding their care and treatment. Staff provided emotional support for patients and their relatives throughout their contact with the service.

The ambulance service had clear operational and clinical leadership. Ambulance staff told us that the level of integration of the ambulance service and being part of the trust allowed them to respond quickly for the benefit of patients. The ambulance service monitored the operation of the service against key performance indicators and consistently met its response time standards.

Are ambulance services safe?

Requires improvement



Overall the ambulance services had procedures to provide safe care. There was a very low occurrence of untoward incidents and we saw there was learning from incidents. There was clear ownership of risk. The ambulance station and vehicles were maintained in a clean condition. The environment, vehicles and equipment were well stocked and maintained. Staffing levels were safe. Staff training was supported by some examples of innovative practice. Planning for major incidents was fully in place, in conjunction with partner organisations. Safeguarding procedures were in place, although some associated staff groups required training.

We identified issues with the stock control and storage arrangements for medicines. Records were mainly electronic, although we did see some not being completed in a timely manner, leading to the receiving hospital not getting a report form with the patient. Security procedures were mainly in place, but we observed a minor breach of security procedures: sales representatives were admitted to the ambulance station who were not accompanied by staff.

Incidents

- A policy for the management of serious untoward incidents was in place, which formed part of the operational procedures for the service.
- One serious incident had occurred in the ambulance service during 2014. The incident was investigated and staff were able to describe the learning from the outcome of the investigation, which was shared with staff. Incident reviews were discussed and action plans prepared that had resulted in changes to procedures. An example was discussed, in which a patient with a suspected stroke who was initially sent an ambulance was subsequently cancelled when the patient declined it. Staff felt the service had learned from this incident.
- Adverse events and near misses were reported and recorded through an electronic system. Ambulance crews reported incidents through the system from the ambulance base, or could use a paper copy of the incident report form.

Ambulance services

Cleanliness, infection control and hygiene

- Arrangements were in place to prevent and control infection, including the provision of personal protective equipment (PPE), such as gloves and aprons. There were adequate supplies of protective equipment available.
- We observed that staff adhered to 'bare below the elbow' policies.
- Systems were in place to ensure cleaning of the environment, vehicles and equipment was carried out appropriately
- The ambulance station was clean and ambulances we saw in the station were clean outside and inside. This included patient transport service (PTS) vehicles.
- Cleaning staff were used to clean and restock the ambulance vehicles. The arrangements for cleaning and stocking worked well, and were supported by dedicated staff working from 7am to 2am. Each vehicle, including those used for PTS, was cleaned each day. Each emergency vehicle was also deep cleaned twice a month, with PTS vehicles being deep cleaned once a month. Cars were deep cleaned as and when required, but at least once every six months. The dispatcher rang ahead to tell the cleaners if a crew required an unscheduled deep clean for their vehicle.
- We saw evidence that vehicle cleanliness was inspected. Cleanliness audits were carried out using a tracker machine. The target was 95% compliance and 98% compliance was being achieved. Staff told us that unannounced infection control audit visits took place at least every two months, including out of hours. Action plans were prepared and the audit was revisited to check compliance. In a 2012 survey, one out of 514 patients surveyed thought the ambulance was not clean.
- The ambulance station was cleaned daily by hotel services cleaning staff and these staff were also available to clean vehicles, if required.
- Clean linen was appropriately placed on shelves in a small, separate storage room.
- Disposable mop heads were used for blood and bodily fluids. For general cleaning, reusable mop heads were used. There was a sign on the wall indicating what colour mop should be used for which area of the ambulance or station.

- The sluice room was clean and contained hand-washing sinks, and two orange linen bags. Red soluble bags for contaminated linen were available in a cupboard. These could be left in the ambulance sluice linen bags, or at the hospital.
- Mandatory training included infection prevention and control and we were informed that 85% of staff had received this.
- The cleaner was aware of which bins to use for the disposal of clinical waste. The main bin was appropriately locked shut. Orange bags were used for clinical waste disposal.
- Some of the boxes designated for the disposal of sharps had not been labelled when assembled. The cleaner confirmed that they did not date them when they disposed of them. These boxes were not clearly labelled to provide an audit trail.
- It was not apparent that hand sanitising gel was being used regularly by ambulance crew. Staff in the ambulance station were not carrying hand sanitising gel and there were no stocks of hand sanitising gel in the station stock room. We found hand sanitising gel dispensers were located in the door pockets of vehicles, although we did not observe staff using these.

Environment and equipment

- The ambulance station was built in the 1970s for 40 staff and there were now more than 100 staff based there. The PTS staff relocated to a separate building in 2012, which had eased the pressure on facilities a little. However, storage facilities were insufficient and a range of plastic storage structures were used within the garage area.
- Five ambulances and a rapid response vehicle (RRV) worked 12-hour shifts. At night, four ambulances and an RRV were used. At night, the RRV also supported the out-of-hours centre. The PTS vehicles were non-blue light to ensure they were left to undertake PTS work.
- Arrangements were in place to service ambulance vehicles through the vehicle manufacturer's service outlets. We found that fleet downtime was minimal. The vehicles used by, for example, porters and catering staff were checked. The vehicle checks undertaken for voluntary car drivers included a check of the Ministry of Transport test certificate. The fleet manager looked after the equipment that came with the vehicles, for example, stretchers.

Ambulance services

- The service was able to access appropriate equipment, including equipment to support the moving and handling of bariatric patients. Other equipment included lifting cushions and easy-glide chairs. PTS also had access to equipment to assist with lifting patients. The suitability of new equipment under consideration for use in the service was assessed with the assistance of clinical staff. A separate room in the station was used to store equipment.
 - Cleaners completed a 'vehicle ready form', which listed all the areas to check. It also included checks such as lights and tyres. Cleaners reported any ambulance vehicle defects. Vehicles that were cleaned, restocked and ready to use were tagged to indicate availability.
 - There was a defect report sheet in the crew room for the crews to report any vehicle defects.
 - Two of the five support staff were also trained to restock the vehicles. The response bags on the vehicle, which contained essential items that staff required when they first arrived at the patient, were steam cleaned, if necessary. The cleaners had access to a store room with a stock of replacement bags and also had stocks of replacement oxygen. In the ambulance, a diagram annotated with photos provided a guide, as to what equipment should be in each cupboard. All ambulances followed the same storage layout, with numbered cupboards and tags on certain equipment to show which piece of equipment was checked and ready to use. We were informed that ambulance crews sometimes restocked their vehicle, if trained support staff were not available.
 - Medical equipment such as defibrillators were maintained by the hospital's medical equipment department. Records of maintenance were kept in the department. We undertook checks of a sample of equipment maintenance records, including defibrillators and suction units. Equipment was labelled with the date it was serviced and equipment was recalled for service when it was due. The department also covered any equipment problems that occurred between service intervals.
- ## Medicines
- Medicines were stored in a secure room at the ambulance station, which was accessed by a key-coded lock. The room was adjacent to the boiler room and was accessed through the sluice. The room housed two locked cupboards containing medicines, as well as a third cupboard. It also contained charging points for defibrillator batteries, radios and mobile devices.
 - Controlled drugs (CDs) were stored in one cupboard. Drugs were delivered three times per week by the hospital pharmacy. Controlled drugs were signed out by the paramedic crew and kept in the ambulance in a locked area. There were drug signing-out sheets in the CDs container to be completed after use.
 - We observed a delivery of CDs. The pharmacy delivery staff gained access to the ambulance station without appearing to notify ambulance staff and were unaccompanied, as they entered the medicine storage room. The consignment of medicine containers were left on the floor outside the storage cupboard, adjacent to a hot radiator. The ambulance manager on duty placed the consignment in the locked cupboard when he next checked the room. During the intervening time, the CDs were available to be taken by anyone who had access to the room. We saw that staff other than paramedics had access to the storage room, which was also used for radio and electronic patient clinical records (ePCR) battery chargers.
 - There was a separate sepsis kit (a toolkit for medical staff to support the prompt administration of antibiotics and resuscitation fluids for patients with sepsis symptoms) available for paramedics who had received training in its use.
 - The second cupboard contained other medicines. These were taken from stock, as needed, by the crews and stored in the red grab bag on the ambulance. These were not checked in and out every day, but were replenished as and when needed.
 - Medicines checks were undertaken daily by the support officer. Medicines that were out of date were marked with a red tag and placed separately in the storage cupboard. However, the medicines containers were not rotated to ensure that the most recent expiry dates were used first.
 - The records of stock drugs did not match entirely with the stock. There were no records of the expiry dates of medicines in stock and no stock-checking system was in place. One ampule of a controlled drug was unaccounted for and this was raised as an incident and

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was being investigated. Another medicine was shown as having a large stock according to the records. None was in stock when we checked and the last entry was recorded as 2009.

- The temperature of the medicine storage room was not monitored by the service. A check of the temperature showed it exceeded 25 degrees which is the temperature below which medicines should be stored. The manufacturer's guidance for the maximum storage temperature for each medicine was not being followed, which could impact on the effectiveness of the medication. At the unannounced inspection that followed the initial site visit, action had been taken to reduce the temperature in this room. The temperature was 20 degrees rising to 22 degrees with three people in the room. There was no evidence of continued monitoring of the temperature in this room to ensure that it remained within acceptable limits.
- Intravenous fluids were now being stored in a cupboard outside this room for ambulance staff to top up from.. There had not been a risk assessment to ensure the safe storage of fluids in this environment.
- Community first responders (CFR) volunteers in each area were supplied with their own set of equipment, including oxygen and reusable supplies. To replace oxygen, the CFR member asked an ambulance crew for a spare cylinder or visited the ambulance station.

Records

- The ambulance service stored patient-related and other information electronically.
- Electronic patient clinical records (ePCRs) were used for patient information. Ambulance crews used laptops to input patient information into the system. Completed records were transmitted to the Hub. Ambulance staff checked electronic documents had been transmitted when they arrived at the hospital. The data on the laptop was erased when the centre received the data. Paper clinical report forms (CRFs) were also used, although we were informed that more than 95% of patient records were submitted electronically.
- The emergency department receiving nurse signed the ePCR at handover. A docking station was situated in the emergency department for ambulance staff to use to upload patient data. The ambulance crew we observed did not use this facility. The crew informed us that they had not filled it in yet, as the patient was not calm enough on the ambulance to allow them to fill it in.

They said they would fill it in later. However, we did not see them do this before they went off to their next call. It was, therefore, unclear whether the ambulance service received clinical records for all their patients. It was also unclear if staff in the emergency department received a completed clinical record for the patient.

- Service managers informed us that if the crew did not complete the ePCR at the time, they were permitted two more calls in which to update it. After this, the remote record was deleted, as it was no longer contemporaneous. This presented some risk to the accuracy of the patient information, and to the timeliness of information available to the hospital emergency department. For some patients there may not be a record of the treatment received from the ambulance crew.
- Patients who were not conveyed to hospital, but left at home did not receive any information about the visit or other supporting information about their condition from the ambulance crew. Information about the crews' observations could be of use to others who would later see the patient.
- The clinical support officers randomly undertook regular audits of document quality. We were informed by service managers that the system produced a daily report of the number of ePCRs sent against the number received.
- Ambulance crews could use ePCRs to undertake patient risk assessments.
- In the station crew room, we observed patient information in open document trays which were potentially accessible to the public and not securely stored. Patient names and addresses recorded on shift running sheets were not locked away out of view. While access was supposed to be controlled it was observed that non-ambulance staff were granted access and then not accompanied when on the premises. Therefore, there was a potential for there to be a breach of patient confidentiality.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. For ambulance patients, consent was included in the ePCR template. Ambulance staff were able to add the reason if they were not able to gain the patient's consent, for example, if the patient was unconscious.

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- The ambulance service used assessment tools for consent that took account of the requirements of the Mental Capacity Act 2005. Staff informed us that, in these instances, they would act in the best interests of the patient.
- Staff had received training in consent for patients using the 111 service. Patient consent was obtained prior to sending information to GPs.

Safeguarding

- Ambulance staff were aware of how to make a referral if they had any safeguarding concerns. Ambulance service managers were able to describe how, in two instances, safeguarding concerns were identified and action was taken, as a result.
- For PTS, managers confirmed that disclosure and barring service (DBS) checks and an annual medical assessment were undertaken for volunteer drivers.
- CFR volunteers received DBS checks. We found that CFR staff did not receive safeguarding training, although CFR operatives worked with children. However, CFR operatives were able to explain how they would make a safeguarding referral, through the integrated care Hub.
- Adult and child safeguarding training was part of mandatory training. Our review of the trust's records showed that 96% of ambulance staff had completed safeguarding children training, and 87% had completed safeguarding adults.

Mandatory training

- Managers and staff described examples of training being undertaken in specific areas of the service. For example, mandatory training included infection prevention and control and we were informed that 85% of staff had received this.
- Training hours were allocated to staff as part of their Individual Learning Plan (ILP). Each member of staff was allocated annual training hours, which varied according to their skill-level and job title. Mandatory training for paramedic staff typically included lifting and handling, back care, child safeguarding, managing behaviour that challenged services, fire extinguisher training and driving support was included.
- The service used electronic tablets for e-learning and ten devices were available for operational staff to borrow. We found that during a recent 30-day trial, 94 e-learning modules were completed, which represented

a 70% increase in the expected level of training for the period. The devices enable e-learning undertaken to be tracked, so that the level of training achievement was known and staff could be individually supported.

Assessing and responding to patient risk

- Patients with a deteriorating condition who contacted the Integrated Care Hub were assessed and triaged. If a patient with a deteriorating condition rang back to the 111 service they were asked if their condition had worsened. If the patient answered affirmatively, they were retriaged to ensure they had received the correct advice and response.
- The service was participating in a trial in early intervention in sepsis. The aim was to identify patients who might have sepsis, and to reduce their mortality. The trial was introduced for 12 response car paramedic (RCP) staff initially and was subsequently being rolled out for other paramedic staff. Following training, paramedic staff carried a stock of antibiotics. The clinical support staff in the Hub and the hospital pharmacy were involved in supporting the closely controlled group of patients involved in the trial.
- Before PTS attended a location, it was risk assessed. Specialist equipment – for example, ramps and specialist chairs – were available to support when required.
- PTS staff told us they had experienced some minor communications problems where the mobility of the patient was wrongly classified on the journey details. For example, a patient that needed two ambulance staff to help lift them in and out of an ambulance might be incorrectly listed as requiring only one staff member. These problems had now been largely overcome.
- There were certain types of calls where a CFR would not respond, as they may not have the skills to deal effectively with the patient. This included road traffic collisions and falls from heights.

Staffing

- Paramedics (band 5) worked on an ambulance with an emergency vehicle operative (EVO), who was band 3. Paramedics with some extended skills worked on a rapid response vehicle (RRV) alone. The extended skills included advanced patient assessment, wound care and identification and treatment of minor illnesses. RRV staff could work on an ambulance or an RRV.
- Most operational rotas for the ambulance service were of 12-hours duration. Staff also operated six, eight, and

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ten hour shifts. We found staff were expected to work beyond their finishing time to complete their work with a specific patient, although we were told this was an occasional occurrence.

- We spoke with an ambulance crew about staffing arrangements. The EVO told us they followed a set shift pattern, but the paramedic described themselves as a “float” with no set shifts. They were required to work with different members of staff to fill gaps in the rota and said their shifts were often changed at short notice.
- Staff told us that ambulance crews attended more patients who genuinely required their help, as others had been redirected by the Integrated Care Hub. This meant that staff were attending genuine incidents, which required them to use their skills.
- We looked at the ambulance, which was designed to transport four stretcher patients. Staff told us that often there was only one member of staff in the back of the vehicle to attend to the patients, although this depended on how serious their condition was.
- Sometimes, due to sickness, an ambulance may be staffed by two EVOs. If possible, a paramedic was moved to work with one of them, but this was not always possible. However, staff we spoke with felt this happened only occasionally.
- Support and counselling arrangements were in place for the ambulance service to support CFRs, if they required any help following an incident.
- We were informed by trust managers that the year-to-date sickness absence rate was 4.25% for emergency ambulance staff and 2.75% for PTS staff.” Human resources (HR) managers informed us they were providing help or assistance to nine ambulance staff in connection with employment issues. Mainly these related to managing long-term absence. Ambulance service managers could elect to have HR support when they considered they needed this.

Major incident awareness and training

- A major incident plan for the ambulance service was in place. The plan described the emergency response structures within which the ambulance service operated, including the Island Resilience Forum (IRF) and a similar body located on the mainland. The ambulance service was a member of these forums and was classified as a category 1 responder under the Civil Contingencies Act 2004.

- We spoke with other agencies on the island, who worked closely with the ambulance service. This included the local authority, the coastguard and the fire service. These agencies spoke positively of the collaborative work undertaken by the ambulance service in connection with awareness, planning and training for major incidents. The ambulance service attended strategic meetings and contributed and assisted with planning. IRF emergency procedures were being developed, which included joint training supported by the ambulance service. The local authority commented on their “constant communications” with the ambulance service, which met their expectations in planning and responding. Both the local authority and the coastguard commented that they would like to see more multiagency major incident exercises.
- Staff told us that, in the event of a major incident, staff reported for work and volunteered to help without further prompting.
- We were informed that major incident training was carried out for all PTS staff. PTS would have a specified role during a major incident. Plans were also in place for PTS staff to be trained to support emergency department staff in the event of a major incident.

Security

- Each ambulance had CCTV installed, internally and externally. The CCTV in the ambulance recorded in a loop, which, in normal operation, was subsequently overwritten. If they chose, the crew could press a record button so the recording was retained. The ambulance service had found this useful, particularly in instances of assaults on staff. The external CCTV was useful for accidents.
- The service encouraged crews to lock down portable devices on the ambulance when they were not in use.
- Although people needed to use a doorbell to gain access to the station while we were there, a member of staff admitted sales representatives who were not classed as staff, and they were not accompanied into the crew room.
- A reminder notice for staff about security was displayed on the medicines store door. We found incidents had occurred when the ambulance station had been left unsecured. We found no evidence that the entry codes for the drugs cupboard were changed, or that a system was in place to do this.

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Are ambulance services effective?

Good



Ambulance services had good procedures to provide effective care. The service followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. A number of innovations and initiatives were used to support evidence-based care and treatment. The early intervention in a sepsis trial was an example. Support for clinical staff in administering pain relief for patients was in place although the service recognised the need to improve its effectiveness.

The Individual Learning Plan used to support the development of staff competency, although only introduced to the service in 2014, was an emerging example of best practice. Tablet devices to support learning opportunities for ambulance staff was being trialled but had already demonstrated their effectiveness. The Integrated Care Hub (Hub), which coordinated access to emergency, urgent and unscheduled care for the island, was an example of multidisciplinary working. The competency of ambulance staff was supported by proactive training arrangements, which anticipated changes to driving regulations.

Evidenced-based care and treatment

- The ambulance service followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. The national guidance was used to inform local practice and guidance. Ambulance staff could access the JRCALC guidance from mobile devices.
- Staff were trained in new guidelines. For example, when the latest JRCALC guidelines were released, staff were trained using an exercise to check their understanding. At the time of our inspection, the latest JRCALC guidelines had been rolled out to all staff.
- Service managers discussed a number of innovations and initiatives being adopted in the ambulance service to support evidence-based care and treatment. The

early intervention in the sepsis trial was an example. Staff told us how they applied the trial for a group of patients with certain conditions. The effectiveness of the trial was to be assessed by reviewing mortality rates.

- The clinical lead undertook a clinical audit for the ambulance service, supported clinical planning and the development of procedures. Procedures for frequent callers (“frequent flyers”) was an example.
- We were informed that CSOs could identify any clinical concerns with the treatment of patients through clinical audit on an almost daily basis. This was effective in protecting patients.
- Local guidance was followed in deploying community first responders (CFRs). CFRs did not attend road traffic accidents, certain falls from a height, patients whose behaviour was known to challenge services or calls for patients who required gynaecological expertise. They did attend calls involving children.

Pain relief

- The Ambulance Patient Satisfaction Survey 2012 showed that, of those patients who were experiencing pain, an average of 3% felt that their pain was not controlled.
- Arrangements to support paramedic staff in administering pain relief for patients were in place.
- Service managers told us they felt paramedic staff could improve their assessment of the impact of pain relief. We observed a performance development session for a member of the paramedic staff that involved a discussion of the approach the member of staff used in administering pain relief. Advice to support technique and practice in administering pain relief was provided by the CSO.

Patient outcomes

- The proportion of calls resolved by telephone advice was 7.8% (based on Apr-Nov 2013), against the England average of 5.9%.
- The proportion of incidents managed by the ambulance service without the need to transport to the hospital emergency department was 46% in 2013 to 14, against the England average of 36%.
- The number of calls abandoned before being answered had followed a decreasing trend, from 2.0% of calls in 2011-12 to 1.2% of calls in 2013 to 14.
- Recontact rates for patients treated and discharged represented about 2% of emergency calls closed over the last three years.

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- We discussed some errors in data with ambulance managers. They agreed that red 1 calls were misreported, as the service had used pilot data that had not yet been agreed nationally. The service confirmed they planned to change this as a matter of urgency. The service also undertook to investigate an anomaly in the data for recontact rate data for February and March 2014, which showed the figure as 0%.

Competent staff

- The ambulance service had developed an Individual Learning Plan (ILP) to support the development of staff competency, which was introduced in 2014. Ambulance staff were given learning objectives and were required to demonstrate learning as part of their continuous professional development. CSO staff developed the ILP approach and were involved in supporting paramedic staff undergoing ILP sessions. We observed one of these sessions in progress and reviewed a completed example of an individual audit. The example showed the level of clinical care and practice that could be reported on through the electronic patient report form.
- The ePCR record for selected incidents was reviewed with the paramedic. Areas for improvement were identified and agreed with the member of staff. Areas of practice discussed included, note taking, falls risk, liaison with GPs, moving and handling, stroke pathway and other medical aspects of care and treatment. The ILP included checks that new procedures had been read, training needs, training attended and the paramedic's concerns.
- The service used tablets to take out on the vehicle to support e-learning. The devices enabled staff competency to be monitored and staff could be individually supported. The system supported audit at individual paramedic-level, which provided individual feedback on compliance with standards and provided staff with a personalised printout with suggestions for what should have been done and alternative ways of approaching their practice.
- Training needs were identified through the ILP. Staff were allocated a "training account", which, in addition to mandatory training, provided for one-to-one support or other specific training. For paramedics, this represented 10 out of a total of 36 hours training annually. CSOs agreed the training need with the member of staff. Ambulance staff also received an appraisal and were able to identify their own training needs. Ambulance

staff told us they thought well of the ILP. If they felt they were becoming unskilled in a particular area of practice, they could request refresher training or a placement in the hospital to shadow and review practice.

- Driving skills training for EVO and paramedic staff was undertaken by the service. If a member of staff was involved in an accident, they were required to undergo an assessment of their driving skills. Members of operational staff who used trust vehicles received a check of their driving standards from a member of ambulance staff who undertook driver training. We were told that staff received vehicle familiarisation training before driving and operating new vehicles. This included the use of tail lifts and the Jumbulance.
- In the Hub, clinical advisers were available to speak directly with 999 or 111 callers if requested to do so by a call taker. Supervisors were considered a good source of clinical support and reference for call takers.
- The ambulance service was aware of, and had made provision for, forthcoming changes in driving regulations under section 19 of the Road Traffic Act 1988. This required that anyone driving using blue lights who was claiming an exemption from the speed limit, when justified, must be on a national high speed register. To become registered the driver must have attended an approved high speed driving course and be reassessed every five years. From November 2014, all drivers falling into this category needed to be assessed and registered. Staff assessed from two years before this date could be included as "assessed". We spoke with the member of staff whose role included driving instruction for ambulance service staff. He confirmed that arrangements were in place to meet these changes. Refresher training was provided for staff every two and a half years.
- CFR volunteers were trained to provide a response to 999 calls within the community, which required immediate life support. The ambulance service undertook monthly refresher training for CFRs.

Equipment

- The ambulance service had appropriate equipment in place to ensure effective care for patients.
- Ambulance crews were supplied with mobile data terminals (MDTs) and Sat Nav systems installed in the

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vehicle. In the event of a breakdown of these devices, which we observed, the dispatcher in the Hub identified the location on the control-room system and directed the crew to the address using static maps.

- The ambulance service trialled and evaluated new equipment to assess its effectiveness. For example, equipment to undertake automatic cardiac compression was being evaluated. This device was considered after some staff reported injuries after needing to undertake cardio-pulmonary resuscitation in the back of a moving ambulance. The proposal to evaluate the device was the outcome of a staff initiative. This device was to be maintained by the hospital's medical devices department and staff were to be trained in its servicing, as part of the cost of the equipment. The ambulance service worked with other staff, for example, for infection control and manual handling in the evaluation of new equipment. A hospital medical devices group, which met every second month included a representative of the ambulance service.

Facilities

- Ambulance crews were able to use designated stand-by points around the island. These included fire stations at Ryde and Shanklin and a GP surgery. Other stand-by points were by the roadside. We were informed that Newport, Shanklin and Ryde were the priority areas, as most calls were received from those places. The fire service told us this arrangement improved the speed of response.

Multidisciplinary working

- The Integrated Care Hub (Hub), which coordinated access to emergency, urgent and unscheduled care for the island, was an example of multidisciplinary working. The switchboard, call handlers, dispatchers, clinical advisers and operational and clinical managers worked well together to provide access to the range of health, social care and voluntary sector services, including the 999 emergency calls service, the NHS 111 service, the GP out-of-hours service, community nursing, adult social care first response, rapid response, call buzzer services ('Wightcare'), non-emergency patient transport services, mental health services and other transport. For example, blood, pharmacy, and the hospital switchboard.
- The Hub included a clinical support desk (CSD) staffed by paramedics or nurses. CSD had access to the crews' clinical patient records. If an ambulance crew out on the

road wanted to make a social care referral, they could contact the staff on the CSD, who would make the referral. We found the CSD did not act as a clinical advice line for staff when they needed to request if they could act outside their guidelines. However, we observed that the CSD explained to some crews the administration of medicines as part of the current sepsis trial and gave other advice within the boundaries of their qualifications.

- The Hub provided a single point of contact for patients both during the day and out of hours. Patients were signposted to the most appropriate professional contact using a directory of services linked to the 111 service. We observed that the 111 service accessed through the Hub complemented and worked well with other frontline services. All services provided on the island were included in the directory. The Hub facilitated multidisciplinary working.
- We spoke with an ambulance crew on their vehicle. The paramedic was enthusiastic about the ambulance service, especially the pathways that were available. They liked being able to call the CSD for advice rather than having to take patients to hospital. The ambulance crew contacted the patient's GP direct by email from the ePCR mobile device to inform them about the patient's current condition. For example, when it came to falls.
- Some addresses had people living there who had presented a previous danger to ambulance crews. These were identified as 'red flag' addresses, where crews may need the police with them before they attended. We were told that the red flag system did not work well with the current dispatch system, so the dispatcher used their experience to recognise the addresses that had caused problems in the past.
- The service managers agreed that action was needed to address the accuracy of the data they held on red flagged addresses. The risk for the service was that staff may have bypassed the information and resorted to local knowledge, as we observed. This presented a risk that the service was holding data that was incorrect. For example, an address where episodes of violence had occurred, but the person involved had since moved from the address. This also presented clinical and data protection risks for the service.
- Although mental health services could be accessed by the Hub, mental health staff were no longer located there as they had been when the centre opened. Although we did not find an instance of specific

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detriment to patient care, the service had moved away from the high level of integration that was achieved with the opening of the Hub. We learned that a pilot was in progress to improve responses to mental health crisis calls jointly with the police service.

- The local authority, the coastguard and the fire service all spoke positively of the collaborative work undertaken by the ambulance service, particularly in planning and training for major incidents. The ambulance service attended strategic meetings and assisted with planning.
- During major events, the Coastguard worked jointly with the ambulance service to ensure a coordinated response.
- The Red Cross service spoke positively of their joint working with the ambulance service, particularly for joint exercises, which provided casualty simulation for the ambulance service. Arrangements with the St John Ambulance Service were in place to provide support to the ambulance service in times of unforeseen high levels of demand, or poor weather conditions that may present access difficulties.
- The fire service worked jointly with the ambulance service to support specific schemes. At two fire stations staff had received additional training in the management of trauma and were trained as co-responders to be able to respond to emergency calls if they arrived prior to the ambulance. Fire service staff provided protection for the patient and initial life support in certain instances. The ambulance service has given positive feedback to the fire service as to the value of these co-responders.

Are ambulance services caring?

Good



Comments on the trust's section of the Patient Opinion website included very positive assessments of the ambulance service. The Ambulance Patient Satisfaction Survey 2012 showed a very high level of patient satisfaction. The survey showed that 99% felt they were treated by ambulance staff with dignity and respect. We observed patients being treated with compassion, dignity and respect by ambulance staff. Staff felt the Hub had been very helpful in facilitating the provision of integrated and compassionate care for patients.

Ambulance crews listened carefully to patients, involving and supporting them in understanding their care and treatment. Staff provided emotional support for patients and their relatives throughout their contact with the service and particularly during handover to the emergency department. We found several examples of PTS and volunteer staff providing emotional support for patients.

Compassionate care

- Comments on the trust's section of the Patient Opinion website included very positive assessments of the ambulance service.
- We reviewed the outcome analysis of the Ambulance Patient Satisfaction Survey 2012. The survey showed a very high level of patient satisfaction. The survey analysis showed a higher than expected response rate overall of 44.6% for a total of 600 surveys. The survey showed that the public had a high confidence in the professionalism and skills provided by the ambulance service. This frontline survey was done every three years.
- The survey showed 99% felt they were treated by ambulance staff with dignity and respect. The ambulance service had drawn up an action plan with the intention of improving further the level of patient satisfaction with their care. Some of these actions involved collaborative working with partners.
- Service managers told us that other patient surveys carried out, which included the 111 service which was undertaken quarterly and for PTS, which was done in January 2014. Although we did not review the results of these surveys, we were informed by service managers that the results of these surveys were consistently positive.
- Call handling staff had received letters of thanks from patients. Staff felt that their training had helped and that the level of 'thank you' letters they received had increased. Staff also said they felt the Hub had been very helpful in facilitating the provision of integrated and compassionate care for patients.
- We observed patients being treated with compassion, dignity and respect by ambulance staff throughout our inspection. We saw that the crew handed over the patient to the emergency department appropriately and with sensitivity. The patient was properly secured on the stretcher and was covered up well with a blanket. Patients had their dignity protected by using blankets.

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- Staff from PTS took care to ensure patients were loaded on and secured properly.
- PTS crews worked in pairs when they transported bariatric patients. Equipment was also available to assist with moving and handling the patient. This helped to ensure that the patient's dignity was maintained.
- A PTS staff member said that they did all that they could to make sure older patients did not have to travel too late in the day, as patients tended to be more confused by this.

Patient understanding and involvement

- The Ambulance Patient Satisfaction Survey 2012 showed 95% of patients thought they or their family were included in the decisions supporting their health when in the presence of the ambulance service.
- We observed a call handler for the 111 service during a call with a patient. The call handler listened carefully while the patient explained their problem and then provided a sympathetic, but clear response and suggested a course of action. The call handler then checked that the patient had understood and advised them to call back if they had further problems.

Emotional support

- The Ambulance Patient Satisfaction Survey 2012 showed that 94% of patients who dialled 999 felt reassured that the call handler would deal with their problem.
- We observed that ambulance crews supported patients and their relatives throughout their contact with the service and particularly during handover to the emergency department.
- A PTS staff member described how they tried to ensure they did everything they could when taking a patient home after a visit to hospital. When they arrived at the patient's home, they put the lights on and made sure their home was warm and otherwise habitable before leaving the patient. They said they made sure the patient was settled and comfortable and, where possible, a telephone was in reach. We were also told about an example where a PTS crew member bought the patient lunch during a trip to the mainland.

Are ambulance services responsive?

Good



The ambulance service consistently met its response time standards. The service met its main performance targets in both 2012 to 2013 and 2013 to 2014.

The Hub enabled a consistent response to demands for emergency, urgent and a range of unscheduled care services from the ambulance service. The Hub provided a single point of contact for patients to enable an appropriate response both during the day and out of hours. The fast text system used to communicate with CFR volunteers supported rapid responses to incidents. Volunteers respond (on average) to <8% of all Red 1 and Red 2 calls, and to less than <2% of all 999 calls. We found several examples of the ambulance service responding appropriately to meet the individual needs of patients.

The ambulance service followed a formal process to investigate complaints. Following a complaint, the member of staff involved prepared a reflective practice case and clinical staff critiqued this before an action plan was prepared. The ambulance service made changes to improve the service in response to patient satisfaction surveys.

Service planning and delivery to meet the needs of local people

- For major public events, for example, during the Isle of Wight festival, the ambulance service provided cover for the roads outside the site. On-site medical cover was provided by a private contractor. Although the ambulance service was not commissioned to provide additional staff, we were informed the Hub deployed extra staff during these events to provide an appropriate response for the additional calls to the service.
- The Hub enabled a consistent response from the ambulance service to demands for services. The Hub provided a single point of contact for patients to enable an appropriate response both during the day and out of hours. Patients were signposted to the most appropriate professional contact using a directory of services linked to the 111 service. The range of referral options available to an ambulance crew was comprehensive and supported an appropriate response to the patient.
- The dispatcher listened in to some of the 999 and 111 calls to anticipate and plan ahead for demands for an

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ambulance. The dispatcher could mobilise an ambulance before a call had been completed in case it needed an immediate response. If, when the call category came through, it was not life threatening, the ambulance would stand down, or the type of response changed.

- A recent change had been made to the mental health call service that was previously located in the Hub, but had been moved elsewhere. Staff in the Hub told us they felt this had reduced the responsiveness of the service. Patients had to wait longer for an ambulance to be dispatched.
- After midnight, the RRV located to the out-of-hours GP centre to assist with the assessment of patients. The RRV also undertook 999 calls. Patients referred to the GP centre were able to travel by car from anywhere on the island in 30 minutes.
- The ambulance service managed CFRs. Some “rapid responders” were provided by the fire service and could respond to emergencies. The fire service rapid responders were supplied with ambulance service radios. The dispatcher at the Hub had a list of the CFRs that had notified as available for that shift.
- A Fast Text system was used to contact other CFR’s. The CFR started by phoning the Hub and booking on. CFRs were alerted to a call by the Fast Text system on a mobile phone. The CFR could then respond to the Hub with a ‘1’ to confirm they were mobile, and a ‘2’ to say they were at the scene of the incident. This meant the Hub had precise response times for the CFRs. The Hub dispatched an ambulance and a CFR at the same time. The CFR used a mobile phone key to indicate a cardiac arrest, updating the Hub without a phone call.
- The Fast Text system for CFRs allowed for more rapid communication responses and more accurate recording of response times. CFR’s did not usually travel more than three miles to respond to a call. The CFR responded using their own cars and within traffic laws. CFRs told us they responded to three calls a week on average.
- The coastguard told us they were called out up to eight times per month to assist the ambulance service. They experienced no real problems waiting for back-up from the ambulance service when they needed them. However, the Coastguard told us that they felt, in certain instances, they were called too late by the ambulance dispatcher. For example, for incidents at remote

locations that required a 4X4 response vehicle. The dispatcher waited for the ambulance crew to assess the situation, when it may be obvious from the call that the coastguard would be needed.

- Helicopters from the Air Ambulance service, an independent charity could be used during the day to transfer patients from the hospital, or directly from the scene of an incident to the mainland. The coastguard helicopter could be requested during the day or night although it needed up to 45 minutes to respond. The decision as to which aircraft to use was a joint clinical and operational one. Helicopter services were needed about once per day on average. Some dispatch staff had completed helicopter dispatcher training and this helped them to decide when the helicopter service was needed.
- Staff discussed their concerns about the unavailability of vehicles for the island when transporting patients to the mainland. On one day of our inspection, the service had received three requests for transport to the mainland. One patient was to be transported by helicopter and another patient using PTS. This left the PTS short of vehicles.

Access and flow

NHS England collected data on three key performance indicators for England’s ambulance services. These were:

- Category A (red 1) incidents: presenting conditions that may be immediately life threatening. The national target is for attendance at 75% of all incidents within eight minutes. The ambulance service achieved 80.2% in 2013 to 2014.
- Category A (red 2) incidents: presenting conditions that may be life threatening, but less time critical. The national target is for attendance at 75% of all incidents within eight minutes. The ambulance service achieved 76.1% in 2013 to 2014.
- Category A calls (red 1 and red 2) that for a vehicle (that is, a vehicle that is capable of moving a patient) attendance at the scene of the incident within 19 minutes. The national target was 95%. The ambulance service achieved 96.6% in 2013 to 2014.
- The ambulance service met each of the Category A targets in both 2012 to 2013 and 2013 to 2014.
- For May 2014, CFR volunteers attended 67 red 1 and red 2 calls, and reached 98% of these within eight minutes. We observed that an appropriate response from the service relied, to a significant extent, on the availability

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of volunteer staff. Volunteers respond (on average) to <8% of all Red 1 and Red 2 calls, and to less than <2% of all 999 calls. Crews buzzed as they came into the emergency department to alert staff that they were present. Ambulance staff explained about the patient to nursing staff and then the A&E staff directed them to a cubicle. They could also call ahead if they had a patient requiring resuscitation and they then proceeded directly to the resuscitation room without waiting.

- We found A&E staff and ambulance staff had differing opinions of the problems with ambulances having to wait to gain access to the department. A&E staff told us that there were rarely delays in the department for crews at handover. Situation reports (SitReps) produced by NHS England which reported on ambulance handovers delayed over 30 minutes, showed there were 79 delays of over 30 minutes for the period from 4 November 2013 to 30 March 2014. 33 of these occurred between 28 February and 30 March 2014. Ambulance service clinical managers told us that ambulances queuing for a long time outside the emergency department was “a catastrophic event”, as it could take ambulances away from attending calls.
- If crews took longer than 30 minutes from arrival at the hospital, the dispatcher contacted them to investigate what was happening. If the delay became a problem, an ambulance operations support officer went to the A&E to see if they could help. Sometimes crews looked after two patients at once to free up another crew. Staff told us they often helped with cleaning up in the A&E, so that they could hand over their patients.
- For PTS patients, the Hub contacted the patient the day before their journey, to confirm the arrival of the transport, and notified the patient if there were any delays.

Meeting people's individual needs

- Staff in the Hub told us that crews could request help from LanguageLine (a translation service), if they required it.
- The dispatcher could communicate with ‘Island Roads’. Island Roads was a partnership between the local authority and external organisations involved in maintaining and upgrading the island road network. The dispatcher liaised with them to keep a road open that was due to be closed, so that an ambulance could get through.

- For patients who had experienced a fall, but were not supported by Wightcare, 999 staff and GPs could refer them to the Single Point Access, Referral, Review and Coordination Service (SPARRCS).
- The ambulance service was able to access appropriate equipment to support the moving and handling of bariatric patients. We found that PTS crews worked in pairs when they transported bariatric patients. Equipment was also available to the PTS to assist with moving and handling the patient.
- Staff told us about the crisis response team that, at the time of our inspection had recently been located in the Hub. The crisis response team consisted of a driver / assistant, (usually an EVO) and a nurse with skills to support the role of the team. The team responded by visiting the patient's house to assess their environment and would often put up hand rails or similar aids at the visit. Other examples of the team's response were treating urinary tract infections (UTIs) and arranging respite beds. This meant a hospital admission could often be avoided. The crisis response team worked 8am to 5pm, seven days per week. We found the hours were shortly to be extended. We heard that the crisis team was known to give a fast response.

Learning from complaints and concerns

- The trust provided a breakdown of complaints for October 2013 to March to 2014. Of a total of 93 complaints for the trust as a whole, six of these related to the ambulance service. Of these, three related to the hospital car service
- The ambulance service provided a summary of complaints for the period 1 October 2013 to 31 May 2014. This showed there were six complaints. The ambulance service followed a formal process to investigate complaints. The analysis showed the reason for the complaint and the performance against timescale targets. In each case, the investigation was now closed. For one of the six cases, there was a breach of the agreed timescale.
- We were informed that the Hub received very few direct complaints. Patients were advised to contact the Patient Advice and Liaison Service if they had a complaint. The Hub was approached for information to assist with complaints investigations. For example, regarding call times and call history. Audits of complaints investigations were completed.

Ambulance services

- Ambulance staff told us that complaints about ambulance crews tended not to be about staff attitude, but mainly they were about response times, when patients did not appreciate they may not always receive an immediate ambulance response.
- Following a complaint, the paramedic concerned was asked to prepare a reflective practice case. The CSO reviewed this to identify where the paramedic fell short of required standards. An action plan was then prepared.
- We reviewed a piece of reflective practice carried out by a paramedic following a concern raised. The reflective practice dealt with the communication of the patient's treatment to other health professionals and demonstrated that the paramedic understood the impact that his poor handover had on subsequent care the patient received. The paper stated an action plan for the paramedic.
- Following the patient satisfaction survey for frontline ambulances in 2012, staff to undertake washing and stocking were introduced in response to patient comments.

Are ambulance services well-led?

Good



The ambulance service operated within the trust's acute and ambulance clinical directorate. Ambulance staff told us that the level of integration of the ambulance service and being part of the trust allowed them to respond quickly for the benefit of patients. Ambulance crews we spoke with said they felt supported by the service.

The NHS Staff Survey for ambulance services included no areas of risk or elevated risk. However, managers and staff expressed some anxieties about feeling the ambulance service was disengaged from the rest of the trust. The structure included several levels of management between the chief executive and operational staff.

The ambulance service used agreed operational procedures and monitored the operation of the service against key performance indicators. Audits were undertaken and action planning was done in conjunction with the service's clinical quality and effectiveness group..

An A&E consultant acted as clinical lead for the ambulance service and provided clear clinical leadership. The ambulance service identified its risks and linked with the trust risk register.

The ambulance service had implemented several innovative projects, which had introduced improvements to the service. Opening the Hub to integrate access to services, developing and supporting staff with the ILP, the use of hand held devices to train crews and the clinical pilot for sepsis, were some of the examples we found.

Vision and strategy for this service

- Ambulance staff told us that the level of integration of the ambulance service and being part of the trust allowed them to respond quickly for the benefit of patients. They felt they should get more recognition from the trust for what they actually did.
- An ambulance crew told us their vision was specific care for patients. They spoke with enthusiasm about the integrated approach the ambulance service followed. One crew member told us that they said to ambulance colleagues in other services, "You won't believe how it works on the Isle of Wight!" and, "You learn as well!"
- Staff saw the ambulance service as an innovative service that adapted technology and used it effectively. Staff had a 'can do' attitude. They felt they should be able to access more multidisciplinary pathways.
- Ambulance service managers felt the vision was to take control of unscheduled and integrated care. Their aspiration was to see the Hub, in its entirety, commissioned as a single entity to prevent other parts of the service becoming disengaged.
- Ambulance service managers told us that most things at the trust seemed to be hospital-centric, for example, IT and mandatory training. This was not suited to a mobile ambulance service. Service managers felt that the trust didn't have patients at its centre. They felt they missed out on the recent refurbishment programme and were asked to save "far too much money". A service manager also told us that staff didn't see the ambulance service as part of the trust.

Governance, risk management and quality measurement

- The ambulance service followed agreed operational procedures. The Ambulance Care Pathway procedure included monitoring procedures against key performance indicators.

Ambulance services

- The procedures included arrangements for biannual audit action planning in conjunction with the service's clinical quality and effectiveness group.
- An A&E consultant acted as clinical lead for the ambulance service and provided clear clinical leadership. The service held a monthly clinical quality and effectiveness group, which was linked to the trust's quality and patient safety group. Clinical support officers (CSOs) attended the clinical quality and effectiveness group and minutes of the quality and patient safety group were shared with the ambulance clinical team.
- The audit included attendance of staff for identified training, compliance with national guidelines and standards, review of patient clinical records, complaints, incident report forms, claims and reviews of non-conveyance rates and documentation.
- A risk register was maintained at trust-level. The ambulance service was able to give examples of identified risks that were included in the risk register. Clinical risk managers were aware of operational risks and how this linked to the risk register for the service. For example, a device for undertaking automatic cardiac compression was included on the risk register. This device was considered after some staff reported injuries after needing to undertake cardio-pulmonary resuscitation in the back of a moving ambulance.
- Within the Hub, there were four members of staff who could undertake call audits. To maintain registration with the call handling system, call audits needed to be carried out on a regular basis. The audit included 111 and 999 calls. Staff told us that audits were not simply for a proportion of staff, but they covered 100% of staff.
- The Isle of Wight Clinical Commissioning Group held a monthly service-level agreement review meeting with the ambulance service. Agendas and minutes were prepared. We saw in the minutes a summary of achievements for 2013 to 2014, which included examples for the ambulance service, PTS, the 111 service and the helicopter.
- A clinical assistant head and an operations assistant head reported to the head of ambulance services. Reporting to the clinical assistant head were four clinical support officers. An emergency department consultant advised the ambulance service on clinical issues. A service delivery manager reported to the operational assistant head. Two support officers for the ambulance service and the Hub, reported to the service delivery manager. This structure came into effect in September 2013. The head of ambulance services told us they felt the structure was appropriate, although they were three levels of management removed from the chief executive of the trust. For paramedics and other operational staff, they were seven levels of management removed from the trust chief executive. Ambulance crews we spoke with did not know the name of the chief executive.
- Ambulance managers informed us that executive directors rarely visited ambulance staff and that ambulance staff saw the head of ambulance as the person in charge of the service. Managers said ambulance staff did not feel part of the trust, as a whole. Both the chief executive and the chair had visited the Hub, although the immediate line manager of the head of ambulance had not. The head of ambulance services felt he was well supported by the chairman of the trust.
- The ambulance service had one manager accountable to the head of service who provided a lead for IT developments for the service. The IT lead did not have a formal deputy although other staff had an interest in IT matters. This represented a single point of failure for the ambulance service.
- Weekly managers' meetings were held at which communications from senior managers of the trust were cascaded. The head of ambulance held staff meetings for ambulance staff four times per year. PTS and dispatch staff were included. Notes were recorded, although the meetings were not formally minuted. The chief executive and the chairman had attended staff meetings. The head of ambulance services also held meetings periodically with trade union representatives. The head of ambulance chaired the national control manager's meeting. We spoke with a senior finance manager of the trust, who told us there was no dedicated or ring-fenced finance department resource for ambulance work. Consequently, the finance department made no contribution to the national agenda for ambulance services.

Leadership of service

- The ambulance service was part of the trust's acute and ambulance clinical directorate. The head of ambulance services was accountable to an associate director who reported to the executive director of nursing. The head of ambulance services was also responsible for the Hub.

Ambulance services

Culture within the service

- The NHS Staff Survey for ambulance services included no areas of risk or elevated risk for the ambulance service. For 10 of the 15 indicators, the score was better than expected.
- Ambulance crews we spoke with said they felt supported by the service. They knew the head of ambulance services and said they saw him often. They said they felt he was friendly, but that they still had respect for him.
- Other managers in the trust told us they felt the head of ambulance services led from the front with an inclusive leadership style. He discussed issues with staff. The ambulance services team were a closely-knit group of people, who worked well together. Ambulance services benefited from being integrated with the rest of the trust, as there were less organisational barriers. For example, in establishing links with primary care. It was easier to meet other staff who you needed to speak with to get things done. Staff could arrange care for patients the same day.
- Staff who commented on culture said they did not feel integrated into the trust, as much as they felt they should be. The ambulance services suffered due to the trust's overall structure, as other things in the trust could take priority. Operational ambulance staff told us their shifts had been changed 14 times in the previous week.
- A member of staff we spoke with in the Hub said they felt they were communicated with appropriately and involved in what was happening. They enjoyed their role.
- PTS staff described how they enjoyed being part of the PTS team. One person commented that they were proud to work for the NHS. Staff commented upon a feeling of detachment from emergency ambulance staff, as they were based in a different building. PTS staff understood that the ambulance station had reached capacity, but they felt a little isolated.

Public and staff engagement

- We reviewed the outcome analysis of the Ambulance Patient Satisfaction Survey 2012. The survey analysis showed a higher than expected response rate overall of 44.6% for a total of 600 surveys. The survey showed that the public had a high confidence in the professionalism and skills provided by the ambulance service. This frontline survey was done every three years.
- The survey showed that 96% of patients thought that the time it took for the ambulance to arrive was acceptable, 96% of patients were satisfied with the comfort of the journey. Patients had a 98% level of confidence in the professional skills of ambulance crews and 97% of those surveyed felt that the overall service provided by the ambulance service was "better than very good".

Innovation, improvement and sustainability

- The ambulance service had implemented several innovative projects, which had introduced improvements to the operation and management of the service. Opening the Hub to integrate access to services, developing and supporting staff with the ILP, the use of hand held devices to train crews and the clinical pilot for a sepsis trial, were some of the examples we found and others are included in this report. Staff expressed enthusiasm in describing their involvement in these initiatives and the improvements they had been involved in to help patients.
- A quality manager for the trust was responsible for awarding commendations to staff and a celebration evening was held to reward ambulance staff. Members of staff were actively recruited as quality champions and 100 staff had taken on this role. Quality champions received regular briefings of key messages for staff and were expected to cascade these messages to colleagues, as part of their day to day work. The quality champions wore a black badge to identify them. Ambulance staff participated in this quality initiative.

Outstanding practice and areas for improvement

Outstanding practice

- There was evidenced based care for orthopaedic patients having hip and knee operations.
- A wide, shared care network for managing children with the most complex and rare conditions had enabled families to be supported and treated closer to their homes. It also enabled access to the best possible advice for these families. For example, the children's ward was a level 1 paediatric oncology shared care unit and could also offer care to visitors to the island with oncological problems.
- The pharmacy service was operational seven days a week. The service was innovative and worked effectively within multidisciplinary teams to improve patient care. For example, electronic prescribing had reduced medication errors and was being used when venous thromboembolism risk assessments occurred. The service offered an advice line and was involved in the preadmissions initiation of antibiotics with ambulance services.
- An integrated call centre (Integrated Care Hub), opened in 2013, provided access to the 999 emergency calls service, the NHS 111 service, the GP out-of-hours service, district nursing, adult social care, telecare services, non-emergency patient transport services and mental health services. The Integrated Care Hub coordinated access to emergency, urgent and all unscheduled care for the Isle of Wight. 64 staff are located at the Integrated Care Hub, including switchboard, call handlers, dispatchers, clinical advisers and operational and clinical managers. Key services were accessed out of hours, through the Hub.
- The use of electronic tablets to enable operational ambulance staff to complete their e-learning.
- The ambulance service was participating in a trial in early intervention in sepsis, jointly, with another ambulance service. The aim was to identify patients who might have sepsis and to reduce their mortality through early intervention.
- The Individual Learning Plan (ILP) that had been developed and implemented to support the development of staff competency that was introduced in 2014. Ambulance staff were given learning objectives and were required to demonstrate learning as part of their continuous professional development.

Areas for improvement

Action the hospital MUST take to improve

The trust must ensure that:

- Staff receive training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The principles must then be applied to ensure that, where people do not have capacity to consent, the correct procedures are followed.
- The leadership of end of life care services is supported to improve service across the trust. A strategy for the service needs to be implemented and the quality and risks to the service need to be appropriately monitored.
- Staff are competent in how to recognise a patient is on an end of life journey, so that decisions are made and their care managed appropriately. The trust must ensure that staff have received the appropriate training and understand the tools available to them. This includes the use of the 'amber care bundle' and the use of syringe drivers.
- DNA CPR orders are completed in their entirety, in a timely manner, for all patients where this decision has been made. There must be clear documentation as to how this decision was reached. Discussion with patients and their relatives should happen and be appropriately documented.
- Risk assessment in relation to patient care must be completed and used to inform the patients' plan of care.
- All patients have a named consultant for the duration of their stay, with clear referral and acceptance criteria when there is change in consultant for clinical need.
- Review the provision of care for patients who have had a stroke, to ensure that the pathway is fully reflective of national guidance.
- National guidance is reviewed, gap analysis completed, and improvement plans put in place and monitored, where required, to ensure that practices are in line with national recognised guidance.

Outstanding practice and areas for improvement

- There is a lead nurse qualified in the care of children (RN for children) and sufficient registered children's nurses are employed to provide one per shift in emergency departments receiving children, as per Standards for Children and Young People in Emergency Care Settings 2012.
- There is a single point of access for children in an emergency situation, where resuscitation may be required. There should be joint working with the A&E and paediatric teams to ensure that any changes are safely implemented.
- Nursing staffing levels are reviewed in the A&E department and the stroke ward to ensure that they are staffed to the agreed establishment and skills mix, in line with current guidance.
- There is an effective and safe procedure for the obtaining, recording, handling, using, safe keeping and dispensing of medicines used by the ambulance service.
- Patients have protected meal times.
- All medication and intravenous fluids are stored in line with current guidance in all areas.
- The number of patient bed moves for non-clinical reasons and out of hours, is reviewed and action is taken to minimise this.
- In all outpatient areas where children are seen, there is a dedicated children's waiting area.
- All resuscitation equipment is checked on a daily basis, unless an area is closed.
- The hospital should consider the provision of a separate children's area in the A&E department in line with national buildings guidance.
- The process for implementing change following an investigation into an incident is reviewed to ensure that it occurs in a timely manner.
- The provision of controlled drugs in the resuscitation area in the A&E department is reviewed.
- The process for streaming patients in the A&E department is reviewed to ensure the decisions are being made by staff who have the knowledge and skill required to do so.

Action the hospital SHOULD take to improve

The trust should ensure that:

- The use of bed rails is risk assessed and the patients' consent obtained for their use. In cases where the patient is unable to consent, then there should be clear assessment of their capacity and a clear reason for the use of the bed rails.
- The environment of the eye clinic is reviewed to ensure that it is fit for purpose and safely meets the need of the patients visiting the department.
- Consultants have protected time for outpatient clinics, so they are not cancelled at short notice when they are called to attend to emergencies.
- Nursing staff are not disturbed while undertaking a medication round.
- Continue to develop seven-day services, particularly for patients requiring emergency care.
- Patient information held by the ambulance service is securely stored at all times.
- There is a clear and current system in place to 'red flag' addresses where there are concerns about safety, so that ambulance crews can use them to make informed choices and manage risk when attending these locations.
- There is a review of the specialist medical care that is available for patients who have had a stroke.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p>How the regulation was not being met:</p> <p>Patients using the service were not protected against the risks of unsafe or inappropriate care and treatment as decision relating to resuscitation were not being accurately recorded and reviewed to ensure they were kept current.</p> <p>Regulation 20- (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010</p>

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff</p> <p>How the regulation was not being met:</p> <p>The registered person did not have in place suitable arrangements to ensure that persons employed for the purpose of caring on the regulated activity were appropriately in relation to their responsibilities to enable them to deliver care and treatment safely and to an appropriate standard as staff were not fully informed of their responsibilities under the mental capacity act 2005 or in the recognition of people at the start of the end of life journey or how to support people through the use of tools designed to support end of life care.</p> <p>Regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010</p>

Regulated activity	Regulation
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This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

How the regulation was not being met:

Patients could not be assured that they are protected against the risk of receiving care or treatment that is inappropriate or unsafe as

- risk assessments were not consistently being completed in their entirety to inform the plan of care;
- patients who had suffered a stroke could not be assured that the pathway of care was fully reflective of national guidance;
- there was not a clear pathway for children to follow to gain access to health care in an emergency;
- the planning and delivery of end of life care did not meet national standards

Regulation 9- (1) (a) (b) (i) (ii) (iii) HSCA 2008 (Regulated Activities) Regulations 2010

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

How the regulation was not being met:

Patients cannot be assured that at all times there are sufficient numbers of suitably qualified, skilled staff and experience employed to carrying on the regulated activity on the Accident and Emergency department on the stroke unit.

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010

Regulated activity

Regulation

Transport services, triage and medical advice provided remotely

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

How the regulation was not being met:

This section is primarily information for the provider

Compliance actions

Patients could not be assured that they are protected against the risk associated with the un safe obtaining, recording, handling using, safe keeping, dispensing of medicines used by the ambulance service.

Regulation 13 HSCA 2008 (Regulated Activities)
Regulations 2010

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p>How the regulation was not being met:</p> <p>Patients could not be assured that they are protected against the risk of in appropriate or unsafe care and treatment by means of effective operation of systems designed to enable the person to regular assess and monitor the quality of services and identify and manage risk to the health , welfare and safety of service user and others. This was because</p> <ul style="list-style-type: none">• Changes required following the investigation of incidents were not always implemented in a timely manner;• There were not robust systems in place for the review of compliance with national guidance.• Patients had a number of bed moves and did not have a named consultant for the duration of their stay. Changes to a patient's consultant were being made for non-clinical reasons depending on the ward they were located on rather than their clinical condition. Patients receiving end of life care that had had several bed moves for non-clinical reasons and were being cared for on wards where the understanding of their condition was limited.• There was not effective implementation and monitoring of the paediatric admissions pathway, or for the streaming, and initial assessment of patients in A&E. <p>Regulation 10- (1) (a) (b) (2) (c) (i) (d) (i) (ii) HSCA 2008 (Regulated Activities) Regulations 2010</p>