Isle of Wight NHS Trust

Quality Report

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

Summary of findings

Ratings

Overall rating for this service	Requires Improvement 
Community services for children and families	**Requires Improvement** 
Community services for adults with long-term conditions	**Requires Improvement** 
Community inpatient services	**Requires Improvement** 

Summary of findings

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Summary of findings

Overall summary

Isle of Wight NHS Trust is an integrated trust providing acute, ambulance and mental health services, and community health services. Community health services are provided to a population of approximately 140,000 people living on the Island. Services include community nursing teams, community rehabilitation teams, health visiting, school nursing, community equipment services and sexual health services. These services are provided across the Island in clinics, children's centres and patient homes. Community inpatient services include general rehabilitation and stroke rehabilitation wards at St Mary's Hospital.

We carried out this comprehensive inspection because the Isle of Wight NHS Trust is an aspirant Foundation Trust, prioritised by Monitor. The trust community services were inspected as part of the second phase of the new inspection process we are introducing for community health services.

The announced inspection took place between 3 and 6 June 2014, with an unannounced visit on 21 June, between 4pm and 11pm.

Overall, we rated the Isle of Wight NHS Trust community services as 'requires improvement'. The trust was good for providing caring services. The safety, effectiveness, responsiveness and leadership of the services required improvement.

We rated community health services for children, young people and their families, community adult services, and community inpatient services as 'requires improvement'.

Key findings related to the following:

- There was a high level of patient satisfaction across community services. The majority of people commented on the caring and compassionate approach of staff . Staff were highly motivated and committed, and treated people as individuals.
- There was good multidisciplinary working, and initiatives to support people at home, and avoid admission to hospital. The trust had taken steps to improve access to appropriate services through the development of the Single Point of Access, Referral, Review and Co-ordination (SPARRCS) team, which was based at the Integrated Care Hub. The Community Stroke Rehabilitation team worked towards specific rehabilitation objectives for patients, and facilitated early discharge from hospital.
- There were elements of good practice across a range of units and teams, but this was not consistent across all services. Some, but not all, teams were benchmarking themselves against other services and taking innovative steps to improve ways of working and productivity, but this needed to be implemented and embedded across all services.
- Staffing establishments were not sufficient in all areas, and there were ongoing challenges in recruiting staff. The arrangements to ensure a safe and consistent out-of-hours district nursing service needed to improve. We were concerned by insufficient medical and nursing staffing on the community inpatient wards, and this was a particular risk when there were inappropriate admissions of more acutely ill patients.
- Risk management systems were in place, and staff were fully aware of their responsibilities in reporting and in implementing new practice. However, the governance of risk management needed to be more robust at all levels of the organisation, as across all core services we found examples of incidents that had not been responded to promptly or adequately.
- The trust had an ongoing programme to improve access to and use of IT across community services, and connectivity issues were a known challenge. Where implemented, the IT system was still not fully functional, and incomplete electronic records created a risk.
- The trust had a statement of vision and values, but community services staff were not consistently aware of these. Local leadership of most community services at team level was good. But there was a disconnect between staff in community services, and the executive team and senior managers, and this impacted upon the culture within which front-line staff were being expected to deliver services. Staff perceived that the community services had a lower profile within the organisation than the acute services.

Summary of findings

We have identified areas of outstanding practice. However, there were also areas of poor practice, where the trust MUST make improvements, and other areas of practice, where the trust SHOULD take action to improve. These are identified in this report.

Professor Sir Mike Richards

Chief Inspector of Hospitals

August 2014

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

Requires Improvement

There was an incident reporting system in place, and staff had a good knowledge of reporting of safeguarding and other incidents. We found evidence of learning from serious case reviews and other incidents, as well as complaints and concerns. However, across all core services we found examples of incidents that compromised staff and patient safety, and that had not been responded to promptly or adequately.

There was a need to review some community staff caseloads, and some community teams were stretched due to staff vacancies. Insufficient medical and nursing staffing, along with the inappropriate admission of more acutely ill patients to community inpatient wards, was compromising safe patient care. We raised concerns with the trust, and our later unannounced inspection identified that changes had been made on the general rehabilitation ward, but risks arising from staffing levels remained on both wards.

A variety of risk registers were maintained, but it was not always clear what actions had been taken and what the timeframes were. Staff were concerned that risk reporting and management mechanisms were not sufficiently robust.

Action was being taken to ensure harm-free care, and reduce the incidence of avoidable harms such as falls and pressure sores, but pressure area care and pressure ulcer prevention needed improvement. Community nursing patients were at risk when not adequately assessed before the use of compression bandaging.

The level of improvement required to ensure safety on the community inpatient wards led to a judgment of 'inadequate' for those services. All other services were judged to 'require improvement' in providing safe care.

Are services effective?

Requires Improvement

We rated adult community services as 'good' for providing effective care. Integrated sexual health services and the Community Stroke Rehabilitation team were particularly notable. National guidance was used to treat patients in adult community services, and local care pathways and care bundles were ensuring consistency of treatment.

Summary of findings

Multi-disciplinary working was widespread across community services for adults, and for children and family services, with evidence of good joint working to ensure that individual needs were met. Excellent examples were observed in the Integrated Care Hub and integrated sexual health services.

We judged that community inpatient wards, and children and family services 'require improvement'. The Healthy Child Programme was not consistently implemented across all areas. We did not find evidence of regular audits of, for example, infection control, or documentation or participation in national audits in children and family services. Continuing issues re IT connectivity and the availability of laptop computers were also impacting on the effectiveness of services. Pressure area care was being prioritised for improvement by the trust, but we found poor practice on the stroke ward.

Whilst numbers attending appraisals and training were good, we found that nursing staff on inpatient wards and some community nursing staff did not receive one-to-one supervision.

Are services caring?

Good

We rated all services as 'good' for caring for patients.

Patients were very positive about the quality of service that they received. We saw care being delivered across a wide range of services, and staff treated patients with compassion, kindness, dignity and respect. Patients told us that they were involved in planning their care, and that they were provided with enough information to make informed decisions.Staff were passionate about the care they delivered. This was reflected in the comments made by patients and their relatives.

Are services responsive to people's needs?

Requires Improvement

We rated community services for children and families as good but other core services required improvement. Most services were accessible, clinics and groups were established in community locations, and services were provided in people's home where this was needed. There were increased waiting times for some children therapies whilst recruitment was ongoing.

The trust had taken steps to improve access to appropriate services through development of the Single Point of Access, Referral, Review and Co-ordination (SPARRCS) team. The crisis team was able to respond within four hours to urgent patient needs. We saw good examples of person-centred care and services that were adapted to meet specific needs in the community, including the stroke rehabilitation team and sexual health services. However, access to

Summary of findings

community nursing out of hours needed to improve. With one district nurse on-call, we found that there were occasions when there was no service available due to lack of staffing. GPs or the ambulance service were called for patients with urgent nursing needs.

Access to inpatient rehabilitation was restricted for some patients due to the number of inappropriate admissions to the community rehabilitation wards.

Are services well-led?

Requires Improvement

Most teams benefited from strong local leadership, with the exception of the inpatient wards, which lacked strong medical leadership on the organisation of care for the wards. This led to regular inappropriate admissions of patients from other specialties.

We saw some good examples of corporate communications that were accessible to all staff; these included consultations on proposed changes, as well as social activities and staff awards. The trust had a statement of vision and values, but some the staff we spoke with were not able to identify these, and could not demonstrate understanding of the trust's development strategy. Staff did not feel included or engaged with some of the changes in services. Almost all the staff we spoke with felt that the community services had a lower profile within the organisation than the acute services. They said that the leadership team at the trust were not visible out in the community, and that communication between the leadership team and front-line staff was not effective. This had resulted in an inward-looking culture within some community service teams.

Risk management systems were in place, and staff were fully aware of their responsibilities in reporting and in implementing new practice. In some areas, staff were not confident that incidents and reported concerns were always dealt with in a timely or appropriate manner. Although there were examples of lessons learnt, trust-wide governance and risk management were not sufficiently robust. The trust had not responded adequately to Department of Health guidance and we saw that at times patients were accommodated in mixed sex bays on community inpatient wards.

The trust had started some initiatives in partnership with the local authority, such as 'My Life, a Full Life' and there were ongoing plans to improve integrated health and social care across the Island. We found that there were a lot of interim management posts in community services. There were also increasing problems in recruiting key staff, and this raises questions about ongoing sustainability of services; for example, the lack of geriatricians in a

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trust servicing an ageing population. There was a workforce strategy and working group, and we heard of plans for an older peoples' centre on the Island. But these initiatives were at very early stages of development, and it was not clear how immediate issues would be mitigated.

Summary of findings

What we found about each of the core services provided from this location

Community services for children and families

Requires Improvement

Community health services for children, young people and families includes safeguarding children, services for children in care, health visiting services, services for children 0-5 years, school nurse services and children's therapy services.

There was good knowledge and reporting of safeguarding and other incidents, with evidence found of learning from serious case reviews and other incidents, as well as complaints and concerns. Information from these areas was collated and reviewed in appropriate committees, and any themes were identified. A variety of risk registers were maintained, but it was not always clear what actions had been taken and what the timeframes were. We also found an example where staff had raised a serious risk, and this was not initially responded to through the trust system; this left concerns that risk reporting and management mechanisms were not sufficiently robust.

The implementation of the new IT system had incurred increased risk. Improvements had been made and lessons learnt for the next stages of the programme. However, the system was still not fully functional, and staff were required to record information in a variety of ways, which created a risk. There was also a shortage of hardware, such as laptop computers and network cables. Some buildings were also in poor condition, and these were known and featured on the trust risk registers.

We found there was a need to review some community staff caseloads, as there was inequity in numbers and weighting in the various locations across the Island. The health visitor recruitment was on track to be achieved under the Department of Health Call for Action programme with Health Visitor students in training. However, there would not be a full staff establishment until 31 March 2015 which contributed to the inequity in numbers and weighting that we found. There were staff vacancies in therapy services with active recruitment underway, but it was not clear when this would be resolved. We found that there were increased waiting times for some therapy services, and antenatal visits were not consistently in place for all pregnant women across the Island.

We found some examples of excellent record keeping, but it was less effective in other parts of the service, and this created a risk to the safety and effectiveness of care. The Healthy Child Programme was

not implemented consistently in all areas of children and family services. There was good communication and multidisciplinary working, both internally and externally, with evidence of good joint working to ensure that individual needs were met.

Parents told us that the services were accessible and that staff were knowledgeable, informative and caring. We received some negative comments regarding continuity of care, but these were in the minority. Staff demonstrated a passion for their work, and good knowledge of the families and children.

Staff reported good and accessible supervision, with good support from their managers. Some staff told us that they could access further development opportunities, but others said they could not. All staff we spoke with felt that community services did not have the same profile within the trust as the acute services. They told of feeling proud of their service and being part of the NHS on the Island, but isolated from the organisation. There was a lack of visibility by the senior leadership.

Community services for adults with long-term conditions

Requires Improvement

We judged that safety within the adult community services required improvement. Nursing staff did not feel safe, and we found that improvements were needed to arrangements to minimise risks to patients and to staff working alone in the community, particularly out of hours. Staff were able to describe the systems for reporting incidents. There was a evidence that improvements had been made to services through sharing of lessons learned, although staff felt more could be done in response to lone working incidents. Staffing levels varied across different locations and were not matching the demand in some localities, with the risk that this would compromise safe and effective patient care. This had been identified as a risk by the trust, and although staff had been recruited for some locality teams, it was not fully resolved. Safety standards were followed for infection control, the use of equipment and medicines management.

National guidance was used to treat patients, and local care pathways and care bundles were ensuring consistency of treatment. Action was being taken to ensure harm-free care, and reduce the incidence of avoidable harms, such as falls and pressure sores, but patients were at risk when not adequately assessed before the use of compression bandaging. Multidisciplinary working was widespread, with some excellent examples observed in the Integrated Care Hub and integrated sexual health services.

Staff were caring, and patients and relatives told us they were treated with dignity, compassion, and respect. We observed staff

Summary of findings

providing compassionate care, and consulting with patients in clinics and in their homes. Patients were involved in planning their treatment. The Community Stroke Rehabilitation team worked towards specific rehabilitation objectives for patients, and facilitated early discharge from hospital. They used the goal attainment scaling to score the extent to which patient's individual goals were achieved in the course of rehabilitation intervention.

Community services were provided in people's homes where this was needed by patients, whilst clinics and groups were also established in community locations. The trust and local authority had initiated a 'My life, a Full Life' programme, for people over 65, to help people to support and care for themselves. The SPARRCS and crisis teams were established to encourage early discharge, or prevent admission if possible. The crisis team was able to respond within four hours to urgent patient need. However, the out-of-hours community nursing service (8pm-8am) was an 'on-call' system and required improvement. The on-call service was staffed by a lone working nurse, often inexperienced, and on occasions, we found that there was no service at all. Staff told us that the weekend and Friday evening hospital discharges were not always well co-ordinated with community services. This had led to inappropriate arrangements of care and possible readmission of these patients.

We found that leadership of local teams was good. But some of the staff we spoke with were not able to identify the trust's vision and values, and could not demonstrate understanding of the trust's development strategy. Most community staff felt disengaged with the senior management of the directorate and the trust. Staff told us that the trust management was acute medical-focused, and did not appreciate the complexity of community nursing and rehab provision.

Community inpatient services

Requires Improvement

We found the community inpatient wards to be clean and well maintained, with staff who were caring and kind, and involved patients in their care and goal planning. However, low medical and nurse staffing numbers and skill mix meant that safe care could not always be delivered, particularly, but not solely, at the weekend and out of hours. The routine use of the wards for patients who were moved from acute medical wards due to shortage of beds, exacerbated this problem. The nurse bank frequently could not provide the skill mix requested, and so healthcare assistants often worked in place of a registered nurse. Whilst numbers attending appraisals and training were good, we found that nursing staff did not receive one-to-one supervision.

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The wards were well maintained and clean, but infection prevention and control needs to improve, as we found damaged equipment that could harbour bacteria. There was also increased need for MRSA rescreening, due to routine use of the ward for medical outliers, and this had not yet started. Some equipment needed by patients was not available, and had not been maintained as required. Some patients were accommodated on mixed sex wards, which is not in accordance with Department of Health guidance.

Staff were proud of the care they provided for stroke patients, and a national audit showed improvements made since 2010. The latest published results showed the trust had improved from the bottom 25% of all the 100 participating trusts in England to the middle half in 2012. A transient ischaemic attack (TIA) clinic was in place, but did not meet national guidelines, because it did not provide carotid Doppler assessments on Sundays. Pressure area care was being prioritised for improvement by the trust, but we found poor practice on the stroke ward.

Discharge planning and multidisciplinary working for patients leaving the wards was good. A dementia pathway was in place and followed in these wards and more widely within the trust. Therapists requested and recorded patients' consent to treatment. However, we found that other practices in gaining patient consent needed to improve.

The staff were not able to be as responsive to the needs of rehabilitation patients as required, because patients who were medical outlier admissions took priority, and reduced the time available to treat them.

Both community inpatient wards lacked strong medical leadership for the organisation of care on the wards, which led to regular inappropriate admissions of patients from other specialties. The service was unable to follow the rehabilitation strategy due to the routine admission of medical outliers. Although low staffing had been reported, leaders on the ward had not influenced senior managers within the trust to take effective action, and a resolution had not been identified. There was a sense that the impact of the cost improvement plan on patients' care was not understood by senior management within the trust, and we found trust-wide governance arrangements needed improvement.

Summary of findings

What people who use the community health services say

We spoke with a number of parents during the inspection, and with patient representative groups before the inspection. We also held a listening event and gathered comment cards from patients and relatives prior to, and during, the week of the inspection.

The feedback on community services was very positive, with many expressing how highly they valued the services. Patients found staff to be kind, caring and compassionate. They were very happy with the care received, and they and their families were involved in goal planning.

On the wards, patients and relatives told us that they found staff be very aware of their needs and preferences, with one or two isolated exceptions. One patient told us that counselling had been made available to them following an incident. Another told us that self-care was promoted. Six patients told us of multiple moves between wards however, before admission to the rehabilitation ward. Two patients had been moved from the rehabilitation ward back to acute wards for appropriate treatment. Patients also told us that they sometimes had to wait for call bells to be answered.

Parents told us that the services were accessible. Where health visitor clinics were run alongside children's centre's sessions, parents told us how these enabled them to meet other parents for support, and prevented them from feeling isolated.

The NHS Friends and Family Tests have been introduced to give patients the opportunity to offer feedback on the quality of care they received. In March 2014, the trust scored slightly lower than the England average for 11 acute and community wards surveyed at the trust. The response rate from the rehabilitation ward was relatively high at 56%. This equated to 18 rehabilitation patients, of whom nine said that they were 'extremely likely' and three 'likely' to recommend the service to their friends and family. The rest were neutral or 'don't know'.

It was acknowledged that regular surveys and other patient feedback processes were not in place within all areas of community health services. We saw from the 16 April 2014 minutes of the Community Clinical Quality, Risk and Patient Safety Committee meeting that it is proposed that the Friends and Family Test be rolled out to all areas during 2014. We saw the results of the 'Getting it right for patients' responses for the period 1 April 2013 to 31 March 2014 in the children's physiotherapy service. 100% of the 91 respondents were either satisfied or very satisfied with the service. The department also surveyed five families seen since January 2014, following intensive physiotherapy treatment for their child. All the comments were positive regarding the provision of service and outcomes for the children. The school nurses did a short outcome-focused survey over the period 3 March to 20 March 2014. Twenty one forms were returned and showed that approximately 80% of respondents found the school nurse team support to be very helpful.

Areas for improvement

Action the community health service MUST take to improve

The trust must ensure :

- There are effective operation systems to regularly assess and monitor the quality of the services provided, in order to identify and manage risks. Risks as a result of the implementation of the IT project were not monitored at all times. Staff did not report all risks and near misses, and the trust was not responding to risks and near misses, particularly with regard to the levels of medical, nursing and therapy staff.
- There are effective and reliable measures and support in place to protect the safety of staff working alone and out of hours in the community.
- Community nursing staff receive regular training and updates for Doppler assessments, and that patients with leg ulcers get regular and timely reviews of risk assessments.
- There are sufficient qualified and experienced nursing and medical staff on the wards, including out of hours, to meet patients' needs; this includes the stroke TIA

clinic, patients who are medical outliers, and those placed in the additional four beds used in rehabilitation. Short-term measures need to be in place whilst longer-term measures are arranged.
- There are clear admission policies to community inpatient wards, and adherence to these policies is monitored. Patients placed on the stroke rehabilitation and general rehabilitation ward must meet the criteria for admission so that they can benefit from the services offered.
- Staff receive regular supervision, and this should include bank staff.
- Doctors are offered adequate training, and sufficient staffing is in place to enable medical and nursing staff to attend all teaching and development sessions.
- Review how they can support school nurses to obtain further qualifications in public health, as appropriate to the work that they perform.
- Infection prevention and control measure are followed. The risks from damaged equipment must be removed, local infection control audits must include a review of equipment; yellow clinical waste bins outside the ward kept locked at all times, and sharps boxes always left closed; patients subject to handover checks and screening for MRSA on the wards.
- There are adequate levels of equipment (including stroke chairs, wheelchairs and other equipment), in good repair, to meet patients' needs; and all equipment is regularly checked and appropriately maintained and systems provide full assurance of this.
- Trip hazards from electric leads in the ward corridors are eliminated.
- Staff have the correct understanding of 'intentional rounding' practices and recording on the stroke ward.
- Standards for pressure area care are followed. All patients at risk of pressure ulcers have appropriate and timely reassessment on the stroke ward, timely action is taken and recorded in response to patients' skin changes, and all patients have use of a pressure-relieving mattress when assessments indicate this is required. The use of incontinence sheets for pressure ulcer care needs review.
- Requests are made and patients' written consent is recorded, to the display of their details on the computerised screen on the wards.
- The DNA CPR policy is updated and wards ensure that they audit their adherence to this policy.

Action the community health service SHOULD take to improve

The trust should:

- Review how they regularly seek the views of community service users, and persons acting on their behalf, to inform them in relation to the standard of care and treatment provided, as this is not currently done across all the services.
- Audit readmission rates to the community wards, to identify whether provision is effective.
- Audit the time of day or night patients are admitted to the community wards, to identify inappropriate transfer times.
- Implement audits to assess the care of pressure ulcers on the community inpatient wards, before and after an ulcer has developed.
- Ensure that spare mattresses are not kept on the ward, and are always returned to the equipment store for full decontamination.
- Address inconsistencies in record-keeping in patient notes.
- Review the levels of therapist staffing, particularly occupational therapists, on community wards and whether there is sufficient cover for annual leave.
- Ensure that nursing staff are trained in the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005.
- Ensure any wards or additional beds that are reopened are adequately staffed without reducing cover on the ward or other wards.
- Ensure a contact point is displayed, for access to information and complaints regarding the use of CCTV on the wards.
- Review the selective completion of the 'This is me' folder, to identify whether this adequately meets patients' needs, including those with dementia.
- Monitor that guidance on mixed sex accommodation is appropriately followed on community inpatient wards.
- Review staff engagement and staff access to senior leaders within the organisation, to ensure equity of value and involvement.
- Review the effectiveness of IT systems in community services, to ensure that staff have safe and efficient access to and use of computerised records.

Summary of findings

- Review the staffing levels, skill mix and caseloads of the community teams, to ensure delivery of safe and effective care, and to release staff for training and development.
- Review clinical audit in the community children's and families service, to provide assurance of the quality of the service provision provided.
- Review the components of the Healthy Child Programme, and share the plans for working towards implementation of the full programme with community staff.
- Review of pathways of care in children and family services, to ensure that all staff are aware of them, their use and their role in each pathway.
- Review the condition of buildings identified on the various risk registers, to ensure clear programmes are developed, with timeframes, demonstrating when improvements or changes will be made.
- Monitor safe handover of hospitals discharges to community staff, to ensure the right care and treatment is implemented when patients go home.
- Continue the work started by implementing the 'Productive Community Series' and ensure that a wider range of services are being benefited by it.
- Review the processes and pathways for managing postnatal depression, to ensure that practice is the same for all relevant community staff, and appropriate emotional support is provided for mothers and their families.

Good practice

- The Integrated Care Hub was an excellent example of efficient multidisciplinary teams working closely together to ensure the best outcomes for patients. This integrated call centre 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. The Integrated Care Hub co-ordinated access to emergency, urgent and unscheduled care for the Isle of Wight. The Hub was effective in ensuring patients had timely access to appropriate services, avoiding unnecessary admissions to hospital, and delivering better outcomes for patients.
- The integrated sexual health service provided a good service to wider groups in the community, and improving access to the service for harder to reach patients. The services provided access for the full range of the demographic population of the Island, including young people, the homeless and vulnerable adults.
- The staff in the Community Stroke Rehabilitation team provided an excellent service by working towards patient-specific rehabilitation goals, facilitating early discharge from hospital, and always putting the patient at the centre of their care.
- Innovative practice and collaborative working was evidenced in the children's physiotherapy department, with a specialist therapy provider that enabled funds to benefit more children.
- A productive series community programme was embedded in the orthotics department. This had demonstrated sustained improvements in the treatment and care of children.
- Changes to the local authority safeguarding arrangements in 2013 and resulted in large increases in safeguarding and child protection referrals. These were being managed effectively to reduce risks to children.
- The trust had introduced an Alzheimer's café, and created a garden for dementia patients.
- A Parkinson's care co-ordinator had been created to meet the needs of larger numbers of patients with Parkinson's disease.
- Staff working in children and family services demonstrated a good knowledge of families and children, and had identified areas of higher needs and risks in different localities across the Island.
- Effective multidisciplinary working and communication was evidenced, both within the service, and with other health and social care professionals and other agencies.

Isle of Wight NHS Trust

Detailed findings

Services we looked at:
Community services for children and families; Community services for adults with long-term conditions; Community inpatient services

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team included CQC inspectors, a variety of specialists and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Specialists included: school nurse, health visitor, sexual health nurse, tissue viability nurse, community nursing manager, occupational therapists and community matron. A geriatrician and junior doctor assisted with the inspection of the community inpatient wards.

Background to Isle of Wight NHS Trust

The Isle of Wight NHS Trust is an integrated trust providing acute, ambulance and mental health services, and community health services. The health of people in the Isle of Wight is varied compared with the England average.

Deprivation is lower than average; however about 4,900 children live in poverty. Life expectancy for women is higher than the England average. Life expectancy is 4.9 years lower for men and 3.9 years lower for women in the most deprived areas of the Isle of Wight than in the least deprived areas. Data indicates that the Isle of Wight has an ageing population.

Community services are provided to a population of approximately 140,000 people living on the Island. Services include community nursing teams, community rehabilitation teams, health visiting, school nursing, community equipment services and sexual health services. These services are provided across the Island in health centres, clinics, children's centres, schools and patient homes. Community inpatient services include general rehabilitation (26 beds) and post-acute stroke wards (26 beds) at St Mary's Hospital, plus four additional beds opened during the winter and still operating at the time of inspection.

Why we carried out this inspection

We carried out this comprehensive inspection because the Isle of Wight NHS Trust is an aspirant Foundation Trust, prioritised by Monitor for inspection. The Care Quality Commission's (CQC) latest Intelligent Monitoring tool identified the trust in band 5 (Band 1 – highest priority for

inspection, Band 6 – lowest priority). We inspected community services as part of our second phase of the new comprehensive inspection programme introduced for community health services.

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 team always looks at the following core service areas at each inspection:

- Community health services for children, young people and families – this includes universal services, such as health visiting and school nursing, and more specialist community children's services.
- Community health services for adults – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
- Community inpatient services.

Before visiting, we reviewed a range of information we hold about the community health service, and asked other organisations to share what they knew about the location. We held a listening event in Newport on 3 June 2014, where patients and members of the public shared their views and experiences of the service. We carried out an announced visit on 4, 5 and 6 June 2014.

During our visit, we held focus groups with a range of staff across community services including district nurses, community matrons, sexual health doctors and nurses, school nurses, health visitors, health care support workers, allied health professionals, specialist nurses and community ward staff.

We visited the community inpatient wards, sexual health clinics and the Integrated Care Hub at St Mary's Hospital. We also visited services away from the main site, including the community equipment service, health centres, children's centres and community clinics, and we also accompanied staff on patient home visits.

We observed how people were being cared for, and talked with carers and/or family members, and reviewed personal care or treatment records of patients.

We carried out an unannounced visit between 4 – 11pm on Saturday 21 June 2014. We looked at how the community services ran at the weekend, the levels and type of staff available, and how they cared for patients.

Requires Improvement

Community services for children and families

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Information about the service

Community health services for children, young people and families include safeguarding children, services for children in care, health visiting services, services for children of 0-5 years, school nurse services and children's therapy services. Staff include safeguarding children and children in care nurses, health visitors, school nurses and children's therapists. Children form about 20,000 of the total 140,000 Island population.

Many of the health visitor clinics run alongside family support worker sessions at the nine children's centres across the Island, with some health visitor clinics run from GP surgeries. The trust does not run or manage the children's centres, or employ the staff who work in them. Children's centres are a statutory service, funded by SureStart government money, for all families to access. This means that service providers work together to provide integrated services for young children and their families.

During our inspection, we spoke to approximately 30 staff, 20 parents and six external health and social care professionals. We reviewed information from comment cards that were completed by people using the services. A listening event was held for members of the public to tell us their stories, and we attended a variety of staff focus groups at all levels of the service.

Summary of findings

Community health services for children, young people and families includes safeguarding children, services for children in care, services for children of 0-5 years, school nurse services and children's therapy services.

There was good knowledge and reporting of safeguarding and other incidents, with evidence found of learning from serious case reviews and other incidents, as well as from complaints and concerns. Information from these areas was collated and reviewed in appropriate committees, and any themes were identified. A variety of risk registers were maintained, but it was not always clear what actions had been taken and what the timeframes were. We also found an example of where staff raised the issue of a serious risk, and this was not initially responded to through the trust system. There was concern that risk reporting and management mechanisms were not sufficiently robust.

The implementation of the new IT system had incurred increased risk. Improvements had been made and lessons learnt for the next stages of the programme. However, the system was still not fully functional and staff were required to record information in a variety of ways, which created a risk. There was also a shortage of hardware, such as laptop computers and network cables. Some buildings were also in poor condition, and these were known and featured on the trust risk registers.

We found that there was a need to review of some community staff caseloads, as there was inequity in numbers and weighting in the various locations across the Island. The health visitor recruitment was on track to

Requires Improvement

Community services for children and families

be achieved under the Department of Health Call for Action programme with Health Visitor students in training. However, there would not be a full staff establishment until 31 March 2015 which contributed to the inequity in numbers and weighting that we found. There were staff vacancies in therapy services with active recruitment underway, but it was not clear when this would be resolved.We found that there were increased waiting times for some therapy services. Antenatal visits by health visitors, which were part of the Healthy Child Programme, were not carried out for all pregnant women across the Island.

We found some examples of excellent record keeping, but it was less effective in other parts of the service, and this created a risk to the safety and effectiveness of care. There was good communication and multidisciplinary working, both internally and externally, with evidence of good joint working to ensure that individual needs were met.

Parents told us that the services were accessible, and that staff were knowledgeable, informative and caring. We received some negative comments regarding continuity of care, but these were in the minority. Staff demonstrated a passion for their work, and good knowledge of the families and children.

Staff reported good and accessible supervision, with good support from their managers. Some staff told us they could access further development opportunities, but others said they could not. All staff we spoke with felt that community services did not have the same profile within the trust as the acute services. They told of feeling proud of their service and being part of the NHS on the Island, but isolated from the organisation. There was a lack of visibility by the senior leadership.

Are community services for children and families safe?

(for example, treatment is effective)

Requires Improvement

Incidents, reporting and learning

- There was a trust-wide electronic incident reporting process, of which all staff we spoke with were aware.
- Staff had good knowledge and understanding of incidents that should be reported, and they told us they were reporting incidents. Most incidents centred around safeguarding concerns for the children's and family service. Examples of other incidents were reported in the children's physiotherapy department. These included a child who fell at school, and the lack of changing facilities, other than for babies, on the therapy site. The lack of changing facilities for patients was reflected on the departmental risk register. Serious issues would be reported directly to the manager.
- Staff were encouraged to openly report individual incidents and concerns, and in most cases these were acted upon with learning disseminated appropriately.
- However, there were serious issues when a new IT system was implemented for the first time with the school nurse teams. The previous paper records were removed for scanning into the new system in the July, with an assurance that all records would be available on the system in the September. This failed to be achieved. This resulted in a high risk for vulnerable children and families, in that no past history of their needs, risk assessments or contacts was available to the school nurses. This also impacted seriously on the staff, in respect of their professional registration, and on their general well-being. We were told that staff were recording information on "bits of paper". The school nurses had to telephone other health and social care professionals for the required information before attending safeguarding children meetings. This continued for several months. The incidents were reported, but staff were not listened to, until eventually they took concerns to executive level. Learning from the experience of these staff has taken place, and was applied in further roll out of the project.

Community services for children and families

- Health visitors told us that there was learning from serious case reviews (SCRs), and that policies and procedures with changes in practice were implemented in a timely way. The risk registers identified risks to safe service provision, in respect of staffing and capacity.
- Incidents involving children were discussed at the trust-wide monthly joint safeguarding committee meetings. Outcomes from serious incident reviews and investigations, together with complaints and patient feedback, were seen on the weekly agenda for the trust executive committee.

Cleanliness, infection control and hygiene

- We attended baby clinics held in three children's centres, as well as accompanying health visitors on three home visits. The rooms where the parents and babies were seen were clean and tidy. We saw that there was disposable paper lining the scales, and staff told us that this was changed between each baby. The scales would not be cleaned unless there was soiling as these were 'well babies' and the mothers usually placed their baby on the scales themselves. However, in one baby clinic staff did not have access to hand gel, although they said they usually would have brought it with them.
- We observed that during the home visits the member of staff did not wash or gel their hands between visits, having handled, although minimally, the babies at each visit. Evidence-based guidelines, such as the World Health Organization 'Five Moments for Hand Hygiene' promotes cleaning hands before and after any patient contact. We asked the health visitors at one of the focus groups they attended, and they demonstrated awareness of hand hygiene practice.
- Staff told us that they received training on infection prevention and control. We were told of an audit of hand washing practice undertaken by a health visitor student, but we were not provided with evidence of regular audits in place across all teams. School nurses told us that they did not undertake specific infection control audits. This meant that senior managers could not be assured that all staff maintained good standards of hand hygiene.

Maintenance of environment and equipment

- Staff told us that equipment used, such as scales and audiometers, were annually checked and calibrated through the trust maintenance programmes. We saw evidence of dated labels on equipment during our visit. Broken equipment was reported for repair.
- Staff told us of several environmental areas of concern throughout the community services. The worst areas were some staff bases, which were not pleasant or comfortable for staff to work in. These had been identified and were high on the corporate and directorate risk registers. Staff continued to raise concerns, and some actions had been taken to reduce the risks. Patients were not seen by community staff in these areas.
- There had been significant issues with the implementation of the new IT system. Work was progressing to resolving these and this was reflected on directorate and departmental risk registers.
- There were, however, insufficient laptop computers to ensure that staff could access the system, further network points and cables were required, and there were ongoing connectivity issues which were 'Island wide'.

Medicines

- Good medicines management was observed with school nurse team, in respect of the human papilloma virus (HPV) vaccination given by the school nurses. There was a protocol seen with appropriate checks and monitoring, such as daily temperature checks, and vaccines logged in and out of the locked fridge.

Safeguarding

- Staff we spoke with demonstrated good knowledge and awareness of safeguarding processes. They were able to describe the processes in place, and knew how to escalate concerns. Child protection awareness posters were in the clinical areas that we visited. These included the named nurse, midwife and doctors for child protection, contact numbers for referring concerns, together with prompts for consideration.
- The trust safeguarding policy was reviewed in March 2014.

- The safeguarding team worked across the trust, and provided daily support on the hospital site and in the community. There was a named nurse, named midwife and two named consultant paediatricians for child protection. There was also a nurse for children in care.
- Following an 'inadequate' report from OFSTED published in early 2013, child protection services run by the Island local authority were moved to be managed by Hampshire Local Authority, with social services support on the Island. This service was now embedded in practice, and all staff we spoke with felt there had been improvement in the service provision. Some staff reported remaining difficulties in communicating with social workers. Where a child protection plan was in place with a named social worker, then they told us there was good communication and joint working. We were told that communications with midwives, school nurses and the police was "excellent".
- The referral pathway to children's social care became fully operational on 1 January 2014. This included a multi-agency safeguarding hub (MASH) to triage and process referrals in respect of children.
- Since the OFSTED report, and the implementation of the MASH, there has been a considerable increase in child safeguarding work, and this has impacted on the safeguarding team, as well as on the community staff. There was an increase in multidisciplinary meetings supporting families and children. This had been raised at the trust's joint safeguarding committee, as well as with the children's improvement board and the clinical commissioning group (CCG) in respect of additional funds. The MASH enquiries for February 2014 were at 38 contacts, involving a total of 95 children. This equated to approximately three days extra work per month for the named nurse. It was recorded that for a subsequent week there had been 60 contacts for 102 children. Additional health visitors were being recruited, and the service was monitored by the children's improvement board.
- There was ongoing working towards joined-up IT systems to link with safeguarding children, children in need, and children in care.
- The new IT system implemented in the school nurse team had an alert to identify children with a child protection plan in place. This was managed by the Child Health team. The school nursing team received weekly lists from the safeguarding office, but these did not include children identified as a 'child in need'. Staff expressed concern about the completeness of information received, and that there was potential risk that a child could be missed in the current process.
- Safeguarding training continued to improve over the past few months. The April joint safeguarding committee minutes reported: 86% of staff trained in adult safeguarding; 85% in safeguarding children level 3; 53% in child protection level 2; 50% in child protection level 1.
- Staff reported good safeguarding supervision, with managers accessible for support as required.

Consent

- The paediatric physiotherapy service documentation recorded consent for assessment, the perceptions and expectations of the children and parents/carers, and the findings that had been discussed with them. There were identified needs and agreed goals, actions and outcomes recorded.
- Staff said that they did not have specific training in consent; however, they demonstrated good knowledge and understanding of working with children and young people in this respect.
- Staff were able to demonstrate knowledge of assessing competency in children and young people, in respect of their giving verbal consent for assessments and treatment.
- We saw several examples of parental consent, such as for health screening to be undertaken, in the records we looked at. We were provided with a copy of the child information and parental consent form used by the school nursing team.

Records

- Paper records were secured safely in the offices that we visited. Electronic records were secure and password protected. The community and mental health risk register identified a risk regarding the different systems recording patient data.
- The IT system had improved greatly; it now had all historic information stored on it and allowed shared information between community staff. There were ongoing discussions about local authority staff, such as social workers having access to the system to allow joined-up working. We were told that lessons had been learned by the teams rolling out the system to other community teams. The community and mental health

risk register, as at 14 April 2014, stated that all issues had been resolved, except for out-of-hours cover from IT. However, anecdotally we heard that staff were still having to work around the system when it did not function fully, such as printing off electronic forms to take to visits, then inputting the information once back in the office, which sometimes meant having to come into work early to be able to input information.

- We also saw that only the child's record was held on the new system, with paper records for the parents. Older sibling information was found at the back of a child's paper record. There was a risk of staff not having all relevant information on all family members available at all times, particularly where the surnames were different between child and parent, or child and siblings.
- Slow electronic systems and lack of laptop computers for staff also impacted on the safety of record keeping, as information could not always be input in a timely manner.

Lone and remote working

- Lone and remote working safeguards for staff remain on the directorate and corporate risk registers, with ongoing work towards improvements. We were told of the staff 'buddy' system, access to mobiles, personal alarms, and current practice with regard to lone working. It was reported that some staff do not follow the correct practice all the time.
- The lone working policy had been reviewed and staff carry out risk assessments for all home visits. There was e-learning provided for staff.
- Staff told us that GPS badges were shortly to be provided for each team, to enable the staff member's whereabouts to be known at all times. Staff we spoke with had not yet received these badges.

Adaptation of safety systems for care in different settings

- Staff carried out risk assessments for home visits. There were also risk assessments of the premises that health visitors worked in, with areas of concern highlighted. Some of the premises were outside the control of the trust.
- There was evidence of discussions regarding staff awareness of risks, and mitigation of risks for when they were in someone else's home. Staff demonstrated good knowledge and awareness of working in different settings.

Assessing and responding to patient risk

- We observed part of the midwife handover, of antenatal women to four health visitors, at one of the community clinics. The handover was comprehensive with full discussions. Health visitors demonstrated existing knowledge of some families. Known risks were highlighted.
- Antenatal visits by health visitors were not available to all relevant women. This meant that not all pregnant women had an assessment by a health visitor prior to the birth, and may not be aware of the services and support available, or who to contact if there were concerns in the postnatal period.
- The systems in place for safeguarding children were much improved over the past year, and the higher numbers of children being monitored in the system demonstrated this. All staff we spoke with were aware of their role in safeguarding children, and felt confident in reporting concerns about a child or young person's well-being.
- However, we found variation in the delivery of the national Healthy Child Programme in different locations on the Island, with variation in the recording of the information and data required under the programme. All information on assessments was not always routinely recorded.
- All the school nurse records we reviewed evidenced that clinical and risk assessments had been undertaken, with care plans and up-to-date progress reports.

Staffing levels and caseload

- We met with the service leads for children during the inspection. We were told that the therapy services had vacancies, and that these were being actively recruited to. We heard that recruiting to Band 6 therapist posts was often difficult. Waiting times for occupational therapy had been highlighted. Physiotherapy usually managed to achieve their targets for new patients, but reviews could then take longer. Waiting times were high for speech and language therapy with "overloaded" staff high on the departmental risk register. Demand for orthotics and prosthetics increased year-on-year. We heard that there was no backfill for posts where a member of staff was on maternity or long-term sick leave. We saw all these risks on the directorate risk register, but some plans for resolution were not clear.

Requires Improvement

Community services for children and families

- The school nursing Team Lead was the only member of the team to work the whole year; all other staff worked term time only. Staff felt that this was insufficient cover for concerns and issues that arose during holiday periods.
- The community and mental health risk register identified workforce capacity and capability as a high risk for the organisation. A workforce committee was established, and the workforce strategy approved in April 2014.
- The data for multidisciplinary family and children meetings attended by health visitors for the year April 2013 to March 2014 equated to an average of around 40 per month, and this was therefore a significant part of the health visitor role. This had been raised as a pressure on the service. We also saw a report at April 2014, demonstrating that the health visitor workforce growth remained on track for 34 whole time equivalent staff to be in place at the target date of 31 March 2015.
- The health visitors caseloads varied across teams and across the Island. There was not a system to demonstrate how health visitor's caseloads were reviewed to ensure equitable weighting of health visiting resources.

Managing anticipated risks

- There were plans in place for bad weather, and staff demonstrated knowledge of the processes.
- Staff told us that in the event of staff sickness they would, and do, cover their colleague's workload. Their team leader would also offer hands-on help. We were told there was limited access to additional staff.
- The new IT project for community staff had not identified all the risks for those where the system was implemented first, which had a significant potential impact on children's safety. The risks were reassessed following this, for the further implementation of the project.
- Following the OFSTED report the Trust's children's services have been working with Hampshire Children's Services and the Children's Improvement Board to manage the expected increase in child protection, safeguarding and numbers of children in care. This has included the Trust's workforce planning to increase health visitor numbers as well as other agencies' work in recruiting additional foster carers.
- The increased referrals to the orthotics and prosthetics department had been identified. We were told by staff, and saw in committee minutes, that commissioners had agreed further funding to 31 March 2014.

Are community services for children and families effective?

Requires Improvement

Evidence-based care and treatment

- Relevant National Institute for Health and Care Excellence (NICE) and other guidance were discussed and disseminated to staff through the monthly community clinical quality, risk and patient safety committees. One example seen was regarding responses to domestic violence and abuse.
- We saw examples of good school nurse record keeping, in line with the 'Healthy Child Programme'. Children's needs had been assessed, plans were in place with progress notes completed, and we saw where referrals had been made to other services.
- We were provided with evidence that 'universal', 'universal plus' and 'universal partnership plus' activities were undertaken by school nurses, according to priority and need. This was also evidenced in the children's records that we looked at.
- At the time of our visit, we saw the list of 234 children educated other than at school. We were told that each child's GP would be informed that the child would not be receiving universal health services from the school nurse team. GPs did not form part of this inspection, and we were therefore unable to consider the effectiveness of health care and treatment provided to these children.
- We saw the clinical and other risk assessments for admission/treatment indicators used by the speech and language therapists that related to an evidence-based care aims model.
- We saw incomplete and inconsistent recording by the health visitors in the personal child health records (PCHR) that we looked at. In one example, we saw the child's details were not completed, the newborn hearing screening section was blank, although the mother reported that it had been done, and there was minimal detail written on the notes, despite the baby's weight being low, and the mother asking for advice on weaning

and feeding. Another example had nothing recorded for the child's details, family history, or the important people in the child's life. The mother said that she felt it was "a shame the books are not filled in", and that it would have been, "nice to get it before you go into hospital".

- The health visiting service specification for 1 April 2014 to 31 March 2015 states "the health visiting service will deliver the full Healthy Child Programme (HCP) 0-5 years ..." However, the antenatal visits by health visitors that form part of the HCP were not carried out for all pregnant women across the Island.

Pain relief

- As part of the productive series programme implemented in the orthotics and prosthetics department, information was collected on improvement in pain levels following treatment. The results for February demonstrated 100% improvement for the children and young people involved.

Nutrition and hydration

- Health visitors told us that they were receiving breastfeeding training as part of the trust's accreditation for UNICEF's Baby Friendly Initiative. Staff told us that parents were able to access breastfeeding support in varying ways, and at times and venues convenient for them. We also spoke with a mother who was training to be a 'breast feeder supporter' and she was aware that there was a big campaign in respect of breastfeeding on the Island. Another mother told us of a 'Breast Friends Group' she had attended for advice and support.
- Health visitor clinics were available across the Island, where babies were weighed and measured. Parents could access advice on feeding and nutrition. Parents we spoke with found the service accessible and valuable.
- Children attending school were weighed, and had their height measured in primary school and at Year 6, with a very small number of parents opting out of this system.

Patient outcomes

- The weight and height measurement data for school children was reported to the national database. A letter was generated to each child, informing them of their results on charts for height and weight. Where school nurses identified concerns that a child's weight was either high or low, they contacted the parents to offer information and support.
- Children's therapy services recorded data on progress towards agreed goals in each child's notes. We saw evidence of effective outcomes in a survey undertaken on a small sample of children seen for intensive physiotherapy since January 2014. The productive series work in the orthotics department tracked outcomes; for example, the improvement in comfort and confidence following treatment for patients between November 2013 and April 2014.
- Vulnerability data recorded by health visitors fed into the Public Health England national database.
- Children's progress was monitored in school nurse records we looked at.
- The school nurses undertook a documentation audit in January 2014, where 10 records were reviewed. Results showed 78 out of 80 (97.5%) indicators completed correctly. The results were discussed at the team meeting in February 2014.

Performance information

- We saw that the orthotics and prosthetics department had introduced a productive series programme, to redesign and streamline the way they worked. Their comprehensive performance data demonstrated significant improvements in many areas. Demand for the service had increased year-on-year, and we saw evidence of how the changes implemented had enabled the team to manage this. The data demonstrated the pressure on the current service provision.
- The health visitor team leader's data on key performance indicators showed that the universal provision of antenatal contacts was improving and were planned to be fully in place by 31 March 2015. We saw evidence that other contacts such as primary birth visits and one year development reviews where targets were achieved.
- The March 2014 Child Health Profile from Public Health England showed the Island's results against the national England or European averages. This demonstrated that the level of child poverty was worse than the England average, and a lower percentage of babies who have ever been breastfed compared with the European

average. Children classified as obese or overweight was similar to the England average, and five year old children with one or more delayed, filled or missing teeth was better than the England average.
- Data demonstrated the high numbers of multidisciplinary meetings for vulnerable families and children that had been attended by health visitors.
- We did not find evidence of regular audits of, for example, infection control, documentation or participation in national audits.

Competent staff

- Low levels of staff compliance with safeguarding mandatory training had been highlighted to the trust board in January 2014. We saw that additional opportunities for training were provided for staff, and by April 2014, the majority of staff had received training. There were plans in place for the remaining staff. This was monitored by team leaders and managers, as well as trust-wide.
- The competency report for April 2014 showed a lack of staff compliance with fire training, either part 1, part 2 or both. Particularly poor compliance was seen for school nurses, where 17 out of 18 had not fully completed the training.
- However, the competency report trend that showed percentages of staff trained on a monthly basis, from August 2013 to March 2014, demonstrated the school nursing teams at 91% compliance. Health visitors were at 83% compliance. The therapy department data was for total staff, the children's service was not separated out. These showed compliance rates between 87% and 92%.
- We saw one physiotherapist's training record that showed 23 of 24 competencies completed, with the remaining one booked for the following week.
- The health visitors we spoke with told us that there were good opportunities for training and personal development. Students spoke of an, "open culture", with a "rich learning environment".
- A risk assessment checklist in respect of the health visiting service, dated 27 May 2014, showed that all staff had a training and development plan.
- There was one school nurse that had the public health qualification in school nursing. The school nurses we spoke with told us that they could not access this qualification, as it required spending one year working on the mainland in order to receive the supervision required to complete the course. One school nurse told us that this objective had been on their personal development plan for the last ten years.
- All staff participated in annual appraisals. Staff told us that they had monthly one-to-one meetings with managers, as well as regular safeguarding supervision every six to twelve weeks; evidence of supervision was recorded on the IT system. Staff all said that managers were accessible and available for help, advice and support.
- We found some skill mix available for the health visiting service, with three nursery nurses across the service, and six support workers.

Use of equipment and facilities

- The shared used of children's centres ensured that families and children accessed a safe and suitable environment. The centres we visited demonstrated that the facilities were well designed and planned for the people using the services. Information was clearly accessible in the centres.
- Some of the children's therapy clinical rooms and facilities had been raised as a concern, as they were not all specifically designed for children, as they were shared areas for adults and children. There was also a lack of adult changing facilities for patients with conditions such as cerebral palsy, many of whom remained within the children and families service. Staff demonstrated awareness of these issues, and described their processes for mitigating risk, such as secure entry points when children were in the areas.
- The IT project was well underway, with some of the initial barriers to effective working resolved and improving. However, not all data and information was yet available on the system, so staff still relied on different recording systems to fill the gaps. There was still insufficient IT hardware in place to promote effective working.

Multidisciplinary working and working with others

- We saw examples of multidisciplinary working, and co-ordination with services outside the organisation. Examples included staff working with social services, and school nurses working with education professionals, as well as with the health visitors and community midwives. Information was shared on the IT

Community services for children and families

system, and could therefore be seen by all staff with access to the system. However, there remained concerns that social services staff were unable to access the system, and work continued towards rectifying this.
- The speech and language therapy service ran monthly clinics alongside the health visitors.
- Health visitors told us, and we saw evidence, that they worked closely with children's centre staff, which ensured joint working and information sharing. We saw examples of monthly meetings, the mothers and babies who were discussed, and that identified needs and risks were highlighted.
- The provider of one of the children's centres contracted a nurse for information and support in breastfeeding, which parents we spoke with found very helpful.
- The community staff had monthly meetings with GPs to discuss children with child protection plans in place.

Co-ordinated integrated care pathways

- We saw some evidence of integrated care pathways, for example, the Healthy Child Programme. We were told that a number of care pathways were currently being reviewed in task and finish groups, comprising of staff working to support this health need.
- We found some inconsistency in the identification of vulnerabilities in families with the use of different criteria. These were also recorded and highlighted differently within teams. Some teams used a red folder for vulnerable families, and some teams maintained a list in the front of their filing cabinets.
- We saw the family needs assessment that had been developed following a serious case review. This had fairly recently been introduced, so was not yet fully embedded in practice, and some staff told us they had not been trained in using it.
- Therapy pathways were seen, such as the pathway for children into the intensive physiotherapy programme.

Are community services for children and families caring?

Good

Compassionate care

- Parents we spoke with told us that they had no concerns about confidentiality with the community staff.
- We observed many examples of kind and compassionate care provided to parents and children during the visit. We saw that community staff listened to the parents, that school age children were listened to, their views encouraged and they were included in the discussion and decision-making. We saw examples of situations where members of staff worked hard to build relationships, understand concerns and anxieties, and that they respected parents' individual preferences. We saw examples of good communication with parents and young people, with use of appropriate language.
- Most of the parents we spoke with described a good relationship with their health visitor, and expressed how highly they valued the service provided. They described the staff as caring, informative and supportive. We heard comments such as, "the health visitor was sympathetic to the fact that I was a new mum".
- In areas where the children's and families' needs were high, and there were known staffing level concerns, we found some parents with a less positive experience. Two parents said that, due to a lack of continuity in health visitor, they did not feel that they had a relationship with individual staff. This had impacted on their attendance at clinics.

Dignity and respect

- Parents we spoke with felt they were treated with dignity and respect by community staff.
- We observed individual community staff treating parents, carers and children with respect. They were welcoming, invited and encouraged questions, and listened to everyone.

Patient understanding and involvement

- We observed good care and support provided by school nurses. Children were included in discussions and decision-making. Information was offered, as well clarity provided regarding the confidentiality of discussions between school nurses and children. Children's views were taken into consideration.
- Children's therapists described how they worked with the child's perception of any issues, as well as with their expectations for the eventual outcome. Staff explained that this was sometimes different to those of the parents or carers. We saw examples of how this was managed and documented, so that all concerned were involved, consulted and agreed with any goals and actions put in place.

Requires Improvement

Community services for children and families

Emotional support

- We observed that generally, patients were supported emotionally. Mothers we spoke with described discussions about their emotional well-being and how this had been supported. We saw evidence of joint discussions between health visitors and children's centre staff, where a mothers' past and current history indicated a potential higher risk. We observed good emotional support provided to young people by school nurses, as well as evidence in the records we looked at.
- We found that there was some inconsistency in how patients with postnatal depression were supported. For example, one mother told us that she felt very depressed, but no one had asked her how she felt. We were told by health visitors that the postnatal depression pathway was currently being reviewed.

Promotion of self-care

- The programme of height and weight measurements for school children reports the results to parents, together with information on weight management. School nurses described how they worked with children and families in this respect.
- Universal Partnership or 'Universal Partnership plus' plans were developed to support children and families in promoting self-care.
- We saw much information available to families on health and well-being, as well as on specific health needs and conditions. These included information on accessing sexual health clinics, exercise, and nutrition. Parents described the help and support provided in this respect.
- We observed a school nurse working with young people towards better healthcare and well-being.

Are community services for children and families responsive to people's needs? (for example, to feedback?)

Good

Service planning and delivery to meet the needs of different people

- The health visiting service specifications for 1 April 2014 to 31 March 2014 demonstrated engagement with commissioners of services and the local authority. The document sets out the requirement to provide the complete Healthy Child Programme (HCP). We found that much of the HCP was embedded in the service provided, but that some elements, such as the antenatal visits, were not consistently in place for all pregnant women. We were made aware of ongoing work to ensure that this was delivered. Staff were being recruited to enable this. The specification referred to the "… transition of 0-5 services to local authority commissioning from October 2015".
- The school nurse service current contract with Public Health England no longer included the provision of public health classroom sessions, such as hand hygiene and healthy eating, as nationally there was no evidence base that these improved public health outcomes. However, staff felt that this was detrimental to the service offered to children and young people.
- The productive series programme embedded in the orthotics and prosthetics department showed how the service planned and delivered services to meet the needs of the children and their families. We saw evidence of positive results for improvement for children in comfort and confidence following treatment, for the period November 2013 to April 2014. The continuous monitoring of performance, together with the weekly meetings, ensured prompt identification of any issues with decision on action to take for resolution. One example was that a drop in the number of children seen within two weeks was identified. The action would be to adjust the appointment system to ensure that this improved.
- The trust safeguarding team closely monitored all safeguarding concerns, children with child protection plans in place, and multidisciplinary family and children meetings, as well as referrals, numbers, and placements of children in care on the Island. They also monitored any children removed to care off the Island. Workforce planning was in place, and areas of concern regarding staffing and capacity were seen on relevant risk registers. These were also discussed at the joint safeguarding committee. Examples of minutes demonstrated that the increased workload was raised with the children improvement board and the clinical commissioning group, with regard to extra funding required.

Requires Improvement

Community services for children and families

Access to care as close to home as possible

- The children's centres were accessible for parents and children. Parents that we spoke with valued the services provided. They told us of the help and support they received from both the health visitors and the children's centre staff. They also told us how important it was for them to meet other parents, babies and children in their locality.
- The clinics and family support sessions provided a relaxed social setting for them to meet parents with children of the same age, as well as an opportunity to discuss concerns and anxieties. They were also able to find out what other services may be available to them.
- There was one paper referral form for health and social care professionals to refer all parents to the children's centres. Health visitor clinics are mostly run alongside other activities, which meant that the parents could access a variety of opportunities and services at one visit. Families could access whichever clinics and centres they chose.
- Home visits were provided for those parents unable to attend clinics.
- School nursing services were available to be accessed at all schools on the Island.
- Some therapy clinics were run alongside health visitor clinics, to enable easy access for parents. Where this did not happen clinics were situated on the main hospital site.

Access to the right care at the right time

- Health visitors offered their services between the hours of 8.30am and 4.30pm. They were able to see parents and carers at times and places convenient to them. Child health clinics were held regularly, both in children's centres and surgeries, and parents were able to access these as they wished. Parents could also ring health visitors for advice, or leave a message for the health visitor.
- New patient appointments were prioritised in the children's physiotherapy service. However, this sometimes meant that review appointments were delayed due to lack of capacity.
- Processes for children in care were described with statutory and other contacts monitored. We heard that the majority of first statutory reviews were completed at 28 days post placement, but that this could sometimes be delayed if all the required information had not been received in time. The designated nurse for children in care supported children and young people at health and social care appointments, when requested by them to do so.
- Health visitors were being up-skilled to start 'chatterbox' sessions, to support children awaiting an appointment with speech and language therapists.
- Children's therapy services, other than podiatry, told us that they struggled to maintain waiting times within their targets. We saw examples of their performance data to confirm this..

Flexible community services

- The children and families service was provided from 8.30am to 5pm, Monday to Friday, but there was flexibility. For example, the health visiting service specifications for 1 April 2014 to 31 March 2015 stated that the "… core service will operate standard hours of 9am to 5pm but will offer flexibility from 8am to 8pm to meet the needs of families".
- We saw evidence of patient/person -centred care that showed community staff were responsive to individual needs, and worked flexibly with them towards improved health and well-being. Examples included individual goal setting with therapists, support and planning to increase young people's attendance at school, and meeting young people in care at venues of their choice.
- The service providers worked together to plan the most appropriate service provision for individuals and their families.

Meeting the needs of individuals

- We saw examples of patient information in all children's centres and clinical areas we visited. This included 'what's on' information with times of clinics, clinical condition-specific information such as diabetes, service-specific information such as children's physiotherapy, as well as information on sexual health, and infection prevention and control.
- We saw evidence of a family needs-based assessment used by the health visitors. This used the national framework for assessment, as well as learning from local serious case reviews, to inform the assessment tool they had developed and introduced.
- Information leaflets could be translated into different languages. A telephone translation service was available as required.

Requires Improvement

Community services for children and families

- Children and young people's views and wishes were encouraged and taken account of. We observed this in practice and saw evidence in the records that we looked at.
- There were processes were in place for children and families who transferred onto the Island from providers on the mainland.
- The multi-agency safeguarding hub (MASH) triaged referrals into children's services.
- The orthotic and prosthetic therapists visited the two special schools on the Island to carry out assessments of need.

Moving between services

- Staff told us that they had regular meetings, where they liaised with health colleagues about patients transferring from one service to another. We observed such a meeting between health visitors and a midwife.
- Health visitors and school nurses held face-to-face handover meetings for children moving from one service to the other.

Complaints handling and learning from feedback

- The Trust Quarterly Patient Experience Report – Quarter 3 2013/14 covered all aspects of patient experience, including feedback, complaints and concerns across the whole organisation. This demonstrated monitoring of the previous quarter's priorities, with progress and other reports that showed the trust's position on a monthly basis throughout the year.
- The trust's complaints analysis for the year 1 April 2013 to 31 March 2014 showed that there was one complaint and four concerns in respect of the health visiting service. The complaint was investigated, and had an outcome and was managed within the relevant timescales. It was also reflected on the directorate complaints action tracker.
- Complaints were monitored and discussed at the directorate monthly community clinical quality, risk and patient safety committee meetings. We saw evidence of identifying lessons learned, and highlighting where themes were found.
- We found a culture of using complaints and concerns for learning and improvement amongst the community staff we spoke with. Staff we spoke with described the process. Concerns were logged and reviewed.
- Numbers of complaints and serious incidents were reviewed at the weekly trust executive committee meetings.
- We saw examples of questionnaires handed out to patients, such as the paediatric physiotherapy and occupational therapy services. The 'Getting it right for patients' questionnaires were handed out to all parents at the initial assessment. The results for the period 1 April 2013 to 31 March 2014 showed 91 respondents, and all were either satisfied or very satisfied with the service provided. We also saw action taken as a result of three comments, regarding difficulties in finding the clinic, where the map has been clarified. One small sample of five families seen since January 2014 for intensive physiotherapy treatment demonstrated very positive experiences for their children and the joint work with other therapists.
- A brief evaluation of school nurse service support was carried out over two weeks in March 2014 that demonstrated positive results in a reduction of concerns following the support provided, that parents/carers found the support helpful, and that parents would know how to contact the school nursing team.
- We did not find any systems in place to ensure regular feedback for analysis, action and learning on the service provision.

Are community services for children and families well-led?

Requires Improvement

Vision and strategy for this service

- The trust had a vision and values around the quality of integrated services provided that was available on their website. There was not written strategy specifically for this service.
- We received varied responses from staff in respect of feeling part of an integrated trust. Some staff told us of the vision and values of the trust, and their service. Most staff were aware that there were more changes planned, but were not always clear on what they were.
- Staff were not always aware of plans within their own team. One team were particularly pressured, but the

staff we spoke with did not know how many new staff had been recruited for them. However, senior management told us that two extra staff had been allocated to that team to start in September.
- Almost all the staff we spoke with felt that the community services had a lower profile within the organisation than the acute services.

Governance, risk management and quality measurement

- The operational management and governance meeting was for the whole physiotherapy service, adults and children, acute and community services. Minutes evidenced information from multiple sources, including health and safety, incidents and complaints, and that these were discussed at the meeting, alongside performance data.
- There were many departmental, directorate and corporate risk registers. Risks such as the poor buildings for speech and language therapies, and orthotics and prosthetics were on departmental and the 'Community Health – Live full departmental risk register'. There were several staff groups with shortages of staff identified on various risk registers, including the community health live full departmental register. There were different end dates on the different registers – varying from March 2014 to September 2014. It was therefore difficult to track individual risks to see where actions had been taken and when these should be completed by.
- All risk registers were monitored and reviewed at the monthly corporate risk management committee meetings. We saw that these meetings included standing agenda items, such as health and safety, infection control and information governance. However, the 'Community Health – Live full departmental risk register' contained 122 risks, some of which had been on the register since May 2012.
- All reported incidents at all levels were monitored and discussed at the monthly community clinical quality, risk and patient safety committee meetings. These meetings were for the whole directorate. Minutes evidenced that any themes were highlighted.
- Themes from the risk registers for the year 1 April 2013 to 31 March 2014 highlighted the risks around staffing levels, poor state of some buildings, lack of IT support out of hours, different systems within community for recording information, and lack of laptop computers.
- There was an occasion when incident reports, identifying a serious risk to a service, were not escalated through the trust systems appropriately. This impacted on the staff's ability to provide a safe service for children and their families. The reported risk and concerns were persistently repeated through the management structure, but no action was taken. This left the staff feeling very frustrated, vulnerable and not listened to about a very important concern. Eventually, one staff member went directly to the nursing and workforce executive director, who responded promptly by attending the next staff meeting. Staff told us that they then felt listened to, and the seriousness of the risk was understood and acknowledged. Actions were taken to mitigate and reduce the risk, and there has been ongoing work towards sustained improvement. We saw evidence of these concerns reflected on the directorate and corporate risk registers. Whilst action had been taken, these staff remain concerned that the trust's reporting processes do not function robustly in all cases.
- The services did not have a local audit programme and did not participate in national audits. We found evidence of some audit undertaken such as an education quality audit for health visitor students done in May 2013. This demonstrated a good learning environment, and there was an action plan seen. The service participated in the recent local authority child protection deep dive audit of randomly-selected cases, with positive results.

Leadership of this service

- All staff we spoke with told us that they felt listened to and supported by their managers within their departments.
- The issues, risks and concerns that staff had raised regarding the implementation of the new IT system had proved challenging for managers and teams, and staff said that they had not always felt supported at that time. We were told that this had been worked through and resolved by all involved.
- The management of children's and families services was described as, "spread very thin". The roles covered a broad range of services, with increasing demands identified, evidenced and escalated within the organisation. The management demonstrated good knowledge of high risk areas within the service set in the

context of the Island locations and communities. However, we found that some staff, particularly those working in the most pressured localities, were not aware of any proposals to manage their "firefighting" concerns.
- We found that there was a lack of regular health visitor case load analysis and reviews. This resulted in inequalities of work and weighting of caseloads, in the localities, teams and for individuals.

Culture within this service

- School nurses we spoke with felt that there was a lack of specialist experience at senior levels in the trust. They felt that they were an "isolated" service within the organisation. They told us of good information provided centrally to them, and described their participation in many of the trust social activities, such as quizzes, sports and the annual ball.
- Staff expressed knowledge of systems and processes for reporting incidents, risks and concerns. They felt able to use the processes and gave examples of learning from serious case reviews and other incidents. They felt there was an open culture within the service.
- All community staff we spoke with described the good support and working within their teams. They felt they communicated well together. All staff stated the high importance of strong communication within the community setting. They valued this highly.
- All community staff we spoke with expressed pride in their services, and were proud to be working as part of the NHS on the Island. We found areas where staff wanted to broaden the service provision and introduce initiatives, but did not have the capacity within their workloads to do this.

Public and staff engagement

- The health visiting team leader told us they took part in the Friends & Family Test, and that their service had received positive feedback. We saw proposals in committee minutes that this should be rolled out across the whole of community services.
- Some teams were inviting feedback from people who used their services, such as school nursing and children's physiotherapy.
- We did not find regular opportunities for people who used the services to comment and feedback to the trust. We were told that this was an area for development in health visiting and school nursing.
- There were good examples of corporate communication that was accessible to all staff. These included consultations on proposed changes, as well as social activities and staff awards. However, some staff we spoke with did not feel included or engaged in some of the changes, such as the new documentation they were required to use. Staff also told us that they did not feel the flow of information from them to the top of the trust was effective.
- Staff told us that the leadership at the top of the trust was not visible out in the community. Staff were aware that acute wards had regular 'walkabouts' by the senior leaders, and that this did not happen in the community. This resulted in many staff feeling that they worked in isolation.

Innovation, improvement and sustainability

- The call to action and health visitor implementation plan, together with the proposed health visitor training and recruitment figures for 2015, were on track. There was evidence of the service managing the increased safeguarding and child protection referrals.
- The productive community series work implemented by the orthotics and prosthetics department demonstrated innovation and improvement sustained over time. Changes and improvements were led by frontline staff. However, it also demonstrated that the year-on-year increase in demand identified concerns in the sustainability of the service at its current level. There were proposals that the programme be rolled out across the service, but we did not find evidence that this had progressed.
- The children's physiotherapy department worked collaboratively with a specialist therapy provider in London. Individual children were funded to attend the specialist provider. The service negotiated with commissioners for an increase in the hours for this service, which has enabled them to invite a physiotherapist from the specialist provider to come to the Island. This meant that the extra money has been used to benefit more children.
- Workforce planning and recruitment for health visitors were in line with the Department of Health's Call for action 2011.
- There appeared a lack of succession planning; we were told of slow recruitment to an important nursing post

within safeguarding children, with the post holder having retired and six months later the recruitment process had not been commenced. We did not see evidence of career progression or secondment.

- We did not find any systems in place to ensure regular feedback from service users for analysis, action and learning on the service provision

Requires Improvement

Community services for adults with long-term conditions

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

Information about the service

The trust provides a wide range of community-based services for adults. Patients receive community services from a range of professionals and support staff in their own home, and through attendance at community-based and hospital-based clinics. Trust staff cared for patients who needed treatment, rehabilitation and care through a pathway of support following acute illness, long-term condition, sexual health conditions, and those requiring palliative and end of life care. Clinical advice, treatment and monitoring were provided by nurses, therapists and other care staff in multidisciplinary teams.

Community services that we inspected included

- District nursing teams
- Community matrons
- Community Stroke Rehabilitation team
- Laidlow day centre (range of clinics)
- Specialist nursing services
- Sexual health clinics
- Community equipment service
- Single Point of Access, Referral, Review and Co-ordination (SPARRCS) team

Our inspection team included three inspectors, occupational therapist, community nursing manager, community matron, tissue viability nurse and an 'expert by experience'.

We spoke with over 25 patients and their family members. We spoke with 60 staff members, including clinical leads, service managers and matrons, support workers, therapists, and non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records. We reviewed information from comment cards that were completed by people using the services. A listening event was held for members of the public to tell us their stories, and we attended a variety of staff focus groups at all levels of the service.

Requires Improvement

Community services for adults with long-term conditions

Summary of findings

We judged that safety within the adult community services required improvement. Nursing staff did not feel safe when working alone in the community, particularly out of hours, and we found that improvements were needed to the arrangements in place, to minimise risks to patients and staff. Staff were able to describe the systems for reporting incidents, and there was a evidence that improvements had been made to services through sharing of lessons learned, although staff felt more could be done in response to lone working incidents. Staffing levels varied across different locations, and was not matching the demand in some localities, with the risk that this would compromise safe and effective patient care. This had been identified as a risk by the trust, and although staff had been recruited for some locality teams, it was not fully resolved. Safety standards were followed for infection control, the use of equipment and medicines management.

National guidance was used to treat patients, and local care pathways and care bundles were ensuring consistency of treatment. Action was being taken to ensure harm-free care and reduce the incidence of avoidable harms, such as falls and pressure sores, but patients were at risk when not adequately assessed before the use of compression bandaging. Multidisciplinary working was widespread, with some excellent examples observed in the Integrated Care Hub and integrated sexual health services.

Staff were caring, and patients and relatives told us they were treated with dignity, compassion, and respect. We observed staff providing compassionate care, and consulting with patients in clinics and in their homes. Patients were involved in planning their treatment. The Community Stroke Rehabilitation team worked towards specific rehabilitation objectives for patients, and facilitated early discharge from hospital. They used the goal attainment scaling to score the extent to which patient's individual goals were achieved in the course of rehabilitation intervention.

Community services were provided in people's homes, where this was needed by patients, and clinics and groups were established in community locations. The trust and local authority had initiated a 'My Life, a Full Life' programme, for people over 65, to help people to support and care for themselves. SPARRCS and crisis teams were established to encourage early discharge, or prevent admission if possible. The crisis team was able to respond within four hours to urgent patient need. However, the out-of-hours community nursing service (8pm -8am) was an 'on-call' system and required improvement. The on-call service was staffed by a lone working nurse, often inexperienced, and on occasions, there was no service at all. Staff told us that the weekend and Friday evening hospital discharges were not always well co-ordinated with community services. This had led to inappropriate arrangements of care, and possible readmission of these patients.

We judged that leadership for the service needed improvement. Some of the staff we spoke with were not able to identify the trust's vision and values, and could not demonstrate understanding of the trust's development strategy. Most community staff felt disengaged with the senior management of the directorate and the trust, this led to an inward looking culture in some teams. Staff told us that the trust management was acute medical-focused, and did not appreciate the complexity of community nursing and rehab provision.

Requires Improvement

Community services for adults with long-term conditions

Are community services for adults with long-term conditions safe?

Requires improvement

Incidents, reporting and learning

- There was an effective mechanism to capture incidents, near misses and 'never events'. (Never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.) Incidents were reported via an electronic incident reporting form. Staff told us that they knew how to report incidents, and were encouraged to use the reporting system.
- There was a robust governance framework, which positively encouraged staff to report incidents.
- From April 2013 to March 2014, the community directorate had 50 serious incidents requiring investigation (SIRI) reported, of which 32 were grade 3 and 4 pressure ulcers. This had been identified as needing improvement in community services.
- Incidents reviewed during our visit demonstrated that thorough investigations and root cause analysis took place, with clear action plans for staff, and sharing with the board.
- Staff were able to explain how learning from incidents and complaints was cascaded to all staff. Their responses indicated learning, and trends from incidents and complaints were disseminated to staff. Learning from incidents was discussed in staff meetings.
- Staff told us about their monitoring of incidents of pressure ulcers, and the changes in practice following the investigation and root cause analysis. Community nurses were given training and a laminated card showing how to grade pressure ulcers correctly. The trust had also introduced a traffic light system for pressure ulcer monitoring and increasing awareness across all the staff.
- Staff told us about an incident related to the safety of a community nurse working out of hours. Staff were encouraged to report this incident, and it was brought into the attention of senior management. In response to this, the trust had decided to issue the community staff with a security alarm devices. However, this was not implemented in a timely manner, and not all staff were aware of arrangements.
- The trust's prevalence of patients with a fall with harm was lower than the England average for 10 out of 12 months in 2013-14.

Cleanliness, infection control and hygiene

- We observed a high degree of compliance with hand hygiene, isolation procedures and the correct use of personal protective equipment (PPE), such as gloves and aprons. We saw that staff adhered to the trust's 'bare below the elbows' policy in clinics and home environments.
- Hand washing facilities and alcohol hand gel were available throughout the clinic area. We observed staff using portable hand gels before and after patient contact during home visits.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinics and home environments.
- Staff told us that they had completed infection control training, and were able to tell us about precautions taken to prevent and control the spread of infection.
- The locations we inspected were clean, and with effective infection control mechanisms in place.
- We saw that in the community equipment store, separate areas were identified for clean and dirty or used equipment, and clear procedures for decontamination of equipment were followed.

Maintenance of environment and equipment

- The community team offices and clinics we inspected were fit for purpose, and well maintained. Firefighting equipment was tested regularly as required.
- Nursing and therapy staff told us they had easy access to equipment. Equipment was delivered to patients in timely manner, so they could be cared for safely at home.
- We observed that the clinic areas had sufficient moving and handling equipment to enable patients to be cared for safely.
- Equipment was maintained and checked regularly to ensure it continued to be safe to use. The equipment was clearly labelled, indicating when it was next due for service.

Requires Improvement

Community services for adults with long-term conditions

Medicines

- During our inspection we randomly checked medicines held in the Laidlow Unit. We found the drugs to be stored correctly and in date. The drug fridge on the Laidlow Unit was at the correct temperature, and was checked and recorded on a daily basis.
- We saw evidence of compliance with patient group directions (PGD) by competent registered nurses. Medicines were monitored effectively. No errors had been reported in last 6-12 months, and there was a good safety record for medicines management.
- A medicines helpline was available for community patients to call if they had any questions about their medicines when they were at home.

Safeguarding

- Safeguarding procedures were clearly displayed on the walls in the clinics and community nursing offices we inspected.
- The nursing and therapy staff had a good understanding of the trust's safeguarding policy. Staff were able to explain what constituted a safeguarding concern and the steps required to report such concerns.
- Staff were able to give examples of when they had invoked the trust's safeguarding policy, and the learning shared following the investigations. 86% of the staff across the trust had completed adult safeguarding training as of March 2014.

Records

- Records were held in paper format. Patient records were generally well maintained and well completed, with clear dates, times and designation of the person documenting. The patient records we examined were written legibly, and assessments were comprehensive and complete, with associated action plans and dates. Records were kept safely in lockable cabinets and confidentiality was maintained.
- The community nursing team had recently produced a new health assessment booklet which consisted of multiple risk assessments (such as pressure injury assessment, wound care assessment, falls and osteoporosis assessment, nutrition assessment) and the relevant care plans. This booklet had been implemented across all areas of community nursing services.
- Appropriate risk assessments were completed for patients at risk of pressure ulcers or falls.

Lone and remote working

- Community nursing staff told us that they did not feel safe working out of hours in the community.
- The district nursing service had one nurse on duty 5-8pm, evenings and weekends. There was one nurse on call between 8pm and 8am, working out of hours across the Island. Staff carried their mobile phones whilst on duty, and sometimes had a buddy arrangement with 111 services at night. Staff told us that this arrangement did not work efficiently, as mobile connections were not always available.
- The trust had a lone working policy, and standard operating procedure dated March 2014, Some of the community nursing staff were not aware of this lone working policy and procedure. Staff told us that often the less experienced staff were working on out of hours duty, which increased risks to staff and patients. The standard operating procedure refers to the support of a senior nurse, but we did not find evidence of this in practice. Staff told us that lone working issues had been escalated to senior management, but they had not been acted upon.
- The trust had recently arranged for staff to have mobile alarm devices, linked to a call centre, for emergencies. However, not all staff were aware of these devices. Staff told us that there had been a long delay in issuing these devices to the front-line staff, and some of the staff were still waiting to be issued with these devices.
- The sexual health outreach workers were aware of the trust's policy on lone working but did not always follow it. They had not been issued with security devices and told us that at times they felt vulnerable.
- We raised concerns about the safety of the out-of-hours service with the trust, who told us that they would ensure the support of a senior nurse on-call between 8pm -8am, to support the lone working district nurse. When we visited the trust on an unannounced inspection out of hours on a Saturday evening we found that there was no on-call district nurse on duty. There was no senior district nurse in support. The 111 service had only been informed of the absence of the on-call district nurse at 8pm that day, and they had no knowledge of senior nurse on call support.

Requires Improvement

Community services for adults with long-term conditions

Adaptation of safety systems for care in different settings

- Staff told us that when they were supporting people at home they worked closely with families and carers where needed, on issues such a manual handling to maintain safety for patients and carers.
- The patients we spoke with were aware of support systems in place should they wish to report concerns.

Assessing and responding to patient risk

- The Single Point of Access, Referral, Review and Co-ordination (SPARRCS) team triaged all the referrals using the SPARRCS screening and assessment tool. This clearly helped to identify patients who were at immediate risks. Staff were able to prioritise and refer these patients appropriately to the relevant teams.
- We observed a handover of community nursing teams, and a team meeting of a Community Stroke Rehabilitation team. Patients' health and well-being were discussed in detail, and risks were identified. Frequency of visits was changed in response to findings.
- Patients' needs were assessed prior to care and treatment being commenced, and we saw robust examples of completed needs assessments and care planning. The daily handovers within the community nursing team were effectively used to identify deteriorating patients in the community. The information was captured on the electronic data sheet, which was available to staff working out of hours and at weekends.
- Staff told us that patients with venous leg ulcers were waiting for a 'Doppler' assessment longer than expected. A Doppler study is conducted to rule out peripheral arterial disease (a condition affecting the arteries) as a possible cause of venous leg ulcers. A Doppler assessment is not diagnostic of venous ulceration, but is of value in defining a safe level of compression bandaging. Nursing staff told us that they did not receive regular training to carry out Doppler tests. Those who were carrying out Doppler assessments had received the training many years ago, and were not updated. Nurses were applying compression bandaging without the training or Doppler assessment, which meant that risks to patients were not assessed and responded to safely.

Staffing levels and caseload

- The staffing for community nurses varied across the different localities. Some of the localities were fully staffed and the vacancies were advertised. Sandown community team felt stretched at times, and staff had been working over their contracted hours. Lower staffing levels had an impact on referrals and training not being undertaken in a timely manner.
- Staffing rotas showed that some district nurses were working consecutive shifts on-call overnight, in one case 17 shifts, in addition to day shifts. This indicated that the service was struggling to staff a 24 hour service. At an unannounced inspection visit on a Saturday evening, we found that there was no district nurse available for the overnight on-call shift.
- We saw that teams were monitoring staffing levels against required activity. The data submitted for one team for one week identified three days as red status, two days amber, and two days green status. There was an escalation plan for local teams to follow for amber and red status, to defer non priority activity, and in extreme circumstances, delay hospital discharges. The service was not able to provide information on how many hospital discharges were delayed as a result of staffing shortages.
- A review of safer staffing in the community had commenced, and staff were starting to record the acuity, as well as the number of patients in case loads, and this would feed into reporting and workforce planning.
- We checked the rota for sexual health services, which demonstrated good staffing levels, and did not have any staff vacancies.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)

- Consent was obtained appropriately from patients who had the capacity to give consent.
- The staff we spoke with told us that they had received training in relation to consent, the Mental Capacity Act 2005, and Deprivation of Liberty Safeguards.

Managing anticipated risks

- The community health directorate had a risk register, listing and ranking areas of risk identified within the

directorate. The risks were clearly documented and monitored. The register included details demonstrating that actions were being taken, where possible, to reduce the level of risk.
- Those risks that could not be resolved at departmental level were escalated to the corporate risk register. These risks were reviewed and updated on a monthly basis by the quality manager, with input from service managers.

Major incident awareness and training

- The trust had protocols in place to respond to major incidents, and staff were aware of escalation procedures for areas of risk.
- Staff we spoke to had a good awareness of the procedures for managing major incidents, such as adverse weather conditions and fire safety.

Are community services for adults with long-term conditions effective?
(for example, treatment is effective)

Good

Evidence-based care and treatment

- Staff we spoke with indicated that the guidance they followed to deliver care was based upon best practice, which included the use of recommendations from the National Institute for Health and Care Excellence (NICE).
- The community health directorate adhered to NICE guidelines for the treatment of patients with long-term conditions such as stroke or diabetes. Local policies, such as the pressure ulcer prevention and management policy, were written in line with national guidelines. Staff we spoke with had a good awareness of these policies.
- Risk assessments in care records reflected NICE guidelines in practice, including pressure ulcer, nutrition, and falls risk assessments.
- In end of life services, the trust had procedures based on other national and regional guidelines, including the 'Gold Standards Framework' (GSF) guidelines. The staff within the community nursing teams were highly trained, and had a good understanding of existing end of life care guidelines, and implemented these effectively. People approaching the end of life were identified appropriately, and care was delivered according to their personal care plans. This included the provision of effective pain relief. Care was regularly reviewed.

Pain relief

- We observed staff assessing and monitoring the pain levels for patients, and recording the information in care plans. The community stroke team used the 'Visual Analogue Scale' to record the pain level.
- We observed staff explaining different types of pain relief medication to a patient who was in a lot of pain, and also making a decision to refer this patient to their GP for treatment of pain.
- Clear guidelines were in place for staff to follow regarding pain relief for palliative care patients, and staff had received appropriate training. Staff also had access to advice from Macmillan nurses and palliative care nurses based in a local hospice.

Nutrition and hydration

- Patients' nutrition and hydration status was accurately assessed and recorded in the care plans.
- The 'Malnutrition Universal Screening Tool' (MUST) was used by the community nurses. There was a clear action plan for patients who were nutritionally at risk.
- Nutrition and swallowing assessment was carried out for patients suffering with stroke, by the Community Stroke Rehabilitation team, and patients identified with swallowing difficulties were referred to speech and language therapists.

Patient outcomes

- The community services monitored the outcomes of interventions for patients using the service.
- In sexual health services, registered nurses had won a national award for their work on addressing hard-to-reach clients for cervical screening. This project had improved the uptake of opportunistic cervical screening in this cohort. The outcome resulted in an increase in the number of women screened, and significantly higher numbers of positive cervical smears requiring further treatment.
- By facilitating early supported discharge, the Community Stroke Rehabilitation team (CSRT) had

significantly reduced the length of hospital stay for patients who have experienced a stroke. Recent figures show that this had reduced from an average of 38 days in 2009-10, to an average of 16 days in 2013-14.

- The directorate had a clinical audit programme, where national guidance was audited and local priorities for audit were identified. During 2013-14, the community health directorate had participated in four national clinical audits and 11 local clinical audits. Some locations also conducted internal audits, including audits of record keeping, care plans and handovers to promote and enable best practice. We did not find evidence of the outcomes or the improvements that occurred following audit.
- The Community Stroke Rehabilitation team had conducted a goals audit to study whether the patients had met their agreed rehabilitation objectives by the end of the rehabilitation phase. The result of this audit showed that 76% of patients had achieved their rehabilitation goals by the end of their rehabilitation phase.

Performance information

- Overall, we found arrangements were in place to monitor performance, and to identify areas in need of improvement. Governance arrangements ensured a robust process of information sharing between operational services and the board.
- Information provided to the board included quality and safety reports with performance and delivery against key performance indicators; outcomes of clinical audit activity; and patient experience information.
- Timely performance information, including outcomes for people using the service, was readily available, and was shared using various communication modes. These included monthly community newsletters for community nursing, information displayed on notice boards, and monthly staff meetings. Staff understood the performance information they received.

Competent staff

- The specialist nurses within the directorate displayed high levels of competence and knowledge in dealing with complex and specialty issues .We noted a good skill mix of staff in the sexual health and Community Stroke Rehabilitation teams to support evidence-based care.
- Community nurses had input from the community, and from modern matrons and a tissue viability nurse as an additional knowledge base resource.
- The specialist nurses had also provided training to other staff. For example, the tissue viability nurse had provided a pressure injury master class and competency training for nurses and therapists within the community service. This class was also extended to nursing staff within the community rehabilitation nursing-home provider, to ensure a whole system approach.
- Fourteen physiotherapy outpatient staff had passed the McKenzie Institute Spinal Credentialing Examination, after completing 16 days of training over two years. The McKenzie Method of Mechanical Diagnosis and Therapy is a comprehensive assessment and management system for patients who have musculoskeletal problems of spinal and extremity origin. This technique was used by all the outpatient therapists across the Island, to assess and treat patients with back conditions, ensuring that a robust system was in place to manage these patients.
- Community nursing staff in some locations had difficulties in accessing important training, such as leg ulcer management and Doppler training.
- All new staff were provided with an induction period in which to undertake mandatory training. A new member of staff confirmed that they had undertaken a period of induction on starting at the trust.
- Staff told us that they received annual appraisals. As of March 2014, 85% of staff in the community directorate had completed their appraisal. The directorate's mandatory training compliance was 86.7% in April 2014.
- Therapy staff told us that they had access to additional training for professional development, and were often encouraged to attend the courses for improving clinical practice. Therapy staff also conducted regular in-service training.
- Community nursing staff told us that they did not receive regular supervision. Some teams had tried to make the daily handover session a part of supervision, but this did not work out effectively. This meant that the nursing staff did not get an opportunity to discuss their role, plan personal development, and consider issues around caring for patients. The staff in other disciplines in the community division were receiving a regular, competency-based supervision.

Requires Improvement

Community services for adults with long-term conditions

Use of equipment and facilities

- Equipment and facilities were fit for purpose, and in good supply. Staff told us they had 24 hour access to pressure care equipment. The crisis team had access to its own equipment store, which they kept well stocked in order to efficiently respond to patient needs within four hours. Staff were able to order mobility and other daily living equipment, by prioritising them as urgent or routine. Therapy staff told us that there were significant delays in delivery of wheelchairs, which could lead to delay in achieving therapy goals and outcomes for patients.
- The community equipment store had robust systems in place to clean the equipment and deliver them to appropriate locations. We also saw that equipment was stored in an orderly manner, and staff had easy access to equipment.
- The community equipment store had a service to make and supply minor adaptations to peoples' homes, such as grab rails, handrails and ramps. Occupational therapists were able to make referrals for this service.

Telemedicine

- Tele-monitoring technology was used for remote monitoring of patients with long-term conditions like chronic obstructive pulmonary disease (COPD) and heart failure. This was achieved through patient-recorded metrics, such as pulse rate, blood pressure and oximetry, coupled with electronic responses to key questions.
- The trust had implemented tele-health technology for patients with long-term conditions. Tele-health was helping clinicians to monitor well managed patients, who had actively accepted and developed an improved understanding of the management of their long-term condition.
- Specialist nurses told us that tele-health technology was well received by the patients, and had resulted in a reduction in hospital bed days.

Multidisciplinary working and working with others

- We observed good collaborative working within the multidisciplinary teams (MDT). This was supported in all areas we inspected. We found that staff worked well together, and the healthcare professionals valued and respected each other's contribution into the planning and delivery of patient's care.
- We saw an excellent example of MDT working at the Hub. The Hub is a whole system approach, providing a single point of contact for patients, by linking the hospital, ambulance, district nursing, multidisciplinary community support teams, and social care, through a call centre. We observed effective communication, appropriate information sharing, and decision-making about a patient's care. The information was shared across different types of services, involving those both internal and external to the organisation.
- The community nursing teams had developed strong links with GP practices and the local hospice, to implement a common vision for timely, flexible and responsive care services.
- The sexual health service was provided by a multidisciplinary team of nurse consultants, registered nurses, a health improvement advisor, healthcare assistants, medical consultant support once a week and a clinic service manager. This enabled it to provide a comprehensive service to patients at the clinic and via the outreach activities.
- Nursing staff told us that they did not have easy access to records from other disciplines, such as therapy assessments, as the records were not held electronically. This was leading to duplication of certain assessments and treatments.
- The trust had initiated a 'My Life, a Full Life' programme for people over 65, in conjunction with the clinical commissioning group (CCG), the Isle of Wight council and voluntary organisations. The aim is to help people to support and care for themselves. The initiative was in the scoping and development phase, and staff in the Community Stroke Rehabilitation team told us that this was leading to better integrated working across the boundaries with voluntary and social services.

Co-ordinated integrated care pathways

- We observed detailed and timely multidisciplinary discussions and handovers, to ensure patients' care and treatment was co-ordinated, and the expected outcomes were achieved. A patient's changing needs were discussed in community nursing team handovers, and references were made to the community psychiatry nurse, and speech and language therapist to ensure continuity of care.
- Care pathways of patients attending rheumatology clinics were shared with GPs. This had led to integrated care between GP and acute care services.

Requires Improvement

Community services for adults with long-term conditions

- The Community Stroke Rehabilitation team (CSRT) was undertaking early supported discharge, which is a pathway of care for people transferred from an inpatient environment to a primary care setting. The team continued to offer a period of rehabilitation, reablement and recuperation at a similar level of intensity as they would have received in the inpatient setting.
- The community staff told us that there was not always a smooth handover when patients were discharged from acute hospitals on Friday evenings and weekends, and this had sometimes led to ineffective care arrangements for patients going home.

Are community services for adults with long-term conditions caring?

Good

Compassionate care

- We found the care and treatment of patients within all services was flexible, empathetic and compassionate. We found staff had developed trusting relationships with patients and their relatives.
- Patients told us “the staff are very caring and friendly" and “I couldn’t be looked after better by my family”.
- In the Community Stroke Rehabilitation team, we observed that individual attention was given to patients, and they were treated at the centre of their care. For example, discharge plans were delayed when a patient needed further support and treatment.
- Discussions in patient handovers provided evidence of a compassionate and caring approach to patient care.

Dignity and respect

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed staff communicating with patients in a respectful way in all the situations. Staff ensured confidentiality was maintained when attending to care needs.
- In our observations of care, in clinics and in people’s homes, we saw that staff-patient interactions were positive and effective. For example, the views of a patient, who did not want to go ahead with nursing interventions, were respected by the nurse providing care. The nurse discussed alternative options, and the patient was referred to their GP for further advice.

Patient understanding and involvement

- Patients and relatives we spoke with stated that they felt involved in their care. Patients told us the staff had explained their treatment options to them, and they were aware of what was happening with their care. None of the patients we spoke with had any concerns with regards to the way they had been spoken with, and all were very complimentary about the way in which they had been treated.
- We witnessed nurses and therapists explaining to patients and their relatives about the care and treatment and options. We evidenced patients under the care of the Community Stroke Rehabilitation team were clearly involved in rehabilitation and goal settings. We evidenced a patient whose goal was to be able to drive again following stroke. The therapist treating this patient had made every effort to support the achievement of this goal.
- There were a variety of comprehensive leaflets that were given to patients explaining their diagnosis and treatment options. The patients we spoke with found this information very useful.

Emotional support

- During our inspection we observed that staff were responsive to patients’ needs, and we witnessed many examples of kindness towards patients and their relatives, from well-motivated staff.
- We observed an effective communication between a community nurse and a Macmillan nurse regarding the most appropriate option of care for an end of life patient. The patient’s family had been included in this conversation, and were being supported.
- We evidenced that a community nurse had made special arrangements for the installation of a lockable cabinet in the home of an end of life patient who did not want to go to hospital. This arrangement was made in liaison with their GP and Macmillan nurse, and meant that the patient was able to store medicines safely in their home.
- The Community Stroke Rehabilitation team had identified a greater need for counselling and emotional

support for patients who suffer with stroke. In response, a psychologist was appointed who was going to start working with the team for one day a week, to offer greater expertise and support to the patients.

Promotion of self-care

- We saw that multidisciplinary working, with social care, crisis teams, SPARRCS , community nursing teams and emergency services at the Hub, was helping patients to receive help and advice that was easy to understand and access. This service helped patients to deal with a crisis situation, and promoted healthy and independent living.
- We observed a patient who was at a risk of developing pressure ulcers. Useful information and advice about self-care and prevention of pressure ulcers was given by a nurse. The nurse had also issued them with pressure relieving equipment.
- We saw that staff were supportive and encouraging to patients, empathised with their difficulties, and promoted a positive attitude towards self-care.
- The Community Stroke Rehabilitation team always worked towards setting and achieving goals with patients to promote independent living. We saw an example of a patient suffering with stroke who wanted to be able to cook dinner using the oven. Staff had set up a programme and worked on goal-oriented activities in order to achieve this.

Are community services for adults with long-term conditions responsive to people's needs?

(for example, to feedback?)

Requires improvement

Service planning and delivery to meet the needs of different people

- The trust had planned and provided nursing and therapy services, to support people with their long-term conditions and rehabilitation needs, in their own homes, and at specialist clinics and in group sessions in the community.
- The sexual health service provided a service for the full range of the demographic population of the Island, including the gay, lesbian and bisexual community, the homeless, and young people.
- The sexual health service worked closely with a range of other community providers, such pharmacies, GPs, the Salvation Army, schools, police, drug and alcohol services, and a variety of young people's services. The clinic staff also liaised with other trust services, such as mental health and maternity services, to offer sexual health services to people using these services. In addition, the service facilitated the signposting of people to other services, such as the continence service, according to their need.
- Staff we spoke with had a good understanding of the needs of the local population. For example, in end of life services staff worked as part of multidisciplinary teams, and routinely engaged with local hospices, GPs and adult social care providers involved in the care of patients.
- We found the trust had improved the co-ordination of care packages for patients needing integrated teams to provide support at home. The SPARRCS and crisis team had been established with the aim of preventing inappropriate hospital admission. These teams consisted of therapists, nurses and social workers. Staff told us that the presence of social workers in the crisis team helped to facilitate the setting up of long-term care packages, and reduced delay in transfers of care. However these services were not provided out of hours.

Access to care as close to home as possible

- Community services were provided in people's homes, where this was needed by patients, and clinics and groups were established in community locations. Therapy and nursing staff undertook home visits where needed.
- The sexual health clinic provided an effective 'one stop' service available to everyone. There were appointment and 'drop in' sessions throughout the week. In addition, there was an outreach clinic, mainly for under 25s and vulnerable adults. This meant that hard-to-reach clients received a good service. Patients told us they appreciated this service, and had been offered screening they had not known was available.

Requires Improvement

Community services for adults with long-term conditions

- Specialist nurses, such as heart failure nurses, respiratory nurses and stoma nurses, also provided community support, and patients had access to these services as required.
- The respiratory service offered provision of a Domiciliary Non-Invasive Ventilation Service for selected Isle of Wight registered patients with chronic respiratory failure.

Access to the right care at the right time

- Staff in the crisis team had robust systems in place to triage and prioritise the referrals. They said that they were able to respond within four hours if there was an urgent need; however, the service was not provided outside normal working hours.
- There was good communication and use made of other organisations to support people at end of life.
- The out-of-hours community nursing service operated between 8pm and 8am. The service was Island-wide and staffed by one, often inexperienced, district nurse. The nurse was on-call to responded to urgent calls received via the 111 service from patients in the community, for example, for palliative care issues and blocked catheters.
- When we visited the trust, on an unannounced inspection out of hours on a Saturday evening, we found there was no on-call district nurse on duty. The 111 service had been informed of this at 8pm, and there was a patient requiring urgent nursing support due to a blocked catheter. The service called an ambulance to bring the patient to A&E, as no district nursing service was available. At the time of our call, the patient had been waiting for an ambulance an hour and a half and an ambulance had not yet been scheduled. The coordinator told us there had been no on call district nurse two months ago.
- Efficient appointment systems were in place at Laidlow Unit for rheumatology patients, and patients were happy with the booking system and waiting times.
- Patients at the sexual health clinic did not experience long waits for services, treatment or care, and they were seen within national guideline timescales.

Flexible community services

- The Community Stroke Rehabilitation team service covered the whole of the Island, from 7.30am to 9pm, seven days a week, although the therapists only worked Monday to Friday. The assistant practitioner staff continued to provide care and rehabilitation to community stroke patients over the weekends.
- The community nursing team operated between 8am to 8pm, seven days a week. Cover was outside these hours was provided by the out-of-hours on call district nurse.
- Therapy staff told us they always tried to be flexible enough with their visits, to fit in with people's lives where possible, such as work and family commitments.

Meeting the needs of individuals

- We found all staff were focused on the needs of the individual patients, and actively sought to minimise risks to them.
- Staff were motivated to seek solutions for people's individual care needs. We heard therapists discussing a patient with visual impairment, and efforts to assist him with IT use. We also heard therapists referring to patients with learning disabilities, and their sensitivity to goal settings.
- There were a variety of comprehensive leaflets that were given to patients explaining their diagnosis and treatment options. The patients we spoke with found this information very useful.

Moving between services

- We saw that SPARRCS and crisis teams were established with a remit to encourage early discharge or prevent admission if possible. This meant that patients could receive a service, where appropriate, for their condition, without the risks of a hospital admission, or could benefit from early discharge.
- Patients referred for multidisciplinary support for rehabilitation were seen within two days if classified as urgent, and within two to four weeks if routine. Patients were seen by the Community Stroke Rehabilitation team within one or two days post discharge, to maintain continuity of therapy and care input.
- The district nursing service was meeting people's needs when they were referred for care and treatment, although in some of the localities, there was delay in assessing patients who needed ear syringing and Doppler tests. Staff told us that this was because teams were not resourced with staffing levels according to the locality needs.
- Staff told us that the weekend and Friday evening hospital discharges were not always well co-ordinated

with community services. This had led to inappropriate arrangements of care, and possible readmission of these patients. Staff gave us an example of a patient with a complex abdominal wound, who was discharged on a Friday evening. This patient was discharged without any dressings, and community nursing staff were not given any handover. This had led to a difficult situation, as staff had struggled to obtain the dressings and specialist advice on how to carry out the dressing over the weekend.

Complaints handling and learning from feedback

- The community directorate monitored both complaints and concerns. The Community Health Quality Report for the year 1 April 2013 to 31 March 2014 listed nine complaints and 30 concerns in respect of community services for adults. The directorate had improved response by contacting the complainant shortly after the complaint was received, and creating a more personal approach to dealing with complaints. Complaints were dealt with in a timely manner, and staff were encouraged to be proactive in handling the complaints.
- Complaints were handled in line with trust policy. Staff showed us that patients were given information on how to complain. We saw that there was a clear complaints process in place, and that there was effective handling of complaints.
- Complaints leaflets were available at the entrance to the clinic areas, and also in patient notes, where these were kept in people's houses, for reference. Patients we spoke with felt they would know how to complain if they needed to.
- Staff told us that any learning from complaint investigations was shared with the team. The trust had introduced a 'Learning lessons' newsletter which was published quarterly. The newsletter shared lessons learnt from the 'four Cs', which were compliments, comments, concerns and complaints across the trust.

Are community services for adults with long-term conditions well-led?

Requires improvement

Vision and strategy for this service

- The trust's vision is 'to be an excellent and trusted provider of integrated patient-focused services that are globally admired'. The trust encompassed its vision in the strapline, 'quality care for everyone, every time'.
- We spoke with staff from all levels within the community directorate. Some of the staff we spoke with were not clearly able to identify the trust's vision and values. However, staff consistently told us that it was their primary concern to ensure that patients were treated with respect and compassion, and received good care on the Island.
- Staff we spoke with were aware of the challenges faced by the trust, being an integrated trust covering a wide range of services, but could not demonstrate understanding of the trust's strategy to face these challenges.
- The community directorate's strategy was based on the trust's aim for improving patient safety, clinical effectiveness and patient experience. The directorate had identified four specific quality goals for 2013/14. These were reducing mortality rates; prevention of pressure ulcers; improving communication; and developing the end of life care bundle. We found that the directorate had made progress implementing this strategy. The amber care bundle for end of life patients was rolled out in some areas, and pressure care prevention plans were in place.

Governance, risk management and quality measurement

- Incidents and complaints were reported at local level and board level, with action plans identified to reduce further risks. There were clear lines of accountability, and managers were monitoring performance of clinical incidents, such as pressure area notifications, falls or other untoward incidents.
- Governance meetings were held monthly within the directorate. Complaints, incidents, audits and quality improvement projects were discussed in the meetings.

Requires Improvement

Community services for adults with long-term conditions

- The trust had employed 'quality champions' who worked with colleagues to promote a 'culture of quality' across the organisation. They helped in giving guidance and direction to any staff who wanted to raise concerns or suggestions.
- The directorate had a risk register, which was reviewed on a monthly basis, and updated by service managers. The risk register for the division had identified risks, and there were action plans in response. The identified risks were being monitored. However, the risks relating to district nursing out of hours service had not been adequately identified and managed.

Leadership of this service

- Community staff based at the main hospital site told us that the chief executive was often visible. Nursing staff in one locality told us that the chief executive had visited their locality. However, most of the community-based staff could not identify visual presence of executive board members.
- Staff told us that the leadership within their individual teams was excellent, and they felt supported by their team leaders. For example, community nursing staff in Sandown locality told us that their team leader was an excellent role model. They said she supported her staff in a positive and dynamic manner, ensuring that high standards of care were maintained.
- We observed a senior member of the therapy staff giving positive feedback to a junior member of the team, recognising their achievements in meeting patient outcomes.
- We found that most community staff felt disengaged with the senior management of the directorate and the trust. Staff told us that the trust management was acute medical-focused, and did not appreciate the complexity of community nursing and rehabilitation provision.
- Senior management told us that clinical leadership and regular clinical supervision within the district nursing was hindered by capacity and work pressures in the service.
- There was a lack of management and clinical leadership in relation to the district nursing out of hours service. Rostering for out of hours was undertaken centrally by an administrator and was not managed or monitored effectively.

Culture within this service

- The majority of staff spoke positively and passionately about the care provision and the service they provided. Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.
- Front-line staff worked well together, and there was obvious respect between, not only the specialities, but across disciplines.

Public and staff engagement

- The trust conducted the 'Friends and Family Test' and 'Getting it right' survey, to seek staff and patient feedback.
- Patients attending the inspection listening event told us that they felt engaged with the trust activities and were keen to support service improvements.
- The 2013 NHS staff survey found that the trust's performance was rated as worse than expected, or tending towards worse than expected, for 14 of the 28 key findings. The key areas where the trust performed worse than average were: communication between senior management, staff job satisfaction, and harassment and abuse from other staff.
- The staff did not feel a part of an integrated trust. The staff described a disconnection within the trust, and considered they had a low profile compared to the acute hospital services.
- Staff told us that the communication between the leadership team and front-line staff was not effective. This had resulted in an inward-looking culture. The overall strategic direction was not taken into consideration by the community staff.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines, although the division did not have effective mechanisms to share and adopt good practice.
- The trust had started implementing the 'Productive Community Series'. This is an organisation-wide change programme, which helps systematic engagement of all front-line teams in improving quality and productivity. Staff told us that the productive series was helping to increase the organisation's capacity and capability for continuous improvement, and it would give positive outcomes in the long term if it continued. Staff in the

podiatry team had found the productive series very beneficial, as it was helping front-line staff to spend more time on patient care, reduce waste and improve efficiency. The same progress had not been made in other adult community services. There was limited evidence of performance review of district nursing teams and community matrons

- The trust had also introduced other innovative services, like tele-health for patients with respiratory conditions and heart failure, which had helped with closer monitoring and to reduce patient anxiety.
- The tissue viability nurse had provided pressure injury competency training for nurses and therapists, and this training was also extended to nursing staff within the community rehabilitation nursing-home provider, to ensure a whole system approach.
- A trust-wide workforce strategy had been approved, and a workforce transformation group was in place, as recruitment was increasingly difficult on the Island, and hard-to-fill vacancies threatened sustainability of, and improvement in, community services. The trust was prioritising implementation of safe staffing in acute services, and had started to review staffing across community nursing services, but there were no clear timescales.

Requires improvement

Community inpatient services

Safe	Inadequate
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

Information about the service

The stroke neurorehabilitation and general rehabilitation wards are run by the community services directorate. They are both located in St Mary's Hospital. The stroke neurorehabilitation ward has 26 beds, including two for patients with acute stroke (reported in our acute services report). The general rehabilitation ward is funded for 22 beds, plus four for patients awaiting rehabilitation. A further four beds are often used for medical outliers, even though they have not been commissioned or funded since March 2014, when they were used for winter pressures. An additional 28 rehabilitation beds are commissioned from a number of local nursing homes, which are NHS funded for up to six weeks. These will be inspected during nursing home inspections.

Care is delivered by nurses, health care assistants, therapists and dieticians, overseen by a sister on each ward and managed by one matron. Medical cover is provided by one full time and one part time consultant, working with a junior doctor on rehabilitation and a locum registrar on the stroke unit.

Summary of findings

We found the community inpatient wards to be clean and well maintained, with staff who were caring and kind, and involved patients in their care and goal planning. However, low medical and nurse staffing numbers and skill mix meant that safe care could not always be delivered, particularly, but not solely, at the weekend and out of hours. The routine use of the wards for patients who were moved from acute medical wards due to shortage of beds exacerbated this problem. The nurse bank frequently could not provide the skill mix requested, and so healthcare assistants often worked in place of a registered nurse. Whilst numbers attending appraisals and training were good, we found that nursing staff did not receive one-to-one supervision.

The wards were well maintained and clean, but infection prevention and control needs to improve, as we found damaged equipment that could harbour bacteria. There was also a need for an increase in MRSA rescreening, due to routine use of the wards for medical outliers, and this had not yet started. Some equipment needed by patients was not available, and had not been maintained as required.

Staff were proud of the care they provided for stroke patients, and a national audit showed improvements made since 2010. The latest published results showed the trust had improved from the bottom 25% of all the 100 participating trusts in England to the middle half in 2012. A transient ischaemic attack (TIA) clinic was in

Requires improvement

Community inpatient services

place, but did not meet national guidelines, because it was not medically-staffed seven days a week. Pressure area care was being prioritised for improvement by the trust, but we found poor practice on the stroke ward.

Discharge planning and multidisciplinary working for patients leaving the wards was good. A dementia pathway was in place, and followed in these wards and more widely within the trust. Therapists requested and recorded patients' consent to treatment. However, we found that other practices in gaining patient consent needed to improve.

The staff were not able to be as responsive to the needs of rehabilitation patients as required, because admissions of patients who were medical outliers took priority, and reduced the time available to treat them.

Both community inpatient wards lacked strong medical leadership in the organisation of care on the wards, which led to regular inappropriate admissions of patients from other specialties. The service was unable to follow the rehabilitation strategy due to the routine admission of medical outliers. We raised immediate concerns with the trust, and our later unannounced inspection identified changes to this practice on the rehabilitation ward, and the indefinite closure of the additional four beds, reducing it to a total of 26 beds.

Although low staffing had been reported, leaders on the ward had not influenced senior managers within the trust to take effective action, and a resolution had not been identified. There was a sense that the impact of the cost improvement plan on patients' care was not understood by senior management within the trust, and we found trust-wide governance arrangements needed improvement.

Are community inpatient services safe?

Inadequate

Incidents, reporting and learning

- There was an effective mechanism to capture incidents, near misses and 'never events'. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.) Staff were encouraged to report incidents, and were aware how to do this. Staff told us however, that action was not always taken by senior trust management to reduce the risks. This discouraged staff from reporting risks and incidents.
- For example, a registered nurse said that they had submitted an incident report, about a month prior to the inspection, that patients, who were medical outliers, were being placed at night on the general rehabilitation ward ahead of patients requiring rehabilitation. The same nurse had also reported a very busy night, when they had only four staff on duty when six were rostered, and when they had 30 beds in use. The nurse told us that nothing had happened as a result, and they received no response.
- Insufficient numbers on duty meant that staff often did not have the 10 minutes needed to report incidents on the electronic system.
- One 'never event' had occurred in March 2014, and there had also been a recent safeguarding incident, both on the rehabilitation ward. We saw that the 'never event', a drug error, had been very thoroughly investigated and corrective action taken. Learning from the 'never event' had led to the introduction of competency-based training' as well as changes in the computer software, which had caused the error to occur.
- Local safety audits were included in those undertaken regularly on the wards' such as hand hygiene, use of the peripheral vascular access device, venous thromboembolism (VTE), goal setting in rehabilitation, nursing documentation, tissue viability, MRSA, nursing observations, infection control, essence of care and saving lives. The MRSA audit had triggered the request for advice about the frequency of re-screening.
- Staffing shortages were regularly reported as incidents, and emails had also been sent to senior managers in

the trust. Medical staffing shortages had also recently been reported as incidents. No sustainable staffing changes had been made as a result of these reported incidents. Staff said they felt there was a lack of understanding of the issue, or a willingness to resolve it.

Cleanliness, infection control and hygiene

- Senior nurses on the ward told us that infection control had deteriorated with the routine use of the additional four beds on the rehabilitation ward, which were not funded. The placement of patients who were medical outliers increased the overall acuity (healthcare needs) on both wards. Staff needed to undertake more frequent MRSA screening for these patients, as outlined in the trust's MRSA policy. Advice had been proactively sought from the infection control lead, who confirmed that practices needed to be updated in order to prevent infection. But increased re-screening had not yet started.
- Some patients arrived on the rehabilitation ward with information which incorrectly stated that they had been screened for MRSA. The sister did not rely purely on the transfer information and undertook further checks on the computer system, ISIS, regularly identifying patients who had not been tested already, and arranging tests. This helped to keep patients on the ward safe from infection.
- During our inspection, we saw that the arms on some pieces of equipment were badly damaged, with the foam showing. We saw a wheelchair's armrests damaged by the hoist, two stroke chairs with badly damaged arms, exposing the foam, and damaged arms on a 'stand aid'. The damaged equipment could harbour bacteria, and posed an infection control risk. Although environmental audits were included in the infection control audit every six months, they had not identified this issue. The trust's infection control policy specified that clinical staff were responsible for cleaning patient equipment and medical devices, and for ensuring that high standards of cleanliness were maintained.
- Staff told us that they were able to access mattresses and pressure-relieving cushions from the equipment store when needed. Despite this, they told us that two spare mattresses were kept on the stroke ward, which nurses cleaned. These were not seen by our inspectors. This was not in accordance with the requirement to return them to the equipment store for decontamination, cleaning and maintenance in-between patients.
- We saw that the yellow clinical waste bin outside the stroke ward was open and unlocked. We also saw the lid left open on a wall mounted sharps box. This put patients, visitors and staff at risk of harm and infections.
- Disposable gloves, plastic aprons and hand gel were available on the ward in several dispensers, and we saw nursing staff using these and adhering to the 'bare below the elbows' policy. Hand hygiene audits were undertaken regularly, and figures showed the wards performed well.

Safety thermometer

- Performance against key indicators was displayed on the ward walls. They included patient safety (staffing levels, falls and pressure ulcers), clinical effectiveness (infections and VTE), and patient experience. We saw that the stroke ward was on or above target for the number of pressure ulcers acquired under care (0), the number of C.difficile and MRSA infections acquired on the ward (0), VTE risk assessment (100%), and patients likely to recommend the trust (100%). The noticeboard on the general rehabilitation ward listed numbers of pressure ulcers, complaints and falls.
- VTE risk assessments were recorded online before medication could be prescribed, and the wards achieved 100% completion.
- The wards had introduced chair and bed sensors, non-slip chair mats, slipper socks and CCTV to help mitigate the risk of falls.
- Pressure area care was being prioritised for improvement by the trust, and a recent external review had been carried out.
- We found that pressure area care on the stroke ward required improvement, and was not following NICE guidance.
- Nursing staff were confusing 'intentional rounding' with patient repositioning, and were applying it selectively to high risk patients and medical outliers. Staff were recording the regular repositioning of patients rather than the condition or changes to patients' skin. The process produced ticks against boxes and no qualitative information. We were concerned this would not help staff to deliver effective care to patients.

- On the rehabilitation ward we saw that pressure area care was provided in response to patients' needs. This was not always the case on the stroke ward. Patients were reassessed on transfer, which was good practice and Waterlow scores were revised if changes in their skin condition were observed. However, our finding that reassessments were mainly carried out at the weekend, combined with the Trust's acknowledged need to improve preventive care, gave us cause for concern. Pressure area care on the stroke ward was not sufficiently responsive to any changes in the patients' condition mid-week.
- We saw patients sitting on inco-sheets, which is not good practice because it is not good for patients' skin.
- A tissue viability nursing (TVN) service was in place, and provided good support for staff, although staff told us that the TVN was often difficult to get hold of, because of pressure of work. The TVN had verified that nurses cared appropriately for a recent patient with a grade 4 pressure ulcer.
- Pressure ulcers were audited quarterly by the Tissue Viability Nurse. Scores for regular internal audits undertaken do not indicate concerns and this is difficult to reconcile with the Trust stating it raised concerns in May 2014, nor with the the commissioning of the external report and its findings
- Pressure area care on the rehabilitation ward was better. Staff followed guidelines and reassessed patients appropriately. We found care plans were informative, and intentional rounding had been fully implemented and was understood and overseen.
- Health care assistants (HCAs) were trusted to refer any changes in patients' skin to registered nurses, in line with their job description to report any change in the condition of patients to a qualified nurse. Senior nurses confirmed that HCAs did not complete the Waterlow assessment tool.

Maintenance of environment and equipment

- The environment was clean, and walls were being painted during the inspection.
- We observed trip hazards in corridors from leads to computers and blood pressure monitors, which were charging. We did not see this was addressed during the inspection.
- A gym, available to rehabilitation patients, was next to the rehabilitation ward and the stroke unit, and included a kitchen to help patients prepare for going home. Both the stroke and rehabilitation wards had an activities room. The stroke unit had a day room, and both wards had outside seating areas.

Too little equipment

- Staff told us that there were too few chairs designed for stroke patients which worked properly. This posed some health and safety concerns, and led to staff needing to improvise continuously. For example, staff had to find other ways to support patients' legs, and we saw small tables being used.
- Staff also told us there were too few working wheelchairs available.
- A therapist on the rehabilitation ward told us that a parallel bar had broken in the gym approximately 10 months ago and despite repeated requests, no replacement had been arranged. We spoke to a patient who had used the gym during the inspection, and another who was waiting to go to the gym, which showed that the gym was used regularly by patients. The therapist told us that the lack of this equipment prevented the provision of proper care and support to patients.
- There was good access to pressure area care equipment, except seat cushions. These were being trialled at the time of the inspection, with the intention to purchase them with donated money.

Equipment maintenance

- Our spot checks on equipment on the wards and in the gym showed that maintenance was not up to date. For example, a hydraulic plinth in the gym was last checked on the 13 June 2012. Poor maintenance could lead to hydraulic fluid leaking onto the floor, causing the floor to be slippery. It could also reduce the effectiveness of the hydraulic mechanism. There is a possibility that the plinth could drop when a patient is sitting on it, which would pose a risk of possible injury to both staff and patient.
- Two blood pressure monitors on the rehabilitation ward were last checked in February 2011 and June 2012, although we were told one was not used. This was corroborated by maintenance records from the equipment store. Maintenance records from the equipment store recorded five blood pressure monitors on this ward, three of which were behind on

maintenance. Two had last been checked in June 2012, and one in September 2012. There was no record of a blood pressure monitor which had been last checked in February 2011, however.

- Hoists were maintained by an external contractor, and we saw these checks were up to date.
- The equipment store told us that "all electrical safety testing and maintenance is behind" owing to a staff vacancy since October 2013, although this had been filled the week before the inspection. Records kept by the equipment store showed that testing was overdue by up to two years for 29 of 55 items on the rehabilitation ward, and 16 of 28 items on the stroke ward. They also reported a delay of several months before the manufacturer had repaired the trust's checking devices. The maintenance programme was on the risk register, and remedial plans had been put in place. These prioritised the maintenance of defibrillators and the decontamination of mattresses.
- A further seven items in rehabilitation and 12 on the stroke ward appeared on the records as several years overdue for maintenance. We were told that this was equipment which could not be located on routine maintenance visits to the wards and was likely, but not certain, to have been disposed of. This indicated that the system in place was not sufficiently robust to provide assurance that equipment used by patients on the wards was fully maintained and safe to use.

Medicines

- The trust had suitable medicine management processes in place for the protection of patients. For example, random checks we made on medicines held on the wards found drugs to be stored correctly and in date. Policies and procedures were up to date and followed.
- The fridge temperature was monitored each day and well recorded.
- A ward-based pharmacist undertook regular monitoring, and ensured medicines were stored and recorded appropriately.
- The electronic prescribing system in use was innovative and effective. This had reduced medication errors and increased the use of venous thromboembolism assessments.
- Resuscitation trolleys were checked regularly. During our inspection the resuscitation alarm sounded and the trolley was used on the stroke ward.

Safeguarding

- Senior nurses on the ward felt that nursing staff were confident to raise safeguarding concerns, and an incident had been raised that morning by a therapist.
- Staff could describe what they should do if they suspected abuse. Senior staff could name the designated lead for safeguarding, who was available to provide support and guidance. They told us that a trust safeguarding lead was being recruited to start the following week, in early June 2014.
- Staff received twenty minutes e-learning on safeguarding vulnerable adults. Records showed that attendance was 88-100%. In addition, more extensive face-to-face training of one or three days had been undertaken by some senior staff. Staff told us however, that safeguarding courses became booked up, and the next one was not available until December 2014.
- We saw 'speak out' posters on the wall on the wards, outlining what people should do in the event of a concern.
- Whilst training and systems were in place to safeguard patients and staff from abuse, we found a serious safeguarding incident had recently taken place on the rehabilitation ward. This was being addressed in line with the trust's policy.

Records

- All notes on both wards were in paper format. The notes were reasonably well maintained on the general rehabilitation ward.
- On the stroke ward, we found many patient notes which were not bound together, which could lead to notes being lost. We found a printout of one patient's test results in another patient's file. We also found that, despite regular audits of patient records, there were inconsistencies in record-keeping on the stroke ward. This meant that the documentation of patients' care available to all professionals providing care on the stroke ward was not routinely complete and accurate. This put patients at risk of receiving care that was unsafe or inappropriate.
- We reviewed the 'do not attempt cardio pulmonary resuscitation' (DNA CPR) lilac forms for five patients listed on the nurses daily summary sheet as being 'not for resuscitation'. Trust policy says that the DNA CPR form must be completed for the relevant patients. It enables clinicians to see at a glance that the decision

has been discussed with patients and/or relatives as appropriate, and has been signed off by the consultant in charge. It provides a safeguard for patients and clinicians. One of the five patients did not have a DNA CPR lilac form. The remaining four were signed by a consultant, but two had left blank the sections confirming whether the person or 'relevant other' had been informed.

- We asked staff about the person listed on the nurses' summary sheet as being for DNA CPR, but for whom there was no lilac form. The trust's policy and reference guide clearly state that the lilac DNA CPR form must be seen in order to withhold CPR. Nursing staff were unaware of this, and did not know there was no form on file for this patient. Nursing staff told us they would not resuscitate this patient. Medical staff however, said they would resuscitate the patient unless a DNA CPR form was in place. Nursing staff were unaware their practice was against the trust's policy and national guidance.
- Nursing staff were not interpreting the DNA CPR policy appropriately. They told us that the DNA CPR process covered heart failure only. They knew to resuscitate patients if they went into respiratory failure.
- The policy stated that the DNA CPR decision-making process is measured, monitored and evaluated to ensure a robust governance framework. However, neither of the two wards had audited these processes. Neither were they one of the ten wards participating in the external audit of DNA CPR processes carried out recently.

Assessing and responding to patient risk

- Patient's needs and risks were assessed prior to care and treatment starting. We saw examples of completed needs and risk assessments, and care planning to mitigate risks. Assessments included Waterlow, MUST, fall risk assessments (including bedrail assessment), and moving and handling.
- The care plans, which were developed to meet patient's identified needs, included assessments relating to nutrition, fluids, pain, falls and dementia. These were regularly updated, although we found some inconsistencies in recording.
- We saw inaccuracies and inconsistencies in some risk assessments and patient records, which

impacted on staff's ability to respond appropriately to risks identified. Fo

- Effective handovers were in place to identify patient risks. However, we saw that staff were not always risk-assessing and recording patients' skin condition appropriately, and only reassessed them at weekends on the stroke ward. This did not respond to risks which could arise from skin changes within the week.
- We saw a patient on the stroke ward with a Waterlow score of 24, indicating that they were at high risk of skin damage. This person was not on an air mattress, which would have helped reduce the risk of skin breakdown.
- Competency-based training had been put in place to help staff to identify and respond to deteriorating patients, and we saw modified early warning score (MEWS) assessments were in place and used. Appropriate responses were made to deteriorating patients. On the unannounced inspection an on-call doctor had been called for a patient with a MEWS score of 3.
- We found that the rehabilitation ward was compelled to admit patients who were not fit for admission, as defined by the Single Point of Access, Referral, Review and Co-ordination Service (SPARRCS). This meant that patients on the ward were more acutely ill than the ward was designed to manage. Medical staff told us this had not currently affected patient safety, but was a concern. Two patients told us they had been moved back to an acute ward, after arrival on the rehabilitation ward, to meet their medical needs. Our unannounced inspection found that medical outliers had not been admitted to the general rehabilitation ward in the last two weeks, but nine such patients were on the stroke ward.

Medical staffing

- The trust did not conduct a needs analysis or risk assessment to determine the medical staffing establishment.
- The medical staffing establishment for two 26-bedded wards was one full time consultant who was a rehabilitation physician, one part time consultant who was an elderly care physician, and one full time registrar and a foundation year 2 junior doctor (FY2). A foundation year 1 junior doctor (FY1) was also allocated to the general rehabilitation ward.
- Out-of-hours medical cover at registrar level, which was needed because of the level of acuity on these wards, was provided by the one on-call medical registrar who was providing cover to the whole hospital, including A&E and the Medical Admissions Unit.

Requires improvement

Community inpatient services

- The actual staffing level was lower because the registrar post had been vacant since February 2014, and cover was provided by a locum registrar contracted to work until 6 June 2014. The locum was not present on the wards on 6 June 2014; we saw that a 'borrowed' registrar, covering both wards, was in place from another specialty. The stroke ward had no medical cover in place on 4 June 2014 until 10 am.
- Trust-wide, the vacancy rate for registrars was 50%, and the department which managed the recruitment of medical staff has been subsumed in a recent restructure. Staff told us that the current service was not adequate and caused delays in recruitment
- The four additional beds were routinely filled on the rehabilitation ward, which meant that the medical staff were often providing cover to 56 patients. Our unannounced inspection showed this practice had stopped following our main inspection, and beds totalled 52.
- Staff told us that there was often insufficient medical staffing provided. There was insufficient medical cover to provide adequate support to the junior doctor covering the rehabilitation ward.
- Clinically inappropriate admissions were made of patients who were 'medical outliers'. They were more acutely ill than the ward was designed to manage. This meant that the junior doctor on the ward could be working outside their competencies.
- Insufficient medical staffing was affecting patient care on both wards. Medical outliers increased the acuity on the wards, and the consultant told us it reduced the time medical staff can spend on rehabilitation patients on both wards. Bed management records showed that 'medical outliers' were routinely placed on these two wards, with an average of seven on the rehab ward, and four on the stroke ward, over the four weeks up to 5 June 2014.
- Staff on both wards told us there were often long waits for doctors out of hours, and patients could wait an hour or two for the medical support they needed, because these wards were low on the priority list. When we asked a nurse on the stroke ward if they had enough medical cover, she said it depended how critical the condition of the patient was. A consultant in another specialty had reported a risk recently, when a very ill patient was placed on the stroke ward out of hours, because no medical staff were present. A meeting had been set up to discuss this incident but not yet held.
- Medical staff told us the admission of medical outliers on the two wards had not currently affected patient safety, but was of concern. A consultant told us "the current medical staffing is not sustainable for patient care and safety".
- The staffing levels, for the stroke and general rehabilitation wards, for the acuity of the patients, was potentially unsafe, and at our inspection we informed the trust that acutely ill patients should not be admitted to these wards.
- On our unannounced inspection on 21 June 2014 we found nine medical outliers on the stroke ward, eight of whom had arrived since the last day of our inspection on 5 June 2014. However, no new medical outliers had been admitted to the general rehabilitation ward; there were three medical outliers all of whom had arrived before 5 June 2014. On the rehabilitation ward a patient waited three hours for a response from the on-call doctor, but the registered nurse said it was not an emergency, and they would have escalated their request if it had been.

Nurse staffing

- The trust had not conducted a needs analysis or risk assessment, to determine the nurse staffing establishment. A needs analysis using the Shelford tool was undertaken for the first time in April 2014 as part of the trust's 'safer staffing' project, and proposals were being prioritised for implementation.
- The 'safer staffing' project for each 26-bedded ward showed that nurse staffing establishments, excluding the sister, needed to be 42.65 WTE on the rehabilitation ward, with a skill mix ratio of 56/44 registered to unregistered staff; and 38.96 WTE on the stroke ward, with a skill mix ratio of 60/40. Staff told us that the stroke figures had not been agreed by senior nurses responsible for the ward because of the higher acuity of patients. For example, patients often needed intravenous fluids, antibiotics and additional investigations which were not accounted for using the tool.
- The proposals required 21 additional Band 5 nurses for the rehabilitation ward. However, there had been no response to four recent advertisements for one Band 5 post. This corroborates information from the trust about wider problems with recruitment.

- The current establishments were 19-29% lower, at 33.07 WTE on the rehabilitation ward, with a skill mix ratio of 46/54 registered to unregistered staff; and 33.06 WTE on the stroke ward, with a skill mix of 61/39. There was a high use of bank staff on both wards.
- Planned and actual staffing numbers were displayed on the wards. The actual number and skill mix on both wards was lower still, because bank sources were unable to supply the staff requested to cover the four additional beds in use on the rehab ward, planned and unplanned staff absence, and requirements for all one-to-one staffing needed on both wards. Staff were also taken away from the wards by the requirement to accompany stroke patients for chest X-rays which had not been carried out before their arrival on the ward. This had occurred on 14 June 2014.
- Registered nurses were also taken away from the wards to provide cover to other wards. This occurred on four days during the week of 29 May 2014, and bank staff were unable to replace them, leaving the rehabilitation ward short staffed.
- Staff told us that often two registered nurses were caring for 30 patients on the rehabilitation ward, which included medical outliers with higher healthcare needs. This was 50% below the trust's proposed ratio of 1:8.
- Rehabilitation ward rosters for the last five weeks corroborated this. Twelve of 32 late shifts from 4 May had been staffed by two registered nurses, when three was the minimum required. On 30 April 2014, there were no additional nursing staff on duty all day for the additional beds in use on the rehabilitation ward. On 8 May 2014, the rehab ward was short staffed, with four medical outliers on the ward. Nine shifts were short-staffed on the rehabilitation ward in the two weeks from 27 April 2014. The same occurred in the following week of 11 May.
- Cover for one-to-one patient care was often not provided if more than one patient on the ward needed it. Two one-to-one shifts were not covered in the week of 11 May 2014 on the rehab ward when it had nine medical outliers. We also observed this during our announced and unannounced inspections.
- The use of the additional four beds on the rehabilitation ward, from 28 April to 5 June 2014, diluted the nurse staffing numbers further, posing further safety risks.
- Additional staffing could be booked for one-to-one care, 24 hours a day, when required. This gave staff some flexibility to respond to patients' needs. However, staff told us that if more than one patient on the ward needed this, it could often not be provided. For example, during our inspection, one patient on the rehabilitation ward was receiving one-to-one staffing, but the nurse bank could not provide this to a second patient waiting to be admitted from the stroke ward. This meant that patients' needs were not always met, and patients could be put at risk of falls, for example.
- Insufficient nursing staffing impacted on patient care. The acute nature of the stroke admissions, and patients who were medical outliers on both wards, put the nursing care provided by the low skill mix at risk of being unsafe. Records showed that referrals had been made appropriately for patients, but also that some assessments were completed inconsistently. We also saw there were not enough staff to provide one-to-one care to patients requiring this, and one of the inspectors on the unannounced visit was asked to keep an eye on one person for a few minutes when the nurse needed to deal with something else.
- The time available to the matron to carry out her role was impacted by the insufficient medical cover. Time was taken up finding and supporting junior doctors, and dealing with other matters, such as a problematic patient discharge we saw, which lay within the remit of the medical team
- On the unannounced inspection on 21 June 2014 each ward had two patients requiring one-to-one care. Only one extra member of staff had been provided by bank sources. Rostered nurses instead provided the one-to-one care, leaving the wards short for all other tasks. On the rehabilitation ward staff had been on duty from 7.30am to 9pm and, because of staff shortages, had only taken one ten minute break and a half hour lunch break each. On the stroke ward, a patient had climbed over their bedrails and had been wheeled around in a stroke chair by a trained nurse, so that she could carry out her duties whilst providing one-to-one care.
- Patients told us that they had to wait for call bells to be answered, for the toilet and sometimes in the toilet. They said there was only one staff member serving meals, and patients also had longer waiting times for meals.

Therapists staffing

- The skill mix on the ward included therapists and therapy assistants, staffed for 22 rehabilitation patients.

- There was no evening or weekend therapy, or dietician provision, and staff told us more cover was needed for annual leave and occupational therapy. Ward staff told us that these issues were reported as incidents, because nursing staff had no control over therapists who were managed separately.
- An extra occupational therapist and physiotherapist had been allocated to the wards with the winter pressures funding, and staff told us this had made a "very big difference" to patients, and reduced their length of stay in hospital.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff on the stroke ward told us that they had not had training on the Deprivation of Liberty Safeguards (DoLS), and had raised this on the ward for discussion.
- Senior nursing staff on the ward told us that the face-to-face safeguarding training covered DoLS training and the Mental Capacity Act 2005 (MCA 2005), but that most staff undertook the 20 minute e-learning course, not the longer, face-to-face course. The director of nursing told us there were plans to include DoLs and MCA 2005 within the mandatory safeguarding training.
- We saw from patient notes that the assessment and recording of patients' mental capacity was carried out. This was undertaken by the dementia nurse. A consultant told us that junior doctors did not feel comfortable making capacity assessments and, in practice, Band 6 nurses and above would carry these out. MCA 2005 e-learning is available, but optional, although there are plans to include this within safeguarding training for nurses.
- A doctor on the stroke ward told us they had sometimes used an independent advocate from the mainland, where this was needed for people who lacked capacity, and who had no friends or family to assist in making decisions in their best interest.
- Staff told us they verbally requested patients' consent for the use of CCTV on the wards, but patients' notes did not document this. A published contact point for access to information and complaints specifically regarding the CCTV was not displayed, which was against the CCTV Code of Conduct 2013.
- Matron and the divisional service manager agreed that consent was not routinely and systematically gained from all patients for their details to be displayed on a large screen visible to anyone entering either ward and that this needed to be rectified. Verbal consent was gained for the use of patient sensors if patients had mental capacity, but not otherwise. Senior nursing staff on the ward confirmed there was no policy which dealt with these issues.
- Our review of patient notes showed that therapists requested and recorded patients' consent to treatment.

Managing anticipated risks

- Senior nursing staff told us that risks and near misses were recorded on the trust's electronic reporting system, and this included concerns about insufficient medical and nurse staffing.
- The risks which could be anticipated from insufficient medical cover, and the impact of this on meeting patients' needs, had not been adequately considered and managed.
- The impact of closing two wards, and the continuous use of the additional four beds on the rehabilitation ward, had not been risk assessed adequately by the trust. This had led to the regular placement of medical outliers on the community inpatient wards, and insufficient staffing numbers and skill mix sometimes to meet patients' needs.
- A bed management meeting, held a few weeks before the inspection, discussed whether to reopen Newchurch Ward. There was concern because, when Appley Ward had previously been reopened, it had not been staffed. Other wards had to provide a nurse each to send to the ward to staff it, leaving their own wards short.

Major incident awareness and training

- The trust's business continuity process and policy was in place, and was last reviewed in 2012.
- The plan was available on the intranet, and staff were able to describe what should happen when, for example, a pandemic or a major vehicle accident occurred. Staff were aware of their roles and responsibilities.

Requires improvement

Community inpatient services

Are community inpatient services effective?

(for example, treatment is effective)

Requires improvement

Evidence-based care and treatment

- The wards were following NICE guidance. The stroke pathway started in A&E, and included assessment for thrombolysis, as well as a chest X-ray, a swallow assessment and CT scan.
- A stroke transient ischaemic attack (TIA) service was in place. At weekends there was a stroke nurse supported by the on-call medical registrar and carotid Dopplers were not available on Sundays. This meant that patients could not always access the care they needed. This service did not therefore meet the criteria of a TIA service.
- A dementia pathway was in place, and patients had a mini-mental state examination before arriving on these wards. If the assessment showed they were at risk of cognitive impairment, they were referred to the dementia liaison nurse, who arranged referrals to psychiatrists where appropriate. There were effective handovers between services.
- Therapists were using evidence-based and nationally-recognised assessment tools that were outcome-focused. There was also flexibility around the 40 minutes of therapy allocated each day to patients. This helped to ensure that evidence-based care was being provided to patients.
- Audits carried out on the general rehabilitation ward were displayed on their noticeboard, and included hand hygiene, infection control, catheter insertion and management, complaints, falls and pressure ulcers. We did not see a similar display on the stroke ward. The Trust told us this was due to the redecoration of the ward being undertaken at the time of the inspection.

Pain relief

- Patient notes we reviewed included assessment and monitoring of patients' pain score.
- CQC's 2013 adult inpatient survey showed that the control of patients' pain had improved in the last year, and was now average when compared to other trusts in England.

Nutrition and hydration

- Most patients we spoke with said they really liked the food and there was "lots of choice".
- Patients had access to a dietician five days a week.
- Mealtimes were protected, which meant that patients' nutritional intake was not compromised by interruptions.
- Staff told us that patients with dementia ate more since coloured plates had been introduced because the colour stimulated their interest.
- Patients with food and fluid monitoring needs were given a red serviette at mealtimes, to denote that recording was necessary.
- We saw completed food charts and malnutrition scoring charts in patients notes, which we selected at random. This shows that patients' nutritional needs were monitored as appropriate.

Patient outcomes

- Results from a 2010 Royal College of Physicians audit of falls showed that the trust performed well for 17 of 19 key indicators.
- Four of eight sets of patient notes on the stroke unit, which we selected at random, contained evidence of participation in the completed sentinel stroke national audit programme (SSNAP). This audits stroke care against evidence-based standards in eight key areas. The latest published results showed the trust had improved from the bottom 25% of all the 100 participating trusts in England in 2010 to the middle half in 2012.
- The community wards did not review readmission rates. This information was compiled by the patient information department, although it was available to the wards on request. Data we reviewed prior to our inspection showed that trust-wide unplanned readmissions to A&E were higher than average, and the trend did not seem to be seasonal. The wards would not be able to ascertain whether the patients they had discharged formed a proportion of these readmissions, and therefore whether discharge arrangements were effective.

Requires improvement

Community inpatient services

- The trust met its quality account target that 90% of patients aged 75 and over should follow the dementia pathway. This was applied to patients in the stroke and rehabilitation wards, as appropriate.
- Healthwatch had received positive feedback about the 'Alzheimer's café', which was in place at the trust.

Performance information

- In addition to safety thermometer data, the community wards monitored other key indicators, including patient falls. Sickness and the use of bank staff were also monitored, and were high on the stroke ward compared to target. Bank usage was 18.6% compared to a target of 5.7%. Sickness was 12.7% compared to 3%.

Competent staff

- There was insufficient support to newly qualified doctors on the wards, due to a shortage of more senior doctors.
- Staff told us that low nursing staffing levels meant that sometimes nurses were unable to attend training
- Nursing staff told us they did not have supervision, and four staff files we reviewed on each ward confirmed this. An unrecorded group supervision was held on the rehabilitation ward in May 2013, which three nursing staff attended.
- Yearly appraisals were broadly up to date. Four staff files reviewed on each ward included a check on competencies, identification of training needs, and the setting of objectives.
- Training was encouraged and undertaken on both wards. The matron had been undertaking training for Band 8 nurses and records showed nursing staff had undertaken a variety of mandatory training. Ward managers told us that therapists' take up of mandatory training was 95%, and nursing staff was 100%. Nurses undertook e-learning at home, and were given time back when this was mandatory.
- Competency-based learning had been introduced for registered nurses after the drug error 'never event', to improve the identification of pressure ulcers and the management of deteriorating patients. However, this training was not available for health care assistants, who observe patients more often than the registered nurses.
- We saw documentation which recorded inductions for bank staff onto the wards. For example, 10 forms were completed for the week ending 24 May 2014.

Multidisciplinary working and working with others

- We saw evidence of effective multidisciplinary working with social workers on the stroke ward, and proactive referral to district nurses for pressure area care on discharge. Patient notes selected at random evidenced the input of various therapists, and referrals to the dietician and multidisciplinary teams. An experienced discharge planning co-ordinator was in post on the rehabilitation ward.
- Ward staff could access community matrons directly, as well as equipment, including pressure relieving equipment, and wheelchairs to facilitate patient discharge. Staff told us that access to hospice care was much improved, and they could also use the palliative care team, which we also saw recorded in patient notes on the stroke unit. This showed the integration of care delivery.
- Patients on both wards could access psychiatric input via a psychologist in the first instance.
- Working with some of the other specialties within the hospital was less straightforward, with medical outliers being placed in the rehabilitation and stroke wards, often in the middle of the night.
- Patients transferred from other wards often arrived with inaccurate documentation, which indicated, wrongly, that they had been screened for MRSA and had undergone chest X-rays, for example. N
- To overcome this, nurses on both wards verified patient status by looking on ISIS and/or asking accompanying relatives.
- On our unannounced inspection staff told us they had received an instant response from the microbiologist when they had bleeped for advice about a patient.

Co-ordinated integrated care pathways

- There were good integrated pathways with community care. The rehabilitation ward's deputy charge nurse was a discharge co-ordinator, and this role helped to ensure that the ward staff started discharge planning on day one. This enabled effective progress towards completion of the patient's rehabilitation phase, which was a necessary extension to becoming 'medically fit'. This meant that discharge was planned, and patients and carers were prepared for care and support within the community environment.
- The wards worked in partnership with external agencies. Staff told us that commissioners had bought pressure

care mattresses for nursing and care homes when this became a barrier to discharge. The ward had lent a hoist, pending a purchase by a care home for deaf people, whose residents were now ageing. Patients were signposted to the council's reablement service, which was free of charge for six weeks.

Seven day services

- These two wards included stroke patients and medical outliers, some of whom were acutely ill. Doctors and therapists provided care and treatment five days a week, 9am - 5pm. Outside these working hours, cover was provided by the specialist registrar on call. This meant that these patients had no access to therapists out of hours, and could only access medical care via the one registrar who covered the whole hospital. Doppler assessments were not provided on Sundays. This meant that patients attending the stroke TIA clinic may not get the care they need at the weekend and out of hours.

Are community inpatient services caring?

Good

Compassionate care

- Patients told us they and their families were involved in goal planning. Patient records corroborated this on the whole.
- Relatives of a patient on the rehabilitation ward told us they felt that care had been excellent.
- Another patient told us ward staff scored "ten out of ten" for compassionate care.
- Ward staff told us that, where patients had no relatives, the occupational therapist would collect their clothes from home for them. This illustrated the caring attitude of staff.
- The latest Friends and Family Test in March 2014 surveyed 11 wards at the trust, including the rehabilitation ward. The response rate from the rehabilitation ward was relatively high, at 56%. This equated to 18 rehabilitation patients of whom nine said they were 'extremely likely' and three 'likely' to recommend the service to their friends and family. The rest were neutral or don't know.
- Patients spoke highly of the medical and nursing staff, and said they were treated kindly, and with dignity and respect, with some isolated exceptions.
- The system in place on the wards sounded only one patients' bell at a time, and there was no visible display to prioritise patient calls in order for their attention.

Dignity and respect

- We observed staff dealing with patients, and found them to be very aware of their needs and preferences.
- Interviews with patients and relatives corroborated this, with one or two exceptions.
- Matron told us that patients were sometimes accommodated in mixed sex bays on the stroke ward because the DH guidance did not apply to these patients. The guidance relates only to hyper-acute patients however which does not accurately describe the condition of all stroke patients on the stroke ward. DH guidelines note that greater protection should be provided where patients are unable to preserve their own modesty. Mixed sex bays mean people are not always afforded the privacy and dignity they are entitled to in hospital.
- We also observed mixed sex use of bathroom / toilet facilities on the rehab ward for women in a four bedded bay able to use the (nearer) male toilets opposite.
- Staff explained they did not put people of a different gender next to each other, and sometimes re-designated bathrooms so that patients could access them without having to pass through an area for members of the opposite sex.

Patient understanding and involvement

- Patients told us they were "very happy" with the care they received, and said they had been involved in their care, and with any changes to care. Another said that their daughter had been involved in their care, and they had found staff to be responsive to changes in their care needs.
- One of two sets of patients notes we selected at random showed evidence of a mental capacity assessment, and a best interest decision made for a patient, with appropriate involvement of patient representatives.
- Patient notes we reviewed were patient-centred.
- A relative told us they were "involved with care every step of the way" and it was "really good".

Requires improvement

Community inpatient services

Emotional support

- A patient told us that counselling had been made available to them following an incident.
- We saw from patient notes that self-care was promoted. This was corroborated when we interviewed the patient and their carer.
- Staff on the rehabilitation ward told us they encouraged friendships on the ward when they saw patients socialising with each other. They also referred people to Age UK's befriending service.
- Visiting hours on both wards were limited to two hours in the afternoon and an hour in the evening, with flexibility provided. This may not be sufficient however to provide for patients' emotional support. CQC received information about a distressed visitor not being able to gain entry to one of the community inpatient wards to support their relative. Ward staff agreed that visitors who did not realise they needed to phone in advance may not be able to gain entry at the door out of visiting times. Staff told us that this was because they sometimes could not answer the door in a timely manner which meant that a visitor may leave, having concluded they will not be allowed in.
- Both wards had an appointed activities co-ordinator, but currently there was only one available due to long-term staff sickness.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Service planning and delivery to meet the needs of different people

- Both community inpatient wards offer rehabilitation to patients who were medically fit, but required further care and treatment before they were safe to discharge. The SPARCCS team determined which patients were eligible, and patients could also be referred from their own home in the community.
- There were no criteria however, to determine the eligibility of non-rehabilitation patients transferred to the wards, and this was at the discretion of the bed manager.
- The number of medical outliers on the rehabilitation ward was reducing the amount of time that could be spent on providing rehabilitation care to patients. This did not allow effective time for rehabilitation or provide optimal care for medical patients.

Access to the right care at the right time

- The trust told us that bed availability had been good up until approximately six weeks prior to the inspection, when renovation work had closed 12 acute beds in the hospital. However, staff told us that over the last two years, two wards had closed, and four months of bed management data showed the number of medical outliers was continuously high. For half the days since 1 March 2014, there were more than 15 outliers trust-wide each day, with 16 to 32 on each day of the inspection. Staff told us that medical outliers were routinely admitted to the community inpatient wards, and a member of staff told us "it's been like this for as long as I can remember". Another said "patients are in the wrong place".
- The daily bed state data showed that, over the four weeks to 5 June 2014, the rehabilitation ward had up to 11 medical outliers each day, with an average of seven. This included a surgical patient on 20 May, and an orthopaedic patient on 11 May. The stroke ward had up to six medical outliers each day, with an average of four.
- The rehabilitation ward monitored the progress of patients on acute wards awaiting rehabilitation or transfers, for example, to community rehabilitation beds, when medically fit. Of the list of 19 patients on 5 June 2014, two were eligible for admission to the rehabilitation ward. One had transferred, three days after they had been assessed and accepted for rehabilitation, and one was waiting to be admitted from the community. On the same date bed management data showed five medical outliers were admitted to the ward because of the pressure on acute inpatient beds.
- Rehabilitation patients were given lower priority access to the two community wards than the medical outliers. However, bed management was also uncoordinated and patients requiring rehabilitation were on acute beds and acute patients were on the rehabilitation wards. Patients waited longer on acute wards for admission to the rehabilitation ward than necessary. The discharge co-ordinator told us that there were usually five or six rehabilitation patients waiting to come onto the

rehabilitation ward. This meant that patients waiting to come onto the ward for rehabilitation were not receiving the appropriate care from the time it was needed, which also delayed their discharge date.

- Patients had experienced many ward moves. For example, of seven patients we spoke with, three told us they had been returned to an acute ward after arriving on the rehabilitation ward, in order to meet their medical needs (two of the patients returned to an acute ward after having been on four other wards prior to settling in rehabilitation). One patient, who had returned to an acute ward, had five moves in 3½ weeks; two patients had each been on three wards before arriving in rehabilitation; one patient told us of several bed moves, but was not specific.
- We identified this concern to the trust, and on our unannounced inspection on 21 June 2014 no new medical outliers had been admitted to the rehabilitation ward, but there were nine on the stroke ward. The rehabilitation list showed that there were no patients waiting to move to the rehabilitation ward, from other acute wards, or from the community. One patient was waiting to move from the stroke ward. Eight patients who had been waiting had been accepted for community rehabilitation beds although their admissions had yet to be planned.
- Insufficient medical cover impacted on discharges on both wards, because patients had to wait for doctors to sign prescriptions for medicines to take out (TTOs), and to produce discharge summaries.
- In the stroke TIA clinic, which was on the general rehab ward, but covered by stroke ward staff, carotid Doppler machines were not available on Sundays. This meant that some patients could not get the treatment they needed.

Meeting the needs of individuals

- We found some patient notes contained the completed 'This is me' folder, which meant that staff took time to understand and record patients' preferences. This was particularly important for patients living with dementia.
- Staff told us that this folder was completed "when necessary". This meant that some people's preferences were not considered necessary, and had not been recorded. This was the case for a patient living with dementia, who told us that they could answer questions, given plenty of time. New staff taking over the care of this patient may not be aware that they needed to give them time to communicate effectively.
- Information leaflets were on display on the wards, including information, for example, on mixed sex bays. We also saw a small notice on the wall on the stroke ward, advertising interpreter services.
- Visiting hours had been flexed to allow families to visit a specific patient in line with their needs.

Moving between services

- Effective discharge planning from the community inpatient wards was facilitated by a discharge co-ordinator, and a weekly multidisciplinary team meeting on a Monday. A Parkinson's care co-ordinator had been newly appointed to respond to the larger number of newly diagnosed patients experienced by the rehabilitation ward. Staff told us they felt joint working was very effective.
- A daily discharge planning meeting was held on the wards Monday to Friday. In addition, a 'board' round was held daily at 9am, where every patient was reviewed by the doctor, nurse and therapists.
- Patients were not discharged at weekends, because there were no weekend ward rounds, and care homes and nursing homes did not accept weekend transfers. A senior member of staff told us of a premature discharge which had become a safeguarding issue. A patient had been discharged who did not have appropriate adaptations to their home. The patient was found not to have left their chair for six hours following discharge.
- Systems for monitoring discharged patients produced inconsistent data . Bed management had different data from the wards. This was because rehabilitation patients had been recorded as ready for discharge by bed management, because they were medically fit, but the multidisciplinary team had not completed their care and treatment enabling safe discharge into the community. For example, on 30 May 2014, a total of 41 patients were as having a delayed discharge but the ward told us this figure was incorrect; it was far too high.

Complaints handling and learning from feedback

- The trust told us that they received 23 compliments for every complaint received. We saw several thank you letters and cards to staff displayed on the wards during the inspection.

Requires improvement

Community inpatient services

- Data returns to the health and social care information centre showed that in 2012/13, 69% of the trust's 333 complaints were upheld. The Community Health Quality Report for the year 1 April 2013 to 31 March 2014 recorded four complaints and 19 concerns in respect of the community inpatient wards and TIA service. The directorate aimed to improve response by contacting the complainant shortly after the complaint was received, and creating a more personal approach whilst dealing with complaints.
- Information on how to complain was visible to the people using the service, along with the numbers of complaints and action taken. Staff told us there had been two recent complaints on the rehabilitation ward, and one on the stroke ward, and these were being investigated.

Are community inpatient services well-led?

Requires improvement

Vision and strategy for this service

- There was a strong desire by staff on both wards to follow the unwritten strategy for rehabilitation. It was not possible to comply with the strategy however, because of the routine admission of medical outliers, and the different policies and staffing arrangements required to support patients with different needs and acuity. This meant that the wards' rehabilitation aims were compromised.
- Staff felt that colleagues working in acute medicine did not understand the complexities of stroke and rehabilitation wards. They commented that patients were inappropriately transferred for rehabilitation as a result. This impacted on the ability of the ward staff to follow the strategy for their service, and to support people effectively for discharge.
- Appraisals included individual objectives, and referred to the trust's strategic objectives.

Governance, risk management and quality measurement

- The only systems used to regularly assess and monitor the quality of care people received from this service were the Friends and Family Test, and clinical governance meetings attended by the matron.
- Staff told us that they reported risks and recorded them on the risk register. This included the shortage of nurse staffing. Whilst there is some evidence that senior managers responded to risks and concerns, there is also evidence of a lack of effective, sustained action to mitigate longstanding issues, for example, relating to staffing levels and medical outliers. A four day bed closure had been authorised but this had been breached on the third day. The action was shortlived in the context of a longstanding problem, which continued following re-opening of the beds.
- Risks and issues were discussed every month at the Band 7's development day, and a list of concerns had been sent to the director of nursing. Concerns had also been raised via the assistant director and the deputy director, who had responsibility for the community inpatient wards. Matron also attended ad hoc meetings within the hospital as they arose, such as a bed management meeting several weeks ago to discuss delays and patient flow.
- Staff reported that the difficulty in recruiting consultants and medical staff had been highlighted at Board level, but no action had been taken.

Leadership of service

- The medical leadership on the wards was not responding effectively to risks and concerns. It was not clear, for example, how medical leads were raising awareness of the medical outliers and low medical staffing on these two wards. A meeting to be held shortly, had been prompted by a risk to a transferring patient, which had been raised by a consultant from another specialty. We also saw that medical leadership which was needed to resolve the transfer of a specific patient on the ward was absent, falling to nursing staff to handle. Consultants' time was short, however, because of the lack of medical cover on the wards.
- The risk to patients due to no out of hours medical cover on the ward had been escalated when the service manager phoned human resources for action. No action

resulted. We asked whether the board were aware of the medical outliers on these two wards and the implications for patient care. There were no minutes to demonstrate the issues had been raised.
- We were told by senior ward staff that junior doctors had written to the medical director about the lack of medical staffing on these two wards.
- Nursing leadership on the wards was mixed, and there was a lack of trust-level understanding of the issues faced by these two wards. Concerns with the lack of nursing staff for these wards, led to a decision being made on 29 May 2014 to close the rehabilitation beds to admissions from 30 May to 2 June, and to give priority to rehabilitation and stroke neuro patients. This action had followed from a request to the director of nursing. An earlier letter of concern had been sent by the service manager for community inpatient wards about their staffing levels. However, on Sunday 1 June, a medical outlier patient was again admitted to the rehabilitation ward. This meant that there was a lack of clear decision-making and leadership for these wards.
- The director of nursing told us that the new proposed staffing levels on both wards had been agreed. Senior nursing staff told us that the stroke ward staffing had not been agreed, because the higher level of acuity of patients on the stroke ward required a higher skill mix than proposed. This indicated a lack of clear communication and direction for the wards.
- Nursing staff were required to attend meetings with pressure area link nurses in their own time, in line with trust directives.

Culture within this service

- Staff on the wards were very proud of the care they offered stroke patients, and how much this had developed. But the ward's priorities of quality care for rehabilitation patients were compromised by other imperatives within the trust.
- Nursing staff were showing signs of reporting fatigue, in respect of inappropriate admissions and staffing levels, as they did not have confidence that action would be taken.
- Junior doctors had written to the medical director about the lack of medical staffing on these two wards, but improvements had not been made. Junior doctors reported high workloads and working under pressure.
- Many staff spoke of the perceived dominance of the acute hospital over community services. The NHS 2013 staff survey rated the trust worse than expected, or tending towards that, for 14 of 28 key findings. This covered acute and community staff, and responses indicated that staff felt pressured to work when they were sick, and staff felt bullied. The survey also highlighted perceived staff shortages, and that staff felt stressed.

Public and staff engagement

- Both wards undertook the Friends and Family Test, which meant that patients and their relatives were asked if they would recommend the hospital. The results were good and on display.
- Board minutes showed that patient and staff stories were tabled and discussed.
- Staff reported that senior management were not listening; there was often no response to their repeated notifications of risks relating to medical outliers and staffing levels, including emails and a letter. The response to close the additional beds on the general rehabilitation ward on 30 May followed from a verbal discussion with the Director of Nursing, the emails from 6 May to lower level managers not having resulted in action
- The chief executive had spoken directly to a complainant on the stroke ward, and her findings were reported at a Band 7 development day by the director of nursing, without first corroborating the facts with senior ward staff. The patient's relative, who was present at the incident, later confirmed that the patient had remembered the situation incorrectly.

Innovation, improvement and sustainability

- The wards repeatedly raised the risks associated with the sustainability of caring for high numbers of medical outliers on the wards. Risks were escalated, but no changes were made.
- It is not clear whether the safer staffing establishments proposed will be sustainable, given that the trust had received no responses to a recent recruitment campaign.
- Nursing leaders were aware of the need to improve pressure area care, and a pressure area action plan had been devised on 14 January 2014. An external review had taken place, and pressure ulcer prevention was a key quality account goal, with targets including no grade 4 pressure ulcers; 50% reduction in grades 1-3, and a 25% overall reduction in incidence.

Requires improvement

Community inpatient services

- The trust told us they had struggled to deliver their cost improvement programme last year. Staff told us that the impact of cost improvement changes on the quality of care did not appear to be understood by senior managers.
- The trust was not adhering to Department of Health (DH) guidelines for delivering single sex accommodation on the community wards. Capital development was planned to create single sex accommodation but was on hold for this part of the hospital for financial reasons.

This section is primarily information for the provider

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	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Care and Welfare of Service Users How the regulation was not being met: Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of: **Carrying out an assessment of the needs of the service user.** - An assessment of patients' skin condition was not made during the 'intentional rounding' introduced onto the stroke ward and the concept was applied only to selective patients - Inaccuracies and inconsistencies in patient records affected risk assessment scores which shaped care - Doppler assessments were not always carried out on patients with leg ulcers prior to use of compression bandaging **The planning and delivery of care and treatment in order to meet service user's individual needs, ensure their welfare and safety and reflect published evidence and guidance.** - Pressure ulcer risk assessments were updated at the weekend and therefore did not respond to any mid-week changes in patients' skin conditions - A patient with a Waterlow score of 24 was not on an air mattress. A patient was observed sitting on an 'inco-sheet' Regulation 9- (1)(a)(b)(i)(ii)(iii)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Cleanliness and Infection Control

How the regulation was not being met:

Service users, staff and others were not protected against the risks of acquiring a health care associated infection because:

- Appropriate standards of cleanliness and hygiene in relation to equipment were inadequately maintained on community wards. Damaged arms on stroke chairs in use exposed the foam and could harbour bacteria

- systems designed to assess the risk of and prevent, detect and control the spread of a health care associated infection were not effective:

- Community ward audits of infection control had not identified the risks from the stroke chairs

- Handover forms arriving with patients admitted to these wards did not accurately record the patients' MRSA status

- MRSA rescreening frequency was inadequate for the casemix on the wards

- The yellow bin outside the stroke ward was seen left open and unlocked

- A sharps box was seen left open

Regulation 12- (1)(2)(a)(c)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation

Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Safety, availability and suitability of equipment.

Suitable arrangements were not in place to protect service users and others from the use of unsafe equipment because:

equipment had not been properly maintained. Maintenance checks were behind for:

This section is primarily information for the provider

Compliance actions

- A hydraulic plinth in the rehabilitation gym, last maintained in June 2012

- Blood pressure monitors on the ward, last checked in 2011 and 2012

- 29 out of 55 items on the rehabilitation ward

- 16 out of 28 items on the stroke ward

- The system in use by the equipment store could not provide full assurance that 7 items on rehabilitation and 12 on stroke had been disposed of. Their last maintenance dates were some years ago.

Equipment was not available in sufficient quantities to ensure the safety of service users and meet their assessed needs:

- Too few working wheelchairs were available

- Too few fully working stroke chairs were available, which meant that staff had to find other ways to support patients' legs

A broken parallel bar in the rehabilitation gym had not been repaired or replaced and could not be used by patients

Regulation 16- (1)(a)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation

Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Staffing

How the regulation was not being met:

The health, safety and welfare of service users was not safeguarded because appropriate steps were not taken to ensure sufficient numbers of suitably qualified, skilled and experienced persons were employed

- There was insufficient medical and nursing staffing for the community inpatient wards, both numbers and skill mix.

- Patients could not access carotid Dopplers on Sundays in the TIA clinic

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	- The out of hours 'on call' district nursing service was not always staffed. Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Supporting workers How the regulation was not being met: Suitable arrangements were not in place to enable staff to receive appropriate training, professional development and supervision - Junior doctors did not have sufficient support or professional development as there were not suitable levels of medical cover and they did not have sufficient supervision to treat patients who were medical outliers - Ward and district nursing staff received no formal supervision - Band 7 nurses were sometimes unable to attend development days because of staffing levels - District nurses had not attended training, or update training, on Doppler assessment - Some school nurses were not enabled to obtain training and qualifications relevant to their role Regulation 23- (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

This section is primarily information for the provider.

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	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the Quality of Service Provision How the regulation was not being met: - Medical outliers on the community inpatient wards were not protected against the risks of inappropriate or unsafe care and treatment. There were no systems in place to identify, assess and manage risks relating to their health, welfare and safety and no systems to regularly assess and monitor the quality of service provided to them. - There were not established mechanisms to ensure that decisions in relation to the provision of care and treatment for service users who were medical outliers on community wards were taken at the appropriate level and by the appropriate person. - Medical and nursing staffing levels and skills mix on the stroke rehabilitation and general rehabilitation wards and on call district nurse service were not monitored appropriately to ensure that people did not receive inappropriate or unsafe care. - There had not been an adequate response to concerns raised by staff. The views of staff were not regularly sought to come to an informed view in relation to the standard of care and treatment provided to service users. - Risks as a result of the implementation of the IT project were not monitored at all times. - There was not effective implementation and monitoring of district nurse out-of-hours services. - There was not effective implementation and monitoring of staffing on the stroke rehabilitation wards.

This section is primarily information for the provider.

Enforcement actions

Regulation 10 - (1)(a)(b) (2)(b)(iv)(d)(i)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010