Isle of Wight NHS Trust

Inspection report

St Mary's Hospital
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Ratings

Overall trust quality rating	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

The Isle of Wight NHS Trust is the only integrated acute, community, mental health and ambulance health care provider in England. Established in April 2012, the trust provides a full range of health services to an island population of about 143,000 people.

Overall, the trust provides 23 core services for acute, community, mental health and ambulance services.

Acute services are based at St Mary's Hospital Newport with 245 beds. Services include emergency department, urgent care service (by referral only), emergency medicine and surgery, planned surgery, intensive care, paediatric services, a special care baby unit (SCBU), and maternity care services. Along with diagnostic and screening, pathology and pharmaceutical and outpatient services.

The community division provides a variety of supported care services within patients' homes, community settings, GP practices and clinics, as well as providing physiotherapy, occupational therapy and podiatry support within the acute setting. The community clinical provision is based in three localities of the Isle of Wight: Northeast, West and Central, and South Wight, with district nursing provision in each area. There is also support offered for children and young people through the paediatric therapy, occupational therapy, physiotherapy and speech and language therapy services.

The mental health division provides community learning disability services; inpatient and community based mental health care. With 32 beds for working age and older adults, supported by a home treatment team and a community mental health team for adults and child and adolescent mental health services.

The ambulance service division includes operational delivery units for the 999 emergency ambulances, NHS111 and patient transport services based at the St Mary's Hospital site.

Our findings

We carried out this announced inspection of a range of the mental health, acute and community services provided by this trust as part of our continual checks on the safety and quality of healthcare services. We did not inspect ambulance service division on this occasion. At our last inspection we rated the trust overall as requires improvement and remained in quality special measures. No use of resources review was carried-out for this inspection.

We inspected the following core services and rated them individually for the five key questions of safe, effective, caring responsive and well led. We also inspected the well-led key question for the trust overall. We rated 11 out of 11 services inspected as good.

At this inspection, overall, we rated safe, effective, caring, responsive, and well-led as 'good'. Our separate rating of well-led for the trust was good.

Acute

Diagnostic Imaging: all five key questions were rated good. Good overall

Medical Services: all five key questions were rated good. Good overall

Surgical Services: safe, effective responsive and well led were rated good, with caring rated as outstanding. Good overall

Gynaecology Services: safe, effective, caring and responsive were rated good and well led rated was rated requires improvement. Good overall

Children and Young People: all five key questions were rated good. Good overall

Mental Health

Acute wards for adults of working age and psychiatric intensive care units: Effective, caring, responsive and well led rated good with safe rated as requires improvement. Good overall

Wards for older people with mental health problems: all five key questions rated good. Good overall

Community based mental health services of adults of working age: safe, effective, caring and well led rated good with responsive rated as requires improvement. Good overall

Mental health crisis services and health-based places of safety: effective, caring, response and well led rated as good with safe rated as requires improvement. Good overall

Community

Community adults: safe, effective, responsive and well led rated as good with caring rated as outstanding. Good overall

Community inpatients services: safe, effective, responsive and well led rated as good with caring rated as outstanding. Good overall

Our findings

On this occasion, we did not inspect the ambulance service division. In rating the trust, we took into account the current ratings of the 11 core services we did not inspect this time but had rated previously.

Our rating of well led improved. We rated them as good because:

The trust leadership demonstrated the delivery of improvement plans over time and had plans for a strategy refresh to progress the quality of care delivery for the future.

There was a clear vision for now and the future of healthcare on the island.

Across the trust teams were determined to meet the needs of patients and the public.

The executive team showed the drive to make the trust a better place for staff to work in.

Staff were mostly satisfied with working at the trust which was the island's main employer.

Staff were able to directly influence the quality of services and make changes in their own areas.

There were quality improvement objectives and audits to identify progress and next steps.

Recruitment internally and externally, including from overseas, had benefited the trust services.

Engagement with staff, patients, partners and the system were much improved and were effective.

New approaches for communication were introduced and there was renewed vigour to continually improve the communication for patients and their relatives.

There were established systems and partnership working for the sustainability of the organisation which was for the benefit of the population of the Isle of Wight.

The partnership links were contributing to the success of supporting patients to have good care and treatment on the island.

The culture, enthusiasm and energy for the quality of patient care showed significant improvement.

There was a greater patient focus than seen before.

There was established support for staff care and wellbeing as confirmed by the improved staff survey outcomes and as seen throughout all areas inspected.

The strategy for equality and inclusion was far more developed and was working towards meeting the needs of people with protected characteristics.

There was a developing research team and projects underway.

However:

Our findings

Delays in mandatory training delivery, such as for safeguarding and resuscitation, could impact on patient care.

The trust had identified information technology systems needed new investment, the continued delays affected the cohesiveness and modernisation of the trust's information management.

The trust's non-executive directors lacked visibility in some services which had previously been identified before the pandemic restrictions.

Recruitment to some key roles was filled on an interim, fixed term or locum basis reducing the stability of the trust.

The trust application of the equality and inclusion strategy across the range of staff and patient protected characteristics was better in some departments than others.

The referral to treatment times waiting lists, both pre- and post-pandemic, remained a challenge for the trust.

The fit and proper person checks for directors were not always completed in a timely way.

There needed continued investment in the estate to ensure appropriate care and support was provided to all patient groups.

How we carried out the inspection

During the core service inspection, we visited the location and sites for the 11 core services inspected, and we spoke to a range of staff, patients and key stakeholders. We also inspected the well-led key question for the trust overall. We conducted well-led interviews remotely.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Trust:

- Major incident response planning had been explored due to the pandemic in a much wider context with drone supplies, armed forces, police and fire brigade support and alternative ways to move unwell patients to mainland trusts such as via hovercraft which will remain in place for the foreseeable future.

Medical Services

- Patients on chemotherapy treatment had access to a home service if they became unwell. Paramedics where trained to attend and administer a first dose of intravenous antibiotics at home. This meant patients were treated quickly and safely without needing to attend the emergency department.

Our findings

- People living with dementia had access to a reminiscence room and a potting shed area. The reminiscence room had activities for patients with dementia such as puzzles, games, art activities and fiddle muffs. The potting shed was situated in an outdoor space and encouraged patients to grow edible plants in a planting trough.
- The stroke service improved in the Sentinel Stroke National Audit Programme (SSNAP). The service is rated A (the highest rating).

Surgical Services

- Luccombe Ward had reduced the number of inpatient falls by undertaking a cluster review and making changes in practice such as clearly defined day and night routines for patients to help them stay orientated and reduce the risk of patients getting up in the night when fewer staff were on duty to observe patients. Staff had created a fall grab bag which contained items such as a falls checklist.
- We were given many examples of patient centred care, ensuring everyone that needed care could access it.
- The orthopaedic department had implemented an incision management pathway – which promoted assessing patients based on their co-morbidities to ensure the most appropriate wound dressing was used to aid wound healing.
- The trust had developed and implemented an island wide dementia strategy.
- The trust had successfully piloted and implemented an app to speed up access to dermatologists for skin conditions.
- Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care and information to meet all their needs. Easy read discharge summaries with pictures were available for patients with learning disabilities to provide information in a way that they could understand.

Gynaecology Services

- Gynaecology services had developed a safety huddle in the early pregnancy unit. Held daily, it allowed nursing staff to review patients with the on-call consultant to agree and confirm treatment plans.

Children and Young People

- During our inspection we heard evidence of outstanding and compassionate care for a child who arrived for emergency care but later died. The service provided a caring and compassionate service for the child and family after death.

Community Adults

- All feedback we received was overwhelmingly positive about the staff and the service patients had received. Patients and carers said that staff went the extra mile and the care and support exceeded their expectations. The service had received numerous compliments, some of which patients had sent directly to senior leaders, including the chief executive officer. The majority of compliments stated staff went above and beyond when providing care and treatment.
- The technology enabled care team had given telehealth kits to all care homes on the Isle of Wight and to some patients living at home. The kits allowed patients to complete their own physical observations such as blood glucose testing, urine testing and blood pressure. This gave patients more independence to monitor their conditions and reduced the number of hospital appointments, admissions and readmissions.

Our findings

- The dietetics team provided freshly made milkshakes twice a week to patients who required their support on the chemotherapy ward. This increased the number of calories patients were able to consume and also improved their wellbeing. The team also spent time on the wards ensuring their patients were able to connect with loved ones during the peak of the COVID-19 pandemic. For example, they passed messages between patients whose loved one was on different wards, arranged for patients to 'facetime' loved ones and arranged for a married couple to have a joint room.

Community Inpatients

- All feedback we received was overwhelming positive about the way staff treated patients and all spoke highly of the care and treatment they were receiving. Staff went the extra mile to support patients. The care and support received whilst on the unit exceeded patient's expectations.
- During the lockdown restrictions, where visitors were unable to visit the hospital, the service had tablets and mobile phones available for patients to use so they could keep in touch with loved ones. We were given an example of a married couple who were able to be accommodated in the same room as they had never previously spent time apart.
- Staff empowered patients to have a voice and realise their potential. Patients' individual preferences and needs were always reflected in how care was delivered and evidenced well in care planning. For example, one patient's only goal was to be able to walk his daughter down the aisle on her wedding day. Staff worked tirelessly to ensure this was possible.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with three legal requirements. This action related to three core services.

Community mental health teams for adults of working age

- The trust must ensure there are enough clinical psychologists/or other appropriate staff to meet the needs of patients requiring this service. The trust must ensure that patients are not waiting for extended periods and ensure they are supported appropriately whilst waiting. (Regulation 18 (1) Staffing).

Mental health crisis services and health-based places of safety

- The trust must ensure the environment at the health-based place of safety on Seagrove ward is fit for purpose and meet the requirements of the Mental Health Act Code of Practice. The trust must ensure that the environment provides dignity and respect to users of the service. (Regulation 15).

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that, on Osbourne ward, staff update patients' risk assessments following an incident to reflect changing risks and care needs. (Regulation 12).

Our findings

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure how to further develop the governance systems and oversight to bring together learning and further improvement opportunities. (regulation 17)
- The trust should consider how the staff mandatory training delivery programme gives priority to those staff needing to complete training as soon as possible.
- The trust should consider the prioritisation of information technology investment for the primary benefit of the Isle of Wight services.
- The trust should consider how the non-executive directors can increase their visibility to all the services.
- The trust should consider how both the workforce and the recruitment strategy can continue to meet the needs of the services on the island.
- The trust should consider how well the equality and inclusion strategy is applied across the range of staff and patients with protected characteristics.
- The trust should consider the processes for due diligence for all fit and proper person checks.
- The trust should consider allowing the Freedom to Speak Up Guardian to present to board in person and not through a director as per National guidelines.

Location/core service

Wards for older people with mental health problems

- The trust should ensure that only the needs of patients that are within the older persons mental health care needs are admitted to the ward. The mixture of patients had the potential to place a more vulnerable patient at risk. The environment should be adapted if the trust continue to offer care and treatment to patients living with dementia and staff should be provided with specialist training such as dementia awareness. (Regulation 12).
- The service should ensure record keeping is assessed and monitored on the level of detail and completeness and where shortfalls are identified the quality and transparency is improved. (Regulation 17)
- The service should consider obtaining more feedback from patients on the quality of care.
- The trust should ensure there are sufficient numbers of staff on duty with the skills needed for patients who are admitted outside the age range and older person's criteria. (Regulation 12).

Community mental health teams for adults of working age

- The service should ensure patients feel confident about making complaints. (Regulation 16).
- The trust should consider ensuring that senior leaders communicate effectively with the staff about changes to the service.

Mental health crisis services and health-based places of safety

- The trust should ensure they take proactive steps to address the lack of substantive nursing and medical staff across the service. (Regulation 12).

Our findings

- The trust should ensure that medication records are properly documented, and patients' allergy status are recorded. (Regulation 12).
- The service should ensure they take steps to improve the quality of patient care plans and ensure all patients are offered copies of their care plans. (Regulation 17).
- The service should ensure they take steps to address recording of best interest meetings and ensure it is done consistently in line with policy. (Regulation 13).

Acute wards for adults of working age and psychiatric intensive care units

- The service should ensure that, on Osborne ward, performance of staff is managed effectively, and clear actions are taken to ensure improvements. (Regulation 18).
- The service should ensure that, on Osborne ward, the audits and the monthly summary include an action plan to address concerns identified, timescales for completion or the person responsible for the action. (Regulation 17).
- The service should ensure information about prescribing is accurate in all documentation, including Mental Health Act documentation. (Regulation 12).
- The service should ensure that medicines with a reduced in use expiry date are identified and appropriately labelled to ensure they are not used post their expiry date. (Regulation 12).
- The service should ensure that, on Osbourne ward, staff update patients' care plans to assist staff to provide safe care. (Regulation 17).
- The trust should ensure that there are always enough staff deployed onto Seagrove Ward to safely manage the health-based place of safety and the ward itself. (Regulation 12).

Medical Services

- The service should ensure staff lock patient notes trollies when not in use. (regulation 17)
- The service should ensure staff appropriately label medicines with a reduced expiry date after opening to ensure they are not used after their expiry date. (regulation 12)
- The service should ensure records relating to returning controlled drugs records are always completed (Regulation 12).
- The service should ensure the service considers the needs of patients from the LGBT+ community and to comply with the requirements of the Equality Act 2010. (regulation 10)

Surgical Services

- The service should ensure medicines with a reduced expiry date after they are opened are labelled to ensure they are not used after their expiry date (Regulation 12).
- The trust should ensure that staff files are kept up to date. (Regulation 18).
- The trust should ensure that complaints are managed within the timescales outlined within the trust's complaints policy. (Regulation 16).
- The trust should consider developing specific competency documents for all staff groups and specialities.
- The trust should consider how to embed the new care group structure and governance processes.

Our findings

- The trust should consider providing patients with a copy of their consent form.

Gynaecology Services

- The trust should consider expediting their plans to relocate outpatient clinics held in the gynaecology department so the emotional needs of patients attending the early pregnancy unit are taken into account.
- The service should consider developing plans for nursing staff to have access to post-qualification level 6 training in gynaecology.
- The service should consider accelerating plans for nurse-led clinics to develop staff skills and enhance services for patients.
- The service should consider how to bridge the gaps in nursing support staff shifts.
- The service should consider providing patients with a copy of their signed consent form following consultation.

Children and Young People

- The service should ensure all staff keep up to date with mandatory training (Regulation 18).
- The service should consider availability of mental health assessment out of hours and during the weekend, as children and young people who required a review before discharge remained on the ward over the weekends.

Diagnostic Imaging

- The service should ensure all staff keep up to date with mandatory training. (Regulation 12, 2.)
- The service should ensure it continues recruitment into radiology posts to increase the availability of services. (Regulation 18, 1.)
- The service should consider integrating use of a pain scoring system into pre-assessment checks, including a system accessible for those who cannot communicate verbally.

Is this organisation well-led?

Our rating of well-led improved. We rated it as good because:

Leadership

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

The board and senior leadership team had seen some changes in the last two years, including new appointees, promotions, change of job roles or role titles and associated portfolios. The chief executive had continued in post, along with the director of finance and the director of people and organisational development.

There was a new chair of the trust who joined in late 2020. The medical director was appointed internally to their role in November 2020. The nominated individual and director of governance and risk joined the trust in 2020. New roles of

chief operating officer and a director of strategy and partnerships had also been introduced. There had been an appointment of a new chief pharmacist. There was also a recently appointed acting chief nurse for nursing, midwifery and allied health professionals, whilst recruitment was underway for the permanent role. There was an associate director of corporate affairs whose portfolio included corporate risk, insurance and corporate governance.

Services were managed in the following four divisions of acute, community, mental health and learning disabilities, and ambulance services. There had been changes since the last inspection with the director for mental health and learning disabilities taking on the lead for the community service.

The executives were supported by both new and established non-executive directors (NEDs). Visibility of non-executive directors had been variable due to the COVID-19 pandemic, in particular with those who were mainly off island and were not able to be on site. However, prior to the pandemic the non-executive directors were mainly seen at St Mary's Hospital and only at other sites if time had allowed.

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

The trust set up a new board committee framework in September 2020 to include committees for: Quality and Performance, Finance and Infrastructure, Digital Transformation, People and Organisational Development, Audit, Charitable Funds and Nominations and Remunerations.

The trust board met virtually every month. The trust published a monthly board report on its website which provided both the board and the public with an overview of performance. There was a Patient Council with a membership of patients who provided representation to the board and trust committees. Staff side and Healthwatch also attend the board regularly.

We reviewed the personnel files for some of the executive team. Appropriate checks had been carried out in accordance with 'Fit and Proper Person' requirements; however, there were delays in some checks being completed. The executive team had an appropriate range of skills, knowledge and experience.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of trust services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust values were "CARE": compassion, accountable, respect and everyone counts. These were applied along with the strategic objectives of: people, performance, place and partnership. The trust had worked with key stakeholders to benefit the whole population of the Isle of Wight. The current approach was to achieve the stability of the services both in terms of finance and quality now and for the future.

The board assurance framework strategic objectives for 2020-2025 were listed as:

- Make our Trust a great place to work and receive care;

Our findings

- Work with our partners and our community to improve services;
- Deliver high quality compassionate care;
- Make sure our services are clinically and financially sustainable;
- Join up health and care services by working more closely with our partners;
- Invest in building and IT that helps our teams make a positive difference to our island community.

There was continuation of the Isle of Wight Care Partnership with the clinical commissioning group, local authority, primary medical services and voluntary sectors. There was an overarching trust strategy dated June 2020. Partnership strategy development had been effective since June 2020 with other acute, community, mental health and learning disability trusts. The trust pharmacy teams were developing partnership arrangements to include medicines information and aseptic chemotherapy. In addition, since 2021 close working with another NHS ambulance service was established to support the development of the trust ambulance service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development. The trust had an open culture where patients, their families and staff could raise concerns without fear.

The culture was consistently positive from the perspective of staff and networks, with wellbeing as a focus for all staff. There were systems for performance management of staff through a revised annual appraisal, which were aligned to the values and strategy. There was a strong reference to patients and the quality of their care expressed more than ever before now. This was reflected in the latest staff survey as well as Family and Friends Test results.

The trust had appointed a Guardian of Safe Working Hours (GSWH) for junior doctors. They provided assurance to the trust board, the General Medical Council (GMC) and Health Education England (HEE) and to the doctors themselves that doctors in training were safely rostered and working hours were reported as compliant with their terms and conditions of service. The guardian was required to raise concerns to the trust board and potentially to external bodies. The GMC and HEE for Wessex had recently removed the trust from enhanced surveillance, following improvements on previous areas of concern for junior doctor's support and supervision. The medical director was praised by staff for being available to them and making the changes needed where there were service or performance concerns.

Since the last inspection the trust had established an equality and inclusion strategy, a diversity and inclusion network was launched in July 2020. The trust identified staff came from 51 different ethnic backgrounds, with staff of different faiths; 20% of staff from a Black, Asian and Minority Ethnic (BAME) background. The trust was aware of the need to develop support and external community links and gave the example of arrangements to celebrate Ramadan. It was noted that other staff networks such as for LGBT+ colleagues were not yet well established. There was an ethnic minority network in development with positive early reports. However, some staff expressed concern about feeling safe in reporting their experiences of racial abuse.

To improve the culture the trust had a freedom to speak up guardian. The guardian lead was appointed in October 2016 and had attended national training. They had 50% of their working time allocated for this role and they were supported by freedom to speak up advocates and anti-bullying advisors as before. Every year in October and November there was a peak in numbers of staff contacts due to the outreach with freedom to speak up month. The majority of concerns were currently around behaviours.

Our findings

The freedom to speak up guardian escalating issues created improvements. For instance, concerns were raised to the guardian with regards to medical records storage which the guardian raised with the chief executive. The chief executive and the guardian reviewed the storage and management issues and significant changes were made. We saw this change of site for the better management of patient paper records, as well as for the staffing of this important aspect of the trust's responsibilities.

The freedom to speak up guardian reported quarterly through a committee and created an annual report. However, the guardian no longer reported directly to the board, reporting instead via the director of people and organisational development. This is not in line with freedom to speak up guardian national guidelines.

In continuing an open culture approach for patients, in April 2021 the trust introduced the Head of Patient Experience role with a portfolio to include the volunteers, chaplaincy and patient experience teams, Friends and Family test, NHS choice comments, Healing Arts and management of formal complaints with the support of the patient experience lead.

Governance

Leaders operated effective governance processes, throughout the trust and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the trust.

Quality governance was overseen by the director of governance and risk. There were individual divisional arrangements for governance. With changes seen since last inspection, some teams were not long in establishment, but we were told staff were clear about governance pathways and how they linked to sub committees, the non-executive directors led quality committees and the board. The non-executive directors informed us they were confident in the information they received and on the core service inspections the staff expressed they had sufficient data.

The trust defined their quality improvement priorities, this was published in the Quality Account 2020/2021. The trust had identified nine key priorities for action in 2021/22 around patient safety, clinical effectiveness and patient experience.

There was a new mental health and learning disabilities strategy 2020 to 2025 with the branding 'No Wrong Door'. The governance in mental health had been identified as potentially hindered by the lack of medical psychiatric leadership however there had been close working with another mental health trust and there were plans to develop support further.

The community division had continued to focus on achieving the priorities set out in the Quality Strategy launched in October 2019.

The ambulance service division had their own head of quality governance reporting to the head of the ambulance service. There were separate national performance targets to achieve to demonstrate quality across its core services, these were in relation to response times, management of suspected heart attacks, response to cardiac arrest, care of stroke patients and patients with sepsis.

There was an acute quality strategy to improve and ensure patient safety. There had been organisational change to the acute division structure to align services more effectively. The previous four care groups were made into two, planned care and unplanned care.

Our findings

The key focus of the acute strategy had been on the National Early Warning Score (NEWS2) with compliance now recorded via the 'medi-aud' system. The safety of deteriorating COVID-19 patients required a new safety process to ensure tracking of a patient's condition and early escalation for example for more advanced respiratory support.

There had been improvement in the earlier recognition of deterioration in patients and subsequent escalation led by the consultant nurse for critical care and the critical care outreach service. A group was established, and met monthly to share good practice; with membership included from the ambulance, acute, community and mental health divisions.

To improve patient safety the leads or heads for all divisions met weekly to review outcomes for patients.

A hospital at night clinical co-ordinator role was introduced out of hours to ensure patients were reviewed in a timely way. From August 2021 there will be a new medical model of out of hours support with the introduction of a residential medical officer role.

Hospital Standardised Mortality Ratio (HSMR) was reported as statistically lower than expected. HSMR is an indicator of healthcare quality that measures the ratio of observed deaths to expected deaths, and whether the number of deaths in hospital is higher or lower than would be expected. The HSMR for palliative care; however, had remained higher than some of the peer group hospitals and an action plan was in place to address the reasons for this. There were established links with the hospice, a new dedicated palliative care unit at the hospital and palliative care seven day working.

A review of serious incidents identified do not attempt cardiopulmonary resuscitation documentation across the trust needed to be updated to avoid active resuscitation and treatment on patients who did not wish to be resuscitated or when it was not in the patient's best interest.

The trust was a test site for the patient safety incident response framework (PSIRF) as part of a national rollout for incident management, as a result the trust had reviewed some existing safety group arrangements to form the PSIRF Oversight and Quality Assurance Group.

The trust was part of a system wide coronavirus coordinating group with a framework to implement change and monitor progress and impact, in the context of the changing national coronavirus guidance. Infection control had taken a significant profile since COVID-19. Delays to treatment due to both pre and post COVID-19 waiting lists were reviewed regularly by the governance arrangements and the plans reported to board. There was ongoing assessment of risks for those waiting for surgery and offers had been made for patients to be treated on the mainland. However, there was little uptake with patients preferring to stay the on island.

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

Our findings

Management of risk, issues and performance

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

The trust had a new risk management policy, replacing the former risk management strategy, which now sets out the current guidance for staff. There were regular meetings about the management of risk through the governance structures. We were informed all staff were routinely trained and supported with risk and each of the board committees were responsible for managing the strategic risks aligned to them.

Operational risks had been identified across a number of services and specialties linking to issues around increasing the post COVID-19 referrals to treatment and associated waiting lists, system capacity and recruitment of some key clinical roles such as in medical staffing.

Services and core services had their own risk registers and staff teams were able to influence decision making. For example, in the ambulance service the staff were concerned when the air ambulance service would not take patients to the mainland during the pandemic and the car ferry service was greatly reduced. In response the ambulance staff went directly to the hovercraft service to determine how they could help resolve this matter. Consequently, formal arrangements were put in place for paramedic escorted patient transfer to Southsea in converted spaces in the hovercraft and retrieval on arrival by a mainland NHS ambulance service. This service is set to continue.

In the maternity services staff completed regional and national benchmarking and were successful in their business plans for new staff to be agreed.

The trust mandatory training uptake for some modules including for resuscitation and safeguarding had been lower than expected in some wards and departments. The programme of roll out had been hindered by COVID-19 restrictions, however since facilities had reopened the trust were by division supporting staff to attend mandatory training.

Whilst oversight of medicines optimisation was retained by the pharmacy team through the introduction of electronic audit tool and reporting systems, the day to day ownership for medicines audits had been transferred to wards and departments. The main pharmacy risk register entries related to the resilience of computer hardware, software and interfaces between computer systems.

Most medicines were managed well; however, a risk was identified on inspection within the emergency medicines kept for children in the emergency department, one medicine was available at two different strengths, but looked very similar. The trust were seeking to address any risks which needed to include how the medicines could be mixed up in an emergency given the way they were presented and stored.

There was comprehensive management of death reviews. Joint integrated mortality review meetings were held and reported on as part of quality assurance achieved better now with three medical examiners in the team. The medical examiners considered trust mortality across all divisions. The structured judgement review process was applied and an avoid ability score attributed. All COVID-19 deaths had a second mortality review and identified trends around age and co morbidities. Deaths of patients under the mental health service were reviewed if they had contact with the service in the last six months and the Royal College of Psychiatry guidelines were followed. All patient deaths were reviewed up to

Our findings

30 days post discharge from the trust. There was a backlog for the coroner's office inquests of up to 18 months on the island, but the trust said they were ready for any inquests and had improved their preparation and evidence collection. In planned care the trust were working with the Royal College of Surgeons using their mortality review tool for areas which could be improved upon.

Mortality meetings reported to the clinical effectiveness committee and the quarterly report was sent to the quality committee. A public report was made available to board and where sensitive information was not for the public domain, it was separately provided to the board.

Risks with the estates were reviewed by an external provider who identified hundreds of non-compliance issues. A service improvement plan was developed, and risks were included on the trust risk register. Every month there was a report on progress presented to the estates committee which reported to the finance and infrastructure committee and progress was being made**.**

Community and mental health services were under invested in the past and the trust was in the process of purchasing two properties for the benefit of service users. In particular Sevenacres Inpatient Unit was still in need of significant change and improvement and the trust confirmed this to be in the integrated care system (ICS) plans. The ambulance service demonstrated plans for their building redesign and extension to modernise their service facilities and were hopeful of achievement in 2022. The emergency department for the first time had a children's emergency department separate from the rest of the department in line with national guidance.

There was a major incident response plan, which set out the trust responsibilities and roles in the event of an incident. Disruptions could be, for example, from severe weather, failure of systems or power, or an outbreak of an infectious disease such as the COVID-19 pandemic. The pandemic had given the trust an opportunity to explore contingency options in a much wider context with drone delivered supplies and alternative ways to move patients to mainland trusts such as via hovercraft. The ambulance service worked with providers such as the ferry service, the fire brigade, the armed forces and the police to ensure its emergency services would continue.

The trust was working in partnership with mainland trusts to reduce risks raised by being an integrated trust delivering in small scale without the critical mass to provide stand-alone services. Service sustainability continued to be an issue.

The trust had a turnover of £260 million and achieved its financial target in 2020-21 with system support. It had an underlying deficit of £30 million, of which between £17 million and £20 million was attributable to the scale of operations required, with partners, to maintain safe services on the island.

The trust had received £48 million national capital development funding to support transformation and sustainability of services for patients. The trust was preparing business cases to ensure agreed projects would be delivered by March 2024.

The director of finance was updating the long-term financial plan taking into account service line costs including overheads. This work would inform system financial plans and underpin partnership development, it was on track for presentation to the trust board in September 2021.

The finance and infrastructure committee and the audit committee oversaw financial governance. The chairs of each sat on both committees, giving a broad oversight. The trust chair was also the chair of the committee in common for overseeing the operation of the acute partnership with another trust and the Investing in our Future Programme Board. However, there seemed to be limited communication to cross reference issues from one committee to another. The

operation of each appeared to work in their own silo and internal audit recommendations were not referred to other committees for detailed assurance. Since July 2021 there have been changes to the committee agendas to prompt inter committee referrals. The audit committee had a main focus on finance, contracts and procurement, rather than wider assurance.

The trust was pleased to have received an assessment from its internal auditors of "reasonable" assurance on the operation of internal control systems and the 2020-21 annual report and accounts had been signed off by the external auditor.

Information Management

The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure but were not yet integrated across all systems. Data or notifications were consistently submitted to external organisations as required.

There were risks with the current information technology and business systems in the services which needed investment to support service efficiency and improvement. Across the trust there continued to be different systems for different services which did not interface; however, there was the intention to revise and bring some systems together. Information technology was a high risk on the board assurance framework.

The digital transformation committee had been set up since the last inspection in response to cyber-security concerns and to oversee the information technology business cases for the trust system modernisation, better integration of the services, with consideration for the impact of off island service support. As at July 2021 there was a digital strategy. Funding had been applied for to allow for the changes needed.

There was a slow move to becoming paper light across the trust with electronic patient records. There had been recent investment in the technology for maternity services, the emergency department and in the ambulance service. The mental health service current system will be changed to be in line with the supporting partner trust to allow for better data sharing and outcomes for patients. Other business cases were underway for further systems which, if approved, would take about two years to implement.

There was ongoing recruitment for a chief information officer, the role was meanwhile covered with interim arrangements.

There had been serious incidents relating to information governance. The trust was assessed by the Information Commissioner's Office and issued with a preliminary enforcement notice in March 2020. The trust took action to address the issues raised and met the provisions of the notice. The trust had one information governance related incident in the year 2020/21 in March 2021; about patient data being sent to a closed GP practice which potentially had caused delays in communication for individuals. This was reported under NHS Digital's Guide to the Notification of Data Security and Protection Incidents.

The use of data was said to be improved and more reliable with new dashboards in mental health and acute services. For example, the mental health services were now using performance information for risk assessment and caseload decisions were now more effectively made.

Our findings

Engagement

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

There were improvements in engagement. The trust had enhanced the associate director of communications and engagement post to a director of communications and engagement to improve the overall engagement of the trust internally and externally.

Most staff felt engaged with through team meetings and the senior leadership team had regular interactions with line managers. For instance, there were regular manager meetings, a staff survey, team briefs and chief executive sessions for staff. The use of technology enabled the development of virtual meetings. Leaders however were said to have been less visible during the pandemic and there had not been a programme for non-executives to meet staff.

The trust celebrated achievements of staff with a programme of awards and both staff and the public could nominate individuals or teams they felt really deserved the recognition. There were also long service awards, #MeetTheTeam, Greatix, thank you cards, staff stories and chief executive awards. The trust shared patient feedback via #FeedbackFriday and Social Shoutouts.

Whilst there was limited engagement with external equality groups, this had been developing for example with faith groups.

We contacted some key stakeholders as part of our inspection all of whom spoke positively of the trust performance and where there had been improvement. Some were seeking to ensure the trust could maintain their achievements for the future to be sustainable.

There was a patient council a representative of which attended the trust board. The trust's medicines use and safety group had patient representation via the trust patient council. Healthwatch also attended the board.

The trust was actively engaged in collaborative working with external partners across all services. In particular in acute services for stroke care, also in all mental health services, for the benefit of staff and patients on the island. The trust was aware of the expectation of health services to recognise the health inequalities in its own population. The trust, being the largest employer on the island recognised the need to support staff throughout the pandemic with wellbeing checks, free car parking and free lunches.

The trust had developed close links with the integrated care system (ICS.) The maturing ICS had as one of its priorities to ensure sustainable services across Hampshire and the Isle of Wight. The trust demonstrated through its strategies and plans it was well-embedded in developing services at both system and place to provide assurance about the quality and sustainability of services.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Our findings

There was improvement in learning and research and development. There was funding for the research team and as a result there was an interim research and development manager arranged for six months as well as a clinical research associate director. Described as previously having undefined structures and low staffing, now with two band 7 lead nurses working with the manager the team could see the improvements. There was now a stronger governance framework and meetings, reported into the quality and performance committee and every six months reported to the board. The strategy was being worked on for 2022. The team were seeking to raise their profile in the trust with 18 active projects including in orthopaedics and podiatry. An example was given of how an intensivist had now been supported and their research published. The trust had supported COVID-19 research projects as designed by Public Health England.

Local training and development were provided through the Isle of Wight College, and the trust was proud of its graduating cohorts of local nurses and allied health professionals.

There were improvements in the patient's experience. An example of improved patient experience was in the preparation for the partnership provision of aseptic services, the administration of chemotherapy process required to improve the patient experience. Whilst patients now attended the clinic twice, the chemotherapy was ready for the patient when they arrived for their second appointment.

A dedicated end of life care unit Wellow Ward was established, during 2020/21 with a focus on care and attention to the specialist needs of people who choose to spend the last days of their life, and die, in hospital. Patients, families and staff provided positive feedback about the ward.

The trust continued to embrace volunteers and in September 2020 the Ambulance Service recruited twenty-four more volunteer community first responders (CFRs). Each CFR was expected to complete training in the form of 'FutureQuals' level 3 award for First Responders on Scene: ambulance service community responders. The Isle of Wight Ambulance service was the first in the country to enrol learners onto the new qualification.

There were service improvements at the trust, for example in acute services the gastroenterology team was awarded the JAG national accreditation for their standards in the endoscopy service following an assessment on 22nd July 2020.

Service continuity was achieved with the introduction of Attend Anywhere for patient video consultations.

Complaints were better managed however the timeliness of response had meant delays for some complainants. The top theme was communication such as between patients and staff, for example patients did not always feel listened to. There was an identified gap in customer services training at the trust which could have contributed to complaints about staff attitudes and behaviours. In response a training package for customer service had been purchased and was due to be rolled out across the trust. Initially it will be rolled out to quality managers and complaints team, and then to the clinical staff.

Family Liaison Officers were introduced during the pandemic to keep families connected with mobile devices, and video calls. A local school raised money to purchase seven iPads for patient use.

During the pandemic the PALS service continued at the hospital, but the public could not access the PALS office. PALS staff still visited patients on wards and held TEAMS or telephone calls with patients and relatives.

The reporting of complaints data was part of the performance report to trust board and the monthly quality report which was reviewed at the quality and performance committee, as well as being reviewed quarterly via the patient

experience and patient safety committee. The trust had been chosen as a pilot site for the new NHS England/ Improvement and Parliamentary Health Service Ombudsman complaints standard starting in September 2021, the team believed this process would help to bring back kindness and compassion into the management of complaints. Challenges with the new process, such as for informal complaints to be completed within 24 hours was recognised.

The complaints team joined divisional meetings and there were posters displayed for how to make a complaint. The mental health team enabled patients to directly phone the complaints team to ensure they had immediate support about their concerns.

A new telephone system was being put in place, where callers would be placed in a queue and not left with a continuous ring.

An example of learning from complaints was demonstrated following some feedback for better compassionate care and breaking bad news in the emergency department. As a result, a dedicated relative's room was established. Also, the chaplaincy provided training about breaking bad news, and the chaplaincy now held a bleep and could be contacted to support relatives and staff in these circumstances.

There was a subcommittee for patient experience and patient safety to bring the understanding of patient and public needs to the attention of the trust; chaired by the chief nurse with staff representation from all services as well as Healthwatch, the patient council and service user representation.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Sep 2021	Good ↑ Sep 2021	Good ➔➔ Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Good	Good	Good	Good	Requires Improvement	Good
Ambulance	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Mental health	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Community	Good	Good	Outstanding	Good	Good	Good
Overall trust	Good ↑ Sep 2021	Good ↑ Sep 2021	Good →← Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
St Mary's Hospital	Good ↑ Sep 2021	Good ↑ Sep 2021	Good →← Sep 2021	Good ↑ Sep 2021	Requires Improvement →← Sep 2021	Good ↑ Sep 2021
Ambulance Service	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Urgent Care Service	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Overall trust	Good ↑ Sep 2021	Good ↑ Sep 2021	Good →← Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for St Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑↑ Sep 2021	Good ↑↑ Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021	Good ↑↑ Sep 2021	Good ↑↑ Sep 2021
Services for children and young people	Good ↑ Sep 2021	Good →← Sep 2021	Good →← Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021
Critical care	Good Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018
End of life care	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Surgery	Good ↑ Sep 2021	Good ↑ Sep 2021	Outstanding ↑ Sep 2021	Good ↑↑ Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021
Urgent and emergency services	Requires improvement Apr 2020	Requires improvement Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019	Requires improvement Apr 2020
Diagnostic imaging	Good ↑ Sep 2021	Not rated	Good →← Sep 2021	Good →← Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021
Gynaecology	Good ↑↑ Sep 2021	Good ↑↑ Sep 2021	Good Sep 2021	Good ↑ Sep 2021	Requires Improvement →← Sep 2021	Good ↑↑ Sep 2021
Maternity	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Outpatients	Good Jun 2018	Not rated	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018
Overall	Good ↑ Sep 2021	Good ↑ Sep 2021	Good →← Sep 2021	Good ↑ Sep 2021	Requires Improvement →← Sep 2021	Good ↑ Sep 2021

Rating for Ambulance Service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019

Rating for Urgent Care Service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services of adults of working age	Good ↑↑ Sep 2021	Good ↑↑ Sep 2021	Good →← Sep 2021	Requires Improvement ↑ Sep 2021	Good ↑↑ Sep 2021	Good ↑↑ Sep 2021
Substance misuse services	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement →← Sep 2021	Good ↑ Sep 2021	Good →← Sep 2021	Good →← Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021
Wards for older people with mental health problems	Good ↑↑ Sep 2021	Good ↑↑ Sep 2021	Good ↑ Sep 2021	Good →← Sep 2021	Good ↑↑ Sep 2021	Good ↑↑ Sep 2021
Long stay or rehabilitation mental health wards for working age adults	Inadequate Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Specialist community mental health services for children and young people	Good Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018
Community mental health services for people with a learning disability or autism	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018
Mental health crisis services and health-based places of safety	Requires Improvement →← Sep 2021	Good ↑ Sep 2021	Good →← Sep 2021	Good ↑ Sep 2021	Good ↑↑ Sep 2021	Good ↑ Sep 2021
Overall	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre (EOC)	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Patient transport services	Requires improvement Sep 2019	Good Sep 2019	Outstanding Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Emergency and urgent care	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019
Overall	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Overall ratings for ambulance services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good ↑ Sep 2021	Good ↑ Sep 2021	Outstanding ↑ Sep 2021	Good → ← Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021
Community health services for adults	Good → ← Sep 2021	Good → ← Sep 2021	Outstanding ↑ Sep 2021	Good ↑ Sep 2021	Good → ← Sep 2021	Good → ← Sep 2021
Community health services for children and young people	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Overall	Good	Good	Outstanding	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community-based mental health services of adults of working age

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all environmental areas and removed or reduced any risks they found. There were up to date ligature and environmental assessments at both locations where patients visited.

All interview rooms had alarms and staff available to respond. Alarms were tested weekly and by the service's administration team.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations.

All areas were clean, well maintained, well-furnished and fit for purpose. The quality of the environment varied at the two locations we visited. The early intervention in psychosis premises was modern and well decorated. The Chantry House community adult mental health base was tired in appearance and in need of redecorating. However, we were advised that a new building had been purchased and the team would be moving into it this year.

Staff made sure cleaning records were up-to-date and the premises were clean. All three locations were visibly clean and tidy.

Staff followed infection control guidelines, including handwashing. We saw that staff followed infection control procedures including hand washing and the wearing of personal protective equipment (PPE).

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe.

Community-based mental health services of adults of working age

The service had a low and reducing vacancy rate. There were three vacancies for registered nurses on the community team. The manager was using agency staff to fill these vacancies and had appointed permanent staff who were due to start in July 2021. Managers limited their use of bank and agency staff and requested staff familiar with the service. The service usually blocked booked agency staff so that they knew their patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. Managers made arrangements to cover staff sickness and absence**.** Managers used a recognised tool to calculate safe staffing levels. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Most community team staff had caseloads that did not exceed the agreed trust figure of 25.

Medical staff

The service had enough medical staff.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to.

Mandatory training

Staff completed and kept up-to-date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. At the time of our inspection 82% of staff had completed their mandatory training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient, using a recognised tool, and reviewed this regularly, including after any incident. Staff gave all patients a risk rating, using a red, amber and green system.

Staff recognised when to develop and use crisis plans and advanced decisions according to patient need. When necessary, staff worked with patients and their families and carers to develop crisis plans. All patient records we reviewed had a crisis plan.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff referred patients to the physical health monitoring group if they had an identified physical health condition.

Community-based mental health services of adults of working age

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased and reviewed their physical health as part of this process. All patients on the waiting list had a crisis plan and were able to contact the duty team if they needed additional support.

Staff followed clear personal safety protocols, including for lone working. Staff recorded their whereabouts and phoned the office if they were not returning after a visit. Staff had agreed code phrases that they could use if they felt at risk during a visit.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role and kept up-to-date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff discussed safeguarding concerns at daily huddle meetings and during supervision sessions. The trust had a safeguarding lead who offered advice and support to staff.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed eight patient records, all of which were of a good standard.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. The service used an electronic note system that was secure and needed logins and passwords to access. However, some staff told us that internet access was not always adequate and time was regularly lost waiting for access to IT systems.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed the storage of medication at both locations and saw that staff followed trust policies. We saw that there were regular reviews of medication by a trust pharmacist.

Community-based mental health services of adults of working age

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The trust had an electronic incident reporting system that all staff could access to report an incident.

Staff reported serious incidents clearly and in line with trust policy. The service had no never events.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff spoke to patients following mistakes and followed this with a letter explaining what had gone wrong and how they would prevent it happening again.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared lessons learnt via emails, team meetings and supervisions.

Staff met to discuss the feedback and look at improvements to patient care. For example, discharge now have the crisis plan for the patient at the top of the letter to remind the patient of what they can do to stay safe. Managers arranged tabletop reviews of incidents so that staff could consider different options if similar incidents happened again.

Is the service effective?

Good ↑↑

Our rating of effective improved. We rated it as good.

Community-based mental health services of adults of working age

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We checked eight records and saw that patients and carers had been involved in assessments and developing care plans. We saw that staff encouraged patients to be as involved as they liked with developing care plans and risk assessments. For example, staff would put in a temporary care plan while they were developing relationships with patients, and then adjust the plan to meet the patient's suggestions.

Staff regularly reviewed and updated care plans when patients' needs changed, the care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). Since our visit in 2019 the community team had introduced care pathways (A care Pathway acts as a guide to treatment), this means staff are now offering patients care and treatment in line with national best practice guidance. There were now care pathways in place for mood disorders and eating disorders.

Staff made sure patients had support for their physical health needs, either from their GP or community mental health services. We saw that staff reviewed patients' physical health needs and developed care plans to ensure that the patient's needs were met.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Staff offered all patients advice on living healthier lives. For example, quitting smoking and arranging exercise groups.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. The teams used Health of the Nation Outcome Scales (HoNOS) to measure patients progress.

Staff used technology to support patients. The early intervention in psychosis (EIP) participated in a pilot programme to trial a pin-prick blood test for patients who were reluctant to have their full bloods taken.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The EIP was part of the EIP network run by the Royal College of Psychiatrists, a quality improvement and accreditation network for early intervention in psychosis teams.

Community-based mental health services of adults of working age

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of each patient. The service employed registered nurses, social workers, doctors, occupational therapists and health care support workers. However, the size of the psychology waiting list shows there is not enough psychologists to meet the current need.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. The managers had developed a pack that included all the information staff need to work in the team.

Managers supported staff through regular, constructive appraisals of their work. Appraisal was used to identify what training staff needed to ensure their skills remained up to date.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. There were regular team meetings and daily and weekly safety huddles that staff could attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they were able to attend training courses and conferences to ensure they kept developing the skills needed for their role.

Managers made sure staff received any specialist training for their role. For example, the EIP team were trained to deliver behavioural family therapy.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff told us that the teams worked well together. We attended the high intensity multidisciplinary meeting and saw good multidisciplinary working with a solution focused approach.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation, such as the child and adolescent mental health service.

Community-based mental health services of adults of working age

Staff had effective working relationships with external teams and organisations. We saw that the teams met regularly with other services including third sector organisations to ensure patients received the most suitable service for their needs.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly.

Staff completed regular audits to make sure they applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when were necessary.

Community-based mental health services of adults of working age

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it. Patients told us that staff were always respectful and supportive.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us that staff worked with them to develop their understanding of their conditions.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Patients told us that the staff were kind and were available when they contacted the service,

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. Patients knew how they would raise concerns about staff. However, some patients told us they did not feel comfortable to raise concerns but did not have any to raise.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans. All patients we spoke to told us they could be involved in care planning if they wanted. Some patients told us that the service had agreed to change plans if they were not happy with a care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Community-based mental health services of adults of working age

Staff involved patients in decisions about the service, when appropriate. Patients were involved in interviewing new staff.

Patients could give feedback on the service and their treatment and staff supported them to do this. The service asked patients for feedback during their treatment and when they were approaching discharge.

Staff made sure patients could access advocacy services. Patients told us they were sign posted to advocacy services, but some told us they had not.

Staff informed and involved families and carers appropriately.

Involvement of families and carers

Staff supported, informed and involved families or carers. Patients told us that when they wanted other people to be involved in their care staff supported this.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and waiting times

The service was easy to access.Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments. However, the waiting list to receive psychological therapies was long and waits were over a year to be seen by this team.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. Staff at the single point of access made all the referrals to the community team. All patients received a risk assessment. If staff rated a patient as needing urgent support, staff would refer them to the home treatment team (this team is able to respond to patients that need immediate support). Staff saw urgent referrals quickly and non-urgent referrals within the trust target time.

At the time of the inspection, the waiting list for the community team was four patients. However, the waiting list for patients to receive psychological therapies from the community team was 243. There was an average waiting time of 64 weeks, with a longest wait of 180 weeks. The service had a 'never just waiting' policy that meant patients on the waiting list were offered a variety of resources, including videos, to start preparing themselves for psychological therapies. Despite initiatives from the team the waiting list continued to increase and patients on the waiting list felt unsupported. This is because there was not enough psychology support to meet the demand.

Community-based mental health services of adults of working age

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff would meet patients at neutral locations such as cafes and in the local park so that they could develop trust with the patient.

Staff tried to contact people who did not attend appointments and offer support.

Patients had some flexibility and choice in the appointment times available. Staff would see patients outside normal working hours when needed.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible.

Appointments ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists and support patients. The service had agreed times for how often they contacted patients on the waiting list based on the level of assessed risk. Managers monitored contact with patients on the waiting list and addressed any issues with the allocated staff in supervision.

Staff supported patients when they were referred, transferred between services, or needed physical health care. The community team has a transition consultant psychiatrist who starts working with patients six months prior to their 18th birthday to ease the transfer to adult services.

The service followed national standards for transfer. Staff contacted local services when a patient moved out of the area. The EIP team used a nationally agreed treatment plan so when patients moved area the local team could continue their treatment from the same point.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Staff would give patients information about how to complain. We saw posters on display in areas patients used in the services telling how to complain. The community team had received nine complaints in the last 12 months.

Staff understood the policy on complaints and knew how to handle them. Managers tried to address any complaints quickly via an informal process.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff referred patients to the trust's Patient Advice and Liaison service. Managers ensured patients received a response to their concern and advice on what action they should take if they are not happy with the outcome.

Managers investigated complaints and identified themes. The main theme was around communication, the service has changed the format of letters to ensure it is clear how patients can contact the service.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers gave feedback to staff and patients about complaints and explained any changes being made to prevent the issue occurring again.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

Staff we spoke to told us that the team managers understood the priorities of the service and help staff to meet patients' needs. The team leaders for the community team were new in post but had identify key areas for improvement and started to address these. For example, they regularly reviewed caseloads to ensure patients were being discharged appropriately.

Community-based mental health services of adults of working age

There was leadership training available to team managers to help them further develop their leadership skills. However, staff did not feel that senior leadership team at the staff were aware of the challenges faced by the teams.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

The staff team and management were aware of the plans in place to address the issues raised at previous inspection. For example, they were increasing the number of psychology staff available to address the waiting list.

Staff told us that the introduction of care pathways and appropriate discharging of patients improved the quality of care provided by the team.

Culture

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff told us that they felt the trust now recognised mental health services needs and were trying to meet them. However, some staff told us that the communication from the trust board could improve. For example, staff found out about the move to a new location from local media.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Staff effectively assessed and managed risk to patients and escalated issues appropriately.

Teams had systems in place that allowed managers to ensure risk assessments and crisis plans were in place and reviewed as required.

Progress on the community team improvement plan is reported to the trust board.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff told us there had been improvement in the electronic patient record system that now allowed them to extract information easier.

Staff told us they were pleased the trust was replacing the current record system.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Community-based mental health services of adults of working age

The EIP team were part of the local quality improvement network. The team attend regular meeting to discuss and share good practice.

Wards for older people with mental health problems

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Safe and clean care environments

The ward was safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

The ward provided mixed sex accommodation. Patients bedrooms were single and en-suite with personal items and belongings. They had access to communal space including separate male and female lounges. There was access to the recently upgraded secure garden with weighted garden furniture, a greenhouse and brightly coloured wooden raised flower beds.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff could observe patients in all parts of the wards.

The risks associated with ligatures were assessed. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. They were knowledgeable about risks and were mindful of the risks in the ward.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished. We spoke with a cleaner who explained how and where they cleaned on a daily basis. We also observed staff regularly cleaning communal areas of the ward and door handles to ensure that the risk of infection was reduced. Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly

Staff checked, maintained, and cleaned equipment. Cleaning audits were completed by the night staff and checked by the ward manager for efficacy.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Staffing levels were not always maintained. There had been occasions when the staffing numbers were not sufficient to provide additional 1:1 support to three patients. The ward manager explained that this was because it was a challenge to get in extra staff and sometimes it was not possible despite going out to the trust bank and to agencies.

Wards for older people with mental health problems

The service had low vacancy rates. Although a registered nurse vacancy was filled there were two registered nurses on long term absences. The ward manager had back filled a vacancy with a bank nurse and had recruited a practice development nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. For example, basic life support and physical intervention was completed most recently. The target for mandatory training was 95% which had improved to 94% from 85% over 12 months. Prevention and Management of Violence and Aggression (PMVA) training due to restrictions of the COVID-19 pandemic had been cancelled and staff were anticipating the opportunity to engage in classroom based training in the near future.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission and reviewed them regularly and after any incident Staff were knowledgeable about risks and took steps to reduce the level of risk to patients. However, the current system was not a standardised risk assessment tool and staff felt the records system impacted their ability to properly document risk. The ward manager told us the trust was moving towards another more efficient system.

Management of patient risk

Adjustments were made to the care and treatment delivered to individual patients based on the risk assessments about their health, safety and welfare. For example, one to one staff support to mitigate the risks depending on individual need.

Staff could observe patients in all areas. There was a nurse's observation station next to the office, and staff had the use of a computer to enable them to directly record health checks as they happened. Staff knew about any risks to each patient and acted to prevent or reduce risks. They had identified and responded to any changes in risk to or posed by patients.

Staff identified and responded to any changes in risks to, or posed by, patients.

Wards for older people with mental health problems

Use of restrictive interventions

Levels of restrictive interventions were low. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. The majority of physical intervention taking place on the ward was to assist patients with personal care. However, care plans lacked clear guidance to staff on the forms of restraint to be used when undertaking personal care.

There were no seclusion facilities on the ward. Staff took immediate action such as taking patients to their bedrooms for behaviours likely to cause harm to others. The staff remained in the bedroom with patients until early warning signs of anxiety and frustrations had passed.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation, such as correctly monitoring a patient after administration

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

The staff were clear on the types of abuse and their responsibility to report allegations of abuse. A member of staff on the ward was assigned the lead role in safeguarding and acted as a point of contact for support and advice.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They told us they worked well with external local authority safeguarding teams

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Patient notes were comprehensive. However, staff were not able to access electronic notes easily due to the IT systems. The trust was moving towards a different record system due to the current system not being fit for purpose.

Staff were kept informed of patient's current needs when they came on shift. Handovers took place when shift changes occurred. Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Wards for older people with mental health problems

Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to best practice guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them and the majority of incidents involved patients with a diagnosis of dementia. Where there was a cluster of issues related to one patient the staff reviewed the occurrences using the new patient safety incident review process.

Staff raised concerns and reported incidents and near misses in line with trust policy. Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service.

There was learning from incidents. Managers debriefed and supported staff after any serious incident. Review meetings were held to assess themes such as incidents with the same patient or to revisit previous decisions that affect the patients on the ward.

Is the service effective?

Good ↑↑

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Physical Health Risk Screening Booklets were completed for patients to assess their overall health. Screening checks included the risk of malnutrition or developing pressure sores. For example, Malnutrition Universal Screening Too (MUST) assessment for nutrition.

Wards for older people with mental health problems

Staff developed a care plan for each patient that met their mental and physical health needs. However, there were inconsistencies in the quality and on the level of detail in care plans across the ward. Care plans were variable, and staff said the content and level of detail was due to their differencing styles. There was no formal care planning training for staff. For example, they physical intervention.

Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The staff were able to describe the process followed for escalating following physical observations. A range of care and treatment suitable for the patients in the service was provided.

Physiotherapists, dieticians and specialist services were sited within the hospital although the level of input was inconsistent. Patients' dietary needs were assessed and met for those needing specialist care for nutrition and hydration. Staff monitored patient's fluid intake where appropriate.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists such as therapists and medical staff to meet the needs of the patients on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. They gave each new member of staff a full induction to the service before they started work and supported staff through regular, constructive appraisals of their work.

Managers supported non-medical and medical staff through regular, constructive clinical supervision of their work. The target for appraisal was reset at 100% for June 2021 and the supervision target was now 85%. Supervision sessions were eight weekly with their line manager and recorded on health roster. At the time of the inspection between 50-60% of supervisions had been met.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Wards for older people with mental health problems

Managers made sure staff received any specialist training for their role. For example, Prevention Management of Violence and Aggression (PMVA). A member of staff was assigned with lead roles in practice development which included developing practice safe ward intervention.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary (MDT) meetings to discuss patients and improve their care. A clinician told us MDT meetings were well organised and with nursing staff treatment decisions were reached for individual patients.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation. For example, acute wards.

Ward teams had effective working relationships with external teams and organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff, including the newly appointed activity coordinator, facilitated section 17 leave and were able to offer patients 1:1 time in the community.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Wards for older people with mental health problems

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

Patients' mental capacity to agree to hospital admission and treatment was assessed. When staff assessed patients as not having capacity, they made decisions in their best interest and considered their wishes, feelings, culture and history. However, records were not clear on how the decision was reached when the patient was assessed as lacking mental capacity.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Is the service caring?

Good 

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Every member of staff we spoke with was passionate and dedicated to older persons' mental health care. We noted a calm atmosphere on both days of the inspection. We observed staff manage situations in a gentle manner and to avoid patients becoming anxious and frustrated they considered swapping staff.

Staff gave patients help, emotional support and advice when they needed it. Staff responded positively to patients to meet their immediate needs.

Staff supported patients to understand and manage their own care treatment or condition.

Wards for older people with mental health problems

Patients said staff treated them well and behaved kindly. Staff told us how they ensured patients knew they mattered to them. They gave us examples such as introducing themselves to patients, there was eye contact when there were interactions and they showed compassion.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff made sure patients understood their care and treatment. However, staff did not always explain the care plans to patients living with dementia.

Patient's meetings were organised by the activity's coordinator and where patients planned the activities for the week. However, patients told us their feedback on the quality of the service was not gathered. Mental Health Survey forms were due to be reviewed as they were not compatible with the existing IT system.

Staff supported patients to make decisions on their care.

Involvement of families and carers

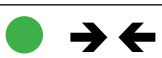
Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers in their loved ones care. A carers lead was appointed and during the admission process they consider the carer' needs such as support throughout the entire journey.

A booking system and access to a carers' lounge was introduced for visitors since COVID-19 restrictions were imposed.

Staff gave carers information on how to find the carers' assessment.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Wards for older people with mental health problems

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

The manager monitored bed occupancy, length of stay and leave. Bed occupancy was 110.6% due to patients on section 17 leave (patients who had gone home for a short period were counted as a bed was always kept available for them should they need to return). The length of stay for patients and readmission rates were around 28-33 days on average which tend to be longer for older people.

When patients went on leave there was always a bed available when they returned.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. There was an identified team of staff who came into the hospital to help support patients to promote the transition back into the community environment. The patient was able to access community resources and going out on a daily basis.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

The nurse's station had been moved to improve privacy and confidentiality, and a multi-disciplinary office had been created in its place.

Each patient had their own bedroom, which they could personalise with personal items and belongings.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The service had an outside space that patients could access easily. The garden had been renovated since the previous inspection and included raised flower beds. It was used as a patient participation project and they had assisted in painting, planting, growing and actively engaging in the development of the project. There were weighted chairs outside for those who didn't wish to work on the project, a greenhouse and brightly coloured wooden raised flower beds.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Patients order their meal choices the day before and their meals arrived plated.

Patients' engagement with the wider community

Staff supported patients with activities outside the service and family relationships.

An activities coordinator was in post and was taking steps to improve patient involvement, for example, weekly meeting and feedback forms.

Staff had access to training in alternative therapies. For example, mindfulness meditation, auricular acupuncture, and there was a once weekly group for acupuncture off the ward.

The occupational therapist undertakes functional skill training with some patients such as budgeting and preparing meals.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff helped patients to stay in contact with families and carers.

Meeting the needs of all people who use the service

Patients living with dementia, or learning disabilities and older and working age adults were receiving care and treatment in the same environment, although the purpose of the ward was for older people experiencing severe mental health care needs (known as a functional ward).

The mix of needs and age range was a challenge to staff. Staff said patients with multiple co -morbidities were inappropriately placed and they were not delivering the same standards of care to patients with functional mental health care needs. Staff's time was also taken up with supporting separate ward rounds from psychiatrist services for younger and from older patients' services. This meant younger adults received psychiatrist services input from adult acute services and older patients from older persons' services.

Staff were not offered specialised dementia training and the ward was not dementia friendly. Medical staff said it was "extremely difficult to care for people with dementia in an environment that is not fit". While we saw one to one staff support for patients living with dementia, the environment lacked appropriate lighting, signage to provide landmarks, meaningful destinations and relatable objects.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service used compliments to learn, celebrate success and improve the quality of care.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they approached the staff with complaints and their concerns were resolved within the timeframe.

Wards for older people with mental health problems

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The ward manager and deputy were clear about their roles, they had a good understanding of quality performance, risks and regulatory requirements. The staff said the ward manager was visible on the ward, knew patients well and was approachable. Patients were aware of who was the ward manager.

The staff told us the ward manager was supportive and the team was working well together. They told us the team had changed with new staff being recruited. The recruitment of new staff had brought a new perspective to the ward and team building with long standing staff was improving.

There were systems in place for staff to receive feedback from the ward manager with the sharing of information and updates on policy changes.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The staff were aware of the values of the organisation and worked within them. They said there was support from the ward manager and the deputy, they had job satisfaction and they felt confident within the team., While they were committed to providing high standards of care, there was some reluctance to change old ways of working. For example, supporting a person centred care approach for patients to develop independent living skills.. A nurse with development lead role said team building was to be addressed as part of their role.

Culture

Generally, staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us they felt listened to and valued. They said information was shared through staff meetings, discussions during supervision and the training attended.

Wards for older people with mental health problems

The ward manager promoted a person-centred approach on the ward. Staff told us the ward manager was ensuring patients were supported in an individual way and treated with dignity and respect.

The ward manager had developed strong links with the primary school. Previously there were visits from schools but currently due to the pandemic the visits were not possible. This work was now done online and reached into the school's assemblies. For example, a virtual school assembly for dementia awareness week.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The ward manager recognised the risks and recent challenges on the ward due to the pandemic and with the admission of patients whose needs were not within the older persons' criteria. The staff had become concerned on the impact this was having on their abilities to deliver safe care to patients with a diverse range of needs. For example, younger adults, patients with learning disabilities and patients living with dementia.

The older persons' workstream was part of the transformation project and where discussions about the future of the ward were taking place. Concerns about the purpose and benefits of the ward were brought to the attention of the workstream. Areas for discussion included the purpose of the ward, the lack of provision for people living with dementia on the island and the potential for providing adequate support on the ward to these patients**.**

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

An audit system to assess and monitor the standards of care was in place and action was taken where shortfalls were identified. For example, restrictive interventions, risk assessment and care plans.

Although there were no actions from the care plan audit tool dated 6 June 2021 an action plan was devised on how to make additional improvements

The Modified Early Warning Score (MEWS) was used to assess physical observation and prevent delays in intervention. The ward was successful in escalating physical needs for further investigation and had achieved 98% in the May 2021 audit. However, there were some shortfalls on the accuracy of recording.

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. However, audits had not identified the quality of records for improvements. Records were not always maintained to the same standard and some were variable in detail and guidance.

St Mary's Hospital

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Description of this hospital

The Isle of Wight NHS has community and acute services based at St Mary's Hospital Newport.

Services at St Mary's Hospital include community health inpatient services and community health services for adults. For acute the services include emergency department, urgent care service (by referral only), emergency medicine and surgery, planned surgery intensive care, paediatric services, special care baby unit (SCBU), and maternity care services. Along with diagnostic and screening, pathology and pharmaceutical and outpatient services.

We carried out this announced inspection of a range of services provided by this trust at St Mary's Hospital as part of our continual checks on the safety and quality of healthcare services.

This summary in respect of the acute services at St Mary's Hospital which has 245 beds.

We inspected the following core services and rated them individually for the five key questions of safe, effective, caring responsive and well led.

We inspected the following core services and rated them individually:

Medical Services: all five key questions were rated good. Good overall

Surgical Services: safe, effective, responsive and well led were rated good, with caring rated as outstanding. Good overall

Gynaecology Services: safe, effective, caring and responsive were rated good and well led rated was rated requires improvement. Good overall

Children and Young People: all five key questions were rated good. Good overall

Diagnostic Imaging: all five key questions were rated good. Good overall

We did not inspect the emergency department, intensive care maternity services or outpatients on this occasion and the existing ratings are applied. We have therefore rated acute services key questions for safe, effective, caring, responsive as good and welled as requires improvement with an overall rating of good at St Mary's Hospital.

Our findings

Our rating of this location improved. We rated it as good because:

- The services showed improvements in the quality of care and outcomes for patients across all acute services inspected. There was a greater focus on patient care. Staff worked well together for the benefit of patients, supported them to make decisions about their care and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions.
- Risks for patients were recognised earlier and acted upon. Better patient records were kept. Incidents for patients were reviewed more thoroughly and there were lessons learnt from reviews of care delivery.
- The services had recruited more staff and there were enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well.
- Key services were available seven days a week or were in development.
- Staff were able to directly influence the quality of services and make changes in their own areas.
- There was established support for staff care and wellbeing.

However:

- Delays in mandatory training delivery, such as for safeguarding and resuscitation, could impact on patient care.
- Some services had vacant clinical posts which could affect the sustainability of services.
- Staff did not always secure and lock patient notes.
- Not all medicines were managed correctly and safely.
- The services did not always demonstrate understanding of the considers the needs of patients from the LGBT+ community.
- Some services had not given patients a copy of their consent form.

Diagnostic imaging

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and managers were aware if this had not been undertaken.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us about how the training supported their role and were able to give examples of this. Department staff received mandatory training, but this was not up to date in all areas. Records showed the service had met some targets for training compliance. Staff completed mandatory training in areas including conflict resolution; equality & diversity; fire safety; infection prevention and control; information governance; mental capacity act; preventing radicalisation; resuscitation; safeguarding. During the pandemic training in manual handling and resuscitation had been halted due to distancing guidelines. The trust had resumed training in these areas and a catch-up plan was in place.

Clinical staff had training on recognising and responding to patients with learning disabilities, autism and dementia. Staff had also undertaken additional training on how to support dementia patients. The service also had appointed 'dementia champions' to support patients and staff. In the main imaging department, not all staff were up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Training for mental capacity was mandatory but not all staff had completed this, evidence provided by the trust showed that in the main imaging department only 75% had completed it.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers viewed training compliance of staff and identified if training was not completed. Staff were alerted electronically when their training was due to expire or if it had expired.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse. Safeguarding training was part of mandatory training and staff had completed this. There were posters with contact details for the trust Safeguarding team. A superintendent radiographer was available if safeguarding concerns were raised and needed to be discussed. A superintendent is a radiographer that manages and oversees staff and the work of a particular area.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us about an incident where this training has supported a staff member to raise a safeguarding alert, learning from this incident was shared at meetings. Sonographers told us they had undertaken additional training in identifying those at risk and signs of female genital mutilation (FGM).

Diagnostic imaging

Staff followed safe procedures for children visiting the department. The department did not have a dedicated paediatric waiting area, everyone waited in the same area. Children attending following GP referral were able to wait in an external area with their parents and given a buzzer. When children came to the department from the emergency department or urgent treatment centre, they waited in these areas as they had dedicated paediatric areas. Access to the emergency department paediatric waiting area for children in the was restricted by secure doors. Staff told us how they would then only call children through when radiographers were ready. This measure meant that children were kept safe from risks in the environment.

Cleanliness, infection control and hygiene

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

Clinical areas and furnishings were visibly clean and well-maintained. Furnishings were intact with no cracks or tears. Privacy curtains were dated and changed monthly, and this process was monitored by audit.

The service had cleaning records which were up-to-date and demonstrated that all areas were cleaned regularly. Guidelines were displayed in clinical areas telling staff what required cleaning and items that needed regular stock replenishment. This was monitored by a daily sign off sheet and a monthly audit undertaken to ensure compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had undertaken trust training on how to use PPE correctly. Staff followed correct 'donning and doffing' procedures between patients and had had visual guides to support knowledge. All staff were bare below the elbow (BBE) and audits monitored this.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment and rooms between patients. They knew what products they would use and explained how these would change depending on the clinical need. The trust used an ultraviolet cleaning machine when a deep clean was needed. Patients with infectious diseases, such as COVID-19 and Clostridioides difficile (C.difficile), had imaging performed at the end of the working session. This ensured equipment and rooms had a deep clean in line with the trust's infection prevention guidance.

Sonographic staff told us how they cleaned all equipment after procedures and had moved to individual use transmission gel packets in line with guidance for intimate procedures. There were 'I am clean stickers' on mobile equipment, such as ultrasound scanners and blood pressure gauges. Staff used an aseptic technique when cannulating patients for contrast procedures, this followed infection prevention guidance. Inspectors saw cannulas being removed and steps taken to ensure to protect patients from infection.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Call bells were within patient reach in changing areas and on the walls of radiation-controlled areas. Staff informed patients about how they could alert staff when bells were not within reach. Staff also visually monitored patients while imaging was being undertaken, so they could respond rapidly to any patient distress or deterioration.

Diagnostic imaging

The design of the environment followed national guidance. The waiting area met the current guidelines for social distancing measures. The setting enabled staff to observe and monitor patients waiting. There were changing facilities and patients were provided with a basket to store their clothing and possessions. This ensured patients transported their own clothes when moving around the department with ease.

The waiting area was used by all patients using the departments, this meant that inpatients were waiting in view of outpatients. Both patient feedback and leaders had identified this as a concern and additional screens had been purchased to shield patients in beds from view. Mangers also said that more screens would be used to shield cannulation areas where patients could see others undergoing venepuncture.

There was no visible waiting time information on display in the waiting area and this was only given when asked. When the staff member allocated to the waiting area was not present patients were not always clear on where to sit.

Resuscitation trolleys were stored in a place easily available to all staff and trolleys were colour coded to differentiate between paediatric and adult equipment. Staff carried out daily safety checks of specialist equipment. Staff told us that resuscitation trolleys were checked in two ways: the full trolley was checked monthly and resealed with a numerical tag and records supported this. The defibrillator, suction equipment and items not stored within secure drawers were checked daily. Records showed equipment checks had been performed and there were areas to record if equipment was replaced. During our records showed equipment had not been checked on 26 of the past 83 occasions. An audit monitored checks taking place and when they had been missed this was escalated and an additional staff member was being trained to complete them. During our inspection an additional member of staff was being trained to undertake these checks and improve compliance.

Staff carried out daily quality checks on the imaging equipment and this was logged in the departments quality system. Superintendent radiographers reviewed this data to make sure staff followed protocol when undertaking checks. Imaging equipment was serviced yearly by the respective manufacturers and this was logged, there was a system in place for the handover of equipment for servicing.

The service had suitable facilities to meet the needs of patients' families. Due to restrictions on the numbers attending hospitals in response to the pandemic, patients were asked to attend appointments alone or if they needed support could bring a carer. Staff understood that some patients may need additional support.

The service had enough suitable equipment to help them to safely care for patients. The service had replaced two of its computed tomography (CT) scanners and had expanded its Magnetic Resonance Imaging (MRI) capacity with an additional MRI scanner.

All imaging procedures had risk assessment that had been undertaken by senior staff and radiation protection advisors. Staff working in the service were monitored for radiation exposure with film badges, these were replaced quarterly, and any exposure relayed to the department by a specialist external organisation.

Clinical waste was disposed of in line with trust policy. Staff disposed sharps in line with national guidance. Sharps bins were dated and partially closed to prevent spillage. Auditing took place that monitored sharps disposal, and this provided staff with good practice advice where indicated.

Assessing and responding to patient risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

Diagnostic imaging

Staff responded promptly to any sudden deterioration in a patient's health. Staff were aware of steps to take in case of patient deterioration and responded promptly when call bells sounded.

Staff completed risk assessments for each patient on arrival, using a recognised tool and reviewed this regularly, including after any incident. Staff spoke with patients before undertaking a radiation exposure to ensure exposure was justified. The department used a three-point identification check with patients before undertaking an imaging procedure. In control areas there were 'PAUSE and check' posters that prompted staff to verify information before exposing patients to ionising radiation.

Staff knew about and dealt with any specific risk issues. Patients who may be pregnant were asked about the possibility of this before undertaking procedures and this followed local policy. Patients from wards attended with notes detailing any additional requirements, these were also communicated verbally by staff from the ward. When patients were given intravenous contrast, they were given advice to follow if they became unwell after leaving the department. Staff received additional training on administering intramuscular adrenaline and had undertaken both deteriorating patient and anaphylaxis simulation training, and these were repeated yearly or sooner if necessary.

Illuminated signs identified when radiation was active in ionising radiation areas to warn people not to enter. The service was supported by a Radiation Protection Advisor (RPA). During our inspection we saw RPA visit reports containing action plans and recommendations. A Radiation Protection Adviser is an individual, or corporate body, that meets the Health and Safety Executive criteria of competence and has the necessary experience and expertise to advise on the organisation's uses of ionising radiation.

There were Radiation Protection Supervisors (RPS) working in the department and radiation-controlled signs gave contact details for them. A Radiation Protection Supervisor (RPS) is appointed for the purpose of securing compliance with the Ionising Radiations Regulations 2017.

Staff shared key information to keep patients safe when handing over their care to others. When inpatients identified as vulnerable, a member of ward staff accompanied them. The department used an electronic image requesting system that alerted staff to individual patient risks such as pacemakers and previous contrast reactions. The service employed radiologists and reporting radiographers and used external teleradiology services for reporting on imaging. The teleradiology service was used to report on a wide range of images and provided this service seven day a week. When imaging indicated an urgent clinical response, the service had a pathway to communicate this and avoid delayed treatment.

Staffing

The service had enough radiographers and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough radiographers and support staff to keep patients safe. Apprenticeships were in place and gave staff an opportunity to train as allied health professionals (AHP) and this measure improved staff retention and provided development opportunities. The service actively sought to recruit staff who trained in the department, so they were familiar with policies more rapidly.

The number of radiographers and support staff matched the planned numbers. There were enough staff in the service, when staffing numbers fell below those needed managers were able to use agency staff to maintain safe levels

Diagnostic imaging

Managers accurately calculated and reviewed the number and grade of allied health professionals, radiographic assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers made sure all bank and agency staff had a full induction and understood the service before they started work. The service recruited agency staff to cover shortages of staff and maintain safe staffing levels. The service had a clear induction booklet for all staff in the department and this included those from staffing agencies. This meant that the department had a consistent approach to induction.

Medical Staffing

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

The radiology staff did not match the planned number of staff. The service had taken measures to recruit into vacant posts and staff shortages in this group had been escalated nationally. This shortage in staff was identified on the trust's risk register, it was discussed at board level risk meetings. Recruitment into these posts had also been delayed due to international travel restrictions preventing successful applicants travelling.

Managers could access a radiology locum when they needed additional staff. Managers made sure all locums had a full induction and understood the service before they started work. The department employed a bank radiologist to support the interventional radiology service.

The service did not have a radiologist on call on evenings and weekends. There were agreements to transfer patients to another hospital if they required urgent interventional radiology.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. The department used electronic systems to store imaging details and scan reports. These systems were only accessible with a personal login which restricted access. Staff used radiology information systems to log scanning requests and these were then vetted by senior staff to ensure they were justified. Staff reviewed previous imaging in the trust undertaken on a patient to inform their decision when justifying exposure.

When patients transferred to a new team, there were no delays in staff accessing their records. When patients were seen in other areas of the hospital reporting information could be accessed by the main electronic patient record. Staff in other trusts could access patient scans and reports through their own medical imaging systems. When reporting was undertaken by the teleradiology service, they were able to access the imaging system directly and report within it, so images did not need to be sent.

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update. Staff told us that some records systems did not have technical support out of hours, and this could delay reporting processes.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Diagnostic imaging

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Radiographic staff checked blood results for patients receiving intravenous contrast to ensure this would not cause harm to body organs. Pre-assessment recording risk of anaphylaxis was also carried out a contrast check with patients on attendance before cannulation.

Staff stored and managed medicines and prescribing documents in line with the trust's policy. Contrast medicines were stored in locked cupboards which restricted access to them. Most anaphylaxis medicines were stored in locked cupboard. However, in one area we visited these were stored within patient reach. There were also instances where the sealed strip on some of these boxes was not intact and steps were not always taken to re-seal them. This meant staff could not be always assured that that they contained all items.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff at all levels could access the incident reporting system.

The service had no never events. Staff reported serious incidents clearly and in line with trust policy. Incidents reportable under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) were reported appropriately and investigations contained action plans.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Incident reports had an area to record duty of candour had been undertaken and these had been completed in the records we saw. Staff told us that investigations were undertaken by staff that were not working in the area at the time of the incident to avoid distress to staff and investigators alike.

Staff met to discuss the feedback and look at improvements to patient care. Managers supported staff after any serious incident and debriefing sessions were held. Managers shared learning at meetings and in staff areas, this provided staff with an opportunity for learning and reflection to inform future practice.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service was developing an imaging optimisation group with another trust to monitor radiation exposure and

improve quality of images. The external teleradiology service audited the quality of reports they produced. Senior staff updated protocols in line with changes to national guidance. The department also held imaging discrepancy meetings with the reporting service where reporting incidences or concerns regarding quality could be discussed, this meant the department could respond and monitor quality.

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice. Staff could access up to date policies and refer to them when needed.

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures. Staff took into account patients individual needs where food or drink were necessary for the procedure.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients were provided with information before fasting scans that detailed how long patients should do this for. Fresh drinking water was available in all waiting areas. Staff told us how they would provide patients with a small snack if they felt unwell.

Pain relief

Staff monitored patients regularly to see if they were in pain but did not use a formal scale. They supported those unable to communicate using a visual guide.

Staff assessed patients' pain using verbal checks but did not use a formal scoring scale. There was a visual guide for patients who may struggle to communicate verbally. Inpatients attending the department would be returned to wards if their pain was not controlled so pain relief could be administered. Patients attending from home were advised to bring any medication they needed to self-administer with them for their attendance. The department did not use patient group directions to administer any pain medicines.

Patients who were unable to communicate verbally were given a book with visual prompts to indicate pain, but this did not have a scale to reflect how bad the patient felt the pain was.

Patient outcomes

Staff monitored the effectiveness of care. They used the findings to make improvements and achieved good outcomes for patients

The service participated in relevant national clinical audits. The department provided evidence to show they were fully compliant with the WHO checklist for diagnostic imaging. The service had registered for audits to monitor best practice with NICE guidance in areas such as neuroimaging and CT spine imaging.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The breast screening department had worked hard to clear their waiting list to make sure all patients waited no more than 2 weeks from GP attendance to diagnosis. The service had been the first department in the south region to achieve this. The service supported the National Alliance action plan and provided women with a single diagnostic assessment reducing attendance and patient anxiety. The service was 100% compliant with six weeks turnaround for diagnostic results following GP referral.

Managers and staff used the results to improve patients' outcomes. The service displayed patient outcomes and waiting list information and were extremely proud of their achievements in reducing waiting times. Waiting times for investigation were similar or better than the national average, identifying patients received the right investigation at the right time.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service carried out a range of audits across all imaging modalities. Managers told us that they encouraged staff to identify audits that they thought would improve the service and were supported to undertake them.

All audits had a clear frequency indication, and this was monitored by the governance lead. Actions from audits were followed up in the next audit report. All audits were stored in a quality management system, this enable staff to access information easily. The governance lead was active in monitoring that files were stored correctly and updated.

Managers used information from the audits to improve care and treatment. An audit of extravasation incidents was used to highlight areas for improved practice and identify risks. Extravasation is when intravenous contrast leaks into the tissues surrounding the vein.

Managers shared and made sure staff understood information from the audits. Improvement is checked and monitored. Information from audits was presented at monthly meetings for discussion of action and improvement from them.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Radiographers, mammographers and sonographers had undertaken higher educational training to undertake their role. These staff were registered with the Health and Care Professions council (HCPC) and this registration required them to agree to a code of professional conduct to maintain registration.

Managers gave all new staff a full induction tailored to their role before they started work. All staff working in the department were provided with an induction logbook which gave details of a systems in the department and a wide range of other information. These logbooks contained sign off sheets for staff to become competent in the relevant areas of their role, it also gave staff a named contact for support. Staff supported newly qualified radiographers to develop their skills and there was a competency-based approach to gaining knowledge to undertake procedures

Managers supported staff to develop through yearly, constructive appraisals of their work. In the breast screening unit and within ultrasound 100% of staff had undertaken an appraisal in the last year. Within diagnostic imaging the percentage of staff that had an appraisal in the last year was below target at 65%. The service acknowledged that some appraisals had been delayed due to the pandemic, there was a plan to catch up with these.

The clinical educators supported the learning and development needs of staff. The service had developed some staff through apprenticeships, and within breast screening staff were training to become mammographers through this route. The department supported students from two universities to undertake training as part of their undergraduate education. These students were fully supervised by qualified staff in all aspects of their work. The Radiation Protection Advisor shared learning slides with the service to keep them informed and up to date with radiation protection knowledge, this was shared among staff and in staff meetings.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings were held monthly and updates from these were shared with the team.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service lead was keen for staff to highlight training needs and was proactive in supporting them to undertake any training they identified would benefit the service and their own development.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that they did not need to wait for appraisals to discuss learning needs and could approach management to discuss this. Improvements in practice were supported and promoted by staff who took responsibility to explore options to increase the quality of patient care. Reporting radiographers carried out a yearly audit to demonstrate proficiency.

Managers made sure staff received any specialist training for their role. The department had identified the need for specialist training in administering intramuscular adrenaline, they closed for the day so all staff could receive training. The training in adrenaline administration was also attended by staff who were not required to administer but support staff when doing so.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Managers told us that multidisciplinary meetings were held virtually across the trust and they attended these. These meetings and their outcomes were recorded in spreadsheets that could be accessed by attendees and were updated during the meeting. These meetings supported managers in planning services that fluctuated in capacity such as interventional radiology. Radiologists would also attend these meetings where their expertise was required.

Patients could see all the health professionals involved in their care at one-stop clinics. In the breast screening department symptomatic patients were able to attend a clinic where a mammogram, ultrasound and physical examination would be undertaken. These clinics were staffed by mammographers and a specialist doctor. If clinical evidence suggested a biopsy was required, this would be undertaken at this visit also. Staff gave patients in this clinic clear guidance on when they would receive results from these tests.

The service supported staff to undertake extended roles such as radiographer reporting. A sonographer was working to support another trust with their head and neck biopsy waiting list, this would give her experience in other areas within this patient group. This would then help the service to develop its offering in this area and improve services for patients.

Seven-day services

Key services to support timely patient care were not available seven days a week.

Staff could call for support from doctors and other disciplines. The service operated a full imaging, dental x-ray and screening service during the week. However, imaging services on weekends and out of hours were restricted to emergencies only. The service did not operate an interventional radiology service during weekends and on bank holidays due to staffing numbers. The limitations of the radiology service were documented on the trust risk register in line with clinical guidance. Patients requiring urgent interventional radiology during the weekend were transferred to another trust if clinical need indicated this.

Diagnostic imaging

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. Due to infection control measure in place during our visit all leaflets in waiting areas had been removed. Staff told us they could; however, access this information on demand or direct patients towards where to find it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Consent documents were completed, and they gave patients details of the procedure and risks associated. When a patient required contrast to be administered during a scan additional consent was gained.

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice. Staff training for mental capacity was mandatory but not all staff had completed this, evidence provided by the trust showed that in the main imaging department only 75% had completed it. Staff could describe and knew how to access policy on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards via the trust intranet site and staff showed us them.

When patients subject to the Mental Health Act required transport, internal systems or the patient's GP highlighted this to staff.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. When patients were unable to consent for treatment an alternative document was used, this document could also be used when a patient was not conscious due to trauma. Staff clearly recorded consent in the patients' records.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Diagnostic imaging

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection was saw that staff interacted with patients in a way that demonstrated empathy and good levels of care. Radiographers took time to speak with patients during procedures and made sure they were fully informed about what would happen. Mammographers in the breast screening unit took time to have detailed and compassionate conversations with women to ensure distress was minimised.

Patients said staff treated them well and with kindness. In the main waiting area, patient feedback had been posted. This feedback was positive in nature and praised staff for their care. Staff at reception spoke with patients and gave clear and simple instructions to patients on where they needed to go. When patients were required to attend an appointment in North X-ray, reception staff made sure directions were clear and would only redirect them there if they were assured the patient understood.

Staff followed policy to keep patient care and treatment confidential. In the main waiting area patients were called by full name only and all conversations regarding procedures happened once the patient was in a restricted area. In the cannulation area there were no doors to treatment areas, this meant that patients in beds may be seen by a patient in the area opposite. There were plans to shield these areas and prevent line of site.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff explained procedures clearly and with compassion, this meant patients were prepared for procedures. If a patient needed additional support or attended with a carer, efforts were made to involve them in these conversations. Staff interacted with patients who required additional support with compassion.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they could access translation services if required but these requirements would need to be known in advance if patients spoke a dialect that was not widely known. Patients were entitled to a chaperone on request and efforts would be made to provide one that was of the same gender. For imaging procedures where the procedure involved an intimate area staff worked in pairs to provide this as a standard and staffing allowed for this.

Emotional support

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. In the main waiting area during the week a member of staff was allocated to monitor patients in the waiting area. This meant that if a patient became distressed, they could alert radiographers and where possible they were seen sooner.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their diagnostic procedures.

Staff made sure patients and those close to them understood their care and treatment. During our inspection we saw radiographers giving patients information on when they could expect results from their scans. Patients were also directed to the most appropriate person to contact if they had not received their results in the expected time period.

Diagnostic imaging

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff showed us a book that be used to communicate with patients who may have difficulty understanding them. The book gave visual prompts for words and feelings. This meant that patients could describe any symptoms and staff were able to explain procedures to them before they started.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The department displayed survey feedback in the waiting area, patient surveys had stopped due to the pandemic, but these would resume once infection prevention controls allowed. Staff felt valued and supported in their role enabling them to provide high quality care. Patient feedback confirmed this was happening.

Patients gave positive feedback about the service. Feedback on display was mostly positive in nature, many of the comments praised short waiting times and caring staff.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The service provided imaging services to the wider hospital and also a walk-in service following GP referral. The service had a main imaging area with 2 CT scanners, 2 MRIs, ultrasound, interventional radiology and plain film imaging. In addition, there was an imaging area in the north area of the hospital that could undertake dental imaging, cone beam CT imaging and plain film imaging.

The service also had a mobile CT scanner which had dedicated parking. The breast screening unit carried out the cancer screening service for the entire population of the island and also symptomatic screening clinics.

Managers planned and organised services, so they met the changing needs of the local population. Facilities and premises were appropriate for the services being delivered. The amount of imaging equipment in the department provided easy access to imaging, and staff were able to book non urgent appointments easily and at short notice. During busy periods reception staff redirected patients requiring plain film imaging to north x-ray, and this reduced waiting times and avoided congestion in the waiting area. There was a walk-in service for plain film imaging.

The main imaging area was signposted clearly and close to the main entrance. However, patients may have struggled to find the north x-ray area as signage was not clear. Patients were provided verbal instructions on how to locate this by reception staff who only redirected patients who they felt were able to walk there.

The service had systems to help care for patients in need of additional support or specialist intervention. All imaging equipment was labelled to clearly demonstrate weight bearing limits, and risk assessments were in place for bariatric

patients. When a ward patient required additional support a member of nursing staff attended with them. Posters and leaflets to support paediatric patients had been created by a radiographer and these were on display in waiting areas. The service had also been working alongside a trust which specialised in paediatrics to improve the experience for this group of patients.

Managers ensured that patients who did not attend appointments were contacted. In the first instance staff contacted the patient directly to make sure they had checked on their welfare and to give an opportunity to understand their non-attendance. Managers monitored and took action to minimise missed appointments. Staff told us if patients did not attend for appointment and they could not establish a reason this was highlighted to the person who had referred them for the scan. This meant that patients who routinely failed to attend were made aware of the importance of attending.

The service relieved pressure on other departments when they could treat patients in a day. The service could report on inpatient CT scans within 24 hours of the procedure 99% of the time. This meant that patients could be discharged faster and did not wait on tests.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Some staff in the department had received additional training in dementia that they felt was extremely powerful, this was fed back to managers. In response to this the department were taking steps to get all members of staff to attend this training.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff were aware of patient passport documents, but as appointments were short these documents could not be used to familiarise themselves fully. Instead staff would approach each patient with compassion and asses the need to adapt communications and positioning throughout the appointment.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff could use a booklet to communicate with patients with additional learning needs. If staff felt that additional advice was needed for this patient group, they were also aware of contact details for the learning disability liaison nurses.

When a patient required transport, administrative staff provided details of any reasonable adjustments that patient would need to the transport service. The transport service was also able to provide information ahead of appointments and at time of booking if the patient was known to them, this information was then recorded on systems for staff to refer to.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff acknowledged the importance of impartial interpreters, particularly regarding consent. This meant that staff could be assured that patients were given the full information surrounding the procedure and gave informed consent. This was achieved by using a telephone interpreting service, it was acknowledged that this service could not always provide a translator and would struggle to do so at short notice. A poster communicating the risk of radiation during pregnancy in multiple languages was not on public display in the main waiting area at the time of our visit.

Diagnostic imaging

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The department was proud of its progress to reduce waiting times and displayed these in clinical areas. The service was fully compliant with national 6 week waiting targets in CT, MRI, Ultrasound and Mammography.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Surveillance scans were being undertaken sooner and waiting times for them were shorter than the previous year.

Patients were able to attend for symptomatic breast screening and receive result of this within two weeks of initial GP referral. When patients attended from internal areas efforts were made to avoid these patients being in the waiting area. This was achieved for emergency patients by calling the patients to attend when radiographers could take them straight in.

Staff did, however, highlight the lack of portering staff as a hindrance to flow, resulting in patients waiting in bed in communal areas due to delays in being brought down from wards. This also had an impact on outpatient waiting times as delays in inpatient transport affected the remaining patient list. The department did not display waiting times in the waiting area and patients had to ask staff for this information.

Managers worked to keep the number of cancelled appointments low. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. When servicing was being undertaken or there was equipment failure, patients were moved to other worklists to avoid delays.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. There were leaflets and posters telling patients how they could complain or raise concerns to PALS. There was also a phone number for the department given on paperwork where patients could contact them.

Staff understood the policy on complaints and knew how to handle them. Staff knew how patients could make complaints and could access the policy on the intranet.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Where complaints had been made these would be communicated to the team at the first opportunity. Managers spoke with patients where possible, so their input was included in all investigations. The service displayed monthly numbers of complaints and compliments, and this could be seen by all staff. When a complaint investigation was completed learning was shared with all staff.

Diagnostic imaging

Staff could give examples of how they used patient feedback to improve daily practice. The department had implemented 'my name is' in their working day and feedback from patients mentioned this.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good.

Leadership

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

Managers were able to detail responsive changes that had been made in the department and plans in place to improve the service. The service had used additional COVID-19 funding to increase CT capacity and this had reduced waiting lists and turnaround. There had also been a drive to reduce breast screening waiting times and managers sought additional funding to support weekend and evening working to reduce this in line with the national standard.

Leaders had an open-door policy, staff said they felt able to approach managers and discuss any concerns with them, they also gave examples of when they had done this. Leaders had knowledge in the area they were working in and used their experience to inform decisions. Where leaders did not have clinical knowledge in an area, they sought input from experienced staff. Staff told us they were able to approach leaders and give insight using their own knowledge of the areas they worked in. There were regular staff meetings and minutes of these showed discussions of service improvement and shared learning discussion. There were also apprenticeships in place to develop and support non-clinical staff though higher education to qualify as radiographic staff.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Leaders demonstrated a vision for their service and were motivated to improve. The service was aligned with the wider plans of the trust, to improve services for patients. Staff were aware of the strategy and were able to tell us about how it affected their service. Leaders recognised the limitations of the setting and were developing plans to improve it. There was a business case in development to incorporate a paediatric x-ray facility into the new build of the outpatient's department.

Change in practice and improvement was supported and promoted by leaders who took responsibility to explore options to increase the quality of patient care. There were regular meetings surrounding equipment planning and improvement of services, and weekly management meetings were in place to discuss ongoing needs of clinical areas.

Diagnostic imaging

Managers were proactive in making changes to benefit patients and supported staff to suggest improvements. For example, staff had identified the need for paediatric information leaflets and posters, this had been developed and implemented, with future plans to work closely with child and youth services to engage directly with young adults through social media.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff spoke positively and were proud of their workplace. Staff spoke positively about managers and said they were approachable and fair. Interactions between leaders and staff were warm and courteous. Leaders checked in with staff throughout the working day and encouraged them to feed back any issues. Staff also told us that they felt heard, and that managers respected and valued them. Leaders considered the wellbeing of staff and made sure they were supported. For example, staff were given flexibility during the pandemic so they could manage home and caring commitments.

Feedback from incident reporting was displayed in a way that did not identify staff and it was used to improve learning and practice. There was a strong focus on incident reporting and transparency in investigations. When incident investigations were undertaken this were done by staff who worked in other areas to avoid distress and bias. A recent staff survey identified that staff felt the response to errors and clinical incidents had improved. Staff also said they felt more confident to address concerns about unsafe clinical practice.

Staff were able to access supportive services through the trust counselling service and there had been a strong focus on making sure staff wellbeing was a priority. Staff who had undergone an appraisal said they felt it supported their needs and there was a focus on the previous year and how it had affected them personally. There was a wellbeing policy in place to support staff. Staff survey results showed staff felt there was improvement in 9 out of 10 areas, this included equality & diversity, and wellbeing. The wider plan for the trust identified the need to address racial discrimination through a range of measures including engagement and data analysis.

Leaders supported an open culture where patients, their families and staff could report concerns. Feedback from complaints was shared among staff and duty of candour had been completed as part of investigations. Staff knew about their responsibilities for duty of candour and could tell us how this was used in complaints and incident reporting. Patient feedback had highlighted concerns that inpatients were able to be seen in the main waiting area, this had also been identified by leaders. In response to these privacy screens had been purchased to shield them from view where possible.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance structure that was supported by a range of meetings. Staff had monthly meetings following an agenda to discuss a range of issues including complaints and incidents. Staff meetings minutes were shared with all staff

in the service. Senior managers had a weekly meeting to discuss issues and concerns, this meeting also informed service planning. The service operated under the planned care group of the trust and attended group meetings for this area. The governance lead told us how they had developed the storage and access of audit information and followed a quality improvement process to achieve this.

The service used a radiology reporting service and quality of this was monitored at monthly meetings, clinical staff could also inform this meeting by providing details to management. The teleradiology service also provided internal audit reports to the service. Another trust provided Medical Physics support and managers were able to contact them when needed. The Protection Advisor (RPA) produced yearly reports detailing areas for improvement and made recommendations the service should take, these actions were given dates of completion and followed up in regular check in meetings.

Management of risk, issues and performance

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

Leaders used systems to manage performance effectively. The service used a systematic approach to continually improve the quality of its services while maintaining standards of care. A governance structure was in place which was effective and promoted staff confidence. During our inspection we were shown the risk register for the department, this featured measures in place to lower risk. For example, the service had identified the lack of radiology staff as a risk, the service had plans in place to increase its offer in this area, but this was hindered by travel restrictions delaying new staff. All risks were discussed weekly at service level. Staff we spoke with were aware of the risks in the department and these matched those identified on the risk register.

Emergency generator testing took place across the trust and this was planned to avoid disruption to the service. The department had several radiation protection supervisors (RPS) who met regularly. They were also supported in their role by deputies. Controlled radiation area signs gave contact names and contact details for radiation protection supervisors. A Radiation Protection Supervisor (RPS) is appointed for the purpose of securing compliance with the Ionising Radiations Regulations 2017 for work carried out in an area which is subject to Local Rules.

There was out of hours support for the picture archiving and communication system *(*PACS) imaging system but some other systems such as the central reporting information system (CRIS) only had support during office hours. However senior leaders did also support staff during these hours if urgent assistance was required.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service ensured data or notifications were sent to external bodies when needed. We saw evidence that notifications such as serious incidents were submitted to the Strategic Executive Information System (STEIS). The service submitted incidents to regulators in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards

Diagnostic imaging

The service used technology systems to monitor and improve the quality of care. The governance lead had developed the storage of documents in a quality system and this enabled staff to access documents easily and in one place. Access to information systems was restricted to only those who needed it, and this kept patient and confidential information secure.

Engagement

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

The service engaged with patients seeking feedback to improve the quality of the services provided. Patient feedback was displayed and shared with the team. It was used to improve the service. Staff knew how to support patients to give feedback and raise concerns,

Staff told us the trust sought their feedback involving them in the direction of the service and the completion of staff surveys. Staff surveys showed that staff engagement in them had increased by 17% from the previous year. One area that had positive results was response to the statement 'Communication between senior management and staff is effective", this was also improved from last year.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training and service improvement. The service used incident reporting to identify improvement and this was shared among staff. Staff were being trained for extended roles and the service supported the development of reporting radiographers. Reporting radiographers underwent yearly audit to ensure the quality of practice was in line with national guidance and this was reported to managers.

The service participated in national research to support breast cancer service development. The need for image optimisation working groups had been identified and this was in the process of being developed. Staff throughout the department were engaged in audit process to improve practice and staff were supported to develop their own audits and improve practice.

Surgery

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service now provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff now received and kept up to date with their mandatory training. Records showed training compliance was now equal to the trust target in the majority of wards and departments. Areas of non-compliance was mainly due to staff members being on long term sick leave. Staff said they received email alerts, so they knew when to renew their training.

Staff now had dedicated time to complete mandatory training to ensure their skills and knowledge were kept up to date. Mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was delivered through e-learning modules with some face to face training modules. Training included recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers now reviewed and monitored mandatory training compliance and presented this as part of report at monthly divisional meeting.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff now had training on how to recognise and report abuse and they knew how to apply it.

Records showed that 95% of staff had completed safeguarding training. Staff said they received email alerts, so they knew when to renew their safeguarding training.

Staff now received training specific for their role on how to recognise and report abuse. Records showed a breakdown of which level of adult and child safeguarding training was required for each role.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had safeguarding policies to support staff, and these could be accessed on the trust intranet. Staff were aware of how to seek advice and support from the trust-wide safeguarding team.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff now used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Records showed that cleaning was undertaken in line with trust policies.

Surgery

Staff were aware of current infection prevention and control guidelines. Surgical site infections had now decreased.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. Cleaning schedules were complete.

Cleanliness of the environment and equipment and hand hygiene compliance was monitored as part of routine monthly audits. Staff could also seek advice and support from the trust-wide infection prevention and control team.

Doctors now completed hand hygiene training and training records confirmed this. All staff followed the World Health Organisation 'Five steps moments of hand hygiene', and hygiene audits confirmed this. Staff and visitors were encouraged to wash and gel their hands. There were enough hand wash sinks and hand gels.

Equipment was cleaned after patient contact and labelled to show when it was last cleaned, equipment we saw confirmed this.

There was clear guidance displayed on how to minimise the risk of spread of Covid-19 staff and patients adhered to social distancing guidelines. Staff followed infection control principles including the use of personal protective equipment. We observed staff challenging other staff members if they were wearing their facemask incorrectly. Patients on wards were offered a clean face mask twice a day, patients wore facemasks unless they were exempt.

Patients underwent infection screening (such as Covid-19 and MRSA) prior to admission. Patient records confirmed this was undertaken. Patients identified with an infection were isolated in side-rooms. Appropriate signage was used to protect staff and patients.

Staff worked effectively to prevent, identify and treat surgical site infections. In theatres we observed theatre staff used aseptic techniques to minimise the risk of infection. There had been one surgical site infection reported as part of the mandatory orthopaedic surgical site infection surveillance for 2019 and 2020.

Surgical wards and departments were categorised depending on their level of infection risk. Red (high risk of patients having Covid-19), amber (medium risk of patients having Covid-19) and green (low risk of patients having Covid-19). The wards categorised as green had ring-fenced beds for elective surgery to minimise the risk of elective patients getting an infection. In main theatres there was a dedicated emergency and trauma theatre for patients on a red or amber pathway.

Environment and equipment

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

There were arrangements for the safe handling, storage and disposal of clinical waste, including sharps.

Some areas in main theatres had been refurbished but there were still some areas in need of updating. Storage areas were cluttered, and staff told us there was a shortage of storage space. However, there was an effective system for safe storage of consumables and surgical implants.

Surgery

During Covid-19 different entrances and exits had been created to the main theatres to allow access to the emergency and trauma theatre which was categorised as a "red area". This was staffed by a dedicated team who had access to a dedicated rest area. This meant patients on a red or amber pathway did not cross over with those on a green pathway.

The design of the ward environment followed national guidance. All the ward areas had sufficient shower and bathing facilities. The majority of side rooms had ensuite toilet facilities.

Resuscitation equipment was visible and accessible. Resuscitation trolleys were kept on all surgical wards and in theatres. Trolleys now had tamper evident tags. The contents of the trolleys were checked in line with trust policy and records were complete. We found emergency equipment was fit for use.

The service had suitable facilities to meet the needs of patients' families. During Covid-19 a balcony area on Mottistone ward which was separate to the ward was used for visitors if patients were well enough to walk there.

Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. Theatre staff told us it could be difficult to obtain specialist equipment if needed for a patient as it had to be transported from the mainland. However, this was only for emergency or trauma patients and it could be expedited if clinically necessary. Equipment needed for elective procedures was ordered in advance of the patient's planned surgery date.

Equipment was serviced by the trust's maintenance team using a planned preventive maintenance schedule. All equipment had a sticker indicating when it last underwent an electrical safety test, so staff knew it was safe to use.

The trust had invested in electronic bed pushers so that staff did not have to manually push patients on beds and risk injury. We saw these being used and staff were positive about their introduction.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff now identified and quickly acted upon patients at risk of deterioration.

Patient records we reviewed, and trust audits confirmed significant improvements had been made to recognise and manage the deteriorating patient.

Staff undertook the World Health Organisations '5 steps to safer surgery' checklist in theatres. Audits showed over 90% compliance '5 steps to safer surgery' checklist in the previous 12 months. We observed staff consistently undertaking all five steps of the checklist and staff told us that the process was now embedded.

Staff now followed appropriate guidelines, pathways and screening tools, based on national guidelines (integrated sepsis recognition and response policy) for the management of patients with sepsis. Staff understood how to identify the signs of sepsis and the management of sepsis in line with national guidelines. There was a quarterly audit of all patients screened for sepsis and compliance with giving antibiotics to patients within one hour of diagnosing or suspecting sepsis to monitor outcomes and staff compliance. Audit data showed in the last quarter 98% of inpatients were screened for sepsis and 98% were given antibiotics within one hour of diagnosing or suspecting sepsis. The sepsis audit showed these patients received appropriate care and treatment.

Surgery

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks were completed. Patient records showed these were consistently completed.

Patients assessed as high risk were placed on care pathways, meaning they received the right level of care. Staff undertook 'intentional rounding' observations at least every four hours so any changes to the patient's condition could be promptly identified. Patient records showed patients were reviewed regularly and escalated when required.

Staff knew about and dealt with any specific risk issues. Safety huddles were undertaken in theatres and on the wards. Patient safety issues were discussed, and action taken to mitigate the risks. For example, communicating patients at risk of falls.

Staff used the national early warning score systems (NEWS2) tool and regular monitoring based on patients' individual needs to ensure any changes to their condition was promptly identified.

Staff undertook monthly NEWS2 audits to assess compliance against trust policies and national guidance. The trust 2020/21 audit showed increasing compliance with NEWS2; in May 2020 compliance was only 60% and in March 2021 it was 91%.

Nurse staffing

The service now had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, it some areas such as theatres there was still a high reliance on agency staff. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction. However, this was not always possible in theatres and this resulted in the cancellation of operations.

The trust had reducing vacancy rates. The trust's vacancy rate was nearly 10% for registered nurses. In 2019, the trust embarked on increasing their international recruitment programme. The programme led to the successful deployment of 147 acute registered nurses since July 2019.

The interim matron for theatres and day surgery told us they had recently started a review of the current staff establishment to determine whether this was sufficient going forward, this was in line with the trust's priorities for improvement quality priorities for 2021/22. Operating theatres were staffed in line with the Association of Perioperative Practice guidelines. Records showed that staffing numbers did not fall below national guidelines and that operating lists were cancelled if staffing was not in line with guidance. In these circumstances' clinicians prioritised the most urgent cases so these were not cancelled.

Managers now made sure all bank and agency staff had a full induction and understood the service including theatres. Staff told us that agency stuff in theatres now had an induction and we saw completed induction records which confirmed this. Agency staff in theatres were employed long term to ensure continuity and minimise the risk to patients.

There was a theatre staffing establishment review being undertaken to assess if additional staff were required to support the departments.

Nursing staff handovers and safety huddles took place these included discussions about patient needs and any staffing issues.

Surgery

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. Ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily. We saw that additional care support staff could be allocated to patients with greater dependency or specific needs to allow 1:1 care across the surgical wards.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, there was a reliance on locums to cover shifts and maintain patient safety. Vacancies were being covered by long term locums who were familiar with the trust. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The trust had a medical vacancy rate of just over 3%. The trust was aware of the challenges surrounding medical vacancies and had plans to address the shortfall. The trust's improvement quality priorities for 2021/22 set out how the trust plan to reduce the medical vacancies. These included partnership arrangements with another trust for joint appointments of consultants, who worked at both trusts.

The trust had strengthened senior medical cover with middle career speciality trainees. Consultants were on call 24 hours a day seven days a week to support junior doctors. The same consultant provided on site and on call cover during weekdays to provide continuity of care. Junior doctors told us that there were no difficulties getting the support they needed. They also reported that senior colleagues were approachable.

The trauma ward was also supported by a medical consultant on weekdays. The medical consultant also carried out daily reviews of patients. Ward staff and junior doctors spoke positively about the support they received from the medical consultant.

Junior doctors were based on wards depending on their surgical specialty areas. The hospital operated some mixed-specialty wards. Patients were seen by their specialty consultants and doctors on a daily basis, including on weekends. Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The majority of locum doctors had worked at the hospital on extended contracts, so they were familiar with the hospital's policies and procedures.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. Patient records were checked for accuracy and completeness as part of monthly audits.

Patient notes were comprehensive. Staff recorded the necessary information. We reviewed 10 patient records, and all had dates, times or notes about patients' preferences or wishes. Staff could find the most up-to-date information about patients when they needed it. Patients told us that staff always knew their preferences or needs.

Patient records were mainly paper based. Patient records were stored securely in locked trolleys. When patients transferred to a new team, there were no delays in staff accessing their records.

Surgery

Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly. Patient risk assessments were reviewed and updated on a regular basis in line with trust policy. Care plans were person-centred.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff now managed controlled drugs in theatres safely and undertook daily stock checks in line with trust policy. Theatre staff monitored compliance with the trust's controlled drug policy and audit findings were consistently 100%.

Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. Controlled drugs stock levels were correct, and the controlled drug registers were completed correctly.

The trust pharmacy department supplied medicines as stock and dispensed for individual patients. Medicines were stored securely and within their recommended temperature ranges.

The hospital used an electronic prescribing and medicines administration recording system. Medicine administration records showed patients were given their medicines in a timely way, as prescribed, and records were completed appropriately with few errors or omissions.

On the surgical wards liquid medicines that had reduced expiry dates once opened lacked either a date opened or revised expiry date. Therefore, the effectiveness of these medicines may have been reduced when administered.

Staff followed current national practice to check patients had the correct medicines. A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.

Monthly ward reports were generated within pharmacy to monitor missed doses. The reports specifically included antibiotics and medicines to support people living with epilepsy and Parkinson' disease.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and now reported incidents and near misses. Managers investigated incidents and now shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff reported serious incidents clearly and in line with trust policy. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.

Managers investigated incidents thoroughly. Incidents were reviewed weekly and monthly at specialty level and divisional level care to identify trends and to improve practice and patient safety.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed during daily 'safety huddles', routine staff meetings and handovers.

Surgery

Managers debriefed and supported staff after any serious incident. Patients and their families were involved in investigations. There was evidence of this in a root cause analysis investigation we reviewed.

Staff were able to give us examples of how reporting incidents had led to the improvement of patient care. For example, in main theatre recovery staff were taking patients back to the ward when they were safe to be discharged because staff on the surgical wards were too busy to come and collect them. This meant recovery staff were spending long periods of time away from recovery and reducing their time to be able to care for patients within recovery. Staff in recovery told us that by reporting every time it happened led to a change in practice and ward staff collecting patients.

There had been one never event reported in surgical services during the 12 months prior to this inspection. However, the event happened two years before, but there had been a delay in this being identified. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The never event investigation had only just begun at the time of our inspection. However, we saw some initial findings and learning had been shared with staff and actions implemented.

Managers shared learning about never events with their staff and across the trust. Staff were able to give us examples of learning and changes to practice from previous never events. For example, site marking for patients undergoing urological procedures.

Staff told us that if a theme was identified from reported incidents then a cluster review was undertaken to look for commonalities. For example, in theatres there was a cluster of patients and staff sustaining a diathermy burn. The cluster review identified that one of the diathermy leads involved was 20 years old. All diathermy leads were replaced, and a system implemented to track the age of diathermy leads. Diathermy is the use of high frequency electrical current to cut or coagulate tissue during surgery**.**

Actions from mortality and morbidity meetings were now clearly recorded and staff reported outcomes from incident investigations now being shared. Meeting minutes confirmed this.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The trust monitored compliance with the duty of candour standards. Records for March 2021 showed 100% compliance had been reported.

Safety thermometer

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

The collection of safety thermometer data was suspended during the Covid-19 pandemic. However, we saw safety thermometer data such as staffing levels and the number of falls on the ward within the previous month was displayed on wards for staff and patients to see.

Is the service effective?

Good ↑

Surgery

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Care and treatment for patients now followed national guidance. We saw that emergency surgery lists were embedded, and patients were treated in line with national guidance. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The trust now had a dedicated emergency surgery list five days a week between 8am and 12:30pm this was in line with the National Confidential Enquiry into Patient Outcome and Death guidance. Patients now had access to emergency surgery when they needed it and staff told us that the process was now embedded.

Staff followed clinical guidelines and pathways that were based on national guidance, such as from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges' standards. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidelines. Clinical guidelines were easily accessible through the trust's intranet.

We reviewed care pathways for a number of surgical procedures and found these were based on best practice guidance. The trust had now reinstated an enhanced recovery programme for patients requiring a variety of speciality operations which included joint replacements or revision joint surgery with an established multi-disciplinary team. Staff spoke proudly and positively about this service. Enhanced recovery is an evidence-based approach to delivering care in a way that promotes a better surgical journey for the patient and delivers a quicker recovery.

The service participated in both national and local clinical audits. The surgical specialties at this hospital were involved in over 30 national and local clinical audits during the past 12 months. Submission to some national audits had been paused during the Covid-19 pandemic. Findings from clinical audits were reviewed during monthly surgical specialty group meetings and any changes to guidance and the impact that it would have on their practice was discussed.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff used specific care plans when providing care and treatment for patients with mental ill health, which included additional measures such as enhanced monitoring and supervision.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff ensured patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support was available from staff such as dietitians and speech and language therapists for patients who needed it. Records showed that there was dietitian involvement with patients that were identified as being at risk. Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff.

Patients with difficulties eating and drinking were placed on special diets. Patients told us they were offered a choice of food and drink including snacks and finger foods. Drinks were readily available and were in easy reach of patients on the wards.

Patients waiting to have surgery were not left nil by mouth for long periods. Arrival times were staggered to minimise the time patients were kept nil by mouth. Staff told us that if there was a delay in theatre this would be communicated wards and departments to allow patients to drink fluids to avoid dehydration.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff prescribed, administered and recorded pain relief accurately. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a numerical score to measure pain experienced by patients as part of the National Early Warning Score 2 (NEWS2) assessment record. 'Intentional rounding' assessments occurred, where staff assessed patient needs on a regular basis included the assessment of pain.

There were pain assessment tools for use with patients who may struggle to communicate and articulate their pain and gave us examples of when they have used them.

Patients told us that they received pain relief soon after requesting it. We saw referrals were made to anaesthetists for specialist pain relieving procedures, when conventional pain relief was not alleviating the patient's pain. An example of this was a consultant referring a patient for a pain-relieving nerve block insertion for broken ribs. Staff told us that the acute pain clinical nurse specialist was responsive should staff request a specialist pain review for a patient.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Managers and staff were aware of the areas it needed to improve upon in national audits and had action plans to address areas of poor performance.

The national hip fracture audit 2019 showed varied outcomes, improvement was shown in some indicators but decline in other indicators. For example, the total length of stay for a patient in hospital had reduced from an average of 18.2 days in the 2018 audit to 13.3. days in 2019 audit. However, the peri-operative medical assessment rate of patients was 32% in the 2018 audit and 19% in the 2019 audit. We saw the trust had developed an action plan to improve performance in this area. However, during the Covid-19 pandemic some theatres were used to care for critically ill patients which impacted on the time of surgery.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The trust used a bespoke software programme to monitor all the audits. This enabled effective oversight of audits across the trust and identified areas were improvements were required. The monthly compliance rate for audit completion had been above 90% every month.

Managers shared and made sure staff understood information from the audits. Audit findings were displayed in wards and departments for staff to see.

Managers and staff used the results to improve patients' outcomes. We saw meeting minutes which confirmed this, audit findings were discussed at ward and departmental meetings. For example, implementing a frailty service which supported the orthopaedic team to improve performance in the National Hip Fracture Database Audit.

Competent staff

The service did not ensure all staff were competent for their roles. Not all staff groups had their competency assessed using a competency based assessment. Staff told us the competencies for different staff types and roles were being developed. Staff told us that managers now appraised staff's work performance and held supervision meetings with them to provide support and development. Appraisal rates had now improved, however the number of completed appraisals did not meet trust targets.

Staff told us they now routinely received regular supervision and annual appraisals. Appraisal completion rates for all surgical wards and departments was 85%. This showed most staff had completed their appraisals but the trust target of 95% for staff appraisal completion had not been achieved. Managers told us all outstanding appraisals had been scheduled.

New staff now had a full induction tailored to their role before they started work. We spoke to a member of staff who was recently employed by the trust. They confirmed they had received a full induction including a period shadowing other staff.

Not all staff groups had specific competency assessments for their role they performed. Staff undertook generic competency assessments for their role. Managers told us they were developing specific competency documents which reflected different roles such as staff working in the day surgery unit. We saw some examples of the draft specific competency documents which confirmed this.

All staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers. There were regular training sessions and staff were supported to attend these.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Doctors in training told us that training sessions had carried on despite the Covid-19 pandemic.

The service had recently recruited a number of newly qualified and international staff on the surgical wards and theatres. The ward managers or other senior staff provided additional support for newly recruited staff and supported them to finish their education to obtain professional registration.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff handover meetings took place during shift changes and 'safety huddles' were carried out daily to ensure all staff had up-to-date information about risks and concerns.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was effective communication and handover of patients who were in HMP Isle of Wight who were admitted to the hospital for care and treatment.

Surgery

Staff told us they had good relationships with consultants and ward-based doctors. We saw there was effective team working and communication between all staff disciplines.

On the wards we observed ward rounds and safety huddles where there was involvement from nursing, medical and allied health professional staff. Hospital navigators identified patients nearing readiness for discharge and supported that process.

Seven-day services

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

Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at the weekend.

There was a 24-hour service with dedicated emergency and trauma theatre meaning patients admitted over the weekend who required emergency surgery could be operated on promptly.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Resident medical officers covered out of hours to support junior doctors. Theatre and ward staff told us that there was good support outside normal working hours and at weekends.

Radiology, imaging (such as x-rays or CT scans) and physiotherapy, was available on call outside of normal working hours and at weekends. Pharmacy services were available seven days a week. There was an on-call service for when the pharmacy closed.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards and units. We saw on the day surgery unit that the wellbeing champion had created a wellbeing noticeboard, with information promoting a healthy lifestyle such as healthy food recipes and the importance of taking regular exercise.

The service promoted different health campaigns and encouraged patients to take ownership of their health. We saw a “love your breasts, be breast aware” campaign encouraging patients and visitors to check their breasts for any abnormalities.

Staff assessed each patient’s health at pre assessment and provided support for any individual needs to live a healthier lifestyle. Patients identified with weight concerns were referred to dietitians for advice and support. Patients with addictions, for example alcohol, were offered support from specialist hospital-wide liaison teams.

Patients on an enhanced recovery programme were offered additional support and guidance, with an aim of enhancing their recovery so that they could go home as soon as possible. Guidance included aspects of care aimed at improving mobility, pain control and general health and wellbeing.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, patients were not given a copy of their consent form for their own records. Staff now knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff now received Mental Capacity Act training and demonstrated a good understanding. Staff compliance with Mental Capacity Act training was over 90% on all surgical wards and departments.

Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient records showed that consent had been obtained and that care was delivered with their agreement.

Staff told us the risks and benefits of the specified surgical procedure were documented and explained to the patient. Consent forms were completed to a good standard with risks and benefits clearly documented. However, patients did not receive a copy of their consent form as recommended by the Royal College of Surgeons of England. Not giving patients a copy of their consent form meant they did not have a copy for reference and reflection.

Staff made sure patients consented to treatment based on all the information available. Patients were consented in clinic prior to their admission for their procedure by a surgeon that would be involved in their care. Patients were provided with written information such as patient information leaflets. Patients told us that they were given enough information and time to make a decision about their operation.

Staff received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Patient records now included documentation of Mental Capacity Act assessments.

If a patient lacked capacity to make decisions about their care and treatment, staff sought consent from an appropriate person that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. There were no patients subject to a Deprivation of Liberty Safeguard during our inspection.

Staff described and knew how to access policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was a trust-wide safeguarding team who provided support and guidance for staff for mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications. Staff gave us examples of when they had accessed them and were positive about their support.

The trust monitored how well the service followed the Mental Capacity Act 2005 and made changes to practice when necessary. For example, staff completed monthly audits in relation to patients with dementia, audit findings were discussed at monthly dementia meetings.

Is the service caring?

Outstanding ☆ ↑

Surgery

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, now respected their privacy and dignity, and took account of their individual needs. Patient feedback about their care was overwhelmingly positive.

Patients were truly respected and valued as individuals and were empowered as partners in their care.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw patients were treated with dignity, compassion and empathy. In theatres we observed that staff took the time to interact with patients during their procedure by explaining the noises they would hear, providing reassurance an updating them on the progress of their procedure.

Staff treated patients with compassion and kindness, comments from patients on thank-you cards included; “Thank-you for your care, kindness and compassion showed to me following my recent stay with you”.

Feedback from people who used the service and those who were close to them was continually positive about the way staff treat them. Patients thought that staff went the extra mile and the care they receive exceeded their expectations.

A national decision was taken to pause the collection of Friends and Family information to allow the NHS to respond to the COVID pandemic. Therefore, data collected has been limited and is not comparable to previous years; for this reason, it has not been included in this report.

The trust had implemented a system which aligned with the amended Friends and Family test questions. The trust received feedback from 3988 patients in 2020/1, 3968 of these were from paper postcard surveys with 20 online surveys completed. The overall trust recommend score was 98% across all surveys. Out of the patients who completed the surveys across the service patients said that their care was good with each area achieving over 90% of patients saying their care was good.

We were given examples of when staff had gone the extra mile for patients. For example, a patient attending for pre-assessment wanted to go into the main hospital to get a coffee but was not allowed due Covid-19.The patient became upset and was threatening to leave without undergoing their pre-assessment, so a member of the administration team went and got a coffee for the patient, who then calmed down and underwent their pre-assessment.

Staff followed policy to keep patient care and treatment confidential. We observed staff lowered their voices when talking to patients about confidential matters.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff in the day surgery unit told us that the pre-assessment team informed them in advance if a patient with mental health needs was attending for an operation, and they would try to seat them in a quieter waiting area, with dimmed lighting away from the noise of the main area.

Staff respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff gave an example of when a female patient wanted an all-female team caring for her throughout her operation for their religious needs. Staff were able to organise this and respected the patient’s religious needs.

Surgery

Staff took account of the individual needs of patients. Staff told us about a patient who needed to come in for urgent surgery. When telephoned to arrange they broke down in tears as they were too embarrassed previously to say they couldn't afford the bus fare to the hospital for treatment. The trust made arrangements for the patient to be transported to hospital for their surgery.

Emotional support

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

There was a strong, visible person-centred culture. Staff told us about a young patient who wanted their mother to wait with them prior to their operation and to accompany them to the anaesthetic room. Staff arranged for the patient's mother to have a Covid-19 test at the same time as the patient, the patient's mother also self-isolated prior to their daughter's operation and staff allowed the patient's mother to accompany the patient throughout their operation.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The hospital had a carers' lounge, which provided a wide range of support to carers. Caring for someone has an impact on many aspects of a person's life and when the cared for person is admitted into hospital it can cause stress, worry and upset. Staff in the carers' lounge recognised the pressures of caring and offered unpaid carers information and a range of support. The service was open to all carers of adults. Carers could visit the lounge and talk to the team in confidence about any issues they were facing and with which they needed support.

Staff in the pre-assessment unit told us about a patient who was distressed on the phone after a recent diagnosis of cancer and needing an operation. The staff member contacted the Macmillan support team in the hospital and arranged for them to phone the patient and offer support. The patient subsequently phoned the pre-assessment department to thank the member of staff.

Staff provided emotional support to patients and were able to recognise when patients were not able to continue with their treatment. For example, a patient was scheduled to have several skin cancers removed under local anaesthetic. Theatre staff recognised when the patient had been through enough and was unable to continue and acted as the patient's advocate. With the patient's agreement staff arranged for the patient to come back on another day to have the remaining skin cancers removed once they had recovered.

Staff told us about a patient who was recently widowed and broke down in front of staff as they felt lonely and isolated. Staff made some enquiries and managed to link the patient up with a local men's support group.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

The hospital service had launched a new service to keep hospital patients connected with their loved ones. The "Message to Loved Ones Service", run by the trust patient experience team, was launched to maintain the important connections between hospital in-patients and their families during the COVID-19 visitor restrictions. Relatives and friends telephoned a dedicated number and left a message for their relative or friend. Messages and pictures were printed out, laminated and delivered to each patient to help keep their spirits up during this difficult time. Staff told us that patients were appreciative of this service.

Surgery

Staff made sure patients and those close to them understood their care and treatment. When visiting was restricted on the wards, the ward manager would make welfare calls to their families to update them on how they were and gain an understanding of the patient's interests or hobbies or what they like to eat. This enabled staff to further engage and support patient's and talk to them about their hobbies and interests.

Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account. Staff gave us many examples of when they had provided patient centred care.

Patients gave positive feedback about the service. We saw wards and departments received many thank-you cards from patients. We reviewed a selection of these on the day surgery unit and comments from patients included; "I could not fault anything, brilliant staff who went above and beyond to make my care excellent" and "Absolutely great, cannot fault treatment given, staff are amazing".

Staff supported patients to make informed decisions about their care. Staff told us about a patient who regularly visited the surgical assessment unit for treatment of a long-term condition. We spoke to the patient who told us that they could ring the unit when they thought they needed to come in for treatment and would make arrangements to come in. The patient told us; "Absolute best of care, I look forward to coming in, its great they know exactly what I need, I have genuinely become friends with the staff, they are always cheerful and friendly."

Is the service responsive?

Good ↑↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service now planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.

Managers planned and organised services, so they met the needs of the local population. There were daily meetings with the site management team so patient flow could be monitored and maintained. Staff were aware of how to escalate key risks that could affect staffing and bed capacity constraints. There was daily involvement by the matron and ward managers to address these risks.

The hospital employed 'navigators' who identified and resolved any issues relating to the admission or discharge of patients. Staff were positive about the 'navigators' who had links to other local organisations and communicated with other health and care organisations to support safe discharges.

A project was launched to help speed-up skin cancer diagnosis on the Isle of Wight. Multiple different agencies took part in the project. The project saw GP practices on the Isle of Wight use an app-based innovation to help rapidly refer people

who were concerned about skin abnormalities. The technology reduced waiting times and the number of follow-up appointments required. The app was used to photograph skin conditions, including skin cancer. It rapidly shared images of suspect skin legions between GPs and dermatologists. This was especially useful for the Isle of Wight, for periods when the dermatologist was not physically on the Island.

The project was initially launched last year, and now every GP surgery on the Island was using the app. The app and associated new ways of working have seen waiting times between referral and review decrease dramatically. Previously, the average wait from referral to first consultant review was 26 days. For referrals managed via the app, the wait time was 0.6 days.

Facilities and premises were now appropriate for the services being delivered. Issues with mixed sex accommodation in the day surgery unit had been resolved.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The areas we inspected were compliant with same-sex accommodation guidelines: male and female patients were cared for in separate areas. Surgical services had reported two mixed sex breaches in the last 12 months, both were due to pressures caused by the Covid-19 pandemic.

The hospital provided a range of elective and unplanned surgical services for the communities it served. This included, trauma and orthopaedics, maxilla-facial surgery, ear, nose and throat surgery, ophthalmology, urology and general surgery. There were arrangements with hospitals on the mainland to allow the transfer of patients for surgical specialties not provided by the trust such as cardiothoracic surgery and vascular surgery.

The service relieved pressure on other departments when they could treat patients in a day. The hospital had a Same Day Emergency Care Unit. The unit aimed to treat emergency adult patients safely and efficiently on the same day avoiding admission to a hospital bed. Patients were assessed, diagnosed, treated and were able to go home on the same day. The unit was open seven days a week between 9am and 7pm, outside of these times, the patient may be offered an appointment for a subsequent day. The unit accepted referrals from health professionals across the trust (including the Emergency Department), the community and primary care. Referrals were made to a senior doctor in training or a consultant on a dedicated phone. Patients attending the unit were given a pager so they could leave the department and when the doctor was ready to review them, they were paged to return to the department. A range of surgical patients accessed the unit for diagnostics such as an ultrasound or review by the surgical team. We spoke to a patient who regularly accessed the unit for the management of a long-term condition, and they could not speak highly enough of the service.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital had dedicated learning disability liaison nurses who provided support for people with learning disabilities.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems.

Meeting people's individual needs

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. **Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Surgery

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs.

Staff told us about a patient with learning disabilities who received person centred care. The patient was scheduled to be admitted for an elective procedure under general anaesthetic. Staff worked together to organise the patient's other health needs to be undertaken at the same time. The patient whilst under general anaesthetic also had chiropody treatment, dental treatment and blood tests. The service had a dedicated learning disabilities anaesthetist and theatre practitioner who cared for patients with a learning disability.

Wards were now designed to meet the needs of patients living with dementia. Staff told us that they had clearly defined routines for the daytime and night-time to help patients living with dementia to orientate themselves to the time of day.

Each ward bay had a board with the day, date and weather outside to help orientate patients living with dementia. We saw these were completed in all areas.

The hospital had replaced white crockery with crockery in contrasting colours to make it easier for people living with dementia to see and recognise food on the plates.

The hospital had a variety of finger foods available for patients living with dementia. People living with dementia may find it hard to use cutlery, chew or swallow. Finger foods are often a better option as they can be eaten easily by hand. Staff confirmed it was easy to access finger foods.

The trust had developed a training plan that empowered all staff to support and care effectively for people living with dementia and those important to them. Each area or department had a dementia champion who had completed additional training, the dementia champion on the day surgery unit confirmed they had completed the training.

The trust had developed and implemented the dementia associate practitioner role. The practitioners supported with ward and memory room based activities to help reduce anxiety, distress and agitation in people living with dementia in the hospital. Staff we spoke to were positive about the role and had accessed it. The hospital also had a dementia outreach team to provide support and advice, the trust had plans to extend the service provision further in the next 12 months.

Staff made patients aware as part of discharge planning that they were able to access services from the Isle of Wight Age UK for 14 days for free. Isle of Wight Age UK could provide welfare calls, undertake shopping and collect medicines for patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us about a patient with hearing loss that underwent an operation under local anaesthetic. Staff obtained an assistive listening device (ALD) for use during the operation when the patient could not wear their hearing aids. ALD’s are designed to be used as a communication device. The inbuilt microphone makes it possible to hear conversations and communication with staff.

A new service to support children and adults with autism during the COVID-19 pandemic was launched in June 2020. The Isle of Wight Autism Support Hub provided support to children and adults who may be feeling isolated or overwhelmed,

as well as to their families and carers. It could be accessed several ways including via a peer support phone line, five days a week. The trust partnered with a local autism support group to set up the support service, which amongst other things helped people with autism understand the sometimes-complex situations encountered during hospital care and treatment.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. For patients receiving planned care, a pre-admission meeting provided the opportunity to discuss the level of support needed, identify any reasonable adjustments necessary to support them during their hospital stay, complete the pre-admission documentation, and share and discuss the person's hospital passport. This ensured that the person with a learning disability or dementia received the support they need throughout their hospital stay. The trust undertook audits to check patients who required a hospital passport had them.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care and information to meet all their needs. Easy read discharge summaries with pictures were available for patients with learning disabilities to provide information in a way that they could understand.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets were also available in different size fonts and on coloured paper for patients with a visual impairment.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff confirmed it was easy to access interpreters when they needed to.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. The service performed worse than national standards for waiting times from referral to treatment. The average length of stay of patients was better than the national average, the only exception was patients having non-elective Urology admission.

From April 2020 to March 2021 the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average, except for May 2020 and January 2021 when it was better than the England average.

From February 2020 to January 2021 the average length of stay for patients having elective All surgery at St Mary's Hospital was 2.7 days. The average for England was 4.0 days.

From February 2020 to January 2021 the average length of stay for patients having elective General surgery at St Mary's Hospital was 2.1 days. The average for England was 4.2 days.

The average length of stay for patients having non-elective Trauma and orthopaedics surgery at St Mary's Hospital was 6.7 days. The average for England was 7.5 days.

The average length of stay for patients having non-elective Urology surgery at St Mary's Hospital was 3.7 days. The average for England was 2.3 days.

Two specialties (urology and ear nose and throat) were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Surgery

Four specialties (general, oral, ophthalmology, trauma and orthopaedics) were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

In Quarter two of 2021/22 the trust operated on 1884 patients and cancelled five operations on the day of surgery. Of these five patients, one was not treated within 25 days of surgery.

Over the last two years, the percentage of cancelled operations at the trust rose from 0% (below the England average) to 17% (above the England average).

The trust had comprehensive plans on how they were going to restore elective and outpatient services due to the Covid-19 pandemic. We reviewed these plans and actions that had already been completed included; ring fenced Covid-19 secure beds, segregated low and medium/high risk theatre pathways for elective and emergency/trauma surgery, increased staffing establishments to reflect revised inpatient pathways, prioritisation of elective and admitted waiting list on basis of clinical need and insourcing of some services. Data showed that these actions were having a positive impact on reducing waiting lists. In March 2021 there were 1200 patients waiting over 52 weeks for their surgery this had reduced to 700 in June 2021.

The recovery plan outlined the next steps which included an additional modular theatre, which would increase day case capacity by 25%. It was expected to be operational by early autumn. Additionally, a surgical optimisation programme was planned in collaboration with community services. This would mean patients on waiting lists would be reviewed in the community to ensure early intervention for conditions that may prevent surgery going ahead on the planned date. New pre-assessment software would allow patients to access their information and to participation in their optimisation. Further expansion of weekend working was also in the plan.

Patients were admitted to the service through a number of routes, such as pre-planned day surgery, through Emergency Department or through GP referral. Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

Managers actively monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. There were weekly access meetings to track and expedite all long waiting patients.

There was an agreement in place with an external health provider to utilise the trust's existing theatre space during weekends to provide surgery for elective procedures. The trust also had arrangements with a number of independent health providers to support elective surgery. The trust had also insourced a pre-assessment provider to undertake pre-assessment of patients at the weekend as the pre-assessment unit did not have capacity to keep up with the amount of pre-assessments needed to match the extra theatre capacity. Staff reported that there had been some issues with this arrangement and that it had created additional work for them. The manager responsible for pre-assessment acknowledged that there had been some initial problems, but they were undertaking weekly meetings with the provider to improve communication and resolve any issues.

Managers monitored that patient moves between wards services were kept to a minimum. Data showed there were minimal ward moves out of hours which could have a negative impact on patients.

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, complaints were not always managed in line with timescales set out in the trust's complaints policy.

The service clearly displayed information about how to raise a concern in patient areas. The wards and theatre areas had information leaflets displayed showing how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients were aware of the process for raising their concerns with the staff.

In quarter four of 2020/2021, the planned care received 23 complaints this was a reduction in complaints compared with the previous quarter.

The number of complaints managed within there timescale had improved during 2020/21. In the planned care group in 2020/21 33 complaints were managed within the timescales and 37 breached the timescales, in 2019/20 55 complaints breached the timescales.

The trust had reviewed their complaint handling process and had introduced the role of of complaint case handlers which provided the clinical divisional teams to focus on a robust and timely investigation.

Managers investigated complaints and identified themes. The ward and unit managers were responsible for investigating complaints in their areas

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff confirmed that information about complaints was discussed during daily 'safety huddles' and at routine team meetings to aid future learning. Meeting minutes confirmed this.

Staff understood the policy on complaints and knew how to handle them. Staff could give examples of how they used patient feedback to improve daily practice. For example, patients attending for their pre-assessment had feedback frustration with parking in the hospital the trust implemented dedicated parking spaces for patients attending pre-assessment.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, the new care group structure needed embedding and there was a number of senior staff in interim roles, the service had been through a long period of instability with interim managers.

Surgery

The trust had recently changed the structure of care groups, now there were two care groups: planned care and unplanned care. The surgical services formed part of the planned care group. The care group was led by a chief operating officer, clinical director, director of operations, associate director of nursing, associate director of operations and head of midwifery. They were supported by two deputy associate director of operations and eight operation managers. Several members of the management team were new to the roles but had a clear understanding of the risks to the surgical services and how to address these. The clinical director only started the role in June 2021, but staff were positive about their impact.

Each surgical ward was managed by a ward or unit manager with support from senior nurses. There was an interim theatre matron who was responsible for overseeing theatres and day surgery supported by only one band seven staff member, the other band seven post was currently vacant. The ward and unit managers were overseen by the heads of nursing and matrons. A number of new ward managers, matrons and senior nurses had been appointed in the last 12 months, so the leadership team was fairly new across the surgical services.

Several staff told us that they felt the hospital had been operationally led and was not nursing or medically led. Staff gave us examples of when operational managers had made decisions without nursing or medical input. For example, the ownership of nursing vacancies and serious incidents sat with the operational management rather than with the nursing or medical teams. Managers told us that this was changing, and some changes had been made. For example, the ownership of nursing vacancies and HR matters relating to nurses was now the responsibility of the associate director of nursing.

Staff told us of a long period of management positions being covered by interim staff which was unsettling and impacted on driving changes forward. The majority of management positions were substantive roles.

The majority of staff spoke positively about the leadership and organisation structure and described their line managers as approachable, visible and who provided them with good support.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's brand statement was 'great people, great place'. The 2020/21 acute services operational plan identified priorities such as a redesign of the acute services, theatres productivity, and getting beyond 'good'. In addition, there was a trust wide quality improvement strategy based on the 'getting to good' turnaround objectives. We saw progress had been made, such as the development of an Island wide dementia strategy, by working closely with the wider health economy.

The vision and values had been cascaded to staff across the surgical services and staff had a good understanding of these. Some wards and departments had developed their own vision or strategy, we saw these displayed on notice boards.

The trust had comprehensive plans on how to restore elective and outpatient services due to the Covid-19 pandemic. Staff were aware of the plan and how they played a part in achieving the plan.

Surgery

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were highly motivated, patient-focused and spoke positively about the care they delivered. There was mainly a friendly and open culture, some staff told us that there was a historic issue with the behaviours of a minority of consultants. Staff told us that these behaviours were now being challenged and managed by senior medical staff and they felt confident the behaviours would be addressed.

Staff including doctors said they received regular feedback to aid future learning and that they were supported with their training needs. Junior doctors and newly recruited nurses said they received good training and learning opportunities.

In theatres, we heard from staff who had been recruited from overseas, they could not speak highly enough of the support and development they had received both during work and outside of work. Staff told us that when they arrived in the UK, they were given a placement in a host family whilst they settled in.

Staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared. All staff were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed.

The trust recognised the impact that the Covid-19 pandemic had on staff and was promoting a culture that it was okay to not be okay and had a variety of support mechanisms work staff. For example, staff could access 'a listening ear' which was a conversation with a trained counsellor. Staff knew about this service and how to access it.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, some governance processes required embedding.

There was a perception amongst some staff that the trust had previously been operationally led rather than medically and nursing lead and operational staff making decisions about clinical matters. Managers were addressing this to ensure that governance ownership and oversight was aligned to the correct group of staff. For example, ward and department managers now had to present audit findings from their area at quality and risk safety meetings.

Senior staff told us that there had been a backlog in outstanding incident investigations and complaints as the responsibility for investigating these was previously with the care group quality manager. These were now the responsibility of the medical and nursing speciality they belonged to. An incident action tracker had also been implemented for oversight of outstanding actions from incidents. Quality and risk safety meeting minutes showed that reviewing the tracker was a standard agenda item.

The surgical services had clear governance structures, but they required further embedding to provide assurance of oversight and performance against safety measures. There were monthly specialty level and care group level meetings to discuss governance and risk. Each surgical specialty had routine monthly governance meetings and governance and operational performance was reviewed. However, staff told us that some meetings required additional speciality input such as the theatre user group meeting.

Surgery

The quality and risk safety meeting minutes showed key discussions around workforce, current risks, clinical effectiveness and performance issues.

The trust had an existing ward accreditation programme to assess the quality of care delivered in wards and departments, these were undertaken by a member of the executive team. The visits were rated the same as the CQC rating system. Accreditation visit reports were displayed and findings were discussed at safety huddles. Main theatres had recently had accreditation visit and we saw action had been taken to address the findings.

Mortality and morbidity meeting minutes showed that these now showed who had attended the meeting and any actions to take forward. This was in line with the Royal College of Surgeons guidelines.

There were monthly ward and unit meetings and minutes showed that incidents, complaints, staffing and risks were reviewed.

Management of risk, issues and performance

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

The trust used an electronic risk register system to record and manage key risks. Each ward and department now maintained a risk register, which fed into the planned care group which fed into the corporate risk register.

Risk registers showed risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to care group and trust level.

Meeting minutes showed key risks were reviewed at the monthly quality and risk safety meetings. Mortality and morbidity meetings followed a set format, with attendance recorded and notes taken.

In each area, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.

Routine audit and monitoring of key processes took place to monitor performance against objectives. The service used a bespoke computer system to facilitate the collection and submission of data for audits, staff took it in turns to undertake the audits. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through team meetings, safety huddles and newsletters.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service now used a bespoke computer system to facilitate the collection and submission of data for audits, staff took it in turns to undertake the audits. Staff were positive about the system and said it was easy to use.

Surgery

We did not identify any concerns in relation to the security of patient records during the inspection. The majority of patient records were still paper based, prescribing was undertaken electronically. Theatres used an electronic system to record the patient's pathway in theatre, it also allowed staff an overview of what was happening in real time. The system was being updated to allow for the recording of the World Health Organisation Safer Surgery checklist, the system did not allow staff to move on to the next step of the five step checklist until they had confirmed the previous step had been completed.

Paper-based patient records (such as patient bed side notes) were kept securely. Staff files and other records were a mixture of electronic and paper based. Staff files in theatres showed they were in need of updating.

Audit records and staff rotas were held electronically. The service used an electronic messaging system as a way of communicating key messages and rotas, in theatres the staff allocation was sent out the day before via the electronic messaging system. If staff printed documents, it was date and time stamped with the name of the person who printed it.

Computers were available across the wards and theatre areas and staff access was password protected. Staff told us that there were several different IT systems used that did not link with each other and all required different passwords, and this could be a challenge to remember them all. Some staff also told us that there could be connectivity issues and that the IT systems could be slow.

Policies, procedures and clinical guidelines were accessed through the trust intranet site.

We saw in the day surgery unit patients' names were displayed in the corridor. Staff explained that they sought consent from patients to display their name and if they did not consent then just the patient's initials were used.

Engagement

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

Staff received good support and regular communication from their line managers. Records showed staff regularly participated in team meetings. The trust engaged with staff through newsletters and staff briefings from the trust's executive team. Other general information and correspondence was displayed on notice boards.

The service collaborated with partner organisations to help improve services for patients. For example, working with other trusts to ensure that patients received specialist treatment when required on the mainland.

The trust had a staff awards programme to recognise and celebrate achievements of staff which was called "Celebrating #TeamIOWNHS." The programme had different awards and both staff and the public could nominate individuals or teams that they feel really deserve the recognition. There were also long service awards, #MeetTheTeam, Greatix, thank you cards, staff stories and chief executive awards.

The trust also had #FeedbackFriday and "social shoutouts" which was when the trust shared feedback with staff that had been sent into the trust from patients or their families/carers/friends.

During the Covid-19 pandemic staff had developed initiatives to boost morale and staff motivated. Day surgery staff had a plank challenge, which was a competition to see who could hold a 'plank' yoga pose for the longest and theatre staff had established a weight loss group.

Staff were provided with emotional support. For example, debrief support was put in place to support staff and staff had access to trained counsellors. The medical and nursing staff participated in specific events and training days that included training and discussions around improvements to clinical processes. For example, there had recently been an away day for theatre staff for them to meet outside of the hospital setting.

Staff noticeboards and rest areas had information detailing the support available during the Covid-19 pandemic. This included details of support available for staff in relation to emotional health and well-being.

Anybody who lived on the Island could become a member of the trust, they would then receive any updates about the hospital and have the opportunity to have their voice heard. The trust undertook focus groups with the local community however these had been paused due to the Covid-19 pandemic.

The local community crocheted and knitted dementia blankets and twiddle muffs for patients living with dementia and donated them to the hospital for patients. The trust had a variety of patient participation groups that the local community could join.

Learning, continuous improvement and innovation

All staff were now committed to continually learning and improving services. They now had a good understanding of quality improvement methods and the skills to use them. Leaders now encouraged innovation and participation in research. Improvements had been made in the service since the last inspection.

The culture across the services was based on quality improvement. There were a number of quality improvement projects and work streams in place across the surgical services, such as the joint appointment of consultants who split their work between this trust and a hospital on the mainland.

Staff across the services were involved in research, innovation and clinical trials to improve patient care and treatment.

Theatres had agreement to start the operating department practitioner apprenticeship course approved by the Health and Care Professions Council (HCPC). The first cohort was due to start in February 2022, and funding had been agreed.

On Luccombe Ward following a cluster review of patient falls a workstream had been implemented leading to a reduction in falls. One initiative was a ‘grab falls bag’ which contained items commonly needed following a patient fall and an action card to follow to ensure a consistent approach in the management of patient falls.

Wards and departments had recently introduced safety briefings and used a standardised quality improvement tool across all wards and departments.

The service had implementation a dedicated trauma and emergency theatre. This had resulted to a reduction in emergency surgery undertaken at night.

The service had secured funding to increase partnership working with another trust on the mainland on urology pathways. The service was employing Advanced Nurse Practitioners to support the pathway.

Medical care (including older people's care)

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory Training

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

Staff received but did not keep up to date with their mandatory training. The trust had set a target of 85% of staff to have completed mandatory training. Endoscopy achieved the training target in all areas. Appley Ward exceeded the target in all training except manual handling which was 81%. Colwell Ward met the target for fire safety and safeguarding adults training but was below target in all other training. Coronary Care achieved the training target in conflict resolution, equality, diversity and human rights, fire safety, infection prevention and control, preventing radicalisation, safeguarding adults and children. The Stroke Unit achieved the target in all training except health, safety and welfare, infection prevention and control, information governance, manual handling, mental capacity act and resuscitation.

The mandatory training was comprehensive and met the needs of patients and staff. The training was aligned to the skills for health core skills framework and included all key topics. Managers monitored staff attendance at mandatory training and alerted staff when they needed to update their training. Each area had an electronic system to monitor when staff training was due and notified staff to complete the training. Ward managers told us staff who had yet to complete training had a date to do so.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. The trust had set a target of 85% for staff attendance at safeguarding adults and children training. All departments in medicine had exceeded this target in all staff groups.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff could describe caring for patients with protected characteristics and how to keep them safe. We reviewed the documentation for two patients with protected characteristics and found them both to be fully completed.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff could clearly describe what a safeguarding concern was and how to make a referral. Each area had visual prompts for the process and the safeguarding adult and children's policies were available for reference on the trust intranet. We reviewed two safeguarding referrals and found them to be completed correctly.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

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

Ward areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained.

The service generally performed well for cleanliness. The most recent Patient Led Assessment of Environment (PLACE) score for 2019 was 93.11%.

Cleaning records were up-to-date and showed all areas were cleaned regularly. All areas displayed the cleaning schedule, and these showed the cleaning had been completed. Cleaning staff were trained how to clean to minimise the spread of infection. All staff took pride in the cleanliness of the ward areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). All ward areas had dispensers of clean gloves, aprons and masks. Antibacterial hand gel dispensers were available, and posters prompted staff and visitors to clean their hands regularly.

Staff were all bare below the elbow and during the inspection all grades of staff cleaned their hands regularly. Each bay and side room on the wards had clinical handwashing sinks and a poster reminding staff of the five moments of hand hygiene. Laminated signs identified patients who were in side rooms on two wards as being barrier nursed to prevent the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

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

The design of the environment followed national guidance. All areas met the standard set out in Health Building Note 04 – In-patient care.

Staff carried out daily safety checks of specialist equipment. Safety checks were carried out on all specialist equipment including the resuscitation equipment and records of this were fully completed.

Electrical equipment in each area had been safety checked and maintained so was safe to use. Each piece of equipment had an asset number which allowed the trust to monitor when it was due for routine maintenance.

Patients could reach call bells and staff responded quickly when called. Patients who needed enhanced observation were allocated beds in bays next to the nurse's station.

The service had suitable facilities to meet the needs of patients' families. Although it was not possible to have routine visiting during the pandemic, the wards had developed a patient communication form. This was used to record relatives' queries and the answers given by staff. This was stored in patients' notes.

The service had enough suitable equipment to help them to safely care for patients. Staff could access all the equipment they needed to provide care.

Staff disposed of clinical waste safely. Waste was separated and stored securely before being disposed of safely. sharps boxes were assembled, used and disposed of correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. The form was within the patient pathway document. Scores were completed correctly. When a concerning score had been calculated the patient would be escalated for medical review.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The patient pathway document included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). Staff knew about and dealt with any specific risk issues.

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used the Safer Staffing model to adjust the planned staffing numbers according to patients' needs.

The ward manager adjusted staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers. Records for the last month showed all areas had met or exceeded their planned staffing numbers. The service had low vacancy, turnover and sickness rates.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe.

Staffing issues were discussed monthly at the trust board meeting and actions were agreed to make any necessary changes.

There were opportunities for further learning and development; nursing staff said there were opportunities for them to progress.

Medical care (including older people's care)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. However, consultants were concerned there were not enough medical consultants to provide a safe service. The trust had agreed five new medical consultant posts would be advertised. In the meantime, mitigation such as rota reviews and nurse consultant cover had been implemented to reduce the risk to patients.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Records showed the medical staff on duty matched the planned number. The service had reducing vacancy rates for medical staff. There was also a low turnover rates for medical staff and reducing rates of bank and locum staff.

Managers could access locums when they needed additional medical staff. They made sure locums had a full induction to the service before they started work.

Staffing issues were discussed monthly at the trust board meeting and actions were agreed to make any necessary changes.

Junior medical staff generally had access to support and teaching and felt the hospitals academic links were an advantage to their ongoing development. However, on the stroke unit, junior doctors felt they did not have access to the support and teaching they wanted. This had not previously been raised by the doctors with the trust.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up to date and easily available to staff. However, records were not stored securely.

Patient notes were comprehensive, and all staff could access them easily. Most records were clear and up to date. However, on Colwell Ward five out of the 10 notes reviewed were disorganised and two had included records from a different patient. This was immediately corrected.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not stored securely. Notes trollies were unlocked and stored against the wall next to the nurse's station. Staff said this was ease of access to notes, because locks were not working, and some trolleys only had one key and not a digital lock code. Staff said there were no visitors to the ward due to the pandemic and this was a low-risk concern. Since the inspection, the trust has implemented an audit to check the notes trollies are always locked. These records showed 100% compliance.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, these were not always effective.

Medical care (including older people's care)

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Liquid medicines that had reduced expiry dates once opened lacked either a date opened or revised expiry date. Therefore, the medicines may not be effective when administered. Records relating to returning controlled drugs were not always complete. Staff took steps to remedy the situation.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, these were not always effective. For example, on the acute admission unit whilst most of the piped medical air outlets were capped, a few caps were missing. This could result in staff mis-selecting medical air instead of oxygen and there was a risk that patients requiring oxygen may be administered medical air. Staff, in line with the 'Reducing the risk of oxygen tubing being connected to air flowmeters Alert' (2019), took steps to remedy the situation.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses

Managers shared learning with their staff about never events that happened elsewhere in the hospital and trust. There were no never events on any medical wards. Each area had monthly meetings and learning from incidents was a standing agenda item. Learning from incidents had been shared at the previous three meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigations of incidents, both internal and external to the service. Staff told us they received feedback from their managers about the incidents they reported.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The Trust was participating in a pilot of a new incident review process called Patient Safety Investigation Framework (PSIRF). Patient safety incident investigations were conducted to identify new opportunities for learning and improvement. Patient safety incident investigations focus on improving healthcare systems not individuals, they do not determine or apportion blame. We saw a completed investigation which focused on areas of good practice, care delivery problems, service delivery problems, root causes, concerns raised by family, immediate safety actions and a final risk rating. The findings had been shared with the staff and the family of the patient who had died.

Managers debriefed and supported staff after any serious incident. It was evident the wellbeing of the staff involved in incidents was considered and they were supported throughout the investigation process.

Safety Information

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

Medical care (including older people's care)

The service continually monitored safety performance and data was displayed on wards for staff and patients to see. Every ward had a notice board with the safety data displayed. This data included number of falls, pressure ulcers and urinary tract infections.

Staff used the safety data to further improve services. The data showed the service achieved harm free care within the 12 weeks prior to the inspection.

Is the service effective?

Good ↑↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff used a patient clinical pathway record to plan, give and evaluate care and treatment. The document referenced National Institute for Health and Care Excellence (NICE) guidance for each plan of care. NICE and trust guidelines were available on the trust intranet. Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

We saw clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

Clinical audit was being undertaken and there was good participation in national and local audits. The trust performed in line with national clinical audits and had shown improvement in all areas since the last inspection.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw patients regularly being offered hot drinks and snacks. Fresh water was freely available and kept topped up by staff. Patients were offered three hot meals a day and there were two planned rounds in addition offering snacks such as biscuits or cake. Patients were supported to eat and drink if needed. Patients were generally positive about the quality and quantity of the food provided.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff gave us examples of supporting patients with specific dietary requirements. We looked at the menus used, which were varied and included suitable alternatives for a range of religious or cultural needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

The hospital had a pain team who supported the ward areas to manage patients' pain as needed. Staff told us the hospital pain team were very responsive to requests for support. Patients told us any pain they experienced was well managed and staff responded promptly if they needed pain relief.

Staff monitored pain level of patients and recorded the information. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patient who could not communicate verbally.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas.

The service participated in relevant national clinical audits. For example, an Audit of the standards of Allergy Documentation and a sepsis audit and the Sentinel Stroke National Audit Programme (SSNAP).

Outcomes for patients were positive, consistent and met expectations, such as national standards. The stroke service improved in the Sentinel Stroke National Audit Programme (SSNAP). The service is rated A (the highest rating).

The trust improved since the last inspection and performed in line with the England national average in most key performance indicators. The trust performed better than the England national average in Emergency readmissions: Chronic obstructive pulmonary disease and bronchiectasis and In-hospital mortality: Acute myocardial infarction.

The trust performed worse than the England national average in Emergency readmissions: Acute myocardial infarction, Emergency readmissions: Fluid and electrolyte disorders and In-hospital mortality: Pneumonia.

Medical care (including older people's care)

Competent staff

The service made sure staff were competent for their roles. However, managers did not always appraise staff's work performance to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff told us the trust induction programme was detailed and comprehensive and provided all the information and support they needed to do their jobs.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The trust had set a target of 95% of staff to receive a yearly appraisal. None of the areas we visited had achieved this target. Rates for individual wards ranged from 48.65% to 94.29%. All wards had an action plan to complete appraisals for staff within the next three months.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Specialist teams provided regular bite size training to ward staff to maintain their specialist skills.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings minutes for the previous three months showed they were well attended by all grades of staff. A hard copy of the minutes was on the notice board and an electronic copy was emailed to the team.

Multidisciplinary working

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

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team.

Staff held regular and effective multidisciplinary meetings to discuss patients' treatment and to ensure they are receiving the correct treatment and care. There were daily multidisciplinary board rounds where doctors, nurses and allied health professionals discussed patient care.

The mental health liaison team was available for advice and to support ward staff care for patients with mental health needs. A patient with a mental health crisis received a mental health specialist opinion within 15 minutes of the referral having been made. Staff told us that was not unusual and felt well supported.

Cancer patients had access to all the needed treatments either within the trust or via tertiary centres on the mainland. There was no delay to being treated on the mainland but on occasion the local team were not informed when the patient had been discharged home. This could lead to a gap in support for the patient while they were waiting for their next appointment. Specialist teams discussed all patients' care and treatment in video conferenced meetings with teams on the mainland.

Seven-day services

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

Medical care (including older people's care)

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day on seven days a week.

There were medical consultants working seven days a week. At weekends consultants were on site between 8am and 8pm. At other times, a consultant was available for advice or to attend the hospital in an emergency.

Out of hours interventional radiology was available on the mainland for patients who presented with an emergency. The trust provided diagnostic radiology such as scans or x-rays at the trust seven days a week.

Allied health professionals which included physiotherapists, occupational therapists and pharmacists were available seven days a week.

The acute oncology service was available in the trust five days a week with remote cover from tertiary centres on the mainland at the weekend. This service planned to increase to a seven-day nurse-led service when recruitment allowed.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. We saw posters and information leaflets throughout the service for patients and relatives to promote a healthy lifestyle. For example, we saw a poster about living well with cancer.

Cancer patients were offered a recovery programme after treatment which included exercise, diet and access to a clinical psychologist. The aim was to support patients to return to a normal life after their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent, but this was not always recorded clearly in the notes. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records in all but one of the notes we reviewed.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. During the inspection staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering the patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

Records showed managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to the access policy and get accurate advice on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff we spoke with could describe the policies and show us where to access them on the intranet. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Medical care (including older people's care)

Is the service caring?

Good 

Our rating of caring improved. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Call bells being answered promptly by staff. Curtains were pulled around the bed areas to provide privacy when needed. Staff of all grades spent time interacting with patients.

Patients said staff treated them well and with kindness. Patients thought the staff were kind and took time to understand and meet their needs. One patient told us a staff member had brought them in a pair of sunglasses to wear as the overhead lights were too bright for them.

Staff followed policy to keep patient care and treatment confidential.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. All staff we spoke to clearly understood patient needs. There was an awareness of loneliness particularly in patients who had moved to the Isle of Wight as a couple and then lost a partner and now lived alone, away from their friends and family.

The trust provided a bereavement service for families who had a relative die when in the hospital. This service provided emotional and practical support for families who had been bereaved.

Understanding and involvement of patients and those close to them.

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us staff had clearly explained their care and treatment and we saw clear communication between staff and patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. All areas invited patients to provide feedback using the national Friends and Family Test (FFT) system. The system was paused during the pandemic and had recommenced in April 2021. All ward areas collecting FFT data had a 95% or above positive feedback response.

Medical care (including older people's care)

Staff supported patients to make advanced decisions about their care. The trust had an end-of-life team who specialised in palliative and end of life care. This team supported both patients and staff to make advanced decisions about care.

Staff supported patients to make informed decisions about their care. All areas had leaflets explaining procedures and medical conditions which informed patients about their care. Staff had access to specialist teams who supported patients. For example, cancer, diabetes, stroke and mental health specialist teams visited the wards regularly.

Patients had access to support groups for various conditions. These met monthly and in person normally. During the pandemic the meetings went online to allow them to continue.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to ensure they met the changing needs of the local population. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia liaison team and their contact details and reported a good collaboration with them.

There was an agreement with another local NHS trust to provide an angiography service (radiography of blood or lymph vessels) and staff said the two services worked collaboratively. Staff reported good joint working with community care services; there was a dedicated hospital navigation team and an online directory to support them.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There was one reported breach in the past 12 months. The trust had documented all the details for the breach and reported no harm had occurred as a result.

Facilities and premises were appropriate for the services being delivered. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations. The premises were mostly airy and welcoming. However, the patient advice and liaison service was not easy to locate, and the office was unwelcoming and small.

Meeting people's individual needs

The service was generally inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff were aware of the mental health liaison team and knew how to

contact them for support. Staff told us they had a good relationship with the mental health liaison team, who were very responsive, arriving within minutes of their calls. Two members of staff gave us examples of patients who had needed emergency mental health support (at risk of self-harming or causing immediate harm to other patients or staff members). Staff knew who to contact for help, and the response was quick and efficient.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff on medical care wards worked closely with the learning disabilities, mental health and dementia liaison teams. Staff all knew contact details for these teams and reported good working relationships with them. Staff were able to give us examples of supporting patients in need of additional support.

Whilst the training compliance rates were on target, staff were not able to demonstrate an understanding of equality, diversity and inclusion. Only two of 12 staff were able to reflect an understanding of the equality, diversity and human rights training module. Most staff we spoke with told us that this training was not mandatory, and that it had not continued during the pandemic. However, we noted that equality, diversity and human rights was a part of the online module in the last 12 months. Staff were able to give examples of when they supported patients from the LGBT+ community. However, when staff told us about experiences of trans patients, they did not use the correct pronouns.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Medical staff explored mental health with patients and sought to understand patients' individual needs outside of their immediate physical health condition.

Wards were designed to meet the needs of patients living with dementia. Staff on one ward told us about the memory room that had been built to support patients with dementia. The room was welcoming and spacious. Staff on one ward told us about the garden patch which had been created to support patients with dementia. Photos of the garden were displayed on two boards on the ward alongside positive feedback received from patients and carers for this initiative.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff had access to "this is me"/ "about me" patient passports which provided information about patients living with dementia, who were not able to communicate their preferences verbally. Staff wrote some patient details on a whiteboard behind each patient's bed. This included the patient's preferred name and most of the time, staff used the preferred name.

The service did not always have information leaflets available in languages spoken by the patients and local community. Only one out of five of the wards had such leaflets to be present. Staff told us the local community was not particularly diverse, and that these leaflets were not always available because there was not an expectation they would be needed. However, managers made sure staff, and patients, loved ones and carers could get help from interpreters, translators or signers when needed. Staff knew how to book interpreters, translators and signers and were able to give examples of when they used interpreters to support patients and carers. However, most of these examples referenced using other staff members from a diverse ethnic background or patient relatives to perform the required interpreting. This is not best practice, unless in an emergency, because the accuracy of the interpreting cannot be guaranteed, and it also creates a conflict of interest.

Staff were able to give examples of good collaborative practice, such as liaison with other hospitals when a patient was transferred which included timely transfer and updates to care plans. Staff also told us the procedure was successful and the patient's family were happy with the care they provided.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. Reception areas had hearing loops to communicate with patients and their carers or family. Staff had access to an equipment library to support patients with learning disabilities, and patients who communicated in ways other than speaking. Staff showed us the materials and explained how they used them. Staff gave other examples of supporting patients with communication difficulties.

Access and flow

People could generally access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The referral system was through the online electronic record used throughout the hospital, so it was quick and easy to refer patients.

Managers generally monitored patient moves between wards and ensured they were kept to a minimum. The service generally moved patients only when there was a clear clinical reason or in their best interest. Staff reported out of hours bed moves were rare and explained the efforts made at multidisciplinary and ward levels to minimise out of hours bed movement. However, we looked at medicine data from May 2020 to March 2021 and found a high number of out of hours bed moves logged. Data from April to June 2021 does however show improvement, as there were no non-clinical bed moves for medical patients.

Managers and staff worked to make sure they started discharge planning as early as possible. Data from the past 12 months showed discharge was planned on admission for over 90% of patients with a diagnosis of dementia.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff reported a good collaboration with the integrated discharge team. Staff clearly understood the process for patients due to be discharged. We observed a medical team providing discharge instructions to a patient. These were clear and set realistic time scales for what time the patient could leave the hospital.

Generally, managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Staff had arrangements for patients in the discharge lounge to be collected within two hours if being collected by patient transport services. However, staff told us that the two-hour wait was being breached for some patients.

Staff supported patients when they were referred or transferred between services. Staff supported patients with additional needs to be discharged to community inpatient hospitals, care homes or patients' own homes. The trust's integrated discharge team process, acute to community pathway and associated checklist were detailed and in line with national guidance.

Learning from complaints and concerns

It was generally easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Medical care (including older people's care)

Patients, relatives and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome.

Wards and departments clearly displayed information about how to raise a concern in patient areas. We saw posters detailing the complaints process on four out of five wards. There were patient feedback leaflets on all the wards. The trust responded to complaints within set timescales and followed their internal policies as well as the national guidance. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families.

External stakeholders were involved in the complaints process. Staff told us about joint working with the clinical commissioning group, who provided dedicated administration support and guidance with handling complaints. This meant the trust could rely on live input from the clinical commissioning group when dealing with a complaint.

Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were discussed with staff and escalated. Staff gave examples of using patient feedback to improve daily practice. For example, staff told us of a complaint leading to changes in visitors' restrictions to better support end of life patients.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good.

Leadership

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

Medicine was part of the unplanned care group. The leaders worked in a multi-professional triumvirate which included a manager, doctor and nurse. Care group senior managers and clinical leads were seen regularly in ward areas. Staff felt able to raise concerns and were confident their concerns would be listened to and acted upon. Ward staff said they were well supported by their ward managers and matrons

Staff were encouraged and supported to develop their skills and take on more senior roles. For example, we spoke to a nurse who had started as a band 4 associate nurse and was now the band 7 ward manager.

We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues. Since our last inspection the leadership structure had been revised and had a focus on shared leadership at all levels. For example, matrons met with the ward leaders on a one-to-one basis and discussed issues such as workforce and current trends and themes around risk.

Medical care (including older people's care)

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Staff at all levels could describe the vision and strategy for their individual wards and the wider care group.

The Health and Wellbeing Strategy 2018 to 2021 for the trust focused on equity, accessibility, integration, effectiveness, sustainability and diversity. These areas were clearly defined so staff could understand them.

The provision of services should be proportional to need and targeted to the areas, groups and individuals that need them the most (to reduce health inequalities)

Within the unplanned care group leaders worked with staff, people who used the service and external stakeholders to apply these key areas when developing and planning services.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a culture of honesty, openness and transparency. Senior staff carried out the duty of candour responsibilities which detailed the involvement and support of patients or relatives in serious incident reports. Staff said there was an open and transparent culture where people were encouraged and felt comfortable to report incidents and where there was learning from mistakes.

The Trust was participating in a pilot of a new incident review process called Patient Safety Investigation Framework (PSIRF). We saw a completed investigation which focused on areas of good practice, care delivery problems, service delivery problems, root causes, concerns raised by family, immediate safety actions and a final risk rating. The findings had been shared with staff and the family of the patient affected.

Staff felt valued, supported and spoke highly of their jobs. Staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work.

On the wards we saw multidisciplinary working which involved patients, relatives, and the clinical team working together to achieve good outcomes for patients.

Patients acknowledged a positive and caring ethos and were happy with their care.

Medical care (including older people's care)

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear governance structures within the trust with good representation from all disciplines. Governance group meetings directly fed into the trust board governance meetings.

There was a clear governance structure within the care group. Monthly meetings took place at all levels to discuss key risk and performance issues. Meeting minutes showed them to run to a set agenda and clearly recorded. Actions could be tracked, and minutes showed they had been completed.

The trust board received routine reports on cancer waiting time performance. The report showed the trust's performance against each of the cancer operational standards and the actions taken to improve and sustain cancer performance.

The cancer steering group met monthly and fed into a quarterly cancer board. Cancer performance was discussed at this meeting and actions were used to drive improvement within the trust.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Risks were recorded at ward division and trust level. The top three risks identified within the unplanned care group were recruitment of new staff, staffing levels due to vacancies or sickness and delays in patient transfer to the mainland for urgent treatment.

Throughout the medicine, clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers had a good understanding of the issues within their clinical areas.

Leaders at all levels could clearly describe the risks in their area of work and the mitigation in place to reduce the risks. The risk register was updated regularly, with risks added to the register relating to patient care, safety performance and current issues. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and members of the public a range of information about the safety and governance of the hospital.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords and all terminals were locked when not in use.

Medical care (including older people's care)

Engagement

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

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test and inpatient surveys.

Oncology services organised ward based patient groups run in conjunction with charitable organisations. Patients and their families were given access to support groups and information resources to help them understand and adjust to their treatment.

The management team said any good ideas put forward by staff were discussed at weekly ward and monthly team meetings. Useful suggestions and good ideas were passed on to the clinical and quality boards. Staff felt informed and involved with the day-to-day running of the service and its strategic direction.

Staff advised us there were regular staff meetings and that managers arranged these for different times and days to ensure all staff were able to attend regularly.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

The medical wards demonstrated several actions they had taken to improve the service they provided.

The SAFER Programme had been implemented on Colwell and Appley wards. This launched on 1 April 2021. This initiative improved the patient experience by reducing length of stay and improved multidisciplinary working. The team was also part of the National Modern Ward Round pilot, which supported SAFER principles.

All areas had started safety briefings. The briefings allowed a focus on core safety information prioritised and delivered efficiently. This information was kept on a prewritten white board and shift leaders talked through the standards briefing agenda with the team.

In the last 12 months innovative work in the endoscopy department delivered improvements based on workforce, clinical quality, and patient experience. The workforce developments included a workforce review resulting in the development of band 3 competencies, leadership development, focus on maintaining mandatory training, core clinical skill compliance, roles and responsibilities and development of in-house training sessions.

Clinical quality had been enhanced by producing a role card for the nurse in charge, maintaining current audits, Band 6 leadership development, new care pathways, updated standard operating procedures and improved patients' pathway through the department.

Services for children and young people

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff had completed it.

Staff received mandatory training, but not all staff kept up-to-date with mandatory training. Staff said mandatory training was easy to access. Records showed nursing staff on the paediatric ward had completed 91% of their mandatory training and community paediatric nurses had completed 86%. Paediatric medical staff had completed 84% of their mandatory training. However, the paediatric diabetic nurses had completed only 66%, outpatients staff 75% and paediatric secretaries had completed 55% of their mandatory training. This was below the trust target rate of 85%. Some staff may not have the key skills to keep children and young people safe.

The mandatory training was comprehensive and met the needs of children, young people and staff. Staff completed mandatory training for example, equality, diversity and human rights and infection prevention and control. Staff received training on sepsis as part of their mandatory training. Staff were provided with mandatory training which equipped them with a variety of skills and knowledge to help keep children, young people and their families safe.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism within their mandatory training. Staff with specialist knowledge in the service delivered additional training sessions to support staff in these areas, examples include self-harm and suicide and Attention deficit hyperactivity disorder (ADHD). Nursing staff told us they would like more training around children and mental health to support them.

Managers monitored mandatory training and alerted staff when they needed to update their training. When there was poor completion of mandatory training managers alerted staff and created an action plan. A recent example of this was when current mandatory training completion rate for medicines management competency assessment was 76%. Managers had created an action plan to address this, which included supervision sessions with staff until training was complete.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Records showed paediatric staff had completed adult and children safeguarding training. Nurses and paediatric medical staff had completed Safeguarding Children Level 3 training in line with the trust policy on safeguarding children training.

Services for children and young people

Staff followed safe procedures for children visiting the ward. Staff showed an understanding of the services' policies such as safeguarding children and young people policy and missing child abduction policy. The safeguarding children and young people policy provided staff with information on child sexual exploitation, child criminal exploitation/county lines, female genital mutilation and radicalisation. Staff had training in preventing radicalisation training.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood how to protect children. We saw posters and leaflets about helplines and advice services for domestic and sexual abuse on the paediatric ward and paediatric outpatient department.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave an example of this in practice with a looked after child who had moved to the mainland. Staff recognised this child was at risk of exploitation and attended regular meetings with local agencies who were now in charge of the child's care, to ensure continued monitoring of the child and make sure information was not lost.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were confident to raise concerns with the senior management team. The service displayed posters at nursing stations outlining the process for staff to follow if they had concerns. Staff knew how to make a referral.

When children missed their appointment the paediatric liaison service followed up on the child. The Paediatric Liaison Service also followed up children with safeguarding concerns, this was to ensure joint working with other agencies.

There was a safeguarding report presented to the trust board annually. When the service identified lessons from safeguarding incidents, information was fed back to staff.

Cleanliness, infection control and hygiene

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

Ward areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained. The, ward areas and the outpatient department were visibly clean and clutter free. Staff cleaned toys between children and young people's use. The furniture and facilities were age appropriate.

The service generally performed well for cleanliness. The service used audits to monitor standards. Results showed full compliance for the paediatric ward and day unit. There was also full compliance with a hand hygiene audit.

Cleaning records were up-to-date and showed that all areas were cleaned regularly. Cleaning records in all areas were complete and showed cleaning had taken place. Cleaning staff were observed working in all areas when we visited.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbows. We saw staff using PPE such as gloves, aprons and face masks. We saw staff washing their hands before and after patient contact. Hand sanitiser gel and hand washing sinks were available at relevant points in the clinical areas we visited.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service used “I am clean” stickers to label equipment which included a date when the equipment was last cleaned. Staff cleaned equipment after patient contact. Staff cleaned patient rooms during a child and young person’s stay and following their discharge.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Children, young people and their families could reach call bells and staff responded quickly when called. We observed staff were quick to give assistance when required and families told us staff were quick to respond when they needed them,

The design of the environment followed national guidance. All children’s areas were secure, and access was limited. The environment was safe for children, for example doors with hinge protection to stop children trapping their fingers. Each room in the paediatric ward had a distinct colour door, which helped children find their room. Areas of the ward had picture labels on the doors, for example a picture of a toilet, to help children navigate around the ward.

Areas were appropriately decorated and furnished for children. Staff were mindful of creating spaces with decoration suited to young people not just smaller children. The paediatric ward had a side room with adjoining bathroom for children who were immunocompromised.

When children presented in an emergency and had sensory needs, they were brought to the waiting area in the separate children’s emergency department as it was a more suitable environment for children with additional sensory needs.

The service had two separate recovery spaces in the theatre recovery area for children and young people, these were sympathetically decorated for children and the equipment was age appropriate. Staff told us children would pass adults following surgery on the way to the day unit. To help protect the children staff pulled the curtains around the adults before they moved the child. When children needed diagnostic imaging, they would remain in the children’s environment until staff were ready for them. Children therefore did not wait with adults in the departments waiting area.

The service had recently developed a separate suite within the department for care and treatment of children with mental health needs. This suite had a separate bathroom, bedroom and family room. The environment and equipment had had a ligature risk assessment completed and was assessed as needing building work to make it safe. The service had carried out the required work on the environment and equipment to ensure it was a safe environment for children with mental health needs.

Staff carried out daily safety checks of specialist equipment. Records showed daily checks were completed on the resuscitation trolley in the children’s emergency department, paediatric ward and neonatal ward. All equipment reviewed had, had a recent service and was within its due date for the next service. Specialist equipment in the diagnostic imaging department, used for children and young people, had regular servicing and were maintained.

Services for children and young people

The service had suitable facilities to meet the needs of children and young people's families. The service had separate quiet rooms for breaking bad news to families in the paediatric ward and neonatal ward. The service had beds for parents to stay with their child. There was a kitchen on the paediatric ward for parents and families to use, however this was outside of the ward itself and in the corridor between the ward and day unit. This meant families had to leave the ward environment to get a drink.

The service had enough suitable equipment to help them to safely care for children and young people. Staff told us they had enough suitable equipment. Consumables were in date. The service completed an audit of patient equipment, the audit focused on ensuring equipment was clean, in good working order and consumables not being reused. The most recent audit showed compliance.

Staff disposed of clinical waste safely. Waste management was segregated with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Arrangements for the control of substances hazardous to health (COSHH) were adhered with. Cleaning equipment was stored securely in locked cupboards.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The service used Children's Observation and Severity Tool (COAST) to generate an early warning score, used to identify children at risk. The COAST tool is specific for infants (less than 1 year), pre-school (ages 1-5), school age (ages 5-12) and teenage (age 12 and above). In the patient records we reviewed, we saw COAST completion and appropriate escalation. Escalation was in line with the trust's policy. The service ensured there was at least one staff member on duty with paediatric advanced life support qualifications.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. The service completed risk assessments for example venous thromboembolism (VTE) prophylaxis, pressure area, falls risk and peripheral venous access device. This helped staff identified risk issues and they took action to reduce the risk. The service audited completion of these risk assessments, the latest audit showed compliance with completion of risk assessments.

Staff screened children for sepsis on admission to the paediatric ward. Staff reviewed the sepsis risk assessment when a child and young person deteriorated. Staff admitted paediatric oncology patients with neutropenia directly into the paediatric ward.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). The service had CAMHS support between Monday and Friday, they were available to visit the child and offer advice to staff. During the weekend the service had access to support and advice from psychiatric liaison and the single point access referral team.

Services for children and young people

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. The service had CAMHS support to complete risk assessments on children who attend the children's emergency department with a mental health need. Staff knew how to make a referral to the CAMHS service and told us the response was timely. The service had a room adapted to keep individuals with a mental health illness safe while they were awaiting an assessment in the children's emergency department.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. The service had a standardised procedure from the anaesthetist to post-anaesthesia care unit staff to the day unit staff, this was to ensure key information was handed over. Staff made sure key information was shared, for example discharge summaries were sent to GPs and health visitors when children and young people were discharged from the hospital.

Shift changes and handovers included all necessary key information to keep children and young people safe. The paediatric ward completed multidisciplinary team handovers and a daily safety huddle; staff discussed children of concern to ensure key information was shared with the team.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep children and young people safe. The paediatric ward planned rotas to ensure a safe skill mix, this included four registered staff and one health care assistant during the day. The ward would have support from a band 5 or band 6 nurse to act as a coordinator. The service ensured that there was at least one nurse per shift with advanced paediatric life support training. Staff who looked after children during day case surgery had relevant training in paediatric life support. The service had trained children nurses in the children's emergency department. Children and young people had access to specific advice from specialist staff including diabetes nurses and clinical nurse specialists in attention deficit hyperactivity disorder (ADHD). The service had support staff including healthcare assistants, nursery nurses, play specialists and allied health professionals.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. The service followed Royal College of Nursing guidance around the proportion of registered staff and unregistered staff (70:30 ratio) to match the medical need of the children on the paediatric ward, day case unit, outpatients department. The neonatal nurse staffing followed British Association of Perinatal Medicine (BAPM) guidelines.

The ward manager could adjust staffing levels daily according to the needs of children and young people. The service operated a flexible model of staffing, this meant staff moved to support staff in other areas if they were under pressure. This meant staffing levels adjusted to meet safe staffing for the number of children receiving care in all areas.

The number of nurses and healthcare assistants matched the planned numbers. The paediatric ward always had a minimum of two registered children's nurses. When the actual numbers did not meet the planned numbers, staff said they escalated this to their managers, who reviewed staffing levels. Shift gaps were filled with bank staff or by moving staff with relevant skills from areas with fewer children and young people to support areas with more.

The service had low vacancy rates. The service had recently appointed a ward sister for the paediatric ward, joining the service in September 2021. The children's ward reported 3.3 whole time equivalent vacancies. The neonatal unit reported 2.69 whole time equivalent vacancies.

The service mostly had low sickness rates. The paediatric ward reported sickness rates of 1.1% for registered nurses and 1% for nursery nurses. However, the neonatal unit reported 8.55% sickness rate.

The service had low rates of bank and agency nurses. Managers limited their use of bank staff. Managers used staff currently working for the service to act as bank staff, this meant working overtime to fill shifts. When staff worked as more than one job role, this was factored into the rota to ensure staff were not working long hours. The service had limited use of agency staff. Agency staff, with specific skills in mental health, were used as extra nursing staff to provide one-to-one support for with children presenting with a mental health need.

Managers made sure all bank and agency staff had a full induction and understood the service. Bank and agency staff had to have a supervisory shift, to ensure they knew how the service ran. Following this shift staff would sign off the bank or agency staff member to say they could work for the service. Agency staff had been checked to ensure they had the relevant paediatric training for acute and mental health presentations in children and young people.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep children and young people safe. The medical staff matched the planned number. The service had advanced neonatal practitioners, consultants, registrars and junior doctors. The service worked with consultants from another NHS trust for their outpatient's appointments for cardiology, neurology, endocrinology and some surgery. Medical staff were scheduled to cover specific areas for example one registrar would cover the paediatric ward, children's emergency department, outpatients and the paediatric assessment unit. There was a named consultant available each day. This meant all areas where children and young people were seen staff always had access to medical advice from a consultant paediatrician. We saw the actual medical staff rota which matched the planned numbers. Medical staffing met the Royal College of Children's and Child health (RCPCH) recommendations.

The service had low vacancy rates for medical staff. The service did not have any vacancies amongst medical staffing. The service had recently recruited.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Staff told us they had low use of bank or locum staff however, they could access them when needed.

The service had a good skill mix of medical staff on each shift. The service had 15 whole time equivalent medical staff. We saw the medical staff rota, the service had a skill mix of consultant, middle career and registrar medical staff and this mix was seen on each shift. For example, each day the service had a named advanced paediatric nurse practitioner, registrar allocated to each area and a named consultant.

The service always had a consultant on call during evenings and weekends. The service had a consultant paediatrician available seven days a week. The service had a registrar and named consultant on-call during evenings and weekends.

Services for children and young people

Records

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

Patient notes were comprehensive and all staff could access them easily. Children and young people's notes were legible, clear, complete and in order of care delivery. Staff could easily access up-to-date information. The service held separate nursing and medical notes. The service audited documentation completion, the latest audit showed compliance.

When children and young people transferred to a new team, there were no delays in staff accessing their records. The service used paper records for children and young people, which meant notes were requested by the ward and brought out from the record storage unit on-site. There were no reported incidents were there was a delay in accessing records.

Records were stored securely. All paper records were stored in locked trollies on the ward areas. Electronic records required password access and therefore secure.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff recorded the child's weight and height to ensure medicine doses could be calculated correctly. Allergies were recorded on medicine charts, staff recorded medicines accurately on medicines charts we looked at. The service completed a medicines safety audit, the most recent audit showed compliance with all elements.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. Children attending the outpatient clinic had their height and weight measured. During their appointment staff reviewed the medicines prescribed and adjust if required. Staff told us they would discuss the medicines with the children and young people and families and give advice.

Staff stored and managed medicines in line with the provider's policy. Medicines were stored in a locked cabinet, which could only be opened using a fingerprint registered to authorised individuals. Medicines were organised and clearly labelled when close to expiry date, this was to ensure staff did not administer out of date medicines. All medicines looked at during the inspection were in date. On a daily basis staff monitored the fridge temperatures medicines were stored at, to ensure they were kept within a safe range.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Senior staff acted on medicines safety alerts and made sure staff knew about alerts. Staff reported medicines incidents, when learning was identified from an incident staff received feedback. We saw learning from a medicines incident in the neonatal unit reinforced by a reminder notice on the medicine's cabinet. This was so staff saw the notice as they went to the cabinet for medicines. The service fully investigated a recent incident around a child's own controlled drugs. The service had identified learning actions such as, updating the locked medicines storage settings to enable the service to store patient's controlled drugs.

Services for children and young people

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. The service had an incident policy, serious incident policy and an ionising radiation medical exposure policy. Incidents and near misses reviewed were reported in line with these policies. Staff showed an understanding of incidents and how to report them. They explained outcomes from reporting incidents and what learning actions had been identified.

Managers shared learning with their staff about never events that happened elsewhere. Staff received feedback from investigation of incidents, both internal and external to the service. Managers represented the service in trust wide discussions of never events and serious incidents. This meant sharing of learning from other departments in the trust. Learning was fed back to staff during regular meetings.

Staff reported serious incidents clearly and in line with trust policy. The service had had two serious incidents, these were both reported in line with the serious incident framework and the trust policy. Both had a full investigation, with root cause analysis and relevant lessons learnt with recommended actions.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Staff were able to describe the principles of duty of candour and this had been applied to the incidents we reviewed.

Staff met to discuss the feedback and look at improvements to children and young people's care. The service held mortality and morbidity meetings every three months. Cases were discussed during this meeting to feedback elements of good practice and identify any recommendations to action.

There was evidence that changes had been made as a result of feedback. The service had seen an increase in incidents involving children with mental health needs. The service set up a children's mental health task and finish group to implement changes as a result of feedback. For example, they discussed with children, young people and their experiences. They and found some of the problems were due to communication and expectation of a stay for children with mental health needs in an acute health setting. The service developed ways to communicate with children and young people's and families around. The actions of the task and finish group has led to a reduction in the number of incidents reported for children with mental health.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. All incidents reviewed showed senior leaders investigated incidents thoroughly. Investigations occurred in a timely manner and involved children, young people and their families. Children, young people and their families received the outcome of the investigation when complete.

Managers debriefed and supported staff after any serious incident. Staff told there were opportunities to talk with colleagues about serious incidents or event such as the death of a child or young person.

Services for children and young people

Managers took action in response to patient safety alerts within the deadline and monitored changes. Managers ensured patient safety alerts were acted on. For example, action around a recent patient safety alert around the risk of inadvertent connection to medical air.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

Safety thermometer data was displayed on wards for staff, children, young people and their families to see. The service displayed information on children and young people's complaints, compliments and incidents with relevant action plans.

The safety thermometer data showed the service achieved harm free care within the reporting period. Data from the patient safety thermometer showed that the service reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from February 2019 to February 2020 for children's services.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and processes to plan and deliver care referenced national guidance and best practice. The service identified when care was not following best practice through local audit and created action plans to meet the gap, for example, the service had an action plan against National Institute for Health and Care Excellence (NICE) guidance for epilepsies in children and young people. This included appointing a clinical paediatric lead for epilepsy.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff showed an understanding for the Mental Health Act Code of practice and ensured children were protected. Staff had access to CAMHS, psychiatric liaison and the single point access referral team for additional advice and support if they needed it.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff offered food and drink to children and young people. Staff used special feeding and

hydration techniques when necessary, such as nasogastric tube feeding and intravenous fluids. Staff assessed safe use of these methods using a nutrition and hydration audit, the recent audit showed compliance with safe management. The service had a policy to support staff on the neonatal ward around infant feeding, including breast feeding. Staff supported mothers to breast feed their babies. There were fridges and freezers available on the paediatric ward and neonatal ward for the storage of breast milk, for those mothers who needed to express and keep their milk.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. Records showed staff had recorded when children and young people drank fluids and when they went to the toilet. A balance was calculated so staff could be assured they had enough fluid and act if not.

Staff used a screening tool to monitor children and young people at risk of malnutrition. The service completed an audit of completion of the screening tool, the latest audit result showed compliance with completion, staff monitored children and young people at risk of malnutrition.

Specialist support from staff such as dietitians were available for children and young people who needed it. A dietitian would see children and young people to advice on specific diets when required for health needs such as, intolerance. They also provided dietary advice in relation to religious and cultural need. Food options had clear allergy advice. Staff on the ward had access to paediatric diabetes team, who could attend the ward to assess a child whilst they were an inpatient.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Records reviewed included completed pain assessments; pain was assessed using a visual aid for children who had difficulty communicating. Records also showed pain relief was given and the effectiveness monitored in line with the services policies. Play specialists also helped with pain relief using play and distraction therapy. Children and young people and families told us they received pain relief promptly.

Staff prescribed, administered and recorded pain relief accurately. Children and young people received pain relief soon after requesting it. Medicines charts showed clear records of pain relief administered. Staff reviewed the children and young people’s pain relief for effectiveness and made changes where necessary.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service was working towards accreditation under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Outcomes for children and young people were positive, consistent and met expectations, such as national standards. The service contributed to the following national audits for example, National Asthma and COPD Audit Program, National Maternity and Perinatal Audit (NMPA) and the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK). This meant the service had means of benchmarking against other services and make improvements where indicated. Participation in national programmes designed to measure outcomes for children, such as National Neonatal Audit Programme (NNAP) and National Paediatric Diabetes Audit (NPDA) were positive and met national standards.

The service was working towards BLISS baby charter accreditation. The Bliss Bay Charter is an accreditation scheme which measures against seven standards which identify the level of family centred care provision within a unit. The services most recent audit against the seven standards showed improvement.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. The services had an annual audit plan which took into account the outcome of previous audits, to ensure further assessments of the impact of any actions taken. Where the service did not meet compliance of elements of the national and local audits an action plan was developed to drive improvement. Improvement was monitored and action plans updated when compliance was met.

Managers shared and made sure staff understood information from the audits. Audit outcomes were discussed during regular team meetings, so staff understood the audit outcomes and where informed of an action they were required to take.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The clinical educators supported the learning and development needs of staff. The service had a clinical educator lead for advanced paediatric life support. They supported the staff with training and the running of scenarios to help consolidate their learning.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Staff, who did not have child specific qualifications, were required to complete training and assessment in an agreed set of competencies. Records showed staff in the operating theatre and recovery area had completed this additional training.

Managers supported staff to develop through yearly, constructive appraisals of their work. One hundred percent of staff in paediatric outpatients and the paediatric secretaries had received an annual appraisal. For the ward this was just below the trust target of 95% at 94%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff received clinical supervision as regularly as required. Staff told us they could ask for supervision following an incident to support their learning and development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings had comprehensive and easy to understand notes. All staff received the meeting notes, so information was shared with everyone.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The service had two advanced nurse practitioners working on the junior doctor rota. They had both recently qualified after being supported by the trust to gain the required experience.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers reviewed staff training and skills aligned to the needs of the service being run. They offered staff training to upskill and develop their knowledge. One consultant, following discussions, had agreed to take on additional responsibilities with regards to end of life care for children. They received support and development from a dedicated end of life care team at another NHS trust.

Managers made sure staff received any specialist training for their role. Training was provided for staff specific to their role such as, newborn basic life support and paediatric life support. The service had policies that detailed training and skill requirements, for example the resuscitation policy outlined the level of training required when working with newborns, children and young people.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. The service ensured necessary staff were involved in assessing, planning and delivering children's care. This included medical, nursing, support staff and specialist staff such as qualified play specialists.

The service held multidisciplinary team meetings to discuss children with cancer, which included the consultant, nurses and community nurses and an outreach nurse from the mainland. These meetings ensured effective information sharing about the child's treatment plan, with the aim of providing a consistent approach to meeting their needs.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff told us there were regular meetings with the community nurses, schools, social workers and CAMHS to discuss children and their care needs. They also said this was beneficial in ensuring coordinated care and the sharing of information. The service ensured others were kept informed with timely discharge information sent to relevant individuals.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. The service had CAMHS support to complete risk assessments on children who attended with a mental health need. Staff knew how to make a referral to the CAMHS service and said the response was timely.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week. There was a reduced mental health service with full cover five days a week. The paediatric ward, neonatal ward and children's emergency department were open 24 hours a day, seven days a week. There was 24 hour nursing and medical cover. The service had support from diagnostic services 24 hours a day, seven days a week. The community paediatric nursing team ran a seven day service.

However, CAMHS was only available between Monday and Friday and young people with mental health issues who required a review before discharge remained on the ward over the weekends. During the weekend the service had mental health support from the psychiatric liaison team and the single point access referral team.

Services for children and young people

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw posters and information leaflets throughout the service for children and young people and their families to promote a healthy lifestyle for example, a poster about the amount of sugar in children's food and drinks.

Staff provided support for any individual needs to live a healthier lifestyle. Staff promoted and empowered children to manage their own health and maximise independence, for example the paediatric diabetes service offered children and young people a continuous glucose monitor (CGM). A CGM is a small device under the skin which measures sugar levels continuously. Children and young people could monitor sugar levels with greater independence and manage their own health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The service had children's policies with reference to consent requirements, this included restraint. The service promoted practice to avoid the need for restraint for example, staff had been trained in de-escalation techniques as part of their conflict resolution training. Staff understood requirements of the Mental Capacity Act 2005 for children over sixteen years old and knew who to contact for further advice on consent.

Staff received and kept up to date with training in the Mental Health Act achieving the trust's target. Staff in the paediatric outpatient's department had compliance of 100% with Mental Health Act mandatory training. Staff on the paediatric ward had 86% compliance with Mental Health Act mandatory training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had access to trust policies on children under 16 years old presenting in mental health crisis and children between 16-17 years old presenting in mental health crisis. Staff told us they would access the CAMHS team, psychiatric liaison and the single point access referral team for advice and support.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The service had no children admissions under the Mental Health Act to the paediatric ward in 2021. The service had recently formed a working group which included staff from the children's emergency department, children's wards and staff from the mental health acute team. This working group had reviewed the policy and pathway for children 17 and under presenting in psychiatric crisis in response to a recent learning.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff demonstrated an understanding of capacity in young people. The service had policies to support staff in making decisions about capacity.

Services for children and young people

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff encouraged children and young people to be involved in making decisions at a level they could understand. When a child was able to show a clear and informed level of understanding they were able to actively take part in the consent process in line with national guidance and the services policies.

Staff made sure children, young people and their families consented to treatment based on all the information available. Children, young people and families felt well informed and able to give consent based on all the information available. The service ensured children and young people and their families understood information and supplied leaflets for them to take home, for example: the day surgery department offered booklets about general anaesthetic and post-operative instructions following dental surgery. Play specialists were used to explain procedures to children and young people in a way they could understand.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. The service had consent forms for investigation and treatment involving anaesthesia or sedation and where consciousness was not impaired. The service had a policy associated with consent forms for staff to follow which clearly explained when a child can consent to their own treatment. Where the child had not been able to consent due to medical need, staff gave clear explanation to the child and families why treatment was necessary.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We saw staff interact with children and young people and their families in a respectful and discreet way.

Children, young people and their families said staff treated them well and with kindness. Families we spoke with during our inspection told us staff treated them well and with kindness. The service scored well for the question “Parents view of child being well looked after” in the CQC children and young people’s survey.

Staff gave an example of compassionate care for a child and family. They told how they managed the last moments of a child’s life encouraging the parent to speak with their child, allowing them time in a private environment and making hand and fingerprints prints for the parent to keep. The parent told staff they felt supported and appreciated the safe and calm environment provided.

Services for children and young people

Staff followed policy to keep care and treatment confidential. The service had a privacy and dignity policy to support staff keep patient treatment confidential. During our inspection we saw staff followed this policy. Staff took steps to ensure care treatment was given in private and that this remained confidential. They achieved this by closing curtains or cubicles doors during intimate examinations and conversations.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. Staff discussed children and young people in a compassionate manner. During our inspection staff told us that children and families often had a differing expectation of what a hospital stay would look like for a child admitted with mental illness. Staff had developed information for children and their families around what to expect to support and manage expectations of children and young people's and families.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff shared with us how they had identified additional emotional support was required for the mother and sister of a child being looked after by the service. They referred them both to services who would be able to provide the additional support required.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. The service had several private rooms for breaking bad news. Staff ensured conversations which may be distressful for young people and families took place in these rooms to support privacy and dignity. Staff responded to young people and families who became distressed in an open environment and encourage them to sit in dedicated private rooms.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on them, and their families, wellbeing. The service offered advice and suggested relevant support groups to support families with their wellbeing. However, staff told us the service did not have a psychologist for emotional support for children with life limiting conditions and they felt it would be beneficial for their children and young people.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Staff in the paediatric diabetic service talked to children about their religious needs around food, staff told us they had access to a dietician who could give dietary advice around religious needs to support their care needs.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment and staff supported children, young people and their families to make informed and advanced decisions about their care. The service had information leaflets available for children and families to take home with them to support understanding of care and treatment. Families we spoke with consistently reported that they felt well-informed about the care of their child and

the treatment options available. This meant staff supported children and families to make informed and advanced decisions about their care. The service scored well for the questions “Explanations parents and carers could understand” and “Parents and carers being given information about next steps” in the CQC children and young people’s survey.

Staff spoke with children, young people and their families in a way they could understand, using communication aids where necessary. During our inspection we saw staff communicating with children and young people in a way they could understand. We saw visual communication aids to help with communication for individuals with additional sensory needs. Diagnostic imaging services had developed leaflets to give to children to explain the imaging procedure to them in a way they could understand.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Children and young people gave positive feedback about the service. In all areas which children and young people were seen the service had patient feedback forms. Feedback forms were in a child friendly format so children could understand them and it supported children to provide feedback. Feedback from children and families was consistently positive.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Managers reviewed the service provision and adapted to meet the needs of the changing population. When the service had had five children requiring chemotherapy staff undertook additional training and assessment to enable them to provide chemotherapy treatment for two of the children. The children and families were able to stay locally for the treatment and not travel to the mainland. The service listened and took steps to improved where children’s needs were not met. In response to frequent complaints about availability of appointments for the attention deficit hyperactivity disorder (ADHD) service the service responded by seeking agreement with the local clinical commissioning group to expand the service to meet demand.

Facilities and premises were appropriate for the services being delivered. Those areas dedicated for the care of children, young people and their families had been designed with their needs in mind. There were facilities for parent ‘s or carers to stay. Where children were seen in areas designed primarily to care for adults, such as the operating department, the service took steps to protect the child and young person. This included not taking children to the area until they were ready for them. The service performed well on the question “Type of ward stayed on” in the CQC children and young people’s survey.

Services for children and young people

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. The service had support 24 hours a day 7 days a week from mental health and learning disabilities liaison team and the single point access referral team. The service had CAMHS support Monday to Friday.

The service had systems to care for children and young people in need of additional support and specialist intervention. The service worked proactively with other health and social care providers to ensure that systems to care for children in need of additional support were joint up. For example, the paediatric diabetes service held joint meetings with social workers and CAMHS to support children with eating disorders.

Managers monitored and took action to minimise missed appointments. In the paediatric outpatient department, if the waiting time was longer than usual and children, young people and their families did not want to wait for their appointment, the service aimed to rebook the appointment at the earliest available date.

Managers ensured that children, young people and their families who did not attend appointments were contacted. The service took steps to ensure children, young people and their families attended appointments including reminder letters, text messages and phone calls. If the child or young person did not attend staff contacted the children and young people and their family. Staff understood the process if children and young people repeatedly did not attend and knew who to contact to refer a safeguarding about the child or young person.

The service relieved pressure on other departments when they could treat children and young people in a day. The service aimed to treat and discharge from the children's emergency department, urgent treatment centre and paediatric assessment unit on the day where possible. The service aimed to treat conditions for children with mental illness at the children's emergency department and then support them in the community.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs. The service had support 24 hours a day on 7 days a week from mental health and learning disabilities liaison for advice and support. The service worked closely with children's community nurses to ensure children with long term conditions received necessary care.

Wards were designed to meet the needs of children, young people and their families. The paediatric ward was child friendly in design and decoration. The facilities were accessible for physically disabled children and families. The service performed well on the question about "appropriate equipment or adaptations" in the CQC children and young people's survey.

Staff used transition plans to support young people moving on to adult services. Staff transitioned young people onto adult services in a careful and considered way. For example, the service organised a joint consultation with their current practitioner and the adult consultant for continued care. This approach helped smooth young people's transition. The service was due to take part in a national audit: Child Health Clinical Outcome Review. This audit reviewed the transition from child to adult health services.

Services for children and young people

Staff supported children and young people living with complex health care needs by using 'My life a full life care passport'. The care passport included information about how to care for the child and young person in a way that met their individual and personal needs.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Children, young people and their families could request information leaflets in their first language to support them understand relevant information.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. Staff asked children and young people about their food preferences and liaised with the catering team, to ensure any special dietary requirements could be met.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. Staff said they knew the children accessing regular care and how was best to communicate with them. The service had a visual communication aid for those with additional communication needs. Staff could request interpreter and translation services to help with communication. The service was able to ensure children, young people and their families had information communicated to them in a way they could understand. This enabled children, young people and their families to be partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Staff told us the average length of stay for a child on the paediatric ward was between 24 and 48 hours. The service had reported some long-term admissions for children with anorexia. The service was working closely with CAMHS to support these children.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. The outpatient department monitored the waiting times for clinic appointments. When the appointments were running behind the staff informed the children and young people and families on their arrival to the department. The service performed well against national targets such as referral to treatment waiting times. The number of children and young people leaving the service before being seen for treatments was low. If children and young people did not want to wait for their appointment staff rearranged the appointment as soon as possible. Staff in the children's emergency department told us the staff on the paediatric ward were responsive in admitting children to the paediatric ward from the children's emergency department.

Managers worked to keep the number of cancelled appointments and operations to a minimum. When children and young people had their appointments and operations cancelled, managers made sure they were rearranged as soon as possible and within national targets and guidance. Appointments and operations were only delayed or cancelled when absolutely necessary. Staff told us when appointments and operations were cancelled, they rearranged as soon as possible. The attention deficit hyperactivity disorder (ADHD) service told us they offered a range of appointment times to suit the children and young people's and their family's needs, for example they offered evening appointments when required.

Services for children and young people

Managers and staff worked to make sure that they started discharge planning as early as possible Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. The service had close links with other agencies and the children's community nursing team. The service held regular discussion with multiagency teams to ensure smooth discharge and avoid delayed care in the community.

Managers monitored the number of delayed discharges and took action to prevent them. The service monitored delayed discharges but had not identified any specific issues or themes around delayed discharge of children. The service had long-term admissions for children with eating disorders, but this was comparable to the national picture due to lack of CAMHS beds for children.

Managers monitored patient transfers. The service monitored patient transfers to NHS trusts on the mainland. When the service identified learning from transfers, it was shared with staff.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The service had a child friendly feedback form if patients wanted to feedback to the service. The service displayed contact information for the Patient Advice and Liaison Service (PALS) in all areas where children were seen. This meant it was easy for children and young people's and families to raise a concern. Staff supported children and young people to raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff had access to a complaints, compliments, concerns and comments policy which included a flow chart to support staff handle complaints. Staff understood the policy and how to apply it.

Managers investigated complaints and identified themes. Managers identified a theme around lack of communication when a child and young person moved between teams such as: acute, community and social services. The service acted to facilitate the whole pathway to improve communication when a child and young person is seen by multiple teams.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. Staff aimed to acknowledge and resolve concerns at the time of care delivery. If concerns were not resolved, they were escalated to the patient experience team. The patient experience team involved children and families in the investigation of the concern and received feedback.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. Staff said they received learning feedback from managers and were made aware of emerging themes. Learning was used to improve the service for example staff told us of a recent complaint that private conversations between staff were overheard by children, young people and their families. Staff used this feedback to ensure private conversations about patients were not overheard.

Is the service well-led?

Good ↑

Services for children and young people

Our rating of well-led improved. We rated it as good.

Leadership

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

There was a designated matron for the paediatric ward, paediatric outpatients, paediatric day surgery, community and the neonatal unit.

Leaders had the skills, knowledge and integrity to run the service. Leaders encouraged and supported staff to develop skills and take on senior roles for example the service had two advanced nurse practitioners recently qualified and on the junior doctor rota, following two years of consolidation.

Leaders operated an open-door policy, which meant staff could approach them to discuss issues or concerns. Staff told us leaders were visible, approachable and supportive.

Leaders demonstrated an understanding of what priorities and issues the service faced and took action to address them. When the service required more support for ADHD services, the service addressed this by submitting a business case to expand the service

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision which was to deliver care that was of high quality, compassionate and family-centred; which would make a positive difference to the community.

The service had a core value around creating a dynamic evolving paediatric service working in collaboration with children, young people and families. This included the service's target linked to the vision around a children's board meeting in June 2021 which sought views from children and young people on the service.

The neonatal service had a separate vision and strategy. The vision titled "You and Your Baby" focused on a friendly and professional environment with modern facilities to meet the needs of babies and their parents. Staff understood the strategy and what their roles were in achieving it.

Each service's vision and strategy integrated into the overall trust strategy as there was a focus on: performance, people, partnership and place.

The service had specific targets and measures of success, this meant managers could monitor progress against the strategies. Targets included: peer review of paediatric service in 2021. Measures of success included: improvement of referral to treatment time.

Services for children and young people

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were positive, enthusiastic and told us they were proud to work for the service. Staff said they felt supported, respected and valued; especially during the last year of the pandemic when the service was busier than usual, and with staff redeployed to other areas.

The service had a strong emphasis on safety and wellbeing of staff. Staff appraisals during the last year focused on safety and wellbeing of staff, to ensure staff felt supported during the pandemic. Managers could access a policy on emotional wellbeing to guide them to support staff.

Staff focused on the needs of children and young people's receiving care, they showed kindness and compassion towards children and young people's and their families. The service had a culture which considered care and treatment for the child and family and the service involved families throughout. The service performed well on the question "confidence and trust" in the CQC children and young people's survey.

The service showed a culture of openness and honesty, staff, children and young people's and families could raise concerns without fear. Staff had a good understanding of duty of candour and we saw evidence of duty of candour being carried out in incident reports.

Leaders showed an understanding of the importance of staff and families being able to raise concern without fear of retribution. Action was taken when concerns were raised, and learning was shared.

The service promoted equality and diversity in daily work. There were positive results in the most recent staff survey to the questions: "I have not experienced discrimination from patients, service users, their relatives or other members of the public" and "I have not experienced discrimination from my manager, team leader or other colleagues". The trust score for equality, diversity and inclusion in the recent staff survey was positive and showed improvement compared to the previous year.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Staff had regular opportunities to meet, discuss and learn. The service held monthly mortality and morbidity meetings, where paediatric deaths and incidents were discussed, with learning shared. Staff had regular debrief following incidents to discuss and learn. The service had daily safety huddles with staff, where staff were able to raise concerns.

The service had effective structures, processes and systems of accountability. Staff were clear about their role and understood who they were accountable to. The service had a whole team meeting every week. During the team meeting incidents, risks, complaints, wait lists and the pathway for children were discussed. Actions for escalation from this meeting fed into a divisional governance update report which was discussed during the planned care quality and risk safety meeting. The planned care quality and risk safety meeting occurred monthly and fed into the acute quality board. All levels of governance interacted appropriately and functioned effectively. All key information fed into the planned care board meeting.

Services for children and young people

The safeguarding children's report was presented to the board yearly. We saw meeting minutes of the board report in September 2020 where the latest safeguarding report was discussed. Meeting minutes were clear and organised. Arrangements with partner organisations were managed effectively, for example the safeguarding children lead fed into Joint Agency Response (JAR) meetings for unexpected child deaths.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Leaders used systems to manage performance effectively. The service had a systematic programme of clinical and internal audits to monitor quality. When audit results indicated improvements were required the service developed action plans and monitored progress against them to improve practice.

The service had robust arrangements for identifying, recording and managing risks. The service had identified risks around a vacant ward manager post, service capacity for the ADHD service, lack of paediatric palliative care lead and an increase in demand for CAMHS services. These risks aligned with what staff told us they were worried about. The service had put into place mitigations against these risks to reduce their impact for example, the service had recently submitted a business case for the ADHD service with the local clinical commissioning group to increase the service in line with the demand.

The service had plans to cope with unexpected events and potential risks considered when planning services. For example, the service had a massive increase of children needing care during the summer months due to holiday makers coming to the island. The service took this into account and reviewed the staffing levels during the summer months.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it. The service collected data on service performance and people's views to ensure a holistic understanding of performance. The service used this information as assurance and to help service improvement.

The service used technology systems to monitor and improve the quality of care. The paediatric ward used an online system for clinical and environmental audits. The service used results from audits to improve the quality of care.

The service had robust arrangements to ensure confidentiality was in line with security standards. The service had secure information systems to access confidential patient information, which ensured only relevant staff had access to confidential patient information.

Staff could find the data they needed, in easily accessible formats, to make decisions. Staff told us the systems were easy to use and accessible. However, staff mentioned the systems were often slow due to the trust internet.

The service had arrangements to ensure data or notifications was sent to external bodies as required. The service evidenced that notifications such as serious incidents submitted to the Strategic Executive Information System (STEIS).

Services for children and young people

Engagement

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

Staff gathered people views and experiences of the service to shape and improve the service. The service gathered feedback using feedback forms, feedback was analysed to seek improvement. For example, the ward had a tree on the wall where children and families were able to write on a leaf with their suggestions or compliments. All comments seen were positive.

The service held a children's board with children at the local schools to ask children for service improvements. The recent children's board meeting was held in early June, this led to ideas around engaging children in pathways in the hospital. The service was looking at developing short videos to put on a popular young person's social media site. The purpose of these videos would be to explain the pathway to children and what to expect when they come into the hospital. The service was also developing 'meet the nurse' style videos which children could access via their smartphones using a QR code.

The service completed 'The Fifteen Steps Challenge' toolkit from NHS England, which encouraged children to walk around the children's areas with staff and share their views and experiences.

The service had positive and collaborative relationships with partner organisations to help improve services for children and young people. The service had a positive relationship with local NHS trusts and facilitated regular discussions to improve services for children and young people's, for example regular discussion with the consultant clinical lead for end of life care at the local NHS trust to gather ways to improve the service provided. The neonatal service had good collaborative links with their local maternity voices partnership (MVP) to gather patient and public views on the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Staff were proactive and committed to learning and improving. For example, staff in the ADHD service created a survey sent to children and young people's and families to determine the benefit of seeing a clinical nurse specialist for an appointment as opposed to a consultant.

Staff told us they took time to work together to solve problems, which led to service improvements. for example, the neonatal service held avoiding term admission into neonatal units (ATTAIN) monthly to discuss admission and improvements.

The paediatric diabetes service had a process for peer review of practice, this meant learning and improvement was identified.

The service had agreement to be part of National pilot for System-Wide Paediatric Observation Tool (SPOT), the service will complete audits against the tool monthly and send to the national pilot team for review.

The service encouraged children to take part in research studies. For example, the trust sponsored research in Asthma and Allergy studies in paediatrics.

Gynaecology

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff had now received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Managers now monitored mandatory training and alerted staff when they needed to update their training. Training was presented as part of a report at monthly divisional meetings. Mandatory training compliance was now equal to the trust target.

Please refer to the surgery core service report for more detailed findings.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

For example, where a patient had been abused staff were able to identify this and knew where support could be found for the patient and themselves. Staff told us incidents relating to female genital mutilation were rare in the service but were aware of the need to report cases should they arise.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Gynaecology outpatients, including consulting rooms and waiting areas, were visibly clean, tidy and well maintained.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment, with 'I am clean' stickers, to show when it was last cleaned. There were weekly cleaning audits to evidence compliance with the hospital cleaning schedule. Results of the audit of the cleaning schedule were displayed on ward or department information notice boards.

Gynaecology

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to enough supplies of PPE and changed items they wore in line with trust policy.

Please refer to the surgery core service report for more detailed findings.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the layout of the outpatient waiting room did not always support the needs of the patient.

The service generally had suitable facilities to meet the needs of patients. However, the layout of gynaecology outpatient department did not always support the emotional needs of patients. There was one waiting room for all clinics. Patients and their partners who attended the early pregnancy clinic could be sat alongside patients attending ante-natal or fast-track clinics. The service was aware and had made arrangements to support individual patients. This involved identifying who attended these clinics and greeting them as they arrived. This ensured patients either didn't have to wait or spent minimal time in the waiting room. Additionally, the service had plans to relocate ante-natal clinics away from the gynaecology clinics to improve the experience for patients.

Staff carried out daily safety checks of specialist equipment. Staff checked resuscitation trolleys and daily checklists had been completed. Resuscitation equipment was visible and accessible. Trolleys now had tamper evident tags. The contents of the trolleys were checked in line with trust policy. We found emergency equipment was fit for use.

The service generally had enough suitable equipment to help them to safely care for patients. The service had identified some ageing equipment, for example, that used for colposcopy procedures. New replacement equipment had been ordered. However, it was reported some clinic capacity had been reduced due to ageing equipment requiring repair.

All equipment we checked had been safety checked and a sticker placed on it indicating when the next service was due. Checks of consumable items such as needles and syringes confirmed they were within its expiry date. Store cupboard in the department was tidy and equipment was accessible.

Staff disposed of clinical waste safely. For example, staff used bins to dispose of sharp instruments, such as needles. Sharps bins were not filled above the safe level indicated.

Please refer to the surgery core service report for more detailed findings.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff now identified and quickly acted upon patients at risk of deterioration. Patient records we reviewed and trust audits confirmed significant improvements had been made to recognise and manage the deteriorating patient.

Safety huddles were observed in the gynaecology outpatient department, including in the early pregnancy unit. Huddles used the word 'SAFETY' to define the structure of discussion: S-staffing, A-activity/acuity, F-feature of the week, E-escalation, T-tasks, Y-you 'caring for you'. Output from the discussions was recorded on notice boards for staff and patients to see.

Please refer to the surgery core service report for more detailed findings.

Gynaecology

Nurse staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Managers described the nursing staffing within the gynaecology outpatient service had been through a period of change. Experienced staff in key roles had either moved to other departments in the trust or had left the trust altogether. Key roles were now being covered or filled by experienced nursing or midwifery staff from within the trust.

Managers could not confirm if anyone in the current nursing workforce working in the service had a level 6 post-graduate qualification in gynaecology.

Managers and staff reported the lack of healthcare support workers contributed to the cancellation of outpatient clinics. Gaps in some shifts meant there was not enough nursing support to enable some clinics to be staffed to sufficiently to provide suitable support for both patients and doctors.

However, there were enough staff in the colposcopy suite to fulfil the national guidance and accreditation criteria. There must always be a registered nurse and a health care assistant to support the clinician during the procedure. Staff reported on this to maintain accreditation and said this was always achieved.

Nursing staff handovers and safety huddles which took place included discussions about patient needs and any staffing issues.

The trust had reducing vacancy rates. The trust's current vacancy rate was nearly 10% for registered nurses. In 2018 the trust's vacancy rate for registered nurses was 25%. In 2019, the trust embarked on increasing their international recruitment programme. This programme has led to the successful employment of 147 acute registered nurses since July 2019. The trust is on track to deliver over establishment of nurses by year end to reduce agency use.

The trust had a variety of specialist nurses who provided care and treatment for women, including bereavement nurses and oncology nurse specialists who liaised with and supported women with cancer.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The gynaecology service operated a consultant-led service. Senior staff planned and reviewed staffing and skill mix so patients using the service received safe care and treatment.

Surgical procedures were consultant led and patients had medical input for their pre- and post-operative care. Junior doctors on shift during day times contributed to elective theatre lists that were consultant led.

There was a named consultant for gynaecology who was on-call 24-hours a day, seven-days a week. Junior doctors told us there were no difficulties getting the support they needed. They also reported senior colleagues were approachable.

Gynaecology

The trust had a medical vacancy rate of just over 3%. The trust was aware of the challenges surrounding medical vacancies and had achievable plans to address the shortfall. The trust's improvement quality priorities for 2021/22 set out how the trust plan to reduce the medical vacancies. These include partnership arrangements with another trust for joint appointments of consultants, who work at both trusts and a contract with a bespoke recruitment consultancy company.

Please refer to the surgery core service report for more detailed findings.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. Patient records were checked for accuracy and completeness as part of monthly audits.

Patient notes were comprehensive. Staff always recorded the necessary information. We reviewed 10 patient records and all had dates, times or notes about patients' preferences or wishes. Staff could always find the most up-to-date information about patients when they needed it. Patients told us staff always knew their preferences or needs.

Patient records were mainly paper based. Staff stored patient records securely in locked trolleys. When patients transferred to a new team, there were no reported delays in staff accessing their records.

Please refer to the surgery core service report for more detailed findings regarding patient records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff stored and managed medicines and prescribing documents in line with the trust policy. The service maintained a limited stock of medicines, all items reviewed were within date and stored securely. Prescription forms were stored securely and there was an effective system in place to ensure all forms were tracked.

The emergency drugs on the resuscitation trolleys were stored in tamper-evident containers, as recommended by the Resuscitation Council (UK).

Please refer to the surgery core service report for detailed findings regarding the management of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and now reported incidents and near misses. Managers investigated incidents and now shared lessons learned with the whole team and the wider service. Staff told us they now received feedback from incidents and believed issues would be addressed. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Please refer to the surgery core service report for detailed findings regarding the management and understanding of incidents.

Safety Thermometer

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

Gynaecology

The collection of safety thermometer data was suspended during the Covid-19 pandemic.

However, staff used the safety thermometer data to improve services. For example, in gynaecology outpatients learning from complaints and concerns was displayed. In addition, the service displayed 'You Said, We Did' comments. The board for June 2021 had concerns highlighted regarding confusing signage within the department. The response from the service which described how the department was being redesigned and the concern would be addressed.

Is the service effective?

Good ↑↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service adhered to guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) guidance.

Staff ensured the surgical aspect of the service was managed care in accordance with NICE guidelines. Staff followed safe practice during theatre procedures to ensure treatment delivered met NICE guidelines for safer surgery. This included checking equipment, reviewing relevant policies, medicines management and seeking and documenting patient consent during pre-operative discussions.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The service had introduced a daily huddle in the early pregnancy unit, attended by the on-call consultant. Staff discussed patients who had attended that day to monitor and agree care plans.

The service did not routinely perform termination of pregnancies. Patients were referred to neighbouring NHS trusts in the event a termination was required. However, staff followed the Royal College of Obstetrician and Gynaecologists guidance 'The care of patients requesting inducted abortion' when treating patients who wished to terminate a pregnancy. This included offering guidance and advice on sexually transmitted infection and contraceptive advice.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff used specific care plans when providing care and treatment for patients with mental ill health, which included additional measures such as enhanced monitoring and supervision.

Please refer to the surgery core service report for more detailed findings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Gynaecology

Patients attending as outpatients were often in the clinics for a short time therefore were not routinely provided with food and drink.

Please refer to the surgery core service report for more detailed findings.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Please refer to the surgery core service report for more detailed findings.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Staff within the service conducted audits and quality improvement projects to ensure the department was treating patients according to evidence-based care and treatment, and specialist professional standards.

Managers and staff carried out a programme of repeated audits to check improvement over time. There was a rolling audit programme that included several audits based on clinical outcomes, environmental aspects, adherence to professional standards and evidence-based practice, and patient satisfaction. The monthly compliance rate for audit completion had been above 90% every month.

Managers shared and made sure staff understood information from the audits. Audit findings were displayed in wards and departments for staff to see.

Staff within the colposcopy service told us they had to see patients within certain timeframes, for example low-grade cases had to be seen within six weeks and high-grade cases within two weeks. This data was routinely submitted to Public Health England (PHE) and allowed the service to benchmark with other similar services.

Managers and staff used the results to improve patients' outcomes. We saw meeting minutes which confirmed this, audit findings were discussed at ward and departmental meetings.

Please refer to the surgery core service report for more detailed findings.

Competent staff

Key roles within the service were filled by qualified and experienced nurses and midwives. The service did not assess relevant staff using a gynaecology specific competency based criteria. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Appraisal rates for the service had improved and now met trust targets.

Gynaecology

Staff told us they routinely received regular supervision and annual appraisals. The appraisal rate for the gynaecology service was 85%. This showed most staff had completed their appraisals but the trust target of 95% for staff appraisal completion had not been achieved. Managers in the gynaecology outpatient department told us all outstanding appraisals had been scheduled with staff.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke to member of staff who was recently employed by the trust who confirmed they had received a full induction including a supernumerary period.

All staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management. Staff told us they had training sessions and were supported to attend these.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Doctors in training told us training sessions had carried on despite the Covid-19 pandemic.

Please refer to the surgery core service report for additional findings.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us they had a good relationship with consultants and ward-based doctors. We saw there was effective team working and communication between all staff disciplines.

Patients could see all the health professionals involved in their care in one-stop clinics. For example, in the early pregnancy unit and the colposcopy clinic.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. patients were reviewed by consultants depending on the care pathway. The acute gynaecology service was available seven days a week and was consultant led for five days and by on-call consultant cover across the weekends. Patients were able to receive care and treatment for pelvic pain and heavy menstrual bleeding.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was consultant and anaesthetic cover available during the week and at weekends through on-site and on-call cover.

In the event of an out of hours gynaecology emergency patients attended the emergency department. If required, patients would be placed onto an emergency surgery list which was available seven days a week to ensure gynaecology emergencies could be undertaken

Gynaecology

Gynaecology outpatient clinics ran, in the main, between Monday and Friday. The service ran a one-stop outpatient clinic and could provide diagnostic scanning, screening tests and tissue sample procedures. The inpatient care was provided on the surgical wards.

The early pregnancy unit was available Monday to Friday. If patients required advice outside of hours the clinic offered an emergency number which connected to the gynaecology department where staff would be available to offer assistance.

Please refer to the surgery core service report for more detailed findings.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff assessed each patient's health at pre assessment and provided support for any individual needs to live a healthier lifestyle. Patients identified with weight concerns were referred to dietitians for advice and support. Patients with addictions for example, alcohol were offered support from specialist hospital-wide liaison teams.

Staff in the early pregnancy unit and pre-assessment incorporated time into patient appointments to discuss and engage patients in making healthy life choices for example with smoking cessation.

Posters throughout the clinics promoted pregnancy loss charities who could support patients in the event of suffering a miscarriage. Patients' mental wellbeing was promoted as being as important as maintaining physical health.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients consent. However, patients were not given a copy of their consent form for their own records. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient records we reviewed showed consent had been obtained and care was delivered with their agreement.

Staff told us the risks and benefits of the specified surgical procedure were documented and explained to the patient. We reviewed a sample of consent forms which were completed to a good standard with risks and benefits clearly documented. However, patients did not receive a copy of their consent form as recommended by the Royal College of Surgeons of England. Not giving patients a copy of their consent form meant they did not have a copy for reference and reflection.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Please refer to the surgery core service report for more detailed findings.

Gynaecology

Is the service caring?

Good

We previously inspected gynaecology jointly with maternity. We rated it as good.

At the time of our inspection there were no gynaecology patients on the wards, the below information is based on observation of the outpatient's department.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The outpatient department was spacious, however the design of the waiting room meant patients attending ante-natal, gynaecology, fast-track cancer and early pregnancy clinics could be waiting together. Staff were aware and described how they supported individual patients.

Staff followed policy to keep patient's care and treatment confidential. The service had policies regarding confidentiality which staff understood and adhered to. We observed staff lowered their voices when talking to patients about confidential matters.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Trained staff were available to act as chaperones when patients attended outpatient clinics.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients who attended the early pregnancy unit were identified early on arrival to the department and supported by appropriately trained and experienced staff.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff described situations where patients were given bad news and how they had supported them initially, and then in the days and weeks after the event.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us they had received enough information regarding their care and treatment.

Gynaecology

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw staff engaged and spoke with patients in a respectful way. Staff supported patients to take the time they needed during their appointments.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service provided paper-based feedback forms to enable patients to give feedback. The service collated responses and displayed them, with actions, on ward and department notice boards. Examples seen included: 'Thank you so much you were all brilliant', 'Excellent treatment, kind and considerate doctor and nurse. Thank you.'

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Staff were aware of how to escalate key risks that could affect staffing and clinic capacity constraints. There was daily involvement by the matron and managers to address these risks.

Facilities and premises were generally appropriate for the services being delivered. The layout of gynaecology outpatient department did not always support the emotional needs of patients. There was one waiting room for all clinics. Patients who attended the early pregnancy clinic could be sat alongside patients attending ante-natal or fast-track clinics. The service was aware and made arrangements to support individual patients. Additionally, the service had plans to relocate ante-natal clinics away from the gynaecology clinics to improve the experience for patients.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital had dedicated learning disability liaison nurses who provided support for people with learning disabilities.

Managers monitored and took action to minimise missed appointments. They ensured patients who did not attend appointments were contacted and supported to re-book where appropriate.

The service relieved pressure on other departments when they could treat patients in a day. For example, in the one stop colposcopy clinics.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Please refer to the surgery core service report for more detailed findings.

Gynaecology

Meeting people's individual needs

The service was inclusive and now took account of patient's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff provided clear advice to patients on what to do if they experienced any problems following their discharge from the hospital for example, excessive bleeding. Patients could contact the acute gynaecology service using a telephone line that was monitored 24 hours a day and seven days a week by the nursing team. If the problem was urgent, patients were advised to go to the emergency department.

Staff ensured patients were given the opportunity of making an informed choice about how to manage the remains of their termination of pregnancy. Patients were asked the question sensitively and in a way which acknowledged their distress but sought a response to a difficult question. Staff explained how they would ask this of patients in a way which would maintain their wellbeing and that of their partner. This included not asking patients to sign whilst in a distraught state and supporting them to seek advice and counselling before making the decision on how they wished to proceed.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets were also available in different size fonts and on coloured paper for patients with a visual impairment.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us it was easy to access interpreters when they needed to.

Clinic and waiting areas were large enough to accommodate wheelchairs. There were patient toilets located in most waiting and clinic areas and were suitable for the use of patients who had reduced mobility and required mobility aids or wheelchairs.

The service used an electronic database that had an alert system for different conditions that could be flagged and shared with relevant areas of the service.

Please refer to the surgery core service report for more detailed findings.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Please refer to the surgery core service report for more detailed findings which include the restoration of services affected by the Covid-19 pandemic.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Patients mostly had timely access to initial assessment, test results, diagnosis and treatment. Action had been taken to minimise the length of time patients had to wait for care, treatment or advice. All referrals for specialist services came through email to a centralised booking team then transferred to the appropriate clinic. Referrals were made by GPs or other health care professionals.

Staff were able to prioritise patients according to their clinical needs and whether they should be seen on the two, six or 18-week pathways.

Gynaecology

Patients with the most urgent needs had their care and treatment prioritised. There was an emergency acute gynaecology unit provided on the early pregnancy unit. They prioritised patients dependent on their acuity. There was an emergency theatre on-site and team of doctors on-call 24-hours a day, seven days a week.

Managers and staff worked to make sure patients did not stay longer than they needed to. Services and clinics generally ran on time and staff made patients aware of any delays or disruptions on arrival.

Managers worked to keep the number of cancelled appointments to a minimum. However, the lack of nursing staff had resulted in a number of short-notice cancelled clinics. Staff reported doctors were supportive with scheduling additional clinics to minimise disruption for patients.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service clearly displayed information about how to raise a concern in patient areas. The outpatient clinic areas had information leaflets displayed showing how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.

Managers investigated complaints and identified themes. The clinic managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff understood the policy on complaints and knew how to handle them. Staff told us information about complaints was discussed during daily 'safety huddles' and at routine team meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.

Staff could give examples of how they used patient's feedback to improve daily practice. For example, patients attending gynaecology outpatients said signage was confusing. The service responded positively regarding plans to improve signage.

Is the service well-led?

Requires Improvement ➔➔

Our rating of well-led stayed the same. We rated it as requires improvement.

Gynaecology

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, the new care group structure needed embedding and there was a number of senior staff in interim roles, the service had been through a long period of instability with interim managers.

The trust had recently changed the structure of care groups, now there was two care groups; planned care and unplanned care. The surgical services at the hospital formed part of the planned care group. The care group was led by a chief operating officer, clinical director, director of operations, associate director of nursing, associate director of operations and head of midwifery. They were supported by two deputy associate director of operations and eight operation managers. Several members of the management team were new to the roles but had a clear understanding of the risks to the surgical services and how to address these. The clinical director only started the role in June 2021 but staff were positive about their impact.

Several staff told us they felt the hospital had previously been operationally led and was not nursing or medically led. However, staff now gave us examples of when operational managers had made decisions with nursing or medical input. For example, the ownership of nursing vacancies and serious incidents sat with the operational management rather than with the nursing or medical teams. Managers told us this was changing and some changes had already been made. For example, the ownership of nursing vacancies and HR matters relating to nurses was now with the associate director of nursing.

Staff told us of a long period of management positions being covered by interim staff which was unsettling and impacted on driving changes forward.

A number of senior nurses had been appointed into key roles in the last 12 months, so the leadership team was fairly new across the gynaecology service. The majority of staff spoke positively about the leadership and organisation structure and described their line managers as approachable, visible and who provided them with good support.

Please refer to the surgery core service report for more detailed findings.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's brand statement was 'great people, great place'. The 2020/21 acute services operational plan identified priorities such as a redesign of the acute services, theatres productivity, and getting beyond 'good'. In addition, there was a trust wide quality improvement strategy based on the 'getting to good' turnaround objectives. We saw progress had been made, such as the development of an Island wide dementia strategy, by working closely with the wider health economy.

The vision and values had been cascaded to staff across the gynaecology service and staff had a good understanding of these. The service had developed its own vision and strategy, we saw this displayed on notice boards.

For example, an area included in the strategy was to develop nurse-led clinics in areas such as colposcopy. At the time of inspection all such clinics were consultant-led. However, leaders described their aspiration to develop the skill-set of nurses so they could expand services to patients.

The trust had comprehensive plans on how they were going to restore elective and outpatient services due to the Covid-19 pandemic. Staff we spoke to were aware of the plan and how they played a part in achieving the plan.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The culture of the services provided were centred on the needs and experiences of patients who used services. We observed staff worked well together and a continuous theme from staff discussions was they felt the services worked well as a team and felt supported by their leaders.

All staff told us they felt the gynaecology service pulled together to meet the needs of their patients. Staff were positive and proud to work in the organisation. They felt supported, respected and valued. Most staff we spoke said how nice it was to work at the hospital.

Some staff told us there was a historic issue with the behaviours of a minority of consultants. Staff told us these behaviours were now being challenged and managed by senior medical staff and felt confident the behaviours would be addressed.

Nursing staff and doctors told us they had access to senior managers and consultants when they required additional support in their role. Senior staff said they felt reassured staff would contact them with staffing concerns when they arose and had done so out of hours.

The trust had appointed a freedom to speak up guardian to support staff to raise concerns and share negative experiences. Staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared. All staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed.

The trust recognised the impact the Covid-19 pandemic had on staff and were promoting a culture that it was okay to not be okay and had a variety of support mechanisms work staff. For example, staff could access ‘A listening Ear’ which was a conversation with a trained counsellor. Staff we spoke to knew about this service and how to access it.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. **However, some governance process required embedding.**

Please refer to the surgery core service report for more detailed findings.

Additionally, the gynaecology service held a monthly risk meeting to discuss governance and risk. This fed into the governance structure for the care group.

Gynaecology

We attended one of the meetings during the inspection and reviewed of previous meetings. There was good attendance by staff of all grades and professions. The risk meeting had a standardised agenda which included reviewing incidents, clinical updates and a review of the gynaecology dashboard.

There were monthly departmental meetings and minutes showed incidents, complaints, staffing and risks were regularly reviewed, and actions taken where appropriate.

Management of risk, issues and performance

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

Please refer to the surgery core service report for more detailed findings.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff ensured they maintained patients' confidentiality through the management of information. Patient's paper records were now stored securely in lockable files or in locked rooms. Staff were able to access the information they needed to deliver care and treatment.

Routine data collections were used to monitor and improve performance issues and to provide assurance to service leaders. Senior staff now used audit data and performance dashboards to have a collective understanding and oversight of the services they managed.

Service performance measures included infection and risk, falls, pressure ulcers, staffing and patient feedback were reported routinely and displayed in public areas.

An electronic patient safety reporting system was in place to ensure incidents were escalated and reviewed by appropriate clinicians and managers. Incidents were followed up and feedback sent to the reporter.

Staff had access to the information they needed via electronic systems. This included patient data and the trust's policies, procedures and general guidance which were updated when required to ensure the information was the most up to date guidance available.

Engagement

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

Patient feedback was sought and obtained through the NHS Friends and Family test. Patients were provided with questionnaires to obtain feedback on how the service could be improved. These were discussed in regular meetings to ensure changes couple be implemented to improve service quality where identified. Meeting minutes confirmed these discussions took place.

Gynaecology

On notice boards in the gynaecology outpatient department 'You said, We did' feedback was displayed. This identified how the service had responded to patient feedback.

The trust sought staff feedback the NHS Staff Survey. This is an annual study which is a requirement for all NHS trusts in England. The results were presented in a format which allowed the trust to compare their results against the results from other directorates within the trust.

Most staff spoke positively about trust engagement. There had been a recent period of change when the gynaecology services changed their divisional structure. Staff said this had been a positive move and felt the service was now more proactive in seeking their feedback and making changes as a result. Service leaders told us they were very keen to get input from all staff on how it the service would develop.

The service had established effective partnerships with neighbouring trusts to support patients and their treatment. For example, the service commissioned external partners and colleagues to support reviews of incidents.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Please refer to the surgery core service report for more detailed findings.

Community health inpatient services

Good ↑

Is the service safe?

Good ↑

Our rating of this service improved. We rated it as good.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Ninety-three per cent of staff in the service had completed mandatory training. The mandatory training was comprehensive and supported staff to meet the needs of patients. Staff also completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service had a close relationship with the local authority. Staff had training on how to recognise and report abuse and they knew how to apply it.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

An infection control audit had been completed in March 2021 and all actions had been completed and tested. For example, the audit found no hand hygiene audits had taken place. The action was to implement these monthly which was completed by the April 2021 and checked again in May 2021.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well and there was a clinical waste audit completed weekly.

Patients could reach call bells and staff responded quickly when called.

The service had enough suitable equipment to help them to safely care for patients.

Assessing and responding to patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Community health inpatient services

Staff identified and quickly acted upon patients at risk of deterioration. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. For example, the service used the malnutrition universal screen tool (MUST) to establish any nutritional risk to patients and the national early warning score (NEWS2) to identify deteriorating patients.

Staff knew about and dealt with any specific risk issues well, for example, pressure ulcers.

Staff shared key information to keep patients safe when handing over their care to others. The consultant nurse linked with staff on the acute wards to facilitate patients moves to the community inpatient ward as soon as they were able and staff worked with colleagues in the community services to facilitate discharge as soon as patients were ready to ensure the risks associated with staying in hospital for long periods were mitigated.

Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers ensured that shifts included activity coordinators and the physiotherapist.

The service had low vacancy, turnover and sickness rates.

The service had access to enough medical staff to keep patients safe.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. Patient notes were handwritten but were comprehensive, legible and contained all necessary information about the patient.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. We reviewed 11 patient medication records and found no administration or recording errors. The clinic room was clean, organised and immaculately presented. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Community health inpatient services

Incidents
The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. The team held 'hot debriefs' immediately after significant incidents such as falls.

Staff understood duty of candour and there was an easy-read duty of candour document available to patients.

The unit had no 'never events'. There has been one serious incident, which was a COVID-19 outbreak in January 2021.

Safety Thermometer
The service used monitoring results well to improve safety. Staff collected safety information and shared it with the community service staff via the divisional newsletter, and with the rest of the trust and the board via the quality and performance committee. The service also made safety information available to the clinical commissioning groups, who fund the community services.

The service continually monitored safety performance.

Is the service effective?

Good ↑

Our rating of this service improved. We rated it as good.

Evidence-based care and treatment
The service provided care and treatment based on national guidance and evidence-based practice, such as prevention and management of pressure ulcers. There were subject experts that worked within the community health division who audited the service to ensure adherence to best practice. Staff protected the rights of patients in their care. Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Nutrition and hydration
Staff gave patients enough food and drink to meet their needs and improve their health. Staff used food and fluid charts when applicable. The service made adjustments for patients' religious, cultural and other needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief
Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Staff used the BARTHEL index on admission and discharge, a scale used to measure performance in activities of daily living, to track patients progress.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. All staff had received an appraisal in the last 12 months.

Staff were able to access training to support their role for example, dementia awareness.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Ninety-three per cent of staff had completed mandatory training. This figure was due to increase once staff had completed manual handling training, which had been booked.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates were the service were 100%.

The clinical educators supported the learning and development needs of staff for example by holding regular group sessions and ensuring staff had access to training to support their role. The practice educator also held bitesize sessions monthly on key topics such as diabetes, continence, and higher or lower chairs.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff we spoke to were positive about the access they had to training.

Managers made sure staff received any specialist training for their role.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. Staff worked across health care disciplines and with other agencies when required to care for patients. The team was made up of a variety of disciplines, including nurses, health care support workers, physiotherapist, activity co-ordinators, nurse consultant and advanced nurse practitioner. The service also had access to an occupational therapist from within the trust.

The team worked well and closely with the wider community division. For example, podiatry, orthotics and prosthetics, and district nursing. The service also worked well with the acute wards to ensure that patients did not have extended lengths of stay in the general hospital

Community health inpatient services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Patient records were handwritten but were clear, legible and contained all necessary information.

Is the service caring?

Outstanding ☆ ↑

Our rating of this service improved. We rated it as outstanding.

Compassionate care

Patients were truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

All six patients we spoke to were overwhelming positive about the way staff treated them and spoke highly of the care and treatment they were receiving. We read numerous written compliments and feedback comments, the majority of which thanked staff for going the extra mile to support them or their loved ones. The care and support they received whilst on the unit exceeded their expectations.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity. All staff we spoke to were passionate about their role and ensured all they did revolved around the patient and their needs. We observed staff constantly engaging with patients, encouraging activities and checking on their wellbeing. Patients' emotional and social needs were seen as being as important as their physical needs. Relationships between patients, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff recognised and respected the totality of patients' needs and found innovative ways to meet them. For example, when working with a patient with a learning disability.

Staff followed policy to keep patient care and treatment confidential.

Community health inpatient services

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

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

Staff supported patients who became distressed in the ward environment and helped them maintain their privacy and dignity. Staff were exceptional in enabling people to remain independent such as sourcing additional equipment and ensuring appropriate packages of care were in place prior to discharge.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. During the lockdown restrictions, where visitors were unable to visit the hospital, the service had tablets and mobile phones available for patients to use so they could keep in touch with loved ones. We were given an example of a married couple who were able to be accommodated in the same room as they had never previously spent time apart.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Those who used the service and those close to them were active partners in their care. Staff were fully committed to working in partnership with patients and making this a reality for each patient. Staff empowered patients to have a voice and realise their potential. Patients' individual preferences and needs were always reflected in how care was delivered, and evidenced well in care planning. For example, one patient's only goal was to be able to walk his daughter down the aisle on her wedding day. Staff worked tirelessly to ensure this was possible.

Staff made sure patients and those close to them understood their care and treatment. They explained all the options available to them so they were truly informed and staff supported patients to make informed decisions about their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary as the service had access to a speech and language therapist.

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

Staff supported patients to make advanced decisions about their care.

Is the service responsive?

Good 

Our rating of this service stayed the same. We rated it as good.

Community health inpatient services

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. The service was originally designed for those over the age of 65 however due to population need the service now accepted all adults over 18 and there was no upper age limit. The service could accommodate a range of needs, including adults with a learning disability or those undergoing substance detoxification, whilst still providing the appropriate care and treatment within the unit.

The service worked with others in the wider system and local organisations to plan care. For example, staff worked closely with adult social care and local voluntary services to ensure packages of care were arranged prior to discharge.

Facilities and premises were appropriate for the services being delivered. Patients had access to a well-kept outdoor space so could access fresh air when they wished to. Patients were encouraged to help with planting and tending plants which they very much enjoyed, and this supported their well-being.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and mild dementia, received the necessary care to meet all their needs.

The service had access to information leaflets in languages spoken by the patients and local community. Information was also available in large print. Staff had access to communication aids to help patients become partners in their care and treatment. The service had access to a speech and language therapist to facilitate this.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it and received the right care in a timely way. All patients were referred to the Integrated Discharge Team through the single point of access and then assessed for admission.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had a target length of stay of 14 days but were consistently under this target, averaging at 6.9 days. The service had a clear inclusion and exclusion criteria, and signposted referrals to other services where needed.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The service had a discharge co-ordinator, who liaised with care providers and ensured packages of care were in place prior to discharge. Staff would not discharge patients at the weekend if it was unsuitable to do so, for example if a residential setting had fewer staff on the weekend however they would also facilitate weekend and evening discharges if this was preferred, for example back to the family home. Staff would try to avoid discharging a patient if it meant multiple transfers of care, for example to a short-stay re-ablement bed or back to an acute setting before moving to a care home. This meant less stress for the patient as they would only need to move once.

The technology enabled care team had implemented a telemonitoring and telehealth system to support safe discharge back into the community.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The service had a low number of formal complaints but acted quickly to resolve informal complaints before they escalated.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good ↑

Our rating of this service improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. At the time of the inspection, the deputy team leader was acting-up into the team leader role on an interim basis. They were being well-supported by the head of nursing. They understood and managed the priorities and issues the service faced. The interim team leader had a 'hands on' approach, and the senior leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Culture

Staff felt respected, supported and valued by the leaders in the service. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. All staff we spoke to had high levels of morale and were passionate about their role and working for the trust.

Community health inpatient services

Governance, risk management and quality measurement

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

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

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Public and Staff engagement

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

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. For example, the service had recently completed a quality improvement project and re-designed the care plan and risk assessment template used for all patients. This had been embedded quickly and all patients had an updated care plan and risk assessment at the time of the inspection.

Acute wards for adults of working age and psychiatric intensive care units

Good ↑

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff removed any new environmental risks and responded to changing risks on the ward.

Staff could observe patients in all parts of the wards. On both wards staff were able to observe patients easily. For example, in Osborne ward the bedroom doors had vistomatic windows that could be operated by patients or staff. Signs on bedroom doors advised staff whether patients would like their window panel left open or closed.

Both wards complied with guidance and there was no mixed sex accommodation. For example, in Osborne ward there was a designated female lounge on the ward and separate quiet area. In Seagrove ward there was a male lounge and a female lounge that male patients had been using. The manager said she will ensure that only females used this lounge going forward and will put a sign up.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff on both wards were able to demonstrate their knowledge of all potential ligature points and the mitigation in place to ensure patients were safe.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and fit for purpose. In Seagrove ward the environment required some attention. There were marks on the wall, graffiti, missing plaster board and paint. The estates work was due to start in August 2021 with a plan to refurbish the ward. There was now a temporary, makeshift entrance to the ward. This meant that patients and visitors did not need to walk through Osborne ward. A new, separate entrance was planned to be built later in the year.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed the infection control policy, including handwashing.

Seclusion room

The seclusion room in Seagrove ward allowed clear observation and two-way communication. It had a toilet and a clock. This met the requirements under the Mental Health Act Code of Practice.

Acute wards for adults of working age and psychiatric intensive care units

Clinic room and equipment

In both wards clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff on both wards checked, maintained, and cleaned equipment.

Safe staffing

The service generally had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service generally had enough nursing and support staff to keep patients safe.

However, the staff working on Seagrove ward also covered the health based place of safety when required. The manager said this left Seagrove ward short staffed if they were not able to access staff from elsewhere in the service. As the health based place of safety was most often used at night this presented them with difficulties finding additional staff to cover Seagrove ward. The manager said the trust were aware of this and there was a plan in place to address this later in the year.

The service had low vacancy rates.

The service had low rates of bank and agency nurses. In Osborne ward they had two full-time agency support workers and on Seagrove ward there were four part-time agency workers. They requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

All agencies staff received an orientation to the ward and an induction. Managers ensure that the agencies provided the same training and that they completed a list of ward competencies.

Both wards had low turnover rates. Turnover rates were low across both wards with staff leaving for career progression.

Managers supported staff who needed time off for ill health. The average staff sickness levels across both wards was low at 4.6% per year.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Apart from the staffing issue on Seagrove ward both managers were able to adjust staffing levels if patients needed additional staff support.

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Staff said when they need to cancel leave, they would rearrange it and offer the patient an alternative time.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Staff attended handovers between each shift were all the information was shared between staff.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and prepared staff to be able to meet the needs of patients.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool. Staff on Seagrove ward reviewed this regularly, including after any incident.

Management of patient risk

Staff on Seagrove ward knew about any risks to each patient and acted to prevent or reduce risks. Staff members in Osborne ward had not fully recorded risk changes on patient's risk assessments in 3 of the 6 patient records we reviewed. These included changing risk in relation to aggressive behaviour towards themselves or other people. The manager said that this was in part due to the recording system which did not have a separate risk assessment. The manager showed us evidence that risk was discussed at handover. However, this was not reflected in the content of the risk assessments. This was identified as an area of concern at the last inspection.

Staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

On both wards the levels of restrictive interventions were reducing. Managers on both wards said that the new audit system had made a significant difference to improving both the frequency and the recording of each episode of prone restraint. Both managers said there was a downward trend in relation to the number of restraints, seclusion and rapid tranquilisation.

The manager of Seagrove ward said episodes of prone restraints had reduced. For example, since January 2021 there were five prone restraints out of a total of 56 episodes. This represented a 50% reduction in the same period in the previous year.

Both wards had also introduced a new grab pack. This contained a mini National Early Warning Score (an early warning system) sheet, an observation sheet and a checklist that fed directly into the restrictive intervention file case note.

The case note recorded each episode of restraint, seclusion and rapid tranquilisation. This included a detailed description of the event including its duration. The information was then collected and analysed by the safety team.

On both wards staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. The policy on rapid tranquilisation included information about monitoring of vital signs. Managers said this policy had been written to follow the NICE guidance. For example, in relation to the timely monitoring of patient's vital signs. Staff members also followed NICE guidelines in relation to anti-psychotic medication monitoring

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. The records about patient's seclusion were well maintained. Patients said that they had been fairly and respectfully treated when placed in seclusion.

There were no patients in long-term seclusion on either ward.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training.

On both wards 100% of staff who required level I safeguarding training had received this training. On Osborne ward 90% of staff had received level II training and in Seagrove 86% of staff.

On both wards the managers said that less than 20% of staff had received level III safeguarding children training as it was classroom-based. They said the trust required that all registered nurses had this training, but staff were not able currently to attend due to Covid 19 restrictions. However, they had a plan in place to address this and anticipated that by the end of the year they will have met the trust target.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe. Staff followed trust policy for children visiting. There was a separate room off the ward for any visits. All visits had to be booked with an appropriate adult. Staff observed first visits. Staff supported patients to develop care plans if they needed to be supervised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

All staff knew who the safeguarding leads were and had regular contact with them when making a safeguarding referral. On both wards managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily.

The staff mostly used electronic records. The current recording system was being updated they were in the process of moving into a more bespoke one.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Access to patient records on both wards was password protected to ensure confidentiality and security.

Medicines management

The service used systems and processes to prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. We observed that liquid and other medicines that had reduced expiry dates once opened lacked either a date opened or revised expiry date. Therefore, we were not assured that the medicines were effective when administered. When we raised this with staff, they took steps to remedy the situation.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. When we reviewed the doses of medicines prescribed for patients against the associated Mental Health Act records, we identified some prescribing was outside of the mental health act records. When we raised this with staff the prescribing was explained, and the Mental Health Act records were updated.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Acute wards for adults of working age and psychiatric intensive care units

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them on the trusts incident reporting system. We reviewed five incident records with a staff member on Osborne ward. All incidents were risk rated. They were all completed well with a good description of the incident and outcome.

Staff raised concerns and reported incidents and near misses in line with trust policy. Incidents were signed off by the ward manager or deputies on both wards. The incident then was allocated to the correct department e.g. Health and Safety. The clinical quality lead had overall oversight of all incidents and decided whether these required a 72-hour report. Incident outcomes were shared with the reporter and learning was shared at staff meetings.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident.

On both wards the managers ensured staff received debriefing after serious incidents. This was completed with the assistance of the psychology team.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

We looked at 10 incidents across both wards and saw they were investigated appropriately. Patients and families were involved and communicated with following the investigation.

Staff received feedback from investigation of incidents, both internal and external to the service.

There was evidence that changes had been made because of feedback. For example, in both wards patients bedrooms have been made safer following learning from incidents.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Acute wards for adults of working age and psychiatric intensive care units

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

In Osborne Ward staff did not always update care plans when patients' needs changed. We looked at six patient records. In two patients' records care plans had not been updated when their needs changed. For example, one patient's aggressive behaviour towards themselves had not been fully described to assist staff manage this behaviour. However, there was more detailed information provided at staff handovers which would assist staff. In Seagrove ward we found care plans were of a good standard. The managers stated that the team had worked hard since the last inspection to develop their care planning.

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff on both wards provided a range of care and treatment suitable for the patients in the service. They delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. They made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. On both wards patients dietary needs were assessed, and their preferences met. For example, there was access to a range of vegetarian food.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff members supported staff and patients to manage smoking. They had recently introduced the no smoking policy across both wards. Patients told us they found it difficult when staff smoked, and they could smell smoke on their clothes.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used health of the nation outcome scales (HoNOS) scoring on the wards and this was analysed every six months or during discharge planning. Staff also used mental state examination tool, psychologist formulation meetings, average length of stay, readmission rate, and mental health confidence scales. An evaluation piece was then completed periodically.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The manager in Osborne ward said that they recognised some of the audits could be improved. For example, the auditing of fridge temperatures. They welcomed the new audit of care plans but recognise these need to be developed further to improve service delivery.

Managers used results from audits to make improvements. Both managers had recently completed an audit of blanket restrictions and had ensured that there were no longer any in place.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service now had a full range of specialists to meet the needs of the patients on the ward. Since the last inspection the managers on both wards had developed patients access to psychology support. There was now a psychological therapist and an assistant psychological therapist on Osborne ward and in Seagrove ward there were two therapeutic coordinators. They ran a variety of emotional coping skills groups and anxiety management groups. These were incorporated into a full therapeutic program seven days a week.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported permanent non-medical staff and medical to develop through yearly, constructive supervision and appraisals of their work. On both wards the appraisal rates were high. On both wards they met the trust target rate of 85%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They made sure staff received any specialist training for their role.

Managers did not fully recognise poor performance, identify the reasons and deal with these. For example, senior managers on Osborne ward had identified areas of poor performance for some staff members but there was no action plan in place to assist staff members develop and improve.

Managers recruited, trained and supported volunteers to work with patients in the service.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

On both wards staff held regular multidisciplinary meetings to discuss patients and improve their care. The managers made sure they shared clear information about patients and any changes in their care, including during handover meetings

Both ward teams had effective working relationships with other teams in the organisation.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff demonstrated a good understanding of the different Sections under the Mental Health Act.

Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. On both wards staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff audited Section 132 rights weekly to ensure these were in date. Section 132 places a duty on the trust to take all reasonable steps to facilitate the patient's understanding of their legal rights. Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. MHA documentation was in place for all patients detained under the Act.

Informal patients knew that they could leave the ward freely. There were no signs around the wards explaining that inpatients could leave freely but it was detailed in the wards admissions pack given to all patients.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. Staff discussed patients who required Section 117 support during MDT meetings.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

Acute wards for adults of working age and psychiatric intensive care units

Staff demonstrated a good understanding about how the Mental Capacity Act was embedded into their practice and were able to give examples of where they would consider capacity.

There were no deprivations of liberty safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

In both wards there were capacity assessments, but they were generalised and there were few records of decision specific mental capacity assessments.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it. Staff members told us that they felt very proud when former patients returned as volunteers on the ward.

Staff supported patients to understand and manage their own care treatment or condition. We spoke with six patients across the two wards. They cited examples of ways they had worked with staff to manage their own treatment.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Patients said they felt confident to complain if they needed to.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Four of the six patients we spoke to said they were involved in their care planning. The other two patients were not clear if they were involved.

Staff involved patients in decisions about the service, when appropriate. In both wards' patients could choose activities, food and their daily routines.

Patients could give feedback about the ward. They completed a questionnaire after they had received treatment, or they contributed to community meetings. Overall patients felt that that they could effect change on the ward. For example, both wards had started providing caffeinated coffee at the request of patients.

Staff made sure patients could access advocacy services.

Patients had access to advocacy services visited both wards

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers.

Carers and families we spoke with felt they were involved in the care of the relative.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good 

Acute wards for adults of working age and psychiatric intensive care units

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%. Both wards were fully occupied at that level at the time of inspection. The managers said occupancy levels fluctuated throughout the year.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. In Osborne ward the average length of stay had recently reduced. The manager said on average 32 days, but in March of this year the average length of stay was 21 days.

In Seagrove ward the manager said the patients have complex needs and finding a placement could be difficult. However, the majority of patients stayed around four weeks.

Neither wards currently had any out of area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

Discharge and transfers of care

The service had low numbers of delayed discharges in the past year. On both wards there were no delayed discharges currently. The managers stated that the new assertive outreach program on the island assisted them with patient discharge.

Managers monitored the number of delayed discharges. The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff members on both wards ensured every patient had discharge plans on the care files.

Staff supported patients when they were referred or transferred between services.

Acute wards for adults of working age and psychiatric intensive care units

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. They had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Both wards had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. In both wards' patients had access to the ward phone and they had their own mobiles when appropriate.

The service had an outside space that patients could access easily. All patients spoken with said they could easily access the outdoor garden space. Patients told us that they had formally used the garden for smoking but could no longer do so following the implementation of the non-smoking policy. Some patients stated they found this challenging.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients told us they could make their own cereal toast and hot drinks at any time of day.

The service offered a variety of good quality food. The majority of patients spoken with were happy about the quality of food provided on the wards.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. For example, former patients were encouraged to volunteer on the wards.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

Patients had access to spiritual, religious and cultural support. Both wards had access to a chaplain who visited regularly.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. They knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

On both wards there were few complaints. For example, on Osborne ward there was only one complaint in the last year. This was about the loss of a patient's personal possessions. The complaint was not upheld. In Seagrove ward there were two complaints. One was from a patient's family who felt they were not being kept fully informed by the staff team. This was partially upheld. The second complaint was about patient transfer and this was upheld. None of the complaints went to the ombudsman

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Both managers said that the learning from the complaints was around better communication between staff and carers.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Both managers had been in place for several years. They had both worked hard to meet the majority of the recommendations and requirements of the last inspection in 2019. Staff members and patients were overall very positive about the way the wards were managed and said that the senior leadership team were visible and responsive, as well as the Chief Executive of the trust.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

All staff, in both wards had a clear understanding of the trust visions and values and were able to apply these to their daily work practice.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

In both wards members of staff said they felt valued and enjoyed the work they did. They said there was opportunities for career progression and felt that they could raise any concerns with the managers without fear of retribution.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level. But performance and risk were not always managed well.

Each month a senior manager in Osborne ward audited five patient records. The manager said this had been introduced to improve staff completion of patients' risk assessment and care plans. However, whilst there was an improvement overall in the care plans since our last inspection, the audits themselves were very basic and did not include specifically updating risk assessments following a change risk. This had been identified as an area of concern at our last inspection.

The audits and the monthly summary did not include an action plan to address concerns identified, timescales for completion or the person responsible for the action. When we spoke to the manager and deputy, they were not fully aware of the findings of the audits. The manager stated that the incomplete care plans and risk assessments were due to individual members of staff 's performance. However, there was no plan in place to address these concerns.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The manager in Osborne ward did not have a clear plan to assist, train and develop staff performance in relation to the maintenance of staff files

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Acute wards for adults of working age and psychiatric intensive care units

Seagrove ward was a member of the National Association of Psychiatric Care Units (NAPICU). They were also involved in a national quality improvement project to reduce restrictive interventions.

Community health services for adults

Good

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. All teams were above the trust's target for training compliance, but manual handling had been difficult to book, and this had the lowest completion rate. Ninety-two per cent of staff had completed mandatory training.

Clinical staff also completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The team had support from the trust's safeguarding team.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, teams had raised concerns in the past about care homes they were seeing patients in and worked with them to provide additional training and worked closely with the local authority.

Cleanliness, infection control and hygiene

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

All areas visited appeared clean and well maintained.

We were told staff followed infection control principles including the use of personal protective equipment (PPE). Patients we spoke to confirmed this.

Community health services for adults

Environment and equipment

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

Patients were predominately seen in their own home, care setting or in inpatient setting however some appointments took place in the community team premises, such as the Ryde health and wellbeing centre. We visited this premises and saw it was clean, bright, spacious and fit for purpose.

The service had suitable facilities to meet the needs of patients.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Staff were trained in infection prevention and control, aseptic non-touch technique and handwashing.

Environmental audits had been completed and action plans developed where required. For example, the dietetics team base was due to be moved to give additional space for clinical areas.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. For example, the use of the malnutrition universal screening tool (MUST), Waterlow score, and skin bundle assessment. However, in June 2021 the North East locality had a 69.5% compliance for completing MUST assessments, South Wight had 72.1% and West and Central had 75.5%. For the North East team, for example, this represented 124 patients who had not had a MUST assessment in the previous 3 months. We found no impact of MUST assessments being missed. Completion rates for the Waterlow and skin bundle assessments were all over 79% in each locality for June 2021.

Community matrons and the community rapid response team used the comprehensive geriatric assessment (CGA) to assess a patient's frailty, medical conditions, mental health, functional capacity and social circumstance to identify their care and treatment needs.

Staff completed risk assessments for each patient on assessment, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues for example, pressure ulcers. Staff would take wound measurements, a series of photos and treated pressure ulcers to avoid them worsening. In March 2021, the service completed a deep dive into pressure injuries and found that the majority developed in care homes. Community nursing staff and the care home support team provided additional training and education to staff in residential care settings to prevent pressure injuries, particularly those that develop on patients' heels.

The service had 24-hour access to mental health liaison and specialist mental health support within the trust.

Staff shared key information to keep patients safe when handing over their care to others.

Community health services for adults

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe.

The service had low and reducing vacancy rates. There was active recruitment when teams had a vacancy and plans in place to recruit to vacant positions.

The service had low and reducing turnover rates.

The service had low and reducing sickness rates.

Medical staffing

The service did not have any medical staff. Community services staff could seek advice from consultant doctors in the acute hospital or the community inpatient unit, Laidlaw, who had a nurse consultant.

Records

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

Patient notes were comprehensive and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. The district nursing team used the same system as the local GP surgery's, and this made accessing records and sharing information easy.

Records were stored securely.

Medicines

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

No concerns were raised regarding patients' medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them, including near misses in line with trust policy. Staff received feedback from investigation of incidents, both internal and external to the service. Managers debriefed and supported staff after any serious incident.

Community health services for adults

Staff understood the duty of candour. They were open, transparent, and gave patients and families a full explanation if and when things went wrong.

The service had no never events.

Safety Thermometer

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

The service continually monitored safety performance. For example, the deep dive into pressure injuries resulted in the community nursing and care home support teams providing additional support to care homes.

Is the service effective?

Good 

Our rating of this service stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave or arranged for pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Teams used outcome measures relevant to their discipline, for example therapy outcome measures (TOMs).

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and ensure patients received high quality care and treatment. The service had a division wide audit plan, including clinical audits. Audits included catheter, documentation, medication charts, and uniform.

The community nursing service also completed a national early warning score (NEWS2) clinical effectiveness audit to ensure that escalation, where needed, had taken place, recording was accurate and to determine any learning. The latest audit showed an improvement in the accuracy and completion of NEWS2 compared to previous years. For example, the West and Central locality improved from 70% to 97%. All three localities had followed escalation processes correctly over 90% of the time.

Some teams also took part in national audits, for example the podiatry team completed the national diabetes foot audit and achieved 100% against National Institute for Health and Care Excellence standards.

Managers used information from the audits to improve care and treatment. For example, in the podiatry team they have reduced the waiting times whilst still providing good outcomes for treatment.

Managers shared and made sure staff understood information from the audits.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had access to monthly group supervision sessions.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role and supported student placements.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Teams also held regular meetings such as daily huddles to discuss risks, themes and issues needed for escalation and specific meetings to discuss referrals and allocation.

Community health services for adults

Staff worked across health care disciplines and with other agencies when required to care for patients. All teams spoke highly of each other and gave many examples of working together to ensure patients received high quality care and treatment. For example, staff from the podiatry team were redeployed to the district nursing team during the peak of the COVID-19 pandemic so that the district nursing team could focus on supporting patients who were end of life.

Community teams worked closely with the wards, such as the emergency department, acute wards and the community inpatient ward. Teams also worked closely with external organisations, and were often co located with colleagues from social services, Age UK and the Red Cross.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff used the Hampshire toolkit to assess capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Community health services for adults

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to either an electronic records system or paper-based records system that they could all update.

Is the service caring?

Outstanding ☆ ↑

Our rating of this service improved. We rated it as outstanding.

Compassionate care

Patients were truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

We spoke to seven patients and carers. The feedback they gave was overwhelmingly positive about the staff and the service they had received. Patients and carers said that staff went the extra mile and the care and support exceeded their expectations.

In May 2021, the service received 13 compliments. One patient, who had received care and treatment from the continence team, called the chief executive officer to express that the team had gone above and beyond to help and had reduced the number of hospital admissions they needed. The podiatry team received a compliment, thanking them for taking the time to explain a patient's issue and ensured they understood exactly what was wrong. The West and Central community nursing team received a compliment from a relative of a patient, stating that the care they provided was excellent.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that is kind and promoted patient's dignity. All staff we spoke to were passionate about their role and ensured all they did revolved around the patient and their needs.

Patients' emotional and social needs were seen as being as important as their physical needs. Relationships between patients, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff recognized and respected the totality of patients' needs and found innovative ways to meet them.

The technology enabled care team had given telehealth kits to all care homes on the Isle of Wight, approximately 85, and to some patients living at home. The kits allowed patients to complete their own physical observations such as blood glucose testing, urine testing and blood pressure. The system then alerted the care home manager or patient's GP. This gave patients more independence to monitor their conditions and reduced the number of hospital appointments and admissions.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Community health services for adults

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The dietetics team provided freshly made milkshakes twice a week to patients who required their support on the chemotherapy ward. This increased the amount of calories patients were able to consume and also improved their wellbeing. The team also spent time on the wards ensuring their patients were able to connect with loved ones during the peak of the COVID-19 pandemic. For example, they passed messages between patients whose loved one was on different wards, arranged for patients to 'facetime' loved ones and arranged for a married couple to have a joint room.

The orthotics and prosthetics team had arranged for a special leg prosthesis for a young patient who was being bullied in school. They arranged for prosthesis to be printed with images from their favourite TV show.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Those who used the service and those close to them were active partners in their care. Staff were fully committed to working in partnership with patients and making this a reality for each patient. Staff empowered patients to have a voice and realise their potential. Patients' individual preferences and needs were always reflected in how care is delivered, and evidenced well in care planning.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary as the service had access to a speech and language therapist.

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

Staff supported patients to make advanced decisions about their care.

Is the service responsive?

Good ↑

Our rating of this service improved. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

Community health services for adults

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day, for example the community rapid response team focused on admission avoidance and prioritised referrals by 'clinician of the day' system to ensure a rapid and appropriate response.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Waiting times across the community division were monitored at a monthly quality and performance committee. At the previous inspection we found some teams weren't able to see patients in a timely way. At this inspection we found this had significantly improved. For example, the podiatry team was now seeing patients within the four week target wait time.

Managers worked to keep the number of cancelled appointments to a minimum. In June 2021, less than 3% of visits were cancelled by the service.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff supported patients when they were referred or transferred between services.

Community health services for adults

Following the implementation of discharge pathways, the community integrated discharge team had supported the reduction in average length of stay in the acute hospital from 7.7 days to 5.9 days.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service had improved processes for complaints management to improve the timeliness of responses. Staff had received bespoke complaints training. The trust was currently responding to 75% of complaints within agreed target times.

Is the service well-led?

Good 

Our rating of this service stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Community health services for adults

Culture

Staff felt respected, supported and valued by leaders. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. The staff survey showed that culture and morale had improved over the last 12 months and this was echoed by staff we spoke to.

Governance, risk management and quality measurement

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The service had a quality forum and transformation committee to ensure sharing of best practice and lessons learnt and ensure effective management of risks, incidents and complaints.

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

The service collected reliable data and analysed it. There was a robust rolling audit programme in place. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Public and Staff engagement

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

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. The division had a 12 week quality improvement cycle in place to empower staff to drive service development. In July 2021, the community rapid response team had been nominated for the ‘Care in Older People’ award for the Nursing Times awards.

Mental health crisis services and health-based places of safety

Good ↑

Is the service safe?

Requires Improvement →←

Our rating of this service stayed the same. We rated it as requires improvement.

Safe and clean environments

The physical environment of the health-based place of safety (HBPoS) at Seagrove ward was not fit for purpose and did not meet the requirements of the Mental Health Act Code of Practice. The design and layout of the unit did not ensure patients' dignity and privacy were respected.

The suite was off the main ward area via a single door with a large clear glass panel which allowed staff and patients on the ward to see into suite. Although staff had made attempts to provide some level of privacy by sticking sheets of paper over the glass, there was a section left uncovered at eye level to see into the suite. This meant that patients on the ward could also see other persons in the suite through this panel, which could be distressing for both parties.

There was a windowless sitting area on entry from the main wards, which opened onto the ward's seclusion room adjacent to the HBPoS suite without any doors separating them. If there was a patient in seclusion and a person admitted to the HBPoS suite, they were able to hear and see one another, which compromised privacy and dignity for both parties. Staff told us if it was noisy in the HBPoS suite when there was a patient in the seclusion room, they took the person admitted to the HBPoS suite to the en suite bedroom on the opposite side of the suite. However, we observed that other patients from the wards were also using the bathroom in this room.

The seclusion room had a small sitting area which was being used as the sitting area for persons waiting to be assessed for the HBPoS. This was not large enough to safely accommodate all professionals involved in an assessment as well as the person. If there was someone in the seclusion room then the assessment would not be completed in private and may not take place. This was not in line with the Royal College of Psychiatry's Standards on the use of Section 136 of the Mental Health Act 1983.

The corridor leading to the suite was narrow. If a person being admitted to the HBPoS required physical intervention, staff may not be able to manage them safely. We saw that the narrow corridors and restricted space inside the suite could be challenging for some wheelchair users visiting the HBPoS. However, the trust had not reported any safety incidents in the health-based places of safety. Staff were managing risks to themselves and to people visiting the health based place of safety well.

We saw that the paint on the walls had not been refreshed in a long time and there were damaged murals which had not been replaced. The room was poorly decorated, and the environment did not promote recovery.

On our last two inspection visits we told the trust that the physical environment of the health-based place of safety needed significant improvement. On this inspection we saw that this remained a concern. The trust informed us that

there were transformation plans for Sevenacres site and they were looking at reconfiguring the entrance to the health-based place of safety, for which a capital bid had been approved. However, it was not clear how this will address the concerns around the environment of the health-based place of safety and the impact it was having on the dignity and privacy of people admitted for assessment.

Safe staffing

The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding.

Nursing staff

Managers used a recognised tool to calculate safe staffing levels.

The home treatment team was reporting a staffing level of 10.40 WTE and 6.20 WTE funded roles for band 6 and band 3 nurses, with a vacancy rate of 3.2 and 0.4 WTE for these staff bands respectively. The trust informed us that although they were finding it difficult to recruit to a number of vacancies in the home treatments teams, the service was taking steps to ensure all shifts were covered. Managers ensured that shifts that could not be filled by substantive staff were covered by bank or agency staff.

Managers told us they were in the process of recruiting new staff and have two band six applicants awaiting interview. Staff told us that a lack of accommodation on the Isle of Wight was partly the challenge of recruiting new staff. Some staff had also recently retired. We saw that staff across the service worked hard to support and keep people safe and managers requested bank and agency staff familiar with the service to ensure that there was consistency and continuity of care.

Managers made sure all locum staff had a full induction and understood the service. Managers told us that the induction programme was an ongoing process and that new members of staff were required to read and understand the trust's policies and procedures and to complete their training.

The mental health crisis teams were reporting a low sickness rate. Managers told us they had been quite fortunate and despite the pressures of the covid-19 pandemic they had been able to provide a safe service.

Seagrove ward provided staff to cover the health-based place of safety, but staff told us that this was quite challenging. The ward's planned staffing levels was two qualified nurses and two support workers. Where staff had to cover the HBPoS suite, the shortage of staff on the ward meant that patients on the wards may not get the support they need, for example, going out on section 17 leave. Managers told us that there was a business case with the trust's finance department to recruit three additional support workers to reduce the burden on Seagrove ward staff. There was no clear timeframe for when this would happen.

Medical staff

The trust had a 24 hour, seven days a week on-call consultant psychiatrist rota. All the consultants were on the specialist register for psychiatry and were able to support both child and adult assessments for people who were admitted to the health-based place of safety. There was also a junior doctor rota dedicated to the mental health services in the trust, although they were not on the specialist register for psychiatry.

However, we saw that there was one consultant psychiatrist who covered the home treatment teams, the early intervention in psychosis clinics, liaison services and supported the single point of access one afternoon a week. There was no consultant psychiatrist cover for the home treatment teams for two days a week. Although managers told us in case of an emergency, they could get support from other consultant psychiatrists in the trust.

The home treatment team did not have administrative staff which meant staff sometimes had to stay longer past their shift end time to complete administrative tasks and sometimes carried them over to the next day.

Mandatory training

Managers monitored mandatory training and alerted staff when they needed to complete their training. The training programme was comprehensive and met the needs of patients and staff. Eighty-eight per cent of staff in the home treatment team had completed mandatory training which fell slightly short of the trust target of 95%. Managers told us this was due to face to face training being cancelled due to the COVID-19 restrictions. There were also errors in the training data which meant some information about training compliance had not yet been updated.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. For example, we saw that staff were working with a patient who had a low level of engagement to develop a crisis plan at their own pace. We saw that this patient was beginning to engage more positively.

Staff followed good personal safety protocols. The service had a lone working protocol in place and staff kept their colleagues informed when they went out for visits.

Staff completed risk assessments for each patient on admission assessment/acceptance to the using a recognised tool, and reviewed this regularly, including after any incident.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to make a safeguarding referral and who to inform if they had concerns. For example, we saw a good an appropriate safeguarding referral made by the home treatment team for a patient who they felt was an inappropriate discharge from the Accident and Emergency department. The teams took steps to ensure that the patient received the care and treatment they needed.

Staff access to essential information

Staff working for the mental health crisis teams could access patient records on the electronic records system. Patient records were detailed and up-to-date and staff recorded changes regularly.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient records were stored securely.

Medicines management

The service stored very few medicines as most medicines were obtained by patients directly from the pharmacy. The trust used electronic prescribing and staff and patients could easily access prescriptions.

Mental health crisis services and health-based places of safety

Staff did not always ensure that medication records were thorough and complete. We saw that staff did not consistently document patient allergy status in their prescription charts. Of the nine patient prescription records we reviewed, four did not have a record of allergy status. Although staff gave patients information about their medication verbally, they did not always provide patients with written information in line with best practice.

We saw that staff did not consistently record multidisplinary team discussions and rationale for prescribing medication. We saw a record where clozapine (an antipsychotic medication) had been prescribed and should have been commenced with the support of the pharmacist but entries in records did not show clearly that discussions and agreements had taken place so it was unclear whether the patient actually got the medicines and the support needed.

Track record on safety

The service had a good track record on safety. There were no serious incidents or never events reported in the last 12 months.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with trust policy. Although there had not been any serious incident or never events, staff demonstrated what actions they would take if there was a serious incident in line with trust policy.

Staff understood the duty of candour. They told us it was about being open and transparent, and giving patients and families a full explanation when things went wrong. Staff told us when things went wrong, they would apologise and give the patient honest information and suitable support.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. For example, the home treatment teams were now required to review patient's current physical health to ensure they are physically well before carrying out a visit. Staff ensured any concerns identified were escalated appropriately.

Is the service effective?

Good ↑

Our rating of this service improved. We rated it as good.

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment for each patient. We saw that staff made sure patients had a full physical health assessment and knew about any physical health problems. Staff ensured there was ongoing physical health care for patients.

Although all patients had a care plan in place, they varied in their quality. Of the six care and treatment records we reviewed, two were not personalised and did not capture patients' views, three were not recovery oriented, and two patients were not given copies of their care plans.

Mental health crisis services and health-based places of safety

Best practice in treatment and care

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes such as the Health of the Nation Outcome Scales (HoNOs). They provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance.

Staff made sure patients had support for their physical health needs, either from their GP or community services and they used technology to support patients.

Managers told us they were working closely with a neighbouring trust to undertake a clinical audit programme. Although they were at the initial stages, they aimed to benchmark their results against other trusts.

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. All new staff went through an induction programme.

Managers supported staff through regular, constructive clinical supervision of their work. Although the majority of staff had a clinical supervision, management supervision was low at 5% across the teams. Staff told us that the manager undertaking supervision had been off on long-term sickness.

Managers recognised poor performance, could identify the reasons and dealt with these.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff attended regular team meetings. They ensure those that could not attend were able to input into the meeting and information from the meeting were also shared with them.

Multi-disciplinary and interagency team working

Staff from different disciplines worked together as a team to benefit patients. We saw that staff supported each other well to ensure that there were no gaps in patients' care. All the staff members we spoke to were positive about their colleagues, and we saw very good working relationships amongst the teams.

The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation including the police and local authorities. The service had a high intensity user group made up of a wide range of agencies including the trust, police, ambulance, fire service, local authority, third sector organisations and housing services that met monthly. The agenda focused on frequent users of services and used an integrated care model to see what services could be used to support these people and how to better meet their needs.

Staff held daily multidisciplinary meetings to discuss patients' condition and improve their care. Although the medical staff were not always present at the meetings, staff could escalate any concerns to the medical team and get support. Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

Mental health crisis services and health-based places of safety

The mental health crisis team working with police had co-produced a monitoring form for people admitted to the health-based place of safety. We saw that staff kept records of people who were admitted to health-based place of safety, and there was good handover between staff and the police. However, there was no section on the monitoring forms to record when the 24-hour detention in the suite had been extended by a doctor. The Mental Health Act Code of Practice states that a patient's detention in the suite must be extended by a doctor once 24 hours has been reached. Although staff told us that patients had not been detained over 24 hours before, it was not clear how and where this would be captured. We also saw that there were discrepancies in recording of the time/ date when the approved mental health practitioner (AMHP) were contacted and the times recorded by the AMHP.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice**.** Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Good practice in applying the Mental Capacity Act

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Managers told us although they had not completed an audit for how the Mental Capacity Act was being applied, they were taking steps to ensure that Mental Capacity Act (2005) provisions were applied correctly.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary, and they knew where to get information and support on this.

However, staff did not ensure that best interest decisions for a patient who lacked capacity was documented. Although we saw that staff discussed this patient's care and treatment in the daily handover meetings, we could not find any documentation about best interest meetings.

Is the service caring?

Good 

Mental health crisis services and health-based places of safety

Our rating of this service stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. All the patients we spoke to told us staff were kind and compassionate, and that staff listened to them, understood their needs and responded to them in a dignified, respectful and non-judgemental manner. During our visit we saw that staff gave a patient and their carer the help, emotional support and advice they needed.

Staff supported patients to understand and manage their own care, treatment and or condition. We saw examples of when staff had referred to other services and organisations supported them to access those services such as MIND and Isorropia Foundation.

However, staff did not routinely give patients information leaflets of how they can seek further support and information leaflets were not displayed it in open areas, especially for patients who may be undecided about seeking support. Staff told us that leaflets were kept in the main office and only gave patients those that were relevant to their needs, as it stopped patients from accessing information not relevant to them.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff involved patients and gave them access to their care plans. However, two of the six patients record we reviewed showed staff had not given patients a copy of their care plan.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff supported, informed and involved families or carers. Staff helped families to give feedback on the service. Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good ↑

Our rating of this service improved. We rated it as good.

Mental health crisis services and health-based places of safety

Access and discharge

The mental health crisis service was available 24-hours a day seven days a week for people experiencing a mental health crisis. The service's single point of access operated a dedicated telephone service which was accessible to people. The crisis team had skilled staff available to assess patients immediately 24 hours a day seven days a week.

The service had clear criteria to describe which patients they offered services to. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Manager told us they did not have a waiting list and were meeting their targets for referral to assessment and assessment to treatment.

Staff assessed and treated people promptly. Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. The team tried to contact people who did not attend appointments. They followed up people who regularly missed appointments and offered support. For example, staff told us they were developing a new plan for a patient who regularly missed their appointment.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Patients had some flexibility and choice in the appointment times available.

Staff told us they made sure all patients' visits were planned and there had not been any cancelled appointments. Patients we spoke to confirmed staff were always available as planned. Patients told us staff called to inform them if they were running late, and they worked around the patient's schedule when plans changed.

Staff supported patients when they were referred, transferred between services, or needed physical health care.

Facilities that promote comfort, dignity and privacy

Interview rooms in the service had sound proofing to protect privacy and confidentiality. There was a range of rooms and equipment available to the home treatment teams and the single point of access to support treatment and care. However, the design and layout of the health-based place of safety did not promote comfort, dignity and privacy for patients

Patients' engagement with the wider community

Staff supported patients to access opportunities for education. One patient we spoke to gave very positive feedback for how staff supported them to return to work. Staff helped patients to stay in contact with families and carers and encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There was a translation and interpretation service available via an external provider for people who needed them.

Staff provided patients information on treatment, local service, their rights and how to complain.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Staff understood the policy on complaints and knew how to handle them. Staff told us they tried to address any patient concern in first instance and if their concerns cannot be resolved, they would support them to make a formal complaint.

Patients, relatives and carers knew how to complain or raise concerns. The trust website contained clear information on how to make a complaint.

Records showed that the home treatment teams had not received any complaints in the last 6 months. Managers told us that if there was a complaint, this will be thoroughly investigated, and themes identified will be used to improve the service. They would also ensure that patients received feedback after the investigation of their complaint.

The service used compliments to learn, celebrate success and improve the quality of care. We saw record of patient who was previously with the home treatment team had baked a cake for the team to thank them for the care and support they received.

Is the service well-led?

Good ↑↑

Our rating of this service improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Staff spoke highly of their managers and leaders were very proud of their teams.

Vision and Values

Staff at all levels knew and understood the provider's vision and values and how they were applied in the work of their team. The trusts' vision was for high quality compassionate care that makes a positive difference to the island community, and we saw that the teams demonstrated this in their day to day roles. The general feedback from patients and carers was that staff were very compassionate.

Culture

Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. We saw that the teams interacted well amongst themselves and with their managers and the managers operated an open-door policy.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. The teams had daily handover meetings where they discussed patients and their care. There was a divisional risk register which captured the risk across the teams. Managers and staff were aware of what the risks were and there was a robust system in place for monitoring and reviewing risks.

The service had monthly clinical governance meetings which fed up to the board.

Mental health crisis services and health-based places of safety

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information well. Although staff reported that the patient record system was slow and difficult to navigate, the trust informed us they were moving on to a new system which will be more user friendly and improve work efficiency.

Information management

Staff collected analysed data about outcomes and performance.

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.