

Isle of Wight NHS Trust

R1F

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
R1F01	St Mary Hospital	Community Services for Adults	PO30 5TG
R1FX8	Shackleton House	Community Services for Adults	PO33 3DT
R1F10	Arthur Webster Clinic	Community Services for Adults	PO37 7HZ

This report describes our judgement of the quality of care provided within this core service by Isle of Wight NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Isle of Wight NHS Trust and these are brought together to inform our overall judgement of Isle of Wight NHS Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement	
Are services safe?	Inadequate	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Requires improvement	

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service = Requirements Improvement

- Patient records did not fully support safe care due to incomplete and non-contemporaneous record keeping and risk assessments.
- The staffing workload and dependency tool database was not 'fit for purpose' with numerous incidents of lost data, visit lists and allocations being incorrect.
- The allocation of community nursing staff to localities was not carried out to reflect the needs of the population, and despite considerable vacancies the assessment scale was still showing 'green or no risk'.
- Due to lack of IT connectivity, there were delays in record keeping, incident reporting and accessing information.
- Community teams had no access to lone worker alarms, despite the poor phone signal, which meant that the lone worker buddy system was not effective.
- There was no duty of candour training for staff; therefore, most staff were not aware of their responsibilities.
- Infection control processes and procedures were not in alignment with trust policies.
- There was variation in the awareness and approach of staff to safeguarding procedures, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Clinic emergency trolleys were not tamper proof and checked appropriately by a clinical person.
- The medicines policy for the trust, did not detail the safe storage of medicines in community clinics or in patient's homes and we saw incidents arising from the lack of guidance. Standard operating procedures submitted by the trust after the inspection were not authorised and had no implementation dates.
- There was insufficient risk assessment of fasting diabetic patients and they were not prioritised in phlebotomy clinics.

- There were no multidisciplinary reviews of community nurse's patients.
- The provision of supervision was variable across the community teams.
- Community matrons were completing all of the continuing healthcare documentation from all patients across the Isle of Wight. They did not know most of the patients.
- Staff felt the executive team were 'unsupportive' with unanswered requests and no updates on issues previously raised.
- There was no integrated falls service on the Isle of Wight, the Isle of Wight were in the lowest quartile nationally for some aspects of best practice clinical care.
- The new physiotherapy service for GPs reduced sessions to three, which meant patients often needed repeat referrals into the system, the trust system for other referrals still provided six sessions.
- Patients told us of little support in repatriation after services were accessed on the mainland.
- Some areas did not support the maintenance of the patient's privacy and dignity.

However

- Staff respected patients' values and wishes. Patients gave positive feedback about the compassionate care they had received and the manner and approach of the staff. A new post organised and coordinated care around the wellbeing of the patient. Support was readily available for community patients and their carers from a variety of sources
- There were many excellent examples of responsive community services and teams who worked collaboratively to meet patients' needs. Access to equipment was good, even out of hours.
- The majority of staff used trust wide systems to report and record safety incidents, near misses and allegations of abuse. These were escalated and investigated appropriately.

Summary of findings

- There was a well-embedded governance structure in place to monitor the progress of incidents, complaints, and risks. Staff knew of their local risk registers and their highest risks
- Staff we spoke with told us of numerous examples of training and development that staff had accessed. Most staff had received an annual appraisal and had opportunities to develop and progress.
- There were systems in place to support patient equality and diversity.
- Recent national audits showed improved outcomes for podiatry patients.
- The trust had implemented tele monitoring for various patient pathways to support patient care in the community.
- Staff felt that local leadership was accessible, supportive and provided a working strategy for the community services based upon the 'My Life, A full Life' vision.
- The staff were aware of their roles in dealing and responding to complaints.

Summary of findings

Background to the service

The trust provided adult community services to support people in staying healthy, to help them manage their long term conditions, to avoid hospital admission and support them at home following discharge from hospital.

Community Services for adults within the Isle of Wight NHS Trust were provided over three localities: West and Central Wight, North and East Wight and South Wight.

Services provided included;

- District nursing
- Community nursing teams
- Community therapists.
- Podiatry
- Diagnostic and rehabilitation clinics.
- Crisis response team
- Reablement
- Continence

- Phlebotomy
- Chronic pain services
- Multiple sclerosis
- Heart failure
- Dietetics
- Diabetes
- Tissue viability
- Orthotics
- Equipment stores

During this inspection, we spoke with 81 members of community staff, 42 patients and carers; face to face and via telephone, and reviewed 18 patient records. We visited numerous locations in the community across the three localities, including visiting patient's homes, nursing homes, clinics and district nursing hubs.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team included CQC inspectors, pharmacist specialist, community services manager, district nurse team leader, occupational therapist, and physiotherapist.

Why we carried out this inspection

We carried out this short notice inspection of the Isle of Wight NHS Trust to follow up on some areas that we had previously identified as requiring improvement or where

we had questions and concerns that we had identified from our ongoing monitoring of the service or if we had not inspected the service previously. We undertook site visits 22- 24 November 2016.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

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

Before visiting we reviewed a range of information we held and asked other organisations to share what they

Summary of findings

knew about the hospital. This included clinical commissioning groups (CCG), NHS Improvement, and IOW Healthwatch. During the inspection we also spoke with the local Hospice

We gave a weeks' notice of announced inspection of community services for adults and trust wide leadership. We visited relevant departments at the main site Newport as well as clinics and teams across the Island 22-24 November 2016.

During the visits 22-24 November we spoke with a range of staff in the departments and teams. Those in the

community health services included community matrons, specialist nurses, equipment technicians, dietitians, orthotists, podiatrists, district nurses and therapists.

We talked with patients in their homes and in various departments, and reviewed comments left in boxes distributed around the hospital. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records and risk assessments of personal care and treatment.

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

What people who use the provider say

We spoke with various patients across the localities, either face to face or via phone. Comments from the patients we spoke with were generally extremely positive.

These included 'phenomenal' 'nothing but courtesy and kindness', 'I have nothing but praise for the staff ...they are absolutely fantastic' 'they are polite and take their time' 'the matron an absolute angel'.

Patients told us that they observed good hand washing techniques, and received healthcare advice. Some spoke of combined visits with tissue viability nurses and all of the patients confirmed that they had contact numbers given for emergencies.

Some negative comments were relating to frequent changes of nurses, 'there aren't enough of them to go round' and about nurses that were late for visits. Patients stated they were not always informed that the nurses were going to be late.

Some patients commented that nurses do not have diagrams or photographs of the wounds so they were unsure how they were monitoring their improvement or deterioration.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

The trust **must** ensure:

- That there are sufficient numbers of suitably qualified staff in all community teams to ensure consistently safe and timely care is given as planned to meet patient's needs.
- Patients are protected against the risks of unsafe or inappropriate care and treatment arising from incomplete patient records or an inability to access patient records when required by staff.

- Patients risk assessments are completed and re assessed regularly.
- Staff are trained and understand the full requirements of the duty of candour, and when to carry out.
- That appropriate standards of cleanliness are maintained in all clinical environments to provide safe patient care. That clean and dirty equipment within the equipment store are sufficiently segregated to prevent cross contamination of cleaned equipment

Summary of findings

- That the IT and phone signal is reviewed to protect patients from delays in staff accessing information and staff from a compromised lone worker policy.
- That staff are familiar with their responsibilities with safeguarding and assessing for capacity, the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.
- That the trust medicine policy is reviewed and includes dated and authorised SOPs for guidance on storage in community clinics and patient homes.
- The provision of supervision across the community is reinforced and made available to all staff.
- That MDT reviews of community patients are set up.
- The community matrons completion of all patients CHC paperwork is reviewed, this should be completed by the people caring and known to the patients.
- That staff requests do not go unanswered and updates are provided when issues are raised.
- That the lack of a falls service is reviewed, particularly the areas where the trust is in the lowest quartile nationally.
- That the external physio service is reviewed when patients need to have more than three sessions.
- More support is provided when patients have to access care on the mainland and need help in repatriation and accessing local services.
- Areas are reviewed in relation to supporting patients privacy and dignity.

The trust **should** ensure:

- That the clinic resuscitation trolleys are reviewed as not ‘tamper evident’ and appropriate clinical personnel carry out checking.
- That risk assessments of fasting diabetic patients needing blood tests are undertaken within phlebotomy and diabetic patients should never be turned away.

Isle of Wight NHS Trust Community health services for adults

Detailed findings from this inspection

Inadequate 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as inadequate because :

- Patient records within the community were not sufficiently well managed to keep patients safe. Staff did not always contemporaneously update paper records; there was delayed and incomplete recording of records and patient's risk assessments.
- Staff knew how to report incidents on line, but the lack of IT equipment or connectivity away from an office base caused delays in reporting. There was evidence of underreporting of verbal abuse towards staff.
- With the exception of senior staff who had been involved in investigations, staff we spoke to did not know about the openness and transparency required by the duty of candour.
- There was variation in the awareness and approach to following safeguarding procedures. Staff were not confident in their actions. There were low levels of compliance in staff that needed level 3 safeguarding children's training.
- There was a medicines policy for the trust, which did not detail safe storage of medicines in community clinics or in-patient's homes and we saw incidents arising from a lack of guidance. Following the inspection, the trust supplied three standard operating procedures relating to medicines in the community. However, two of these were dated 2014, one was undated and all had no authorised signatory or implementation date.
- The emergency trolleys within the clinics were not tamper proof, in public areas. The checking of the equipment was not well embedded across all areas with inappropriate delegation to non-clinical staff.
- The segregation of clean and dirty equipment within the equipment store was not sufficient to prevent cross contamination.
- We observed some poor infection control practices in the clinics.
- Fasting diabetic patients in the phlebotomy clinics were not prioritised.



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- The workload and dependency spread sheet held within the locality hubs was 'not fit for purpose'. Although, it had been on the business unit risk register for the past two years, there were no mitigating actions identified.
- The nurse staffing vacancies of 21% in the community caused unmet or delayed patient visits, yet this was still classed as 'green or no risk' on the locality leads rating scale, this assessment scale was raised as a concern on inspection. There were wide variations between caseload per locality and numbers allocated per community nurse. These varied between six visits per day plus additional 111 calls or residential home visits to 12-15 visits per day. Some CNS's felt their service 'was completely overwhelmed' by demand.
- There were two serious incidents (SI) reported for patients in the community health services for adults between January and September 2016, a grade four (severe) pressure ulcer and an accidental harm caused to a patient during a procedure. The business unit monitored the progress of investigations on a spreadsheet and shared the outcomes with the commissioners and staff for learning.
- Staff in the community teams we spoke with, did not recall receiving any safety alerts; these were received centrally by the trust for dissemination to junior staff for their awareness and to prevent harm to patients.

However

- Staff used trust-wide systems to report and record safety incidents, near misses and allegations of abuse, and these were escalated and investigated appropriately. Most staff were keen to share learning and practice changes that had occurred because of incidents.
- Access to equipment was good, even out of hours. The single point of access (SPA) hub administration team managed equipment requests centrally.

Safety performance

- The trust monitored NHS safety thermometer data about the care provided by the community services for adults. The NHS safety thermometer was a monthly snapshot audit of progress in providing harm-free care for patients. The types of harm monitored included falls, new pressure ulcers, urinary tract infections and venous thromboembolism (blood clots). For the months of April 2016 until November 2016, there was an average of 81 patients per month on the community caseload. There were a total of 43 pressure ulcers (all grades), one patient fall and two patients with a venous thromboembolism or blood clot declared.
- The business unit of Ambulance, Urgent Care and Community (AUCC) produced a monthly quality performance dashboard for discussion at the trust board. The dashboard monitored patient safety information, such as healthcare associated infections, avoidable pressure ulcers acquired in the community and patient experience feedback.
- There was a process for reporting incidents, near misses and 'never events'. (Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers). All community staff had access to an electronic reporting tool to report any incidents; there was ongoing training to ensure staff could all use the reporting tool. However, some staff reported that due to a poor IT signal, access was only possible on trust premises. Although staff made every effort to report immediately, there could be an unavoidable delay, which may have caused a delay in any actions needed to prevent recurrence.
- Most staff working in the community teams told us they were comfortable raising concerns or issues; however, some staff reported they had never raised an incident or concern. Although they described situations where patients had been verbally abusive, staff had not reported these formally as incidents. Their manager had discussed the incident and advised them on how to deal with the patient next time. Therefore, the AUCC business unit may have significantly under reported verbal assault rates.
- Some of the staff who worked within the community specialist teams and hub reported that they received no information relating to learning or changes following incidents. They told us that following reported incidents, issues raised were not always addressed.
- Another staff member described that following a 'near miss' sexual assault taking place a 'while ago' by a

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patient living with early dementia, the lone worker ‘buddy system’ was changed. The trust amended the lone worker policy; staff needed a clinical rather than administration person for a ‘buddy’. There was no electronic tracking in place apart from the staff’s electronic diary; and the staff member still felt stressed and unsafe when lone working.

- The trust held a senior nurse and governance group (SNAG) meeting weekly to review any serious incidents (SIs); they aimed to involve more district nurses (DNs) in root cause analysis (RCA). Community Band 7s, community matrons, the tissue viability specialist nurse, locality leads and the practice educator also attended this group, which fed into the trusts governance and quality group.
- The teams held a table-top review of the SI in the locality if possible, learning was cascaded to the local locality team and to the others across the island. Junior community staff confirmed this process. Community teams always reported grade three and four pressure ulcers, staff told us that the RCA process helped their learning.
- Staff could describe SI’s that had changed practice, for example a coroner’s case when a bank community nurse missed a visit. The outcome was a change in practice to ensure unmet visits were reported and handed over. Nurses described it as ‘a big learning curve’. Another example was from the community outreach infusion team, who recalled an incident where a patient was discharged from another trust without a handover whilst self-administering intravenous infusions. The team discovered the patient was at high risk of infection due to building work at home and attended the St Marys unit instead. The team had amended the handover referral to include information about the social situation to prevent a recurrence. Some localities had ‘lessons learned from SIs’ white boards. Most staff confirmed that they obtained good feedback from reporting incidents.

Duty of Candour

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires

providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person.

- With exception of senior staff who had been involved in investigations or coroners’ cases, staff had no understanding of DoC. No training had taken place and most staff when asked did not know about DoC or how it was applied.
- The senior teams acknowledged that the awareness of DoC needed attention with junior staff. They felt that although senior nurses took the lead, junior staff should understand the principles of openness and transparency of the DoC.

Safeguarding

- We saw some variability in the awareness of safeguarding and the alert process across the community adult localities. Most staff showed a good awareness of safeguarding in the community and knew how to access the lead if needed for support. Within the localities, senior nurses dealt with safeguarding referrals and shared the concerns with the team; they received email updates and feedback from safeguarding leads. Most staff we spoke with were able to describe the two recent cases and their outcome.
- The training rates for safeguarding training in community adults staff were 88% for safeguarding adults (no distinction of which levels), 91% for level one children, 72% for level two children and 39% for level three children’s safeguarding (11 out of 28 appropriate staff had completed training).
- We saw that from 1 November 2015 until 31 October 2016 there had been eight safeguarding referrals from the community localities, one from South Wight, two from West and Central Wight and five from North East Wight.
- Most localities had a link or lead nurse for safeguarding. The staff entered the referral onto the GPs electronic system so they were aware and could access further details.
- Community adult senior nurses confirmed the safeguarding process, and described how the last two referrals had recommended earlier escalation by the community teams.

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- The specialist physiotherapists working in the Laidlaw centre we spoke with had received child safeguarding training for level three and adult to level two and were fully confident in the process. The clinical nurse specialists (CNS) we spoke with knew how to access the trust lead, and were able to describe the process confidently.
- Other staff we spoke with identified an issue, which they felt, should have been a safeguarding alert. They told us that there had been no actions from their senior team following the alert so were unsure if was correct.
- However, some junior staff working in a patient facing role in one locality showed little understanding of the process of safeguarding, despite having had the training. Staff had not considered another incident we identified as a potential safeguarding.

Medicines

- The trust had a medicines and CD policy for inpatients, however there was no specific guidance for medicine administration in the community or safe medicine storage in people's homes. We saw some issues relating to a lack of guidance. Medicines management formed part of trust mandatory training, which 48% of community staff had completed.
- Following our inspection the trust submitted three standard operating procedures (SOPs). They related to the management and administration of medicines within the community, two were dated 2014, one was undated. However, there were no authorised signatures or implementation dates. Staff we spoke with on inspection did not appear to be aware of these SOPs.
- We saw that teams used competency-based assessments to support safe insulin administration practice. We witnessed the administration of insulin to community patients, all relevant checks were carried out appropriately and sharps disposed of properly. Most diabetic patients were encouraged to use pens to self-administer their insulin; three quarters of community patients used them. We looked at the insulin administration chart; the relevant blood sugar records were complete.
- We observed a district nurse's practice and saw good medicines management. We reviewed an updated medicine administration chart, which carers used for

administering medicines. The charts were correctly completed, although there were no core staff signature lists in any of the records to identify staff signature to names. This was so teams could identify errors or omissions to individual staff easily.

- The outreach infusion team supported intravenous lines and inserted peripherally inserted central catheters (known as PICC lines) in the community; the community teams managed them out of hours.
- Syringe drivers were available and used for end of life patients or for as required medications. These were small powered syringes, which administered high-risk medicines to patients in a controlled rate to prevent overdose or side effects.
- All community matrons were independent prescribers, which meant they could respond to patients' needs and prescribe appropriate medication in a timely way; they told us they received regular prescribing updates. They managed and prescribed medicines for patients on their caseload, with the input of the GP, patient and carer. They also prescribed 'rescue' medicines if the patient deteriorated or had increased pain.
- Staff told us of a new process starting for adrenaline administration, to be given via a pen (as insulin), although had been advised by pharmacy, this had not yet been followed through, and was still only available via ampoule. We saw adrenaline was stored in an unlocked staff fridge, with no monitoring of temperatures, in the district nurse's office at Tower House, Ryde. We raised this as a concern to the trust senior team. In clinics, we saw prescription pads locked away securely, with access restricted to registered nurses.
- There was a home oxygen service supplier who installed oxygen for patients who needed it at home. They supplied a written training and a detailed booklet to all patients using oxygen at home. The information detailed the hazards and risks associated with the use of oxygen at home.

Are services safe?

Environment and equipment

- We visited many varied and diverse locations for community clinical services across the trust. Ryde health and well-being centre was a new, purpose built, single storey centre which had opened in 2015 which was used for patient clinics and reviews.
- The centre had emergency resuscitation equipment; which was checked by administrative staff not by clinical staff (over 85% of the time). The safety test for the emergency suction equipment was out of date since 2015. We looked at other electrical equipment in the podiatry room and across the rest of the centre and found that all was out of date for safety testing. There did not appear to be a system for alerting staff when safety tests were due.
- The Laidlaw Unit was not purpose built. Patients waited and received treatment infusions in a 'café style' public environment on upright armchairs. We saw it was impossible to retain the patients' privacy if they had a reaction or collapsed. In the corner of the same area, staff completed patients' weight checks and observations with no privacy screening.
- We saw that the majority of the electrical equipment including ultrasounds in the Laidlaw Unit was out of date for safety testing. One nebuliser we saw had been out of date for some years; we alerted the senior nurse immediately about these issues. We also saw a diabetic 'kit' for treating low blood sugars held inappropriately in an old biscuit tin.
- In the Laidlaw unit, staff had regularly checked the emergency resuscitation kit; there was a paediatric as well as adult kit. However, we saw that the emergency trolley was stored in a public area and was not tamper evident, there was a curtain covering open storage trays. The paediatric resuscitation kit was in a non-tethered bag, which could be easily removed by a passer-by.
- The trust's two patient equipment supply streams were shared between the NHS integrated equipment stores (IES) and the Red Cross. IES supplied different pieces of equipment; usually the larger pieces such as beds, bedside rails, pressure relieving equipment and hoists. The Red Cross supplied equipment such as walking aids and toilet frames. There was a complex historical system where patients had to rent equipment from the Red Cross, but had equipment supplied free from the IES.
- There was also a peripheral equipment store based on the St Mary's site for the crisis team, managed by the trust, with seven-day access and a van. Equipment, such as small aids were available in case of urgent need, for example, commodes. GP surgeries would take returned equipment if more convenient to the patient.
- The Isle of Wight local authority employed the equipment team; they supplied equipment for people weighing up to 40 stone. Servicing of equipment was by schedule either six monthly or annually as per manufacturers' guidance. The equipment store tested and delivered beds direct to patients' homes. The equipment team also supplied equipment to residential homes, and occasionally loaned equipment temporarily to nursing homes to support a patient's discharge.
- The equipment team made and issued wooden adaptation ramps, after 6 months their maintenance became the responsibility of relatives or carers. Galvanised outside rails were also provided.
- The equipment store supplied up to 50 telecare items such as oxygen saturation sensors, blood pressure leads and epilepsy sensors. The store supported the nurses in the community, one example given, was of the early identification of a deteriorating patient. The patient was then able to have a discussion with their GP and chose to die at home.
- When we went out with community staff on visits we observed one patient with a ceiling hoist and regular turns, however there was no moving and handling care plan in their notes. There was a potential safety concern to the patient if moved incorrectly or not frequently enough, but also to staff if they used the equipment incorrectly.
- Despite the community staff catheterising patients frequently, there were no bladder scanners to ensure that insertion of a catheter was indicated, or to rescan a patient after a trial without catheter to ensure that there was no retention of urine. There were only two machines for checking venous flow (known as Dopplers) in limbs at risk of leg ulcers in each of the localities.
- There was a 'pendant call' alarm service run by the local authority and paid for privately. Activated alarms called the service, and if needed they would send responders

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to assist with basic issues and care needs. The service saved the need for a paramedic call and was able to call them if required. Most patients were happy to pay a small fee for this service.

- Staff raised wheelchair availability as an issue. Two hundred and three patients were on the waiting list for wheelchairs, awaiting an assessment or for funding approval. The current situation was described as ‘under strain’ with 107 chairs in the community awaiting collection with nowhere to store them. One hundred chairs were waiting to be reconditioned.
- The prison service had agreed to recondition chairs, which the service would then just check. There were 50 outstanding repairs. The team told us that the whole service was going out to tender but commissioners wanted to hold a public meeting before this happened. The equipment teams were trying to work collaboratively with companies in the meantime.

Quality of records

- Whilst on inspection we reviewed 18 paper care records across different teams in multiple locations. District nurses and community matrons used paper records; most nurses had ‘read only’ access to an electronic system, which the GPs used. Matrons were able to access the GPs electronic record to duplicate their notes.
- The quality of patients’ records varied. There were paper records in the patient’s home, but with no core signature sheet attached. There was no process to amalgamate records regularly. We saw that the community nursing assessment, which contained a summary of care needs, care plans and a regular entry for each activity was often incomplete.
- The records, we inspected, were incomplete with numerous issues, the most concerning were 44% of risk assessments incomplete. Forty-four per cent patient care plans were poor and patient consent was documented in just 11% of records. Two, out of 19 records, had no malnutrition universal screening tool (MUST) screening and three MUST screenings were of poor quality.

- The monthly audits by the community teams also had identified poor MUST completion and a lack of baseline observations across the localities, there were no actions identified.
- We saw a wound photo in one record; but there were no initials to indicate the taker or a rule to indicate the size of the wound. This meant it would be difficult to recognise the wound was improving or worsening by its size. As part of a patient’s record the taker should be recorded.
- We saw out of date care plans and information board for a rehabilitation patient in a nursing home.
- We observed a nurse appropriately referring to their GP to change a patient’s medicines. The nurse made the call back in the office hub because of the poor phone signal; there was no method of updating records and care plans, which was a potential safety issue. The notes in the patient’s home were therefore not contemporaneous.
- Community records had carbonised care plans, we were told that one copy could be brought back to the hub for updating; however, most were still attached in the patients home. There was no way of consulting records remotely. We saw at the hub, some care plans being updated, and some care plans in records within patient homes, which had not been updated. We saw two out of date care plans, which had potential safety issues. We saw a patient’s records that had not had an updated malnutrition (MUST) assessment since April 2016 despite them having a leg ulcer. This assessment was important, as adequate nutrition was vital to wound healing. We saw signatures and dates within most records.
- We observed some nurses writing updates within records, then duplicating and updating the hub based IT system. Staff told us repeatedly that the electronic system was not effective or fit for purpose. Staff shared examples of worklists being lost, patient names being lost or duplicated and unintended visits scheduled and taking place for patients who had died.
- There were care plans for dressings, Waterlow scores (to assess the risk of a pressure ulcer), pressure ulcer checks which were updated weekly. Community patient records were stored in an unlocked cabinet within the

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district nurses' hub office for one year and then sent to storage. As an interim measure, the locality team lead told us that there was a scanner on order for patient records, although the process was still to be decided.

- There were plans for hand held tablets and a new electronic care record in spring 2017 to feed into the GPs system. The new system awaiting executive sign off will enable nurses to view medical notes, and social services to read nursing notes. However, with the poor IT at the hub bases, there was no easy solution identified.
- Different teams in the community had different working records; the crisis response team had their own records, which they scanned into the trusts E record for storage. The reablement team used paper records, held within the patient's home. They also used an office based electronic system for recording electronic records. They had 'read only' access to the GP system.
- The clinical nurse specialists (CNS) records varied, the multiple sclerosis CNS used paper print offs for patient visits. They had no access to clinic letters on visits, which could be a potential patient safety issue. Heart failure CNS also had paper records, with a duplicate set kept in the office and updated.

Cleanliness, infection control and hygiene

- Most community staff had infection control training; the trust divided training into different subjects. Compliance was 83% for infection prevention and control, 71% for hand hygiene, 86% for blood borne virus training. The target for the trust was 85%.
- We observed good aseptic techniques used in wound dressing by community nurses.
- There was adequate hand washing facilities and alcohol hand gel available throughout the clinic areas. We observed compliance with hand hygiene, isolation procedures and the correct use by community nurses of personal protective equipment such as gloves and aprons. Staff adhered to the trust 'bare below the elbows' policy in clinics and home environments.
- There were variations seen in the cleaning of clinical areas, and the safe disposal of sharps within the community areas. For example, we saw that Ryde centre was visibly clean in patient areas, had good supplies of

hand gels and personal protective equipment. However, it did not have systems to monitor the changing of disposable privacy curtains, some were clearly out of date and others had no visible dates.

- We saw there were some incorrectly closed sharps boxes, which would not prevent injury or unauthorised access. Staff told us that infection control had not visited the centre for the past 12- 18 months and there had been no environmental audits. In the phlebotomy service, there were no couch rolls and no cleaning of chairs between each patient.
- In the Sandown medical centre, they did not audit the environment, the district nurses or their visits. The infection prevention and control lead had not visited the site 'in a while'. The Laidlaw Centre was an older building, with some cleanliness issues such as dust seen.
- When we visited the infusion unit on the acute site, we saw that the disposable privacy curtains were out of date for changing; the senior nurse was informed.
- Within the equipment store, there was an industrial washer for cleaning commodes and a washing machine for washing mattress covers. However, due to a severe lack of space, clean and dirty equipment were not adequately segregated which caused a cross infection risk. We raised this as a 'high risk' to trust senior leaders at the time of the inspection.

Mandatory training

- Mandatory training was provided by the trust via e learning or face to face depending on the subject, and staff were given protected time to complete their training.
- The trust's mandatory training covered a large range of up to 37 topics, these included information governance, resuscitation, conflict resolution, equality and diversity, medicines management, safeguarding and people handling. Overall, the community adults' compliance was 84%.
- Community teams described an on line tracker which kept them up to date with mandatory training and their competencies. This was their personal responsibility,

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although their manager reminded them if they were not compliant. Sandown medical centre, displayed the whole team compliance as 76%. This had increased over the last 18 months from 58%.

Assessing and responding to patient risk

- We observed some variation in the assessment and response to patients' risks.
- There was an effective system for receiving community referrals through the single point of access Monday to Friday from 9am until 4.30pm. After that, until 8.30pm a Band 6 or 7 district nurse covered the entire island which included dealing with any 111 and 999 calls. Out of hours cover was by the ambulance paramedics and specialist practitioner team.
- The electronic referral system was able to flag any previous high-risk patients or challenging home situations. However, it did not flag safeguarding concerns.
- The community teams kept patient's risk assessment booklets and care plans appropriately in the patient homes. All patients should have a thorough multidisciplinary assessment at the start of their case. Staff also described risk assessing pressure ulcers and liaising with GPs to review patients care. However, within the records we saw, the patients' risk assessments were either absent or not in date in 44% of patient records.
- Tissue viability clinical nurse specialists were accessible and available for joint visits with district nurses. They attended pressure ulcer review meetings, looked at action plans and shared learning. They had also visited patients to advice on care planning.
- Nurses demonstrated a good knowledge of sepsis, the national early warning system (NEWS) based upon regular levels of patient's observations, and acute kidney injury (AKI). We witnessed that patients had appropriate observations carried out, and patients were encouraged to use contact numbers they were given.
- Community matrons received escalations of care, generated by patients or GPs. GPs had access to beds at several nursing homes that the community Matrons could admit to. If a patient caused some concern, the crisis team would be alerted and would monitor the patient out of hours.
- Senior staff were on a locality rota and attended 'in reach' bed meetings; for professional advice related to any patients who could be managed in the community and admission prevented.
- We witnessed staff discussing safeguarding referrals at handover. They raised safety risks relating to patient turns, nutritional intake, and social situations and actions were discussed.
- It was reported that some private 'riser recliner' chairs often used in the community would not fit pressure relieving cushions, it was necessary for Occupational Therapy to do a risk assessment of the cushion in the chair before it was fitted.
- Staff confirmed that although pressure ulcers were photographed securely in the community, wounds were not routinely photographed. This meant that staff might not recognise clinical deterioration and the need to access expertise in wound management.
- We witnessed that diabetic patients attending phlebotomy clinic for fasting bloods were not prioritised above others waiting. This could be a risk to them if they were an unstable diabetic, this was not risk assessed or recognised as a safety concern by the staff.

Staffing levels and caseload

- The trust reported that there were over 455 whole time equivalent (WTE) permanent staff working in the community for adults teams. There were 73 WTE locality community nurses, 46 WTE physiotherapists and 29 WTE occupational therapists. The vacancies in October 2016 for community nurses were at 15.86 WTE, which equated to 21%.
- We were shown information that across all localities the community nursing team had reduced in total from 86 WTE in November 2015 to 76 in October 2016. This equated to 50 shifts less per week. Seven new community practitioner posts started in November 2016.
- There was an ongoing plan from the new locality leads for each locality to mirror their staffing. This was to enable the movement of staff interchangeably between localities.
- The three localities had individual rotas, the staff worked staggered times. There was a rota to cover

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weekends and on call evenings between 4.30 and 8pm at night, when a senior district nurse screened the calls. The community nurses stated that the process which started earlier in 2016, had improved since the last CQC inspection.

- We saw some variation between the localities on how they were managing their workload despite staffing gaps. One locality, despite two WTE vacancies was able to share their staff with other localities. In another locality which had five WTE vacancies, nurses worked at least one-hour overtime daily to cover their workload. The third locality team despite five WTE vacancies appeared to work within their hours.
- Staff reported ongoing staffing and recruitment problems. Staff we spoke with told us there had been a chronic shortage of staff for four years with overtime needed to cover. The community nursing team leads had recently introduced Band 4 posts to release the Band 5 from routine tasks
- The trust data, illustrated that over the past twelve months the localities had used 686 shifts of qualified bank nurses to fill gaps, on average 13 shifts per week or two and a half WTE. There were 11 shifts not filled. Despite the 21% nursing vacancies, the localities were still showing as 'green or no risk'. This status was raised as a concern on the inspection, as the impact of vacancies was on unmet visits or delays which were reported by patients.
- Community teams had a patient caseload of approximately 1100 patients shared between the three localities; the majority of the patients were aged above 70 years. This number was similar to that of a year ago. We saw wide variations between caseload per locality and numbers allocated per community nurse. The localities varied between allocating six visits per day plus additional 111 calls or residential home visits to 12-15 visits per day.
- There was a local workload and patient dependency tool, which staff were trying to use for the management of patients and workload. There were many reported issues with the local spreadsheet and staff generally regarded it as no longer fit for purpose. There had been numerous incidents of patients being deleted, lost staff visits and even visits being given to staff for deceased

patients. This was on the risk register although there were no actions detailed to mitigate the risks. Staff had to repeatedly check the system details to prevent patients being 'lost'.

- There was a daily handover in each locality to try to manage patient workloads safely; these were used for care updates and any relocation of visits due to staff sickness or absence.
- The community matrons' (CMs) caseload for each locality was approximately 30 complex patients managing their personal care budgets, and organising care packages. They were rostered as senior nurse cover once a fortnight to cover bed meetings and facilitate community discharges for the medical assessment unit and the emergency department at St Marys Hospital. Additionally, they were required to complete the continuing healthcare (CHC) paperwork for all patients. The CMs highlighted that due to the increased demands on their time; only half of their time was available to spend directly caring for their patients.
- We met various clinical nurse specialist (CNS) roles supporting people within the community, most shared feelings of extreme pressure and described a huge workload. For example, the heart failure CNS's, felt their service was completely overwhelmed by demand. They felt a struggle to improve services on top of big clinical commitments. The chronic obstructive pulmonary disease CNS felt stretched and spoke of needing a bigger team to provide care for their patients. Other CNS roles we spoke with echoed these statements and some spoke of uncertainty relating to their roles.
- Phlebotomy clinic staff at Ryde told us that their clinics were oversubscribed and they frequently turned patients away. Staff told us there was 'no hope' of any extra staff; although they had not raised this issue formally as an incident or concern.

Managing anticipated risks

- The last CQC inspection in 2014 raised concerns regarding out of hours cover across the island. Since July 2016, the out of hours cover, was by clinical practitioners coordinated via the ambulance headquarters. The team dealt with urgent calls within

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one hour. They attended in a car with radio access, and had a laptop for reporting the care given. Staff all felt that the recent changes had improved the safety and services for patients.

- All nurses had mobile phones; they were basic phones with no smart phone technology so were unable to be used reliably with the poor phone signal across the island.
- The community teams relied on access to IT, and due to the lack of a stable IT network, duplication of workload had to take place. Staff could not access caseload data, emails or report incidents through an electronic system whilst with the patient on site. Instead, staff scanned and saved the patient daily care record pages as a historical record.
- The integrated hub monitored patients remotely in conjunction with CNS and community matrons.
- The community team were working on developing a falls care plan for patients who had fallen, there was no falls pathway in place despite the usual age of their patients being over 70 years and prone to falling.

Major incident awareness and training

- The trust had policies and procedures for dealing with major incidents, the staff we spoke with were not aware of any recent practices in the community.
- The single point of access hub had a backup generator, in case of a power cut.
- If there was a poor weather warning, the community teams had a standard operating procedure to follow or help staff to prepare.
- A senior nurse at home managed the caseload allocation via a laptop if the weather situation was poor. The team had not practiced the plan regularly but staff confirmed it had worked previously in snow. Nurses visited diabetic patients on foot; a 4x4 from hospital driven by volunteers will transport district nurses to patients. Team leads also used this plan for extreme shortages of staff, which occurred on one of the days of our inspection due to staff sickness.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as requires improvement because:

- There was variable access to specialist medical advice, and in some areas for example multiple sclerosis and heart failure, noncompliance with NICE recommendations for the inpatient part of the patients' pathway.
- The community matrons were able to prescribe 'breakthrough' pain relief, however they had received no supervision for the past year and only had access to a paper copy of the British National Formulary due to lack of IT access.
- The lack of phone and IT signal affected the staff's ability to access information relating to their patient in a timely way.
- There were no multi-disciplinary team patient reviews involving the community nursing teams.
- There was no integrated falls service on the Isle of Wight, they employed a CNS and an orthogeriatrician but there was no cover for these roles. The trust participated in submitting data to the national hip fracture database. The 2016 report (2015 data) showed that the Isle of Wight were in the lowest quartile nationally for some aspects of best practice clinical care.
- The provision of staff supervision was variable across the community teams. With some teams accessing supervision and other staff in key roles not receiving any.
- Patients were not always consented appropriately and correctly, some staff did not understand their roles and responsibilities regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Community matrons were completing all of the continuing healthcare documentation from all patients across the Isle of Wight. Most of the patients were new to them and staff felt patients would be disadvantaged by this.

However:

Are services effective?

- The chronic pain team were members of the International Association for Study of Pain and the Physiotherapy Pain Association, which enabled them to keep up to date with current best practice.
- Patients followed rehabilitation pathways, for example in pulmonary, neurological, stroke and orthopaedic rehabilitation
- Some monthly audits were undertaken for example; one locality's results showed records were 65% complete, catheter care 81% complete, end of life 100%. Staff told us that practice changes had taken place after an audit identified a need. For example, the patients' care plans were changed to include a falls checklist, tissue viability, standardised referral processes and more prompts for care planning following an audit.
- There was a national chronic obstructive pulmonary disease audit, in which the community team participated. This provided benchmarks against the national average, for pulmonary rehabilitation as a whole pathway but did not detail the community part. The team looked at patient readmissions, but had no data to prove that they prevented them.
- There was also a programme of audits in residential homes for example, of nursing records. Staff told us that action plans were agreed following audits.

Pain relief

- We witnessed appropriate discussions relating to patients' pain and plans for pre dressing pain relief at the community handover. One team discussed a specific instance relating to a care home when advance warning of a wound-dressing visit and a request to administer pain relief, did not happen. However, the dressing still took place. The team was unaware if this was followed up as a safeguarding concern.
- The community matrons as independent prescribers were able to prescribe break-through pain relief medicines for their patients to ensure their pain was well controlled out of hours.
- There was a chronic pain multidisciplinary team service, which incorporated anaesthetics, physiotherapy, clinical psychology, and a nurse specialist. The team worked together with an emphasis on the patients' education and self-management of pain.

Nutrition and hydration

- The community teams accurately assessed most patients' nutrition and hydration status using the 'Malnutrition Universal Screening Tool' (MUST) and recorded it in the patients care plans.
- We witnessed discussions of patients at risk from malnutrition or weight issues that may affect their health at the community handovers. The nutrition lead had left a checklist to remind staff of patients' nutritional issues.
- Community dietitians were available for at risk patients and responded to urgent and routine needs of patients. And the speech and language team supported patients in the community with swallowing difficulties

Technology and telemedicine

- The trust had implemented tele-monitoring technology for various patients with long-term conditions such as, chronic obstructive pulmonary disease (COPD) and heart failure.
- The hub monitored patient's oxygen levels in their blood (saturations), weight and blood pressure three times per week. Community heart failure teams recorded observations into their mobile phones and sent it to the hub for monitoring and admission avoidance. COPD teams had 20 telemedicine kits in use for patients to help them self-manage, which were monitored by the hub to pick up any deterioration
- Community matrons (CM's) monitored their patients via telehealth and the in reach team. They monitored oxygen levels in patients' blood, blood pressure, temperature, urine testing and their weight. The patient or carer uploaded information via an I-pad to St Marys Hospital. Safe, normal parameters were set up, and alerts took place if levels were outside of them. The CMs accessed their details within the community hubs, patients lived in residential homes or at home. They used standardised management plans, which included self-management plans. There was a new database of patients' details but no outcome data was available as the system was 'too new'.
- The local authority ran a scheme, which provided patients with private community alarms and a telecare service. They

Are services effective?

Patient outcomes

- Most services participated in the national audits for which they were eligible. These included the British Heart Foundation National Cardiac Rehabilitation, Chronic Obstructive Pulmonary Disease National Audit, National Diabetes and the Sentinel Stroke National Audit Programme (SSNAP).
- We saw that there was an action plan for all of the areas below the national average in the SSNAP audit. For example, the percentage of patients admitted within four hours was 32% on the Isle of Wight and 59% nationally. There were 64% of patients assessed by a stroke consultant within 24 hrs on the Isle of Wight, whereas nationally this occurred in 81% of patients.
- Podiatry services took part in the national paediatric, diabetes, and inpatient audits. The team told us the Isle of Wight used to be one of the worst in the country for incidents of amputations but now were second best. We saw in the national diabetes inpatient audit, in 2013 21% of diabetic patients were admitted with active foot disease, but in 2015 this had reduced to 8%.
- The pain management team had outcomes based on patients' physical factors. The team had results of local audits, which proved the service made a significant difference to their patients' quality of life in the short and long term.
- There were some schemes under Commissioning for Quality and Innovations (CQUINs), which aimed to improve holistic care in the community. The tissue viability service identified the correct choice of dressing to reduce the number of patient visits required. The service, however, was not sure of the patient outcomes.
- Community nursing teams audited some patient outcomes. Locality staff showed us examples of the recent audit results and action plans. For example south Wight locality were clear on their outcomes, they had had the worse grade 3 and 4 pressure ulcer incidents of all localities. Following the implementation and use of the skin bundle, they had an 84% reduction in grade 3 and 4 pressure ulcers in the last 18 months.
- The COPD CNS's were often involved in local audits, projects and research but due to staffing constraints, they often completed them in their own time.

- There was no integrated falls service on the Isle of Wight, although the trust participated in submitting data to the national hip fracture database. The 2016 report (2015 data) showed that the Isle of Wight were in the lowest quartile nationally for some aspects of best practice clinical care. These were perioperative medical assessment, patients receiving a falls assessment and receiving specific anaesthetic techniques. There were gaps in the service when the consultant or CNS was away and the vacancy was not backfilled. There were variations in the care that hip fracture patients received.

Competent staff

- We were told that new staff were given both a trust and local induction, some of which was electronic via the electronic staff record (ESR) system; staff confirmed this and said they felt well supported when they first started in the organisation.
- Most staff told us they received regular annual appraisals. As of September 2016, 59% of staff within the Ambulance, Urgent Care and Community business unit had completed their appraisal. Community staff confirmed that their annual appraisals were taking place; and included their training plans.
- Staff told us the trust offered great training and development opportunities, with an excellent education department and a local practice educator. There was e-Learning, face-to-face or external learning, if identified as needed for their development. All clinical business support teams received customer service national vocational qualification training.
- 80% of registered nurses (RNs) were competent to do full leg ulcer assessments and treatment plans. RNs had received Doppler training (to assess venous blood flow) from the tissue viability CNS. Staff confirmed that compression bandaging was never applied to patients without first having a Dopplers undertaken. However, we did not see any evidence of routine post healing Dopplers or any remeasurement of hosiery, which could be a safety concern as patient's limbs may change.
- The CNS teams provided broad education for practice and other nurses, for example in pulmonary rehabilitation and asthma updates, continence and dementia.

Are services effective?

- There was some variability in the community teams in respect of supervision, some nurses felt that there was little senior support in actual care delivery as the senior nurses were hub based. However, they did have facilitated supervision every quarter, shared between localities. One example given was of issues that followed the death of a palliative care patient at home; supervision helped to support the teams' compassion fatigue. Other staff told us of supportive managers who were available for supervision; the single point of access team and community rehabilitation had peer reviews in addition to monthly supervision. The crisis team received supervision from occupational therapist manager. Managers told us that all community staff received monthly clinical supervision; however, some staff told us this was not the case.
- The CNS teams accessed various training and supervision depending on what was relevant for their roles. Most had no supervision in place for them on the island, so they linked with other local or appropriate national NHS trust CNS's for peer supervision every two months
- The podiatry team were all specialist practitioners, they all received annual appraisals, and had their competencies assessed by the College of Podiatry guidelines. The team provided a yearly update to DNs, practice nurses, GPs and nursing homes and won 'educator of the year' from Southampton University students.
- The community matrons (CMs) were non-medical prescribers, who set their own parameters and attended the Isle of Wight non-medical prescribers meeting held twice a year. Staff told us there used to be a register of non-medical prescribers but were unsure if it still was in place. Staff we spoke with told us that they had received no prescribing supervision over the past year. The CMs maintained their own competencies by reading and double-checking. They used a hard copy of the British National Formulary as IT did not support the on line version and their phones did not have smart technology.
- Staff told us that a Band 6 district nurse in each locality hub was office based and allocated visits; they felt the Band 6s were deskilling although staff appreciated their support and advice.

Multi-disciplinary working and coordinated care pathways

- Many teams across the community services for adults worked within a multidisciplinary team. However, there was no formal multidisciplinary team meetings (MDT) for district nurses, the lead told us that 'it was a priority' to develop and there was secured funds for six months of MDT admin support.
- The community rehabilitation and reablement team had weekly MDT meetings, these meetings reviewed patients' goals, their discharge plans and any need for referrals to psychology or neurology. They worked closely with the Stroke Association. They referred patients back to their GP if the patient needed access to a memory clinic or a falls assessment done.
- There were good links between podiatry and orthotics with joint shoe clinics held. Consultant podiatrist had links with diabetes and rheumatologists. The vascular consultant from a local NHS trust visited once a week and provided MDT support to the service. They also had support from tissue viability and the amputee service. The podiatry services were part of an award winning insulin educational programme for diabetic patients.
- There were new 'care navigators' who helped support social care links for example, for financial, social care and help to access services. Social care was 'a challenge', and increasing care packages was difficult. It took up to 5 weeks, the social service teams were not contactable by phone, and they usually did not have time to update the teams.
- Occupational therapy and speech and language therapy provided support by referral to the community.
- The Parkinson's CNS had a caseload of approximately 400 patients, they did home visits one day per week, had a shared monthly clinic with a visiting neurologist. Neurologists visited every fortnight from local mainland NHS, and the CNS was able to review their caseload.
- The COPD CNS liaised directly with GPs, therapists, consultants and psychologists, they did joint visits with the community matrons for complex patients. The continence CNS worked closely with GPs, DNs and patients.
- The community hubs reported improved integrated working and communication with GPs. There were a few

Are services effective?

MDT meetings led by GPs, and a named link district nurse for each GP practice. Normally the community team informed GPs of a patient's admission to hospital, as there were no virtual wards.

Referral, transfer, discharge and transition

- There was a range of services and teams with clear referral criteria, designed to meet the needs of patients along care pathways. The single point of access, referral, review, coordination service initiative (SPARRCS) did a general MDT assessment for occupational therapy (OT), speech and language therapy (SALT) and physiotherapy. Approximately 12 referrals per day went through SPARRCS to access the community rehabilitation team. There were 30 rehabilitation beds, spread through six nursing homes. The reablement team, offered up to 12 weeks of extended services to patients with long-term conditions, funded by the patient after the initial six weeks.
- There was evidence of teams referring patients appropriately to services for their individual needs, for example, the community stroke service rehabilitation team (CSSRT) did a two person 'welcome home' visit on discharged patients to check them. They risk assessed, agreed goals, and planned their visits. The senior OT had in reach reviews of all patients on the ward, and the early discharge team discharged patients following intensive rehabilitation. There were challenges reported in getting social services to provide care packages when therapy was no longer required.
- The crisis response team was focused on admission avoidance, and patients received in reach response within four hours and had up to 72 hours of support by the team. The team liaised with other teams, to hand over the duty of care and reported seeing increased referrals for end of life care.
- The heart failure CNS received patient referrals from other acute NHS trusts when patients had devices fitted, also from GPs, self-referrals, CNS and DNs. The patient had to have an IOW GP and be over 18 years old.
- The district nurse coordinator took patient referrals and actioned problems as they arose. We witnessed a detailed discussion of a patient's diabetic management with an action plan and their management agreed at the handover meeting.

- Referrals to community OT or physiotherapy took up to six weeks, if marked urgent it took two to three weeks.
- The community matrons oversaw the setting up of resources for any new patients. They highlighted there was often a communication gap with the acute hospital. For example, the hospital did not always know the CM or other services had been involved with the patient. Therefore, the hospital did not inform them of their patient's admission, and did not involve them in their treatment plans or discharge planning. Patients had been found at home with an inappropriate care package, or the hospital were unaware the patient was funded for continuing health care. The community heart failure team, the palliative care team and rheumatology had all reported this happening. The locality leads had escalated the issue to the senior team, but no changes had happened yet.

Access to information

- The community services for adults faced challenges with the poor phone signal and inconsistent IT connection; this meant that staff could not access web-based systems and calls were missed from patients or other staff. Serious incident investigations identified IT issues as a major problem. There was poor WIFI access in the district nurses hub, where staff could not always update the database, record incidents, their mileage claims or access emails. These issues meant repeated checks to ensure data was not lost; these issues were on the risk register.
- There was a plan (not confirmed) for an integrated care record. To be linked with the GPs system and accessed by social services. Staff told us, it was an acute need due to there being a lack of patient tracking and an inability to update records in a timely way.
- The single point of access hub viewed alerts on the system if a patient was a high risk for example from sepsis, or had a do not attempt resuscitation order. The acute hospital usually generated, 'do not attempt resuscitation' (DNAR) documents. Community teams drew up a checklist of essential actions for example, just in case drugs, checking and signing of the DNAR form by the GP to avoid gaps and upsets in the final days of a patient's life.

Are services effective?

- Staff worked to an on line agreed dressing formulary, which the tissue viability CNS maintained and updated and included a process for staff feedback on dressings.
- Rheumatology services used a ‘paper light’ electronic system for all appointments and patient letters, which linked into the acute hospitals, x-ray images, pathology, and cardiology but not into the GPs system. The nurse specialists used an electronic template for their letters. Users in the acute hospital searched the system for information.
- Staffing rotas were prepared using e-rostering.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw variability within the community teams relating to consent processes, for example, the in reach, assessment notes contained signed consent forms. However most patient records even initial assessments we reviewed did not contain any documentation of patient consent apart from specific photography consent when tissue viability referrals were made.

- We witnessed community nurses verbally asking the patients for consent, although it was not documented in any way. The knowledge and understanding of the consent process appeared to be lacking in some staff.
- Senior community nurses told us that there had been lots of work to train staff in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, some staff we spoke with could not provide an understanding of how to undertake a capacity assessment although they had received training.
- Other staff we spoke with demonstrated no real understanding of how to assess a patients’ mental capacity or its implications across the wider multidisciplinary team. We saw that some patients recommended for capacity assessment had no evidence that this had this carried out.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as good because:

- Throughout the inspection, we observed respectful discussions about patients and their families, it was clear that there was a genuine concern for their wellbeing. Staff respected patients' values and wishes.
- We spoke with over 40 patients and carers of patients, in clinics, in their own homes or by telephone. Patients gave positive feedback about the compassionate care they had received and the manner and approach of the staff.
- Patients told us the staff had explained their treatment options to them, and they were aware of what was happening with their care. Patients and relatives confirmed that they felt involved in their care.
- There was a new post called a 'care facilitator' to organise and coordinate care around the wellbeing of the patient.
- Support was readily available for community patients and their carers from a variety of sources; for example, specialist teams, charities, and specialist services.

However

- There was variable access to psychiatric and carer support.
- We saw some treatments being given in public areas in Laidlaw Centre, which would not uphold patients' privacy and dignity in some situations.

Compassionate care

- Throughout the inspection, we observed respectful discussions about patients, their families, the staff knew the patients well, and there was a genuine concern for their wellbeing.
- The community heart failure team respected patients' values and wishes, even if they didn't agree with them. We witnessed patients and families had care planned, received care and agreed goals with the community rehabilitation team.

- We spoke to over 40 patients and carers for feedback on their care, patients fed back that the 'staff were brilliant although overworked' and 'staff were all very caring'. We saw evidence of compassionate care.
- The locality leads felt that the 'I want great care' feedback was useful in getting feedback into the community service. The team worked with the quality team on how to access patients not on line.
- Friend and family feedback responses had proved difficult to get in large numbers in the community, which meant the figures were not always reliable. For example, between August and October 2016 most feedback for individual teams was in single figures, although there were a few exceptions. The feedback was entirely positive with scores between four and five.
- The AUCC business unit shared a monthly update on 'good news' received each month from patients, divided into teams, the responses had varied between 17 and 34 over the past six months.

Understanding and involvement of patients and those close to them

- Community teams had a new 'care facilitator' to organise and coordinate care around the wellbeing of the patient. In particular, they identified social isolation and services to support the patient.
- The chronic pain services reviewed the patient's self-set goals with them weekly; these reflected the patient's personal values.
- Patients living with dementia or autism at Ryde Health and Wellbeing Centre accessed quiet facilities to avoid them waiting in a noisy area.
- We witnessed a good rapport with a learning disability patient with clear advice and communication by the community nurse. The nurse offered further advice on the management of the patient to the patient's rest home and carers.
- The tissue viability team educated carers on pressure ulcer prevention and community matrons supported patients with education for self-management.

Are services caring?

- Staff told us that there was a carer support group for the Isle of Wight; the attendance was variable with some carers saying they had no time to attend or they did not want to go.

Emotional support

- We witnessed emotional wellbeing and family support considered by the community teams at handover. There was reassurance regarding patients about 'what's important to them is what is important' being discussed when speaking about an end of life patient.
- Patients who needed end of life care were shared between community nurses and the hospice at home team; they liaised with the patient to help choose their preferred place of death.

- The community heart failure team had good links (although unfunded) with psychologists for ad hoc emotional support for their patients. They had patient support groups, and on line support groups to empower patients.
- The COPD team had limited psychologist support, (once a week) which provided motivation and mindfulness. They had a singing group to support respiratory function and wellbeing.
- Admiral Nurses, had provided support over the last two years to carers of patients living with dementia across the Isle of Wight.
- The community rehabilitation team felt their patients were well supported by the nursing homes, as they engaged with the nursing home patient activities and resources.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

- There were many excellent examples of responsive community services and teams who worked collaboratively to meet patients' needs. They provided care close to or within the patients' home environment, and aimed to prevent hospital admissions.
- Most community staff had completed equality and diversity training, 97% across all localities and could demonstrate an understanding of the issues. There were adequate disabled facilities, assistance from specialist teams with patients who had a learning disability, and translation or interpreter services when required.
- The single point of access hub flagged any patients with safeguarding issues.
- The local team were aware of their role in responding to complaints and formal complaints were reviewed weekly at the senior nurse and governance meeting.

However

- The new physiotherapy service for GPs reduced sessions to three, which meant patients often needed repeat referrals into the system.
- Patients told us of little support in repatriation after accessing in-patient services on the mainland, with therapy referrals having to come from their own GP.
- There were a number of patients waiting for wheelchairs, which could impact on their mobility and wellbeing.
- There were privacy and dignity issues within one clinical area, which needed to be reviewed. If the patient was unwell they could be compromised.

Planning and delivering services which meet people's needs

- There were examples of responsive community services and teams who worked collaboratively to meet patients' needs. They provided care close to or within the patients' home environment, and reduced hospital

admissions. The aim was to work with all health and social care partners to provide responsive services to maintain health and wellbeing avoid inappropriate hospital admissions and support early discharge.

- The community nursing services were provided in three localities across the Isle of Wight. However, not all services were arranged in the same way, as they were too small to split into three. As a result, there were some differences in the way services were planned and delivered in each locality. There was an attempt via the workload and dependency tool to manage the nurses capacity to the caseload. However due to unreliability of the spread sheet tool, this was not effective.
- The rehabilitation team had three locality teams. There were 40 rehabilitation beds, which were spread across each locality in nursing homes and one residential home. Seven non-weight bearing beds were available exclusively for slow stream trauma patients. Admission to the rehabilitation beds was mostly from acute hospital patient discharges (90%), with the remainder direct from GPs. There was a triage (risk assessment) response to referrals; urgent within two days, 'routine A' within 10 working days and 'routine B' within 30 working days. Staff told us there had been significant delays earlier in 2016 when routine B patients were waiting up to six months for admission. At the time of our inspection, those waits were down to one month, although the system was prone to 'blocking' as the average length of stay per patient was six weeks.
- A crisis response team provided a seven-day service. They were using the 'Adult first response' team's social workers, as theirs was vacant. Referrals came from all professions, with the aim to keep people at home whenever possible. The team provided up to a maximum of 72 hrs input, and then would refer the patient on to other services. They reported good links with GPs, but had challenges in getting social care packages. There was a rising trend in caseload numbers, and recognition that some patients consistently used the 111 services or ED.
- The community teams had different key performance indicators, which aimed to provide the best care for the

Are services responsive to people's needs?

patients. For example, the crisis response team had up to four hours to respond to referrals, this allowed for 'time with patients, and not rushed to get to see things through'. The trust measured reablement service outcomes; they were a goal led service. At the start of the service's visits, they would provide eight hours of support per day decreasing at the patients discharge to no care, saving up to eight hours of care daily. We did not see any formal evidence to support these savings.

- The rehabilitation team also measured patients' outcomes routinely, for example, they use a mobility score, a complexity scale and a goal attainment scale. Staff held patient data centrally in a database, although we did not view this.
- Procedures and services were not always available on the island, for example, patients having a heart attack were taken to a local acute NHS on the mainland, which some caused issues in relatives visiting and the patient getting home. Patients felt there was little support with returning home to the island after accessing outsourced care.
- We saw that all community teams worked hard to support their patients in the community, and avoid hospital admission. These included for example the heart failure team, the COPD team and the community nurses.
- Infusion services for outpatients who required iron transfusions, blood transfusions, magnesium, and immunoglobulins administered were provided on the acute site. Patients stayed under the care of their hospital consultant. Normally some support was provided in the community but staffing issues meant that when we visited this was not possible.
- The chronic pain team held group-based therapy twice weekly over a five-week programme, which incorporated self-management, education and relaxation. Any patients who may benefit were offered acupuncture. New patients were waiting up to 18 weeks to access the service with patients requiring individual physiotherapy waiting between four and five months.
- GPs referrals for physio went to an external provider; the patients had three sessions provided locally. However, referrals from the acute hospital consultants provided by the trust were for six sessions. Some users perceived this as a 'two tier' system.

- There was no integrated falls service, although patients who had fallen were signposted to a range of services. Thematic analysis had showed that a patient often fell within 48 hours of discharge, with inadequate footwear and difficult commode access providing a red alert for their care planning.
- The commissioners commissioned podiatry under a block contract, which did not allow for home visits. An annual discussion took place between the commissioners and providers before any business planning to make sure the plans reflected the contract.
- The equipment team were responsive and dealt with requests relating to hospital discharges within same day. Adaptations were completed within a week and special requests up to four weeks unless for a palliative patient when it was prioritised.
- The wheelchair provision and maintenance contract was under review, the previous contract holder did not now want contract for maintenance, which was going out to tender March 2017. There were 203 patients on the waiting list for wheelchairs, either awaiting assessments or funding. Staff told us that there used to be 70 patients waiting when the previous contract holder was providing the service. These longwaits could impact upon the patients mobility and wellbeing.
- Ordering wheelchairs was through the NHS procurement. However, we were told of cases where the request had not been authorised or other issues, which meant the patient was waiting for their wheelchair a long time.
- We were informed that GPs had withdrawn funding for the tissue viability support for GPs so CNS' were no longer able to organise leg ulcer clinics in GP surgeries for complicated cases.

Equality and diversity

- Mandatory training for all staff included equality and diversity issues, 97% staff had completed this and could demonstrate an understanding of equality and diversity.
- The community services we visited were accessible with ramps for those less mobile. There were allocated disabled car parking spaces and assisted and disabled toilet facilities available. The newer facilities had quiet waiting areas for dementia or patients bothered by noisy environments.

Are services responsive to people's needs?

- Patient who were not English speakers were able to access an interpreter, there were leaflets available via the patients advice and liaison (PALS) team, which detailed how to obtain these services. Staff knew to contact PALS for support with other languages. There was help with lip reading support for patients who were deaf.
- We saw in the Laidlaw Centre that there was patient information available on display; however, none was printed and available in alternative languages. Staff told us it was easily available on request from the charities who supplied the literature.
- The heart failure team engaged with a patient support group to help produce a new patient information leaflet. They used two non-English speaking patients with interpreters. It was written in 'patient terms and language'.

Meeting the needs of people in vulnerable circumstances

- The single point of access hub flagged the patient record if there had been a safeguarding alert. We saw community nurses attempting to solve issues for patients, they described how the complexity of patients had increased, many with multiple problems to help sort.
- We saw a newly referred palliative patient visited by the community nurses and had care planned within four hours. This included appropriate referrals made and equipment requested. The nurses discussed and arranged access to Macmillan nurses.
- There were two Macmillan nurses in each locality; there were end of life champions who had monthly meetings to talk through patients and their risks. The whole team was trained in palliative care, syringe drivers and medicines. They discussed the patient's priorities of care and individualised their care plans.
- The CNS for COPD actively implemented interventions to prevent patient admissions to the acute hospital. For example, they monitored blood gases, provided nebulisers, ensured good inhaler techniques with the GPs and pharmacists, and provided smoking cessation advice.
- The community matrons had been completing all the continuing healthcare (CHC) paperwork for all patients;

this could have been against the patient's interests as they did not know the patient well. Funding panels were every week for CHC and six weekly for personal healthcare budgets. The decision support tool took 15-20 hours to complete to include all other agencies input. We were told that patients could wait for months for funding.

- Fast track continuing care patients could get funding agreed on the same day but due to shortages of care agencies on the island, care may not be available. If there was no other solution, teams accessed hospice 'carers' teams.
- A patient with MS we spoke with, was in a rehabilitation bed in a nursing home for the previous three weeks, following a five-week inpatient stay. The patient stated they had had MS since 2001 but had not seen the MS CNS. Although the patient had a history of two falls in past two years, they had received no follow up. They had seen a neurologist on this occasion and had a medication review. They had been asking for continence advice for past three weeks. There was a plan in place for a trial discharge overseen by therapists.
- Patients having disease modifying intravenous treatments in Laidlaw received intravenous infusions within a public café area. Other patients and members of the public sitting in the café could witness and overhear conversations between healthcare professionals and patients. There was an area for weighing and taking observations but staff could not uphold the patients' privacy and dignity if they became unwell in full view of the public area.
- Powered wheelchair referral forms had eligibility criteria; the patient had to be unable to use a manual chair, for example, have motor neurone disease. The housing adaptations team looked at the patients' environment, and planned for a joint approach to undertake assessments.

Access to the right care at the right time

- We were informed that the district nursing service was commissioned within a block contract and there were no locally agreed quality indicators with the commissioners for response times. The integrated hub administration role took patient calls, referrals from wards and accessed equipment for district nurses and

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the palliative care team within their response times. There was a long-term plan for all referrals to go through this route. Patients were able to reschedule their home visit through the hub.

- The nurses responded to referrals from the hub in order of patients' priority, the coordinator in each locality undertook this and shared out the workload.
- Two district nurses from each locality attended regular bed meetings in St Marys Hospital. Their role was to identify any patients that could be moved from inpatient wards into the community.
- The rehabilitation team sisters covered 8am-5pm, with physiotherapists covering 24 hours per day seven days per week and occupational therapists 24 hours over five days per week. Each nursing home had designated therapists and assistants, with the sisters 'floating' between homes. The home's GP provided medical cover. If the patients did not manage to get home with reablement support or a social package of care, they moved into the nursing home beds when one became available.
- The diabetic clinic, was seen to be busy, patients told us 'it could run over an hour late, but was available when you need it'. The referral pathway was from the GPs via an email or fax, and responded to in 24 hours for urgent appointments and new insulin starts. Each specialist nurse took part in both clinics and home visits; one had a more acute focus to pick up any new patient referrals.
- The MS CNS held a monthly GPs clinic in Freshwater, and attended home visits and rest homes as required. Prescribed disease modifying drugs were administered to the patient via the mainland NHS or on the island; the CNS monitored the 50 patients, as the trust infusion service was not used. Patients confirmed that were given NHS helplines and support numbers. The CNS had expertise in neurological examination, and held a joint monthly clinic with continence services for any MS related issues. The CNS referred their patients to other services as required although they did not follow up on the referral.
- The heart failure team were able to access therapy for any palliative patients via the hospice as the community services for adults had long waits for therapy. The

patients could wait for up to three months for therapy, described as a national problem due to patient referral numbers. Clinics prioritised patients according to the severity of their symptoms.

- COPD CNS liaised with the medical admissions unit and responded when required, due to them leaving capacity in their work plan for urgent responses. All patients had anticipatory care plans agreed for short-term interventions. Their waiting times were to see urgent cases as soon as possible and routines in two weeks. We saw that they were very responsive and moved patients according to their clinical priority to prevent admission.
- Some referrals to community matrons (CMs) came direct from GPs; these were for patients with long term conditions such as heart failure, fluctuating blood pressure or unstable blood sugars in diabetic patients. CMs normally had no more than two to three patients waiting. Sometimes the GPs waited for a couple of weeks prior to referring to the CMs to ensure that the patients did not need long-term management rather than acute management. The CMs visited patients every day to monitor them and prevent their admission to hospital.
- The phlebotomy service based at Ryde was extremely busy. There were between 1500 and 1700 patient attendances per month. Two to three times a week the service had to close the clinic and turn patients away. They did not carry out any home or care home visits, but provided walk in and wait clinics. The service did not prioritise fasting patients; which meant some diabetic fasting patients had to wait for up to two and a half hours. This had not been risk assessed and we raised this as a potential safety concern at the time of the inspection.
- Patients who had treatment on the mainland felt they were not supported to get home 'I was told to make my own way home from Southampton after surgery'. Physiotherapy and occupational therapy referrals to had to be made from their own GP on the Isle of Wight, and discharge planning was said to be 'poor' from the mainland.

Learning from complaints and concerns

- There was a trust complaints policy, and staff were aware of their roles within it. There were two stages detailed within the policy, local resolution and

Are services responsive to people's needs?

escalation for independent review by the Parliamentary Health Services Ombudsman. There was a trust patient advice and liaison service team and a timescale for complaint responses within 20 days. The chief executive read and signed off all complaint responses.

- There had been 14 complaints specific to community services for adults over the past 12 months, four of them (28%) related specifically to wheelchair issues.
- Teams told us that they tried to deal with complaints and concerns locally before they became formal as per the trust policy. The locality teams made direct contact, to acknowledge the patients complaint and to apologise. They tried to do something about the issue, then went back to patients and explained their actions.

- The senior nurses and governance (SNAG) meetings discussed complaints and concerns. A variety of complaints were received, often related to a lack of continuity and not seeing the same nurse at each visit, access to specific dressings and missed visits by nurses. The locality lead dealt with formal complaints with the involvement of the community staff.
- The chronic pain team received the 'lessons from trust wide complaints'. They described not having very many formal complaints themselves in the last year. They understood the clear process to follow.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well led as requires improvement because:-

- Some staff felt the trust level executive team were ‘unsupportive’ with unanswered requests for visits, no updates after submitting business plans and delays in allowing recruitment. Others said they had no updates following issues raised such as the inadequate phone signal.
- There was no plan for the new IT system despite the money being set aside and it being on the risk register.
- There were two risk registers relating to the business unit, one with over 80 identified but incomplete risks and another with only six but completed risks.
- The workload and dependency tool had no IT support and was not fit for purpose, was put on one of the risk registers with no mitigating actions in 2014.
- The patient workload was not equally spread across localities, some teams having to visit twice the number of patients another team did.
- The lone worker ‘buddy’ system as per trust policy was compromised due to the lack of phone signal, some CNS teams were not supported in lone working at all. There were no electronic monitoring systems for staff during the day, only at night despite staff reporting they felt unsafe.

However

- Staff felt that the new local locality leadership was accessible, supportive and provided a working strategy for the community services based upon the ‘My Life, A full Life’ vision.
- There was a well-embedded governance structure in place, this fed from locality teams upwards into the executive board. The teams used governance dashboards and a governance tracker to monitor the progress of incidents, complaints, and risks.
- Staff knew of their local risk registers and knew their highest risks that had been escalated to the trust wide governance and assurance group.

- Most staff felt supported and listened to, with opportunities to develop and progress

Service vision and strategy

- The trust had its own vision and values. The vision was ‘quality care, for everyone every time’. The trust’s values were ‘we care, we are a team, we innovate and improve’.
- The AUCC senior team had developed a five year vision to align itself to the strategic overview the trust provided, this included for example transformation work and the acute frailty pathway.
- The local community vision was for more integrated working; based upon the ‘My Life, A full Life’, which enabled a closer working relationship with care home managers and voluntary organisations.
- The community nursing teams talked about the strategy for all three localities to have an identical team structure, which fitted in with the ‘My Life a Full Life’ concept. The team structure however, did not reflect the different caseloads experienced in each locality, and some locality services, such as SALT were too small to be able to split effectively. There was a three-month project for integrating localities, which planned for nurses and therapists to work alongside each other in the future. There was an identified locality lead nurse for each GP practice.
- Some staff felt there was a lack of clarity of how the service would be in the future. Staff we spoke with said because it had taken some time to agree the ‘vision’, people had lost their enthusiasm. Staff felt that the trust put more emphasis on the acute services, although they acknowledged the new combined clinical business unit with acute and ED had given community a bigger voice than previously.
- Staff we spoke with expressed their views regarding potential changes in the future. The loss of part of the MSK physio service to a private provider had left uncertainty. Teams had anticipated changes but following the outsourcing were unsure. There was a common view expressed that a frailty service was

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required on the island, although there was not an integrated falls service. The equipment team stated they would like to combine telehealth, telecare and the independent living service all under one roof, they had knowledge of other areas in UK where it worked well.

- There was an agreed ‘in principle’ proposal for a new electronic record system, which had funding set aside for some time. It was a multiagency approach, although the mobile community system and the project plan had yet to be agreed.

Governance, risk management and quality measurement

- The lead locality nurse or business unit head of nursing and quality, chaired the weekly ‘SNAG’ meeting to discuss serious incidents, complaints, new initiatives and trust developments. Senior leads, some CNSs, practice educator and community matrons attended and disseminated the results of the discussions to Band 7s and the rest of the team. Junior staff were not involved and were not aware of the duty of candour process and had not been trained in its use despite it being a requirement since 2014.
- The teams used governance dashboards and a governance tracker to monitor the progress of reported incidents, complaints, and risks. The under reporting of some incidents such as verbal abuse to staff, would have meant some issues had not been identified and discussed. There was a peer review of caseloads every month, although staff told us this happened inconsistently.
- The community team felt that the trust had acknowledged the increased complexities of the patient caseload and their need for more support.
- The allocation of staff according to locality was not reflecting the population needs with the result that some locality nursing teams had to visit almost double the number of patients other teams did. There appeared to be no variation of establishments according to workload.
- Locality staff knew their local risk register; and described how local issues escalated onto the trust wide risk register by the locality leads. We were given two risk registers, one with a number of risks (over 80) related to the business unit but with no ratings attached, and the

other fully completed but with only six risks. The community teams knew their highest risks and identified the excel spreadsheet caseload management as one. It had contributed to ‘lost data’, missed visits and even requested visits for deceased patients. However, only one of the risk registers had this risk listed, dated 24 October 2014 and it was incomplete with no mitigations. The risk of a patient management tool which had been identified as not fit for purpose and which was not supported by IT was not on the ‘short’ risk register.

Leadership of this service

- Community staff described the clinical director as visible, approachable and accessible. The Director of Nursing had visited the community nurses four times in the past year. The trust Chair had visited community teams the week before our inspection. The majority of staff commented that visibility of the senior team had improved since the last inspection. The COPD team lead felt well supported by their clinical business unit management team and by the senior executive
- Staff we spoke with told us the new senior team (the locality leads) in the community had provided good leadership in each locality. Nurses stated they felt well supported, with clear direction. They felt listened to with any concerns and assisted with problem solving. Staff described it as “a good place to work”. They felt that previously vacancies and sickness management had been poor, although they stated it was improving with the new management support.
- However, some staff did not feel the board valued the highly trained workforce, although they felt local managers were supportive. For example, despite their repeated requests for a visit by the chief executive a team had not received a response. Another team lead had a planned absence from their role for approximately three months. The trust had not planned any backfill; therefore, there was a significant gap. Staff who were the victims of abusive or rude patients were not aware of any actions taken since they raised this issue.
- CMs felt that although part of their role should be the leadership of district nurses, they had no capacity to fulfil this.

Are services well-led?

Culture within this service

- Equality and diversity was part of the trust mandatory training, which all trust staff had to complete. Staff explained that due to the age of the general population, there were sometimes issues of patients refusing care from different members of staff. For example, this had occurred with a German staff member recently.
- Community teams stated that they worked in an open, safe environment. Staff felt supported and comfortable to share issues, worries and concerns with their local leaders. The locality leaders were accessible and had open door policies. The safe care of patients was their priority.
- Some staff described the trust as 'old fashioned and stuck in a rut'. For example, they felt that the trust needed to look at recruitment more creatively, for example, what was on offer to attract more staff. The trust had not considered 'golden hellos' or similar as other trusts had locally. Some staff we spoke with said they felt angry about the length of time it took for re-advertising vacancies.
- Some staff told us that the development of business units had not helped to retain staff, and they were not sure that the 'managers above were listening'. There was a culture of change aversion or fear in some staff who had worked for the trust for some time, therefore the managers may not be listening to 'perceived' obstacles.
- The community nurses were lone workers; although they did not carry safety alarms. No skyguards (electronic tracking device and alarms) were available during the daytimes, only at night. The hub team tracked nurse's locations by their work sheet. The lone worker policy detailed a 'buddy' system, alerting the buddy by phone at the beginning and end of their shift. However, the lack of an adequate phone signal across the island compromised this. Nurses confirmed that if there were any concerns identified then a two-person visit was done.

Public engagement

- The operating plan for the AUCC, detailed little patient involvement despite there being many redesign of patient services proposed.
- Some of the teams we spoke with told us of events when the trust had engaged with the public. The chronic

pain team had witnessed the trust board communicating in an adhoc way with waiting public when they used the conference room at Ryde for their meetings. There was no strategy to engage and involve public in their services that we were shown.

- The podiatry service had developed patient appointment cards with their patients input, which included the level of risk the patient's condition was. This meant that when they phoned the admin staff, the administration staff would know how to prioritise them. For example, low risk patients were booked as routine, high-risk patients booked within six weeks.
- There were over 16,000 wheelchair users on the island, and a user group held three or four times per year. The commissioners wanted to consult via a public meeting, prior to a new wheelchair service being put out to tender

Staff engagement

- 'Friday flame' was an online weekly update by the trust chief executive about trust business, which, staff described as keeping them involved.
- Community nursing teams felt that their local managers had listened to them. For example, some staff had said they wanted more time with clinically complex patients. Therefore, managers had introduced new roles for some of the routine tasks. The teams felt that more staff were required on early shifts, so managers had changed shift patterns. The shift changes provided an extra nurse for any extra patients or unscheduled visits.
- The new IT solution had engaged clinical and non-clinical staff to learn what was required from a new system, in one example we heard the continence service had given them a list of their requirements.
- There was access for staff to book different sized pool cars with reserved parking, which alleviated the need to find parking at SMH. The cars could be booked for visits, for training on the mainland, for patient visits or for transporting equipment.
- The trust circulated regular safety bulletins, although many community staff were not aware of them.
- There were some frustrations expressed in some teams. One team had for example, submitted three business cases for a 'work pressure loan' to support

Are services well-led?

improvements to the poor storage space in the equipment store. The team had attended the operational board but so far had not received any outcome.

- The community teams had raised the issue of poor radio signals and the trust had organised an assessment, they told us there had been no changes as a result despite the risks to patient care and staff safety.

Innovation, improvement and sustainability

- The Community team leads looked at developing their whole locality. Staff worked to recognise the signs of a deteriorating patient and other comorbidities, and community matrons needed to maintain their skills. The team leads had developed advanced nurse practitioner roles to manage complex patients' within agreed frameworks; these posts linked to ITU to gain competencies.
- The trust had introduced new posts; the leads described the post holders as previously employed but with considerable experience. They were being trained to apply compression bandaging, administer insulins, and manage catheters. They reported to registered nurses who retained any complex patients such as paraplegics (paralysed patients) or patients with tracheostomies (a breathing tube opening out of the neck). The physiotherapy amputee team were training another physiotherapy technician to be an amputee counsellor, with support and clinical supervision from the trust.

- The equipment store was working to support wards as well as community with their expertise.
- Community teams had no access to lone worker alarms, despite the poor phone signal, which meant that the lone worker buddy system was not effective. The CNS teams did not use the buddy system although they were lone workers.
- The current method of allocation of community staffing was not seen to be equitable, the workload and dependency tool had not helped identify the gaps in staffing. Despite considerable vacancies the system was still showing as green – no risk.
- There had been recent changes to the musculo skeletal physiotherapy patient referrals from the GPs, these went to a private provider for three sessions. Many patients needed to come back after the three weeks, to go back to their GP and needed a repeat referral.
- An external consultancy company had been working on the integration project; they had been looking at case managers and multi-agency management planning. The team told us that the GPs were not going to be part of this project.
- There was a new pilot project about to commence for the Islands prison to provide wheelchair reconditioning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises
Personal care	
Treatment of disease, disorder or injury	How the regulation was not being met <ul style="list-style-type: none">There was inadequate segregation of clean and dirty equipment in the equipment cleaning area in the Integrated Equipment Store. There was a risk of contamination of clean equipment issued for patient use and an infection control risk.
Regulated activity	Regulation
Nursing care	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Personal care	How the regulation was not being met <ul style="list-style-type: none">There was inadequate supervision of independent non-medical prescribers in community adult services with no supervision having taken place in 2016.There were not sufficient numbers of staff in some community teams to meet the requirements set out in the fundamental standards.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Nursing care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
Personal care	How the regulation was not being met <ul style="list-style-type: none">Patient consent was not consistently sought and documented within the patient records
Treatment of disease, disorder or injury	
Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Nursing care

Personal care

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met

- Systems were not in place to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decision taken in relation to the care and treatment provided.
- There were two risk registers in place and there were limited risks on the one that was complete.
- The IT and phone signal are not supporting safe care of patients by the inability to access timely information.

Regulated activity

Nursing care

Personal care

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met

- Adrenaline was stored in an unlocked staff fridge, with no monitoring of temperatures, in the North West district nurses team office.
- Patients did not have completed risk assessments and when in place they were not regularly updated

Regulated activity

Nursing care

Personal care

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

How the regulation was not being met

- There was no training for duty of candour.
- No junior staff we spoke to understood the open and transparency requirements of the duty of candour, including a written apology from the trust and the offer of a copy of the investigation report to the patient.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Nursing care

Personal care

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met:

- Key staff groups were not trained to safeguarding children level 3 as recommended in national guidance.
- Staff understanding of safeguarding was variable, and not all registered staff had a clear understanding of the Mental Capacity Act (2005).

Regulated activity

Regulation

Nursing care

Personal care

Treatment of disease, disorder or injury

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

How the regulation was not being met:

The trust medicines policy did not give guidance on the safe storage of medicines in the community clinics or patient homes. Standard operating procedures were not dated or authorised.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.