

Isle of Wight NHS Trust

Quality Report

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

Ratings

Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Good



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

The Isle of Wight NHS Trust is an integrated trust that includes acute, ambulance, community and mental health services. Services are provided to a population of approximately 140,000 people living on the Island, and St Mary's Hospital in Newport is the trust's main base for delivering acute services for the Island's population. Ambulance, community and mental health teams work from this base, and at locations across the Island.

We carried out this comprehensive inspection because the Isle of Wight NHS Trust is an aspirant Foundation Trust, prioritised by Monitor. The inspection took place on the 4, 5 and 6 June 2014 with an unannounced visit on 21 June between 4pm and 11pm.

We inspected the following core services:

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

Community health services for children, young people and their families, community adult services and community inpatient services.

Primary Mental Health Services, learning disability services, Children and Adolescent Mental Health Services (CAMHS), older adults, Acute, PICU and S136 Place of Safety, rehabilitation inpatient services, drug and alcohol services, community mental health and crisis resolution services.

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

Overall acute and community services were rated as 'requires improvement'; ambulance and mental health services were rated as 'good'.

Our key findings were as follows:

Overall, we found that staff were caring and compassionate, and treated patients and people using services with dignity and respect. Staff were highly motivated, and treated people as individuals. However, NHS Friends and Family Test results rated the inpatient

wards as lower than the national average, and people accessing community mental health services expressed some concern that they were less involved in their care, and had little information about services.

Staff followed good infection control practices, although for community inpatient services better MRSA screening was needed. The hospital was clean and well maintained, and infection control rates in the hospital were in an acceptable range.

The hospital monitored harm-free care in all in-patient areas, and had taken action which was reducing avoidable harms, such as pressure sores and falls.

Staff were aware of safeguarding procedures, and there were effective processes in all services to safeguard people from abuse or harm.

There were clear processes for taking people's wishes into account, and seeking their consent where they had capacity to do so. People who did not have the capacity to consent did not always have their needs considered in a safe and proportionate way, as not all staff were informed about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

The Mental Health Act Code of Practice was appropriately followed, although the trust was an outlier for second opinion appointed doctor (SOAD) requests, when there were treatment changes for service users.

Patients were not always appropriately identified for 'do not attempt cardiopulmonary resuscitation' (DNA CPR) orders. When the orders were used, decisions were not always clearly documented or reviewed, and were not always discussed with the individual or their family. In some ward areas, staff told us that this was being avoided, as there was a reluctance to have these conversations.

Incidents were reported, and lessons were learnt and shared across services, to minimise risks and prevent reoccurrences, but this was variable. We found examples of incidents that had not been responded to promptly or

Summary of findings

adequately, some areas did not share lessons, and staff in community mental health services were under-reporting incidents because of limited staff capacity within the service.

There were risk registers to monitor and take action on risks, but these were also not consistent. Risks were not always appropriately identified or escalated, there were concerns raised by staff where no action had been taken or had been delayed, and some risk registers had not been appropriately updated for months or, as in community health services and community mental health services, for years.

Staffing levels were not sufficient in all areas, and there were ongoing challenges in recruiting staff to work on the Island. Nurse staffing areas had been reviewed, but there were insufficient appropriate qualified staff in children's care in A&E, the acute services, community rehabilitation wards, district nursing and older adult mental health wards. Staff had reported concerns in these areas, and were disappointed that no action had been taken for some time. The succession planning in some services that would imminently be needed for sustainability, such as in maternity services, was not evident. The trust had recently signed off a recruitment plan, but the actions taken and updates were not well communicated to staff.

Medical staffing was a similar challenge for many specialities, and the trust had employed locums to cover vacancies. Some services were run by locums who had changed over several years, and this had not provided consistency of leadership or treatment for patients and services users. The trust was actively trying to recruit to these areas, but many staff told us about the inadequate and bureaucratic human resources processes within the trust. The current support, in terms of recruitment and retention, was causing delays and frustrations at a time when recruitment needed to be timely and exact.

The majority of people who used the services and staff said they felt safe; however, there were examples of people stating that at times low staffing numbers affected people's care and treatment.

In many areas, national guidelines and evidence-based practice were being used to treat patients. In pharmacy, ambulance and mental health teams there was innovative work to embed this practice, and outcomes of care were benchmarked and monitored to improve the

effectiveness of services. This approach was inconsistently applied in community health services, community mental health services, and in the acute hospital. For example, the trust had considered the relevance of National Institute for Health and Care Excellence (NICE) guidance, but this was not consistently implemented, monitored or adhered to. People accessing community mental health services were not monitored or reviewed appropriately, to assess their progress or recovery.

There was good multidisciplinary and integrated working, with GPs, community teams and social care teams, to support people at home, avoid admission to hospital, and support early discharge. There was also work with housing and employment teams, and with the police, in mental health services, to co-ordinate people's recovery, and support their independence and self-care. The trust was working to develop three locality-based integrated teams across the Island; teams and staff had said that this had already improved communication and joint working. However, community teams were under-resourced and there was ineffective caseload management and supervision; patients did not have appropriate assessment and care, and discharge was delayed for patients with complex needs.

In March 2014, the trust mortality rates were within the expected range; there were care bundles and pathways for emergency care prior to hospital, and in use in the emergency department. Patients who were acutely ill were appropriately escalated, but care pathways and bundles were not always followed through during their inpatient stay, for example, for sepsis care. Seven-day working was developing for emergency care and pharmacy support, but this was less well developed in other areas.

The trust was working to provide services to people on the Island, where this was economically viable and appropriate, to avoid the need for people to travel to the mainland. There were good examples of innovative practice, and the use of technology and staff working flexibly to share knowledge and skills, although systems to share learning needed to improve. There was effective working with mainland services, for example, in cancer multidisciplinary teams, but the trust needed to ensure that communication worked well across all these services.

Summary of findings

People received the right care at the right time. Ambulance services achieved national response times, patients were seen and treated in the A&E within four hours, people had surgery, diagnostic tests and outpatient appointments within national waiting times. However, in the acute hospital, the pressure on beds meant that patients were being moved several times for non-clinical reasons, and were not always on the correct ward for the care and treatment they required. Weekend discharges did not happen in some inpatient areas, or were not well co-ordinated with on-call community services. This had led to inappropriate arrangements of care, and possible readmission of these patients. There were long waiting times for assessment and treatment in community mental health teams.

The integrated nature of services helped to support the care of vulnerable people, for example, people living with dementia, and people with a learning disability. The specialist liaison was described as effective by staff. However, there were delays where staff had limited capacity, such as with the support that could be provided by the community psychiatric nurses in A&E to do timely assessments for people with a mental health condition. There was good access to advocacy services for people with a mental health condition.

There was a palliative care team to support patients who were coming to the end of their life. However, patients were not always being identified as being on an end of life care pathway in a timely manner, and did not always receive the care and support they required.

Complaints processes were understood by staff, patients and service users, and in many areas concerns and complaints were being used to improve services. The trust only responded to 44/93 (47%) of complaints (October 2013 to March 2014) within the 25 days target, or within agreed extended timescales.

The trust was developing IT systems towards an electronic records scheme. Where this was working well, it had a great impact, such as in A&E with GP practices. There was an ongoing programme to improve access and use IT across community services, and connectivity issues were a known challenge. Where implemented, the IT system was still not fully functional in community services, and incomplete electronic records created a risk. There were disjointed IT systems in mental health

and learning disability services, and this caused delays to care and treatment. In some areas there were fewer computer stations, and staff were often waiting to use the system.

The trust had a statement of vision and values, and many staff were aware of this, but not in all areas. There was a five-year strategy to develop integrated services across the Island, working across health and social care, and to develop sustainable quality care. This would mean expanding community-based services, the centralisation of some services, and developing clinical networks where specialist expertise was in the interest of patients and the prevailing economics of providing a service.

Many staff were not aware of the trust strategy, but could verbalise the strategic direction of their own service; but in many areas these were not devised or written, or considered in alignment with the trust strategy. Mental health services, for example, had little knowledge of why the trust had a clinical network with Hertfordshire. There was a trust strategic overview of the integration of services, but there was less operational support and direction to cope with service demands, resource needs, and manage effective integration within and across the divisions.

The trust had comprehensive corporate governance processes: there was a committee structure, reporting and review processes to monitor key performance indicators, incident, complaints and business risks, at trust level, and across the three divisions of acute care, planned care and community care. However, the trust needed better clinical governance and assurance system to have an overview of the actual quality and delivery of services and practice. There were examples of risks, clinical audit, reporting and learning from incidents, and use of national and evidence-based guidelines that did not happen appropriately, or at all.

The Island had a slow pace of life, and this was the culture within the trust. Some of the issues faced by the trust are as they were in the wider NHS a few years ago. Pressures in terms of bed capacity were not high comparatively, but were recent issues for the trust. The responsiveness of services needed to be better prepared for the service demands and pressures that, with an older population on the Island, will increasingly be experienced by the trust.

Summary of findings

Staff engagement did not happen effectively. The trust leadership team and senior managers were changing services and policies, but these were not effectively implemented. Communication came down from the trust leadership, but change happened without effective consultation or discussion. Staff at all levels and in all parts of the organisation told us that they were not being listened to, and there were predictable problems because of this. There were many examples where implementation of change did not happen effectively, and was not monitored appropriately, and this was increasing the risk to patients. There was low morale in the pathology services where service reorganisation and work pressures were affecting staff, and they felt that they had little knowledge, communication or ability to influence decisions.

Many staff in ambulance, community and mental health services described a disconnection with the trust, and considered they had a low profile compared to the acute service. They felt like it was an acute trust with satellite services, and the leadership of the trust did not reflect the complexity and integrated nature of its services.

There were several issues where we were concerned enough to ask the trust to take immediate action.

The paediatric emergency admission pathway required a single agreed point of entry for paediatric admissions. The current criteria of medical / surgical patients to the paediatric ward, trauma patients to A&E, and babies under 14 weeks to the neonatal unit, was confusing (and had caused confusion) for hospital and ambulance staff. There had been two serious incidents prior to this, with ambulances being redirect with children who required emergency care. During our unannounced visit, we found that the trust had implemented a single point of entry, and all children now had emergency care in the A&E. The proposals had previously been discussed with the paediatric team but the immediate change had not been done in consultation with paediatric teams; it did not take account of children who had previously had direct access to the children's ward and staffing levels on the paediatric wards. The risks in terms of delays to treatment still remained for some children.

Staffing levels on the stroke rehabilitation and general rehabilitation wards were unsafe, and the stroke unit was a concern. There were inappropriate numbers of medical and nursing staff, and stroke patients received

inconsistent care, and risks were not being managed appropriately. The ward also had medical and surgical outliers, and staff did not have the appropriate numbers, experience and skills to also care for acutely ill patients. There were patients requiring rehabilitation on other wards in the hospital who should have been on this ward. The admissions to the ward were not organised. The trust informed us that they had stopped medical outlier admissions to the ward, and were reviewing staffing levels. During our unannounced visit, we found that the trust had restricted medical outliers to the general rehabilitation ward, but outliers still remained on the stroke rehabilitation ward. Staff were still under pressure and had not had breaks. They could struggle to cope when a patient required one-to-one care, and an elderly patient was being wheeled around in a chair, as this was the only way nurses could observe them.

In adult community services, district nurses worked as lone workers from 8pm to 8am, and were at risk in terms of protection and security. This issue has been highlighted as a risk, but no action had been taken. The nurses were also identified as recently qualified or inexperienced (Band 5) nurses, who did not have the appropriate experience and skills for the decisions that they were being asked to make, such as to triage patients, and determine appropriate levels of care. The trust informed us that they had introduced an on-call senior district nurse and hospital at night team support for the district nurse on-call. During our unannounced inspection, we found that there was no district nurse on-call, and ambulance staff had only been informed at 8pm that night. There was no senior nurse on call, and the hospital at night team were not aware of the support they should be providing to the district nurse service. Patients who could be treated in the community, had delays to treatment and had to attend A&E.

The medicines kept in the ambulance station were kept at an inappropriate temperature. The temperature in the room was above 29 degree Celsius (and could get higher because of the radiator and computer equipment in the room). The drugs should be kept at 25 degrees Celsius or below; one drug should have been refrigerated. The ambulance station did not have a system for stock control, so even though drugs were within their expiry date, the drugs stored the longest were not always the first to be used. The heat degradation would mean that the efficacy of the medication would be reduced. The

Summary of findings

trust told us that they had put an air conditioner in the ambulance station room, to keep the medicines cool. During our unannounced visit we found that medicines were appropriately stored at the correct temperature, and the stock had been reduced. However, we found that records of the temperature in the room were not kept, and there had not been a risk assessment done for the movement of IV fluids to another storage area.

The A&E had a non-clinical screener for patient attenders. The receptionist in A&E was determining where patients went for assessment. Triage was not undertaken by a nurse or doctor. The trust told us that this practice had ceased, and assessment and triage was now undertaken by a trained nurse. During our unannounced inspection we found that triage was being undertaken by a nurse, but patients were waiting over an hour to be assessed and triaged. Patients were being assessed in order of attendance, and there had been no triage of patients in terms of priority.

We have served a warning notice under Regulation 10 (Assessing and monitoring the quality of service provision), because there was a lack of effective implementation and monitoring of quality and risks in services.

We saw several areas of outstanding practice including:

Trust-wide

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, tele-care 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. There were 64 staff located at the Integrated Care Hub, including switchboard, call handlers, dispatchers, clinical advisors, and operational and clinical managers. Key services were accessed out of hours through the Hub. The Hub was effective in ensuring that patients had timely access to appropriate services, avoiding unnecessary admissions to hospital, and delivering better outcomes for patients.

The pharmacy service was operational seven days a week. The service was innovative, and worked effectively

within multidisciplinary teams to improve patient care. For example, electronic prescribing had reduced medication errors, and was being used to ensure that venous thromboembolism risk assessments occurred. The service offered an advice line, and was involved in the pre-admissions initiation of antibiotics with ambulance services.

The trust was developing integrated information systems, and was working towards electronic patient records. There was connection between the A&E and ambulance services, and local GPs.

Acute and Ambulance Service

There was evidenced based care for orthopaedic patients having hip and knee operations.

A widely shared care network for managing children with the most complex and rare conditions had enabled families to be supported and treated closer to their homes. It also enabled access to the best possible advice for these families. For example, the children's ward was a Level 1 Paediatric Oncology Shared Care Unit, and could also offer care to visitors to the Island with oncological problems.

Ambulance staff used electronic tablets to enable operational staff to complete their e-learning.

The ambulance service was participating in a trial in early intervention in sepsis, jointly with another ambulance service. The aim was to identify patients who might have sepsis, and to reduce their mortality through early intervention prior to admission to hospital.

The Individual Learning Plan (ILP) had been developed and implemented to support the development of staff competency in the ambulance service. This was introduced in 2014, and staff were given learning objectives and were required to demonstrate learning as part of their continuous professional development.

Community Mental Health Services

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.

Summary of findings

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 were identified 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 demonstrated a good background knowledge of families and children, as well as areas of higher risk in different localities across the Island.

Effective multidisciplinary working and communication, both within the service and with other health and social care professionals, was evidenced.

Mental Health Services

Primary mental health services teams provided and referred people for a range of evidence-based psychological therapies, on both a group and individual basis.

The service had developed new and innovative services to protect vulnerable people, and reduce the use of the Mental Health Act. One example of this was 'Operation Serenity', where there was joint working with the police, to treat people at home, or in the community. This had reduced the use of the S136 Place of Safety, and decreased the number of people having to be detained under the Act.

The Learning Disability Service was innovative in its use of assistive technology, to help people with communication difficulties, to encourage their choices and preferences.

The Drug and Alcohol Service had introduced a range of health promotion measures, and had integrated its work with GPs. Service outcome measures were used to improve the service.

The outside garden space on Afton Ward for older adults was funded and developed by staff. The garden was gender-specific, and had a quiet and restful area, as well as areas that encouraged activity and learning. It was described as inspirational by people and their families.

On the acute, PICU and Rehabilitation wards (including S136 Place of Safety) there was effective debriefing for staff following incidents, and staff shared lessons learnt in team meetings. Reflective practice was provided to staff through a skilled psychologist.

There was effective use of the wellness recovery action plan (WRAP) for patients on the acute, PICU and Rehabilitation wards (including S136 Place of Safety). Discharge planning started on admission and the discharge tree was used on the PICU. The wards had excellent relationships with housing and employment services.

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

Importantly, the trust must ensure:

Trust-wide

The clinical leadership of services improve, and there must be operational support and co-ordination to cope with service demands and to manage effective integration.

Staff engagement is effective, so that service changes and developments are owned and effectively implemented, to reduce risks to patients and people that use services.

Complaints need to be responded to within 25 days, or agreed timescales.

Summary of findings

Acute and Ambulance Services

Staff receive training on the Mental Capacity Act 2005 and the Deprivations of Liberty Safeguards. The principles must then be applied to ensure that where people do not have capacity to consent, the correct procedures are followed.

Staff are competent in how to recognise when a patient is on an end of life journey, so that decisions are made and their care managed appropriately; the trust must ensure that staff have received the appropriate training, and understand the tools available to them. This includes the use of the AMBER care bundle, and the use of syringe drivers.

'Do not attempt cardio pulmonary resuscitation' (DNA CPR) orders must be completed in their entirety, in a timely manner, for all patients where this decision has been made. There must be clear documentation as to how this decision was reached.

Risk assessments in relation to patient care must be completed, and used to inform the patient's plan of care.

All patients have a named consultant for the duration of their stay, with clear referral and acceptance criteria when there is a change in consultant for clinical needs.

The provision of care is reviewed for patients who have had a stroke, to ensure that the pathway is fully reflective of national guidance.

National guidance is reviewed, gap analysis completed, and improvement plans put in place and monitored where required, to ensure that practices are in line with nationally-recognised guidance.

The trust must ensure there is a lead nurse qualified in the care of children (RN(children)) and sufficient registered (Children) nurses are employed to provide one per shift in emergency departments receiving children as per Standards for Children and Young People in Emergency Care Settings 2012.

There is a single point of access for children in an emergency situation. Short-term measures should be safely implemented while long-term plans are developed.

The nursing staff provision is reviewed within the Accident and Emergency Department and the Stroke ward, to ensure that they are staffed to the agreed establishment and skill mix, in line with current guidance.

There is an effective and safe procedure for the obtaining, recording, handling, using, safe keeping, and dispensing of medicines used by the ambulance service.

Community Health Services

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 is 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 ensure 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, the needs of 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 must be monitored. Patients placed on the stroke rehabilitation and general rehabilitation wards must meet the criteria for admission, so that they can benefit from the services offered.

Staff receive regular supervision and this includes bank staff.

Doctors are offered adequate training, and sufficient staffing needs to be in place to enable medical and nursing staff to attend all teaching and development sessions.

Summary of findings

Infection prevention and control measures 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 must be kept locked at all times; sharps boxes must always be left closed; and patients must be given appropriately 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 must be regularly checked and appropriately maintained.

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. Patients with pressure ulcers must have appropriate and timely reassessment on the stroke ward, action must be taken and recorded in response to patients' skin changes, and all patients must have use of a pressure-relieving mattress where assessments indicate this is required. The use of inco sheets for pressure ulcer care needs to be reviewed.

Staff request and record patients' written consent to the display of their details on the computerised screen on the wards.

Wards display a contact point for access to information and complaints regarding the use of CCTV on the wards.

The trust must update the DNA CPR policy, and ensure wards audit their adherence to this policy.

Mental Health Services

Risk management and care planning in people's records in the Community Mental Health Team must be improved. Records were not reviewed consistently or updated in a timely manner.

The caseload management and line management supervision of caseloads in the Recovery and Rehabilitation Team are regularly undertaken to identify issues that may impact on care delivery and quality.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Isle of Wight NHS Trust

The Isle of Wight NHS Trust provides an integrated acute, community, mental health and ambulance health care service to the population of the Isle of Wight. It was established in April 2012, following the separation of the provider and commissioner functions within the Isle of Wight Primary Care Trust.

The Isle of Wight NHS Trust provides services to 138,265 people on the Island, and employs around 3,038 staff. The main trust services are located at St Mary's Hospital, a 246-bed general hospital, based in Newport.

The trust board had not changed significantly in the last 18 months. The chief executive had been in post since 2012. The director of nursing and workforce was appointed in January 2013, and a director of planning, ICT and integration was appointed in January 2014.

The trust has been selected for inspection under CQC's revised inspection approach, as it is an aspirant Foundation Trust, prioritised by Monitor. CQC's latest Intelligent Monitoring tool identified the trust in band 5 (Band 1 being the highest prior for inspection and band 6 the lowest priority).

The inspection team inspected the following core services at the Isle of Wight NHS Trust:

Acute Services

- Accident and Emergency

- Medical care (including older people's care)
- Surgery
- Intensive/Critical care
- Maternity and Family Planning
- Children and young people's care
- End of life care
- Outpatients

Ambulance services

Community Health Services

- Community Health Services for Children, Young People and Families
- Community Health Services for Adults
- Community Inpatient Services

Mental Health Services

- Primary Mental Health Services
- Learning Disability Services
- Children and Adolescent Mental Health Services
- Older Adults
- Acute, PICU and S136 Place of Safety
- Rehabilitation Inpatient Services
- Drug and Alcohol
- Community Mental Health
- Crisis Resolution

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 Radiologist

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The teams 79 people 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.

In the acute services, our specialists included: a midwife; obstetrician; emergency department consultant; an anaesthetist; a critical care nurse; consultant surgeon; a theatre co-ordinator; junior doctor; student nurse; physiotherapist; two medical consultants; paediatrician; nurse qualified in the care of sick children; head of clinical quality; general nurse; medical director; an emergency department nurse; an expert by experience; a paramedic and an ambulance service director.

In community health services, our specialists included: a school nurse, health visitor, sexual health specialist,

Summary of findings

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.

In mental health services, our specialists included: a consultant psychiatrist, specialist advisor in patient

advocacy, Mental Health Act Commissioner, specialist advisors in mental health nursing, specialist advisors in occupational therapy, a specialist advisor in learning disability, and a consultant psychiatrist in CAMHS.

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?

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

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

We carried out an announced inspection visit on 4 to 6 June 2014. We spoke with a range of staff in acute services within the hospital (including nurses, junior

doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assailants, pharmacy technicians and pharmacists); in the ambulance service; in mental health services (including consultants, junior doctors, approved mental health practitioners); and in the community health services (consultants, junior doctors, health visitors, community midwives and district nurses). We also spoke with staff individually as requested.

We talked with patients and staff from ward areas, outpatient services, and in clinics in the community. We also spoke with the members of the patient's forum, and one of the support groups. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

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

We would like to thank all staff, patients, carers and other stakeholders, for sharing their balanced views and experiences of the quality of care and treatment at the Isle of Wight NHS Trust.

What people who use the trust's services say

We held a public listening event in Newport on 2 June 2014, and we spoke with approximately 55 people. People told us that they had experienced excellent care in the breast cancer services, maternity services and drug and alcohol, and family support services. They also talked about the joined-up cancer pathway, and a good experience of end of life care. However, many people also

raised concerns about the lack of response for service users in mental health crisis, poor experiences of end of life care, lack of joined-up pathways for patients having to travel to Southampton or Portsmouth for treatment, poor staffing in A&E and in ward areas, safeguarding concerns

Summary of findings

when Deprivation of Liberty was not understood or had gone unreported, long waits for ophthalmology surgery, and poor responses to complaints in terms of timelines and inadequate replies.

During the inspection we left comment cards in wards, outpatient areas and community clinics for people using services to complete. There were positive comments for maternity services and surgery, but negative comments about the outpatient environment in ophthalmology. The majority of comments were for mental health services, and these were negative, referring to oppressive and controlling services. This was not the experience, however, of the people we spoke with during our inspection.

The results of the Friends and Family Test (FFT) for December 2013 to March 2014 showed that the trust scored below the England average for all four months on the inpatient wards. The A&E scores showed that the trust was performing above the England average for all four months. Response rates were above the England average, but were decreasing across the four month period.

The CQC adult inpatient survey (2013) demonstrated that the trust had performed within expectations for all 10 areas of questioning. The trust was worse than expected for the question 'do you think the hospital staff did everything they could to help control your pain?' although this had improved compared to the previous year's result.

The Cancer Patient Experience Survey (CPES) by the Department of Health, is designed to monitor national progress on cancer care. One hundred and fifty two acute hospital NHS trusts took part in the 2012/13 survey, which comprised of a number of questions across 13 different cancer groups. Of the 69 questions, for which the trust had a sufficient number of survey respondents on which to base findings, the Isle of Wight NHS Trust performed better than other trusts nationally for 14 questions, and worse than other trusts for 21 questions.

The CQC Survey of Women's Experiences of Birth 2013, showed that the trust was performing about the same as other trusts on all questions on care, labour and birth, staff during labour and birth, and better than other trusts for care in hospital after birth.

Patient-led assessments of the care environment (PLACE) were self-assessments undertaken by teams of NHS and independent healthcare staff, and also by the public and patients. They focused on the environment in the acute hospital. In 2013, the trust scored higher than average for cleanliness (98.4%), privacy, dignity and well-being (88.9%), and facilities (92.6%), but below the national average for food and hydration (78.1%).

The Community Mental Health Survey 2013 relates to a survey of persons over 18 years who were seen by the trust between 1 July and 30 September 2012. The response rate was the same as the national average at 29%. Of the 23 questions reviewed, 17 were similar to the England average, and these included questions on help and support, and the role of their care co-ordinator. Three questions were an 'elevated risk', and all related to the quality of information provided to respondents about new medications. Two questions were identified as a 'risk' and related to respondents not having a care review in the last 12 months, and to receiving assistance from mental health services in getting help with finding/keeping work. The trust was better than expected for respondents being able to identify who they could contact for out-of-hours support.

The Isle of Wight NHS Trust had 67 reviews on the NHS Choices website. It scored 3.5 out of 5 stars overall. There were nine comments which were rated as five stars, and 20 rated as one star. The highest ratings were for excellent specialist care, and care in A&E, competent staff, caring, efficient, and timely day surgery. The lowest ratings were for upsetting treatment of cancer patients, lack of ensuring patient hygiene, awful care, lack of concern towards sick patients, unsuitable waiting times, and poor treatment from A&E staff.

During our inspection, patients and service users told us that they were treated with compassion, dignity and respect. They spoke highly of staff, and told us they were given enough information and were kept informed. This was not the experience, however, of people using community mental health services, who told us they would have liked more involvement and information about the service.

Summary of findings

Facts and data about this trust

Isle of Wight NHS Trust: Key facts and figures

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

- **Acute Care Services** – Services include A&E, the Beacon Centre (providing walk-in access to GP services), emergency medicine and surgery, planned surgery, intensive care, comprehensive maternity, NICU and paediatric services. A number of planned care services, including chemotherapy and orthopaedics, are also delivered.
- **Community Care Services** – Care services include district nursing, health visiting, community nursing teams, a primary dental care service and orthotics, as well as inpatient rehabilitation and community post-acute stroke wards.
- **Mental Health Services** – The portfolio includes specialist CAMHS, Tier 3 Drug and Alcohol Service, Early Intervention in Psychosis and Memory Service, and intensive outreach service for residential and nursing care homes.
- **Ambulance Service** – The Island's ambulance service delivers all emergency and non-emergency ambulance transport for the Island's population. The service operates from a single base across the Island. The service is also responsible for transporting patients to mainland hospitals.

1. Context

- The hospital had around 246 beds.
- The island population is around 138,265 of which 20% is urban, 80% rural.
- Deprivation is lower than average, but varies (126 out of 326 local authorities). About 4,900 children live in poverty.
- The proportion of people aged over 50 years is greater than that of England and the proportion of people between 0 – 49 is less than that of England.

- Life expectancy for men is not significantly different from the England average, but is significantly better for women.
- The number of staff was 3,038.
- The annual turnover (total income) for the trust was £169 million in 2012/2013.
- The trust surplus (deficit) was £509,000 for 2012/2013.

2. Activity

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

3. Bed occupancy

- General and acute: 79.4% (October–December 2013). This was below both the England average of 87.5%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Maternity was at 19.9% bed occupancy – lower than England average of 58.6%.
- Adult critical care was at 77.8% bed occupancy – lower than England average of 85.7%.
- Neonatal Intensive Care Unit was at 0.0% – lower than England average of 71.0%.

4. Intelligent Monitoring

Acute Safe

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

- Domain score: 2

Effective

- Risk: 1

Summary of findings

- Elevated: 0

- **Domain score: 1**

Caring

- Risk: 1

- Elevated: 0

- **Domain score: 1**

Responsive

- Risk: 0

- Elevated: 0

- **Domain score: 0**

Well led

- Risk: 1

- Elevated: 0

- **Domain score: 1**

Total

- Risk: 3

- Elevated: 2

- **Domain score: 5**

Mental Health Safe

- Risk: 1

- Elevated: 0

- **Domain score: 1**

Effective

- Risk: 0

- Elevated: 0

- **Domain score: 0**

Caring

- Risk: 0

- Elevated: 0

- **Domain score: 0**

Responsive

- Risk: 1

- Elevated: 0

- **Domain score: 1**

Well led

- Risk: 1

- Elevated: 0

- **Domain score: 1**

Total

- Risk: 3

- Elevated: 0

- **Domain score: 3**

Individual risks/elevated risks

- **Elevated risk:** Proportion of patients risk assessed for venous thromboembolism

- **Risk:** Dermatological conditions

- **Risk:** CQC survey – pain control in hospital

- **Risk:** GMC National Training Survey - Trainees overall satisfaction

- **Risk:** Proportion of SOAD requests (detained patients only) when significant change made to treatment (SOAD: second opinion appointed doctors, relating to the Mental Health Act)

- **Risk:** Users on new Care Programme Approach (CPA) that have not had a Health of the Nation Outcome Scales (HoNOS) assessment in the last 12 months

- **Risk:** Proportion of those on CPA reviewed in at least the last 12 months

- **Risk:** Proportion of service user requests that have waited more than 28 days from referral request to received date, to date of first treatment

5. Safe

'Never events' in past year

1 (January 2013 to March 2014). No evidence of risk

Serious incidents (STELs)

Summary of findings

78 (April 2013 to March 2014) – 30 Acute, 29 Community; 10 mental health services: 56% of these were for pressure ulcers

National reporting and learning system (NRLS)

March 2013-February 2014. No evidence of risk

Death

- Acute: 11
- Community: 1
- Mental health: 6

- Total: 18

Severe Harm

- Acute: 48
- Community: 26
- Mental health: 6

- Total: 80

Moderate Harm

- Acute: 83
- Community: 24
- Mental health: **13**

- Total: 120

Totals

- Acute: 142
- Community: 51
- Mental health: **25**

- Total: 218

Safety thermometer (March 2013 – February 2014)

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

Infection control (April 2013 – March 2014)

- 6 cases of Clostridium Difficile – No evidence of risk

- 3 cases of MRSA – No evidence of risk

Safety Mental Health Services: Within expected limits

- Elevated risks for proportion of SOAD requests (detained patients only) when significant change made to treatment
- Better than expected: episodes of absence without leave (detained patients)
- Excellent: Accreditation status by Royal College of Psychiatrists for ECT service

6. Effective

- Hospital Standardised Mortality Ratio (HSMR): No evidence of risk (Intelligent Monitoring)
- Summary Hospital-level Mortality Indicator (SHMI): No evidence of risk (Intelligent Monitoring)
- Mortality Outlier: Composite indicator: In-hospital mortality – Dermatological conditions
- Mental Health Service minimum dataset - No evidence of risk except – elevated risk for proportion of users on new Care Programme Approach (CPA) that have not had a Health of the Nation Outcome Scales (HoNOS) assessment in the last 12 months; risk for proportion of those on CPA reviewed in at least the last 12 months

7. Caring

- CQC inpatient survey (10 areas): Within expected range all areas
- FFT inpatient (March 2014): Below the England average
- FFT A&E (March 2014): Above the England average
- Cancer patient experience survey (68 questions): Highest scoring 20% of Trusts for 19 questions; average for 28 questions; and lowest scoring 20% of trusts for 21 questions
- Mental Health National Survey 2013 (36 questions): 9 questions better than average; 27 average

8. Responsive

- A&E 4 hour standard: mostly better than England average during the course of the year (2013/14)

Summary of findings

- Emergency admissions waiting 4–12 hours in A&E from decision to admit to admission: worse than England average
- A&E left without being seen: below the average
- Cancelled operations: similar to expected
- Delayed discharges: similar to expected
- 18 week referral to treatment time (RTT): 89% (slightly below the NHS operating standard of 90%)
- Mental Health Act services database: similar to England average
- Ambulance response times (January 2014 – March 2014): targets met
- No evidence of risk for indicators above.

9. Well-led

- NHS Staff survey (28 questions): Better than expected (in top 20% of trusts) for 4 questions; tending towards better for 5 questions; similar for 5 questions; tending towards worse 4 questions; worse than expected (in bottom 20% of trusts) for 10 questions.



- Sickness rate 3.7 % (below 4.1 % which is the England average)
- No evidence of risk for indicators above.
- GMC National Training Scheme Survey (2013): The Trust was worse than expected in one or more section of the GMC survey for Endocrinology and diabetes mellitus; gastroenterology; General Practice; General surgery; Obstetrics and gynaecology and Trauma and orthopaedic surgery. The Trust was better than expected for local teaching in acute internal medicine and General psychiatry)

10. CQC inspection history

- Four inspections at the trust since its registration in April 2012.
- St Mary's Hospital inspected in March 2012 and January 2013. The hospital was compliant on the most recent inspection.
- Sevenacres (inpatient wards) inspected in October 2013 and March 2014. The hospital was compliant on the most recent inspection.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Overall, we rated the safety of services in the trust as 'requires improvement'. For specific information, please refer to the acute services report, community health services report and mental health services report for the Isle of Wight NHS Trust.</p> <p>Nurse staffing levels had been reviewed in services, but these were not being monitored effectively to ensure safe staffing levels and appropriate staff skill mix, particularly in acute and community services. Medical staffing levels, particularly out of hours and at the weekend, were impacting on patient care. Acutely ill patients were appropriately escalated, and we observed good, informative medical and nursing handovers. Infection control was appropriately managed, although community inpatient services needed to do better screening for MRSA. Equipment was not well maintained, or regularly checked across services, and there were not adequate levels of equipment in community services. Standards for medicines management were good, except in the ambulance service.</p> <p>Incidents were reported. The trust had a newsletter which provided monthly updates on lessons learnt from incidents, but many staff said that they did not receive feedback or information on lessons learnt for their areas. We found examples of incidents that had not been responded to promptly or adequately, some areas did not share lessons, and staff in community mental health services were under-reporting incidents because of limited staff capacity within the services.</p> <p>Action was being taken to ensure harm-free care and reduce avoidable harm, such as pressure ulcers and falls. There were well established safeguarding procedures for both children and adults. Patients were not always appropriately identified for 'do not attempt cardio pulmonary resuscitation' (DNA CPR) orders. When the orders were used, decisions were not always clearly documented or reviewed.</p>	<p>Requires improvement</p> 
<p>Are services at this trust effective?</p> <p>Overall, we rated the effectiveness of services in the trust as 'requires improvement'. For specific information, please refer to the acute services report, community health services report and mental health services report for the Isle of Wight NHS Trust.</p> <p>Patients were treated according to national evidence-based guidelines, and clinical audit was used to monitor standards of care;</p>	<p>Requires improvement</p> 

Summary of findings

however, these were not consistently applied. There was evidence that national guidance or programmes were not implemented or followed across all services, and clinical audit was not routine in many areas to monitor and ensure adherence to standards. Seven-day services were developing for emergency care in acute and community services, and crisis services in mental health, but had not consistently developed elsewhere.

Overall, there were good outcomes for patients, for example, in surgery and in mental health services, which were effective in developing and monitoring outcome measures to improve services. Staff worked in multidisciplinary teams to co-ordinate care around the patient, and many services were integrated across health and social care.

Staff were encouraged to learn and improve, but this was not apparent in all areas, where capacity issues were affecting time available for learning and development. There were good examples of clinical supervision and reflected practice in places, particularly in mental health services, but this again was not consistent or fully developed across the trust. Some areas in acute and community services did not have supervision, or the frequency of supervision was insufficient to ensure staff had appropriate skills, and that caseloads were appropriately managed to risk assess and treat patients.

Are services at this trust caring?

Overall, we rated the caring aspects of services in the trust as 'good'. For specific information, please refer to the acute services report, community health services report and mental health services report for the Isle of Wight NHS Trust.

Patients and service users received compassionate care, and we saw that patients were treated with dignity and respect. Patients, service users and relatives we spoke with said they felt involved in decisions taken about their care, and they received good emotional support from staff. Surveys of how patients and people use services were overall similar to other trusts. There were areas for improvement, and the NHS Family and Friends Test was slightly below the national average for inpatient wards. People's experience of end of life care, and feedback on cancer services and pain control in hospital required improvement, and community mental health service users needed better involvement in the review of their care plans, and to have explanations about the side effects of medications.

Good



Summary of findings

Are services at this trust responsive?

Overall, we rated the responsiveness of services in the trust as 'requires improvement'. For specific information, please refer to the acute services report, community health services report and mental health services report for the Isle of Wight NHS Trust.

The trust had been innovative in its redesigned or development of services to improve access and the co-ordination of care, and meet the needs of the local population in a safe and responsive way. The A&E had been redesigned to include a clinical decision unit and children's area. The Integrated Care Hub was introduced in 2013 to triage patients via telephone for urgent, emergency or unscheduled care, and this had been effective in reducing patient admissions to hospital. The single point of access in community services had improved the community services response to people with urgent needs and specific needs, and the 'Operation Serenity' project had improved the policy and mental health services response to service users in crisis at home, and was reducing the number of people who may have been detained under the Mental Health Act.

Ambulance response times were achieved, and patients in A&E, waiting for surgery or outpatient appointments, received care within national waiting times. There were long waiting times for children's therapy services in the community, and for psychological therapies in mental health services.

The number of unnecessary patient bed moves in the acute hospital was high, and many patients had several moves and were on wards that were not appropriate for their medical condition. In community inpatient services, patients were not appropriately located on rehabilitation wards, and out-of-hours services were not always appropriately staffed to provide a service for people's urgent care needs.

Early support discharge was being planned in many services. In mental health, discharge started on admission, and recovery pathways were supporting discharge across health and social care. In acute and community services, discharge arrangements were improving, but there were still some delays for patients with complex care needs, and some ward areas did not discharge over the weekend. The on-call community 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.

Requires improvement



Summary of findings

Multidisciplinary support for patients with a learning disability, or for people living with dementia, was available, and staff liaised across services. There were some delays where staff were working with limited capacity, for example, mental health assessments in A&E. Translation and interpreter services could be accessed by all staff.

Patients, or their relatives or carers, who received end of life care, were not always fully informed about 'do not attempt cardio pulmonary resuscitation' (DNA CPR) decisions. In some ward areas, staff told us that this was being avoided, due to a reluctance to have these conversations.

Are services at this trust well-led?

The trust leadership was rated as 'requires improvement'.

The trust strategy was to work 'beyond boundaries' and make full use of its unique integration of services to manage care, so that patients and people using services had the right care in the right place at the right time. New services had been introduced to manage emergency, urgent and unscheduled care, and the trust was working with its partners, such as social care, the police, GPs, and housing, to support patients to remain independent of hospital, or to receive care as close as possible to their own home.

There were comprehensive corporate governance arrangements. Quality and performance were monitored in some areas, and in the acute service, information on quality was displayed in ward areas for patients to see. This was not the same in community and mental health services. Clinical governance and assurance systems were not as well developed, and the trust seemingly relied on reassurance rather than assurance around important areas of quality, effectiveness and patient experience. Risks were not always managed in a timely and appropriately way.

Staff were positive about their services, their line managers and the people they worked with, and the trust. They did receive communication and information from the trust leadership, and many said they were an approachable team. However, many staff said they did not feel listened to, and gave examples of service change or implementation to their service where they had not been involved, and where they had predicted that problems would occur. There were also examples where changes, in reorganised services and the implementation of national guidance, were not effective because of the lack of staff consultation and engagement. Staff in the ambulance, community and mental health services said that they felt disconnected and isolated from the trust, and described the trust as "an acute service with satellites". Staff were not aware of any future clinical strategies or clinical networks to build a

Requires improvement



Summary of findings

sustainable future. For example, the trust had recently entered into a clinical network with mental health services in Hertfordshire, but the majority of staff in mental health teams either knew nothing about this, or nothing about the implications for future services.

The trust was innovative, and used technology well to serve the needs of people, and bring specialist and expert services where possible, to the Island.

Vision and strategy for this trust

The trust encompassed its vision in the strapline, 'providing quality of care for everyone, every time'. Staff throughout the organisation were aware of the trust vision.

The trust had a five-year clinical strategy, described as 'beyond boundaries', and this had the ambition to deliver health and social care in a radically different way. There were five objectives to this strategy to deliver high standards of care: to achieve high standard of care for patients in terms of outcomes, safety, and patient experience; to deliver integrated services with partners to provide seamless care and move care into the community and closer to people's home, using teams and technology to support hospital directed care; to work with partners in health and social care and within clinical networks and flexible staffing roles; to improve financial sustainability by delivering on performance and efficiency to benefit patients; and to develop a modern workforce to meet these changing requirements. These plans will be supported by care pathways, IT and tele-medicine, across health and social care.

There were good examples of integrated care models in the trust, such as the Integrated Care Hub, the Single Point of Access, Referral, Review and Coordination (SPARRCS) team, electronic patient records in mental health and community services, tele-medicine in community services, and the trust 'My Life is Your Life' project, which is developing working arrangements with the local authority, GPs and voluntary sector around three localities on the Island. The projects focus on improving people's self-care and self-management, crisis and re-ablement, and co-ordinated care in localities. The aim is to build confidence to care for people in the right place and bring care closer to people's homes.

Although the trust-wide strategy was clearly defined, few services had a clinical strategy, and most only had a short-term operational focus. Staff were not aware of the trust's clinical strategy, and were not aware of some of the developments that had an impact on them. For example, staff in mental health services did not know about the clinical network with services in Hertfordshire, and those

Summary of findings

that were aware of the arrangements, did not understand the purpose or aims. Community services were under-resourced and were not 'geared up' to develop services in this way. Some of these services were under pressure.

Governance, risk management and quality measurement

The trust had a structure of three divisions that covered acute, planned care, and community services. The trust had a good corporate assurance framework, and there were standardised processes for risk assessment, reporting, and monitoring performance. Each of the divisions produced a monthly performance review, which provided updates on key contracting performance indicators, incidents and complaints, business risk and good practice initiatives. There were trust and divisional committees on quality, risk and patient experience. There were, however, gaps in the corporate assurance framework, and although issues were documented, actions were not taken to address issues sufficiently. For example, staffing risks in acute services were not actioned, the community mental health services risk register had not been updated since July 2012, and supervision in community services had not been undertaken for two years.

There were quality dashboards at corporate, division and inpatient ward levels, and quality and safety indicators were displayed on wards for patients to see. These included safety information on avoidable harms, such as falls and pressure ulcers, staffing levels, and complaints. Staff on the wards were not always clear on how the information was generated, and action was not always taken to address the issues detected. Information was not similarly displayed in community or mental health services, and these quality and governance processes were less well established in A&E, for end of life care, and for some community services, and some mental health services.

Clinical governance arrangements were not as well developed, and there was less information available on quality, audit and effectiveness, and the patient experience. There were examples of risks, clinical audit, reporting and learning from incidents, and use of evidence-based guidelines that did not happen appropriately. For example, there was not a formal process for the implementation and audit of NICE guidance, and we found that actions taken following a mortality outlier had not been implemented effectively. There was good participation in national audit, and local audit programmes were undertaken, but this was not consistent. Improvements as a result of audit were demonstrated in some places, such as in stroke care, but again, this was not consistent. Management of kidney injury, end of life care, and fractured neck of femur for example, demonstrated no improvements. There was good use of outcome

Summary of findings

measures in surgery, critical care, maternity and community, children's and family services, and in mental health services, and these were reported nationally and locally to improve the services. Outcome measures were not as well developed in other services.

The NHS Staff Survey 2013 identified that the trust was trending towards the top 20% of trusts for reporting errors, near misses and incidents. Staff were reporting incidents and received feedback. There was a corporate newsletter, and formal systems in some teams, such as in mental health services, to share lessons learnt. Some areas did not have formal systems, and there was under-reporting in a few areas, where staff identified capacity as an issue.

Leadership of service

The trust board had not changed significantly in the last 18 months. The chief executive had been in post since 2012. The director of nursing and workforce was appointed in January 2013, and a director of planning, ICT and integration was appointed in January 2014.

In the results of the 2013 NHS Staff Survey, the trust was trending towards the bottom 20% of trusts for the percentage of staff reporting good communication between senior management and staff. Staff reported that they knew who the leadership team were, and many reported that they were generally accessible and approachable. The chief executives 'Friday Flame' email was well known, and staff found this informative and helpful.

The leadership team undertook trust board walkabouts, and had action trackers to identify and address areas for improvement. Many staff commented that they had not seen a member of the leadership team in their areas, and wish that they were more visible, either in person, or through their own communications.

Staff told us that they felt well supported by their line managers, but not by the trust leadership team. This was particularly apparent in ambulance, community and mental health services, who considered that the Isle of Wight NHS Trust felt like "an acute hospital with satellite services". These services did not have specific representation on the trust board, from staff working within their services, to be able to reflect their issues and mirror the trust strategy for integrated services.

Culture within the service

The trust identified that working in an island environment had meant that 95% of staff know a colleague, friend or relative who use the service. The positive aspect of this was seen to be that the staff had good reason to ensure that people across the Island had good

Summary of findings

quality care. The negatives were seen to be the potential for confidentiality to be unintentionally breached, and that staff might also be reluctant to speak out where there might be performance issues with colleagues.

The trust was encouraging staff to be open about performance issues, or where standards were not met, and raising concerns had been promoted by the 'see something; say something' initiative. They had introduced quality champions to raise concerns in the services. Staff were positive about this, but felt that this had just started, so they had yet to see the benefits. We found that staff were focused on confidentiality, but in many areas, patient information was available in public areas, and patient and service users had not been asked for their consent.

The Island did experience a slower pace of life, and the trust acknowledged that this was the culture that the trust was working with too. Some of the pressures faced by the acute hospital were those which the NHS had experienced a few years ago, and the services were being challenged by these. Some services, including the ambulance, and some community and mental health services, had a more flexible and responsive approach to the speed of change.

Staff focus groups were well attended by staff. Many wanted to express how positive they felt about working in the trust, and in particular, working within their teams. Staff described the trust as a good, friendly place to work, with good supportive teamwork. There was a sense that the hospital belonged to them and the Island community, and they cared about its reputation, their colleagues, and the patients. Staff in all services were committed to providing good quality care, and considered that quality and safety were everyone's business.

Partner organisations and commissioners said that the trust was open and transparent, and had a good focus on integrated working. The trust was also outward facing, and had developed its strategy taking into account how this should and could work, with social care policy, the police and other agencies on the Island. The trust was open about performance issues, and was candid in its response to problems and challenges.

Public and staff engagement

The CQC adult inpatient survey 2013, identified that the trust performed similar to expected in obtaining the views and experiences of patients on the quality of their care. The strategy for patient experience was identified in the Trust Long Term Quality

Summary of findings

Plan (May 2013), and this was to continue to develop patient and public engagement, use information from comments, concerns and complaints, and report monthly to the trust boards on patient experiences.

The trust public engagement included a patients council, who were able to undertake visits and feedback on the quality of services and patient experiences, particularly vulnerable people, such as the elderly, those with learning disabilities, and those having cancer services. The patient's council representative told us that they had a very good relationship with the trust, and they saw many positive changes as a result of their feedback. There were also patient-led focus and support groups, such as in diabetes care, and patient were represented on a few trust committees.

There were over 560 volunteers who worked in the trust; they could easily be identified by their orange T-shirts. Volunteers enhanced people's experience, and supported people as guides in and around the acute hospital, and in the outpatient departments, and worked to support patients in ward areas, such as by providing help and support to elderly patients.

The trust had a good relationship with the local Healthwatch. There were examples of consultation with the local Healthwatch providing feedback on services, including positive feedback about the Alzheimer café, which was in place at the trust, and of the local Healthwatch undertaking patient experience surveys that demonstrated what services did well and where they needed to be improved, such as in maternity. Staff were aware of these surveys, and were taking action as a result.

The NHS Staff Survey (2012) identified that the trust was in the bottom 20% of trusts nationally for staff engagement. Concerns about engagement were mirrored in our discussions with staff. Many staff were enthusiastic, motivated and committed to their teams, but the majority wanted staff engagement to improve. Staff reiterated that the trust leadership made decisions without effective engagement, and this was causing frustration and low morale in places; staff had also predicted many of the problems that happened following changes. There were examples in all services where staff engagement was not optimal. The reorganisation of wards had caused problems with medical outliers and staffing, and these were highlighted as issues; the AMBER care pathway was not well embedded, as its implementation had happened without engagement; the paediatric emergency pathway continued to cause risk issues and a poor patient experience, as its implementation was not appropriately discussed; and risks in community health services and mental health services were raised, but had not been acted upon.

Summary of findings

Some staff told us of the good support and engagement they had received from the trust, for example, in maternity, where the chief executive had supported staff following a serious incident. Many staff, however, in all services, and at all levels, wanted their concerns to be heard and appropriately represented. It was acknowledged that the impact of this was affecting patient care, and would pose further risks if this remained unresolved. There was low morale, or a level of concern in some services, where staff did not feel a level of involvement or communication, such as in the pathology workforce review, and the tendering of drug and alcohol services.

Innovation, improvement and sustainability

In the NHS Staff Survey 2013, the trust tended towards the bottom 20% of trusts for staff who contributed to improvements at work, with work pressures, motivation and satisfaction being worse than expected. The Survey also found that the trust was in the top 20% of trusts for staff receiving job related training, learning or development. Staff were encouraged to learn and improve, but this was not apparent in all areas, where capacity issues were affected time for learning and development. There were many examples of innovative services across the trust, with partner organisations and innovation within services. However, some staff felt change within their service was often out of their control, and would be directed by the trust, rather than from staff contributions.

Staff in focus groups told us that work pressures were increasing, particularly as it was proving difficult to recruit and attract people to work on the Island. Many services had locum staff, some being led by a series of locum staff, and consistency of services and development was becoming an issue. The trust acknowledged that their main challenges were with staff communication, recruitment, and workforce stress, particularly where they had asked staff to raise their performance.

The trust had a number of financial challenges ahead because of changes to funding around the Island premium. Services needed to run even though they may not have the economies of scale, but the rationalisation of funding meant that greater efficiencies would be required. The trust was investing in an integrated model of care and clinical networks with mainland services, to sustain services, and ensure quality, safety and patient experience met requirements by commissioners, to maintain standards and to meet national expectations of care. It was understood that with the centralisation of some services, decisions would need to be made about what could change and what should remain on the Island, to ensure that there was not a negative impact on patient care.

Cost improvement programmes (CIPs) would constitute approximately 4% of the total budget per year, but the trust had not

Summary of findings

met its targets in 2013/14, and would be under pressure to meet these in 2014/15. The trust had a good process for the quality impact assessment of CIPs, and risks to patient care were identified prior to approval.

Overview of ratings

Our ratings for St Mary's Hospital (Acute Services)

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Requires improvement	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity & Family planning	Good	Good	Good	Good	Good	Good
Children & young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Requires improvement	Inadequate	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Good	Good	Good
Ambulance	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community health services for adults	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community inpatient services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
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Our ratings for Mental Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Primary mental health	Good	Good	Good	Good	Good	Good
Service for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Child and adolescent mental health services	Good	Good	Good	Good	Good	Good
Services for older people	Good	Good	Good	Good	Good	Good
Psychiatric intensive care units and health-based places of safety	Good	Good	Good	Good	Good	Good
Rehabilitation services	Good	Good	Good	Good	Good	Good
Drug and alcohol services	Good	Good	Good	Good	Good	Good
Community mental health team	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Community-based crisis services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Our ratings for the trust overall

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

Notes

Overall caring was considered to be good as this was reflective of the majority of services across the integrated trust.

Outstanding practice and areas for improvement

Outstanding practice

Trust-wide

- 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, tele-care 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. There were 64 staff located at the Integrated Care Hub, including switchboard, call handlers, dispatchers, clinical advisors and operational and clinical managers. Key services were accessed out of hours through the Hub. The Hub was effective in ensuring that patients had timely access to appropriate services, avoiding unnecessary admissions to hospital, and delivering better outcomes for patients.
- The pharmacy service was operational seven days a week. The service was innovative, and worked effectively within multidisciplinary teams to improve patient care. For example, electronic prescribing had reduced medication errors and was being used to ensure that venous thromboembolism risk assessments occurred. The service offered an advice line and was involved in the pre-admissions initiation of antibiotics with ambulance services.
- The trust was developing integrated information systems, and was working towards electronic patient records. There was connection between the A&E and ambulance services, and local GPs.

Acute and Ambulance Service

- There was evidenced based care for orthopaedic patients having hip and knee operations.
- A wide shared care network for managing children with the most complex and rare conditions had enabled families to be supported and treated closer to their homes. It also enabled access to the best

possible advice for these families. For example the children's ward was a Level 1 Paediatric Oncology Shared Care Unit, and could also offer care to visitors to the Island with oncological problems.

- Ambulance staff used electronic tablets to enable operational staff to complete their e-learning.
- The ambulance service was participating in a trial in early intervention in sepsis, jointly with another ambulance service. The aim was to identify patients who might have sepsis, and to reduce their mortality through early intervention prior to admission to hospital.
- The Individual Learning Plan (ILP) had been developed and implemented to support the development of staff competency in the ambulance service. This was introduced in 2014, and staff were given learning objectives and were required to demonstrate learning as part of their continuous professional development.

Community Mental Health Services

- 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 were identified in the children's physiotherapy department, with a specialist therapy provider that enabled funds to benefit more children.
- Sustained improvements were seen where the productive series community programme was embedded in the orthotics department.
- Improved management of large increases in the number of safeguarding and child protection referrals followed changes made in 2013.
- The trust had introduced an Alzheimer's café, and created a garden for dementia patients.

Outstanding practice and areas for improvement

- A Parkinson's care co-ordinator had been created to meet the needs of larger numbers of patients with Parkinson's disease.
- Staff demonstrated a good background knowledge of families and children, as well as areas of higher risk in different localities across the Island.
- Effective multidisciplinary working and communication, both within the service and with other health and social care professionals, was evidenced.

Mental Health Services

- Primary mental health Services teams provided and referred people for a range of evidence-based psychological therapies, on both a group and individual basis.
- The service had developed new and innovative services to protect vulnerable people, and reduce the use of the Mental Health Act. One example of this was 'Operation Serenity', where there was joint working with the police to treat people at home, or in the community. This had reduced the use of the S136 Place of Safety, and decreased the number of people having to be detained under the Act.
- The Learning Disability Service was innovative in its use of assistive technology, to help people with communication difficulties, to encourage their choices and preferences.
- The Child and Adolescent Mental Health Service (CAMHS) had effective multidisciplinary team and inter-agency working, with a range of support networks to other agencies. There were a wide range of therapies available, and treatment outcomes were monitored to drive service improvement.
- The Drug and Alcohol Service had introduced a range of health promotion measures, and had integrated its work with GPs. Service outcome measures were used to improve the service.
- The outside garden space on Afton Ward for older adults was funded and developed by staff. The garden was gender-specific, and had a quiet and restful area, as well as areas that encouraged activity and learning. It was described as inspirational by people and their families.
- On the acute, PICU and Rehabilitation wards (including S136 Place of Safety) there was effective debriefing for staff following incidents, and staff shared lessons learnt in team meetings. Reflective practice was provided to staff through a skilled psychologist.
- There was effective use of the wellness recovery action plan (WRAP) for patients on the acute, PICU and Rehabilitation wards (including S136 Place of Safety). Discharge planning started on admission and the discharge tree was used on the PICU. The wards had excellent relationships with housing and employment services.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve The trust must ensure:

Trust-wide

The clinical leadership of services improve, and there must be operational support and co-ordination to cope with service demands and to manage effective integration.

Staff engagement is effective, so that service changes and developments are owned and effectively implemented, to reduce risks to patients and people that use services.

Complaints need to be responded to within 25 days, or agreed timescales.

Acute and Ambulance Services

Staff receive training on the Mental Capacity Act 2005 and the Deprivations of Liberty Safeguards. The principles must then be applied to ensure that where people do not have capacity to consent, the correct procedures are followed.

Staff are competent in how to recognise when a patient is on an end of life journey, so that decisions are made and their care managed appropriately; the trust must ensure that staff have received the appropriate training, and understand the tools available to them. This includes the use of the AMBER care bundle, and the use of syringe drivers.

Outstanding practice and areas for improvement

'Do not attempt cardio pulmonary resuscitation' (DNA CPR) orders must be completed in their entirety, in a timely manner, for all patients where this decision has been made. There must be clear documentation as to how this decision was reached.

Risk assessments in relation to patient care must be completed, and used to inform the patient's plan of care.

All patients have a named consultant for the duration of their stay, with clear referral and acceptance criteria when there is a change in consultant for clinical needs.

The provision of care is reviewed for patients who have had a stroke, to ensure that the pathway is fully reflective of national guidance.

National guidance is reviewed, gap analysis completed, and improvement plans put in place and monitored where required, to ensure that practices are in line with nationally-recognised guidance.

The trust must ensure there is a lead nurse qualified in the care of children (RN(children)) and sufficient registered (Children) nurses are employed to provide one per shift in emergency departments receiving children as per Standards for Children and Young People in Emergency Care Settings 2012.

There is a single point of access for children in an emergency situation. Short-term measures should be safely implemented while long-term plans are developed.

The nursing staff provision is reviewed within the Accident and Emergency Department and the Stroke ward, to ensure that they are staffed to the agreed establishment and skill mix, in line with current guidance.

There is an effective and safe procedure for the obtaining, recording, handling, using, safe keeping, and dispensing of medicines used by the ambulance service.

Community Health Services

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 is 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 ensure 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, the needs of 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 must be monitored. Patients placed on the stroke rehabilitation and general rehabilitation wards must meet the criteria for admission, so that they can benefit from the services offered.

Staff receive regular supervision and this includes bank staff.

Doctors are offered adequate training, and sufficient staffing needs to be in place to enable medical and nursing staff to attend all teaching and development sessions.

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 must be kept locked at all times; sharps boxes must always be left closed; and patients must be given appropriately 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 must be regularly checked and appropriately maintained.

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.

Outstanding practice and areas for improvement

Standards for pressure area care are followed. Patients with pressure ulcers must have appropriate and timely reassessment on the stroke ward, action must be taken and recorded in response to patients' skin changes, and all patients must have use of a pressure-relieving mattress where assessments indicate this is required. The use of inco sheets for pressure ulcer care needs to be reviewed.

Staff request and record patients' written consent to the display of their details on the computerised screen on the wards.

Wards display a contact point for access to information and complaints regarding the use of CCTV on the wards.

The trust must update the DNA CPR policy, and ensure wards audit their adherence to this policy.

Mental Health Services

Risk management and care planning in people's records in the Community Mental Health Team must be improved. Records were not reviewed consistently or updated in a timely manner.

The caseload management and line management supervision of caseloads in the Recovery and Rehabilitation Team are regularly undertaken to identify issues that may impact on care delivery and quality.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records.</p> <p>People who use services were not protected against risks of receiving care or treatment that is inappropriate or unsafe.</p> <p>How the regulation was not being met:</p> <p>Acute Services risk assessments were not consistently being completed in their entirety to inform the plan of care;</p> <p>patients who had suffered a stroke could not be assured that the pathway of care was fully reflective of national guidance;</p> <p>there was not a clear pathway for children to follow to gain access to health care in an emergency;</p> <p>the planning and delivery of end of life care did not meet national standards</p> <p>Community Health Services Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of:</p> <p>Carrying out an assessment of the needs of the service user.</p> <p>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.</p> <p>Inaccuracies and inconsistencies in patient records affected risk assessment scores which shaped care.</p> <p>Doppler assessments were not always carried out on patients with leg ulcers prior to use of compression bandaging.</p>

Compliance actions

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.'

Mental Health Services

There was little evidence of physical health checks for people in Community Mental Health Services,

Care plans were not regularly reviewed to reflect people's progress in Community Mental Health Services,

People did not have timely review of their care planning approach (CPA), at least within the last 12 months in Community Mental Health Services.

Regulation 9- (1)(a)(b)(i)(ii)(iii of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

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

How the regulation was not being met:

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.

Compliance actions

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

MRSA rescreening frequency was inadequate for the case-mix 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

Transport services, triage and medical advice provided remotely

Regulation

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

How the regulation was not being met:

Ambulance Services

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

Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA 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:

How the regulation was not being met:

Community Health Services

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

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

Compliance actions

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 seven 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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

Suitable arrangements for the obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them,

How the regulation was not being met:

Trust-wide

Suitable arrangements were not in place for obtaining the consent of service users to the display of their details on a computerised screen on display on the wards.

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity

Regulation

Compliance actions

Treatment of disease, disorder or injury

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Patients using the service were not protected against the risks of unsafe or inappropriate care.

How the regulation was not being met:

Treatment, as decision relating to resuscitation were not being accurately recorded and reviewed to ensure they were kept current.

Regulation 20- (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

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.

How the regulation was not being met:

Acute Services

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

Community Health Services

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

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

Regulated activity

Regulation

Compliance actions

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

The registered person did not have suitable arrangements in place to ensure that staff were appropriately supported to enable them to deliver care and treatment to service users, and to an appropriate standard by receiving appropriate training, professional development and supervision.

How the regulation was not being met:

Acute Services

Staff were not fully informed of their responsibilities under the Mental Capacity Act 2005, or in the recognition of people at the start of the end of life journey, or how to support people through the use of tools designed to support end of life care.

Community Health Services

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.

Mental Health Services

Staff had high caseloads and did not have the appropriate levels of supervision to manage these.

Staff had not attended mandatory training.

Regulation 23- (1) (a) (b) 3 (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p>Patients could not be assured that they are protected against the risk of inappropriate or unsafe care and treatment by means of effective operation of systems designed to enable the person to regular assess and monitor the quality of services and identify and manage risk to the health, welfare and safety of service user and others.</p> <p>How the regulation was not being met:</p> <p>Acute Services</p> <p>Changes required following the investigation of incidents were not always implemented in a timely manner.</p> <p>There were not robust systems in place for the review of compliance with national guidance.</p> <p>The action plan to address the mortality outlier for unspecified renal failure was not implemented. Staff were not using NICE guidance for treating kidney injury and the sepsis care bundle had not been rolled out across the trust.</p> <p>Patients had a number of bed moves and did not have a named consultant for the duration of their stay. Changes to a patient's consultant were being made for non-clinical reasons depending on the ward they were located on rather than their clinical condition. Patients receiving end of life care that had had several bed moves for non-clinical reasons and were being cared for on wards where the understanding of their condition was limited.</p> <p>There was not effective implementation and monitoring of the paediatric admissions pathway, or for the streaming and initial assessment of patients in A&E.</p>

Enforcement actions

Community Health Services

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.

Mental Health Services

Outcomes for people were not monitored in all areas to improve the effectiveness and quality of services.

No action was taken in response to an external review of caseload management in August 2011. The review identified that community teams did not focus on people presenting with the highest clinical risk who had severe and enduring mental health issues. The recommendation was that a structure for undertaking caseload management should be developed and maintained. Caseload management guidelines outlined that individual meetings with staff should take place 4

Enforcement actions

weekly for at least an hour, discussing all cases on a three monthly cycle. Staff did not have regular supervision meetings and this meant that within the RRT the trust's own guidelines were not being adhered to.

No action was taken in response to staff reported concerns about the locks and lack of hand rail in the assisted bathroom on Shackleton Ward.

The risk register in the Community Mental Health Team had not been reviewed since July 2012.

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