

# Isle of Wight NHS Trust

## Quality Report

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

## Ratings

|  |   |
|--|---|
| <b>Overall rating for this trust</b>   | <b>Inadequate</b>            |
| Are services at this trust safe?       | <b>Inadequate</b>            |
| Are services at this trust effective?  | <b>Requires improvement</b>  |
| Are services at this trust caring?     | <b>Good</b>                  |
| Are services at this trust responsive? | <b>Inadequate</b>            |
| Are services at this trust well-led?   | <b>Inadequate</b>            |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Isle of Wight NHS Trust is an integrated trust that includes acute, ambulance, community and mental health services. Services are provided to a population of approximately 140,000 people living on the island. The population increases to over 230 000 during the summer holiday and festival seasons. St Mary's Hospital in Newport is the trust's main base for delivering acute services for the Island's population. Ambulance, community and mental health teams work from this base, and at locations across the island. The trust also provides a GP led urgent care walk in centre and NHS 111 services which were not included in this inspection and will be subject to separate inspection and rating in 2017.

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 and an additional inspection of mental health services 18-19 January 2017.

We undertook a comprehensive inspection of the following core services across acute hospital, ambulance, community and mental health services:

- Accident and emergency, medical care (including older people's care) and end of life care.
- Community health services for children, young people and their families, community adult services and community inpatient services.
- Acute inpatient mental health, psychiatric intensive care unit, rehabilitation wards, community mental health, community learning disability services, community children and adolescent mental health services, older adults wards, and substance misuse services.
- Urgent emergency ambulance, emergency operation centre, patient transport services

We also inspected and assessed the 'well led' domain, which covers the overall leadership and management of the trust.

Overall, we rated this trust as inadequate. We rated the safe, responsive and well led domain as inadequate overall. We rated effective as requires improvement overall. The trust was rated good for caring. We rated 'well led' as inadequate.

We rated mental health and ambulance services as inadequate overall. Community services were rated as requires improvement overall. Acute services urgent and emergency care and end of life care were requires improvement overall, medicine was rated as inadequate.

Immediately following our inspection, we issued a notice of decision under Section 31(HSCA 2014) to urgently impose conditions on the trust's registration in relation to mental health services, as we had reasonable cause to believe a person would or may be exposed to the risk of harm unless we did so. We also formally wrote to the trust asking for a report on urgent action to address a number of other serious concerns across all services.

### Our key findings were as follows:

- Since our last inspection in 2014, some services had seen deterioration in safety and quality, including care for patients with mental health conditions.
- The trust had not made sufficient progress to improve services as required at the last inspection and there was continued non-compliance with regulations that had been identified at the last inspection.
- Inpatient mental health wards were not safe, and the ambulance station was not secure
- There were deficiencies in organisational structures, processes and the trust leadership which prevented staff from providing good services
- Staff in many services were disillusioned and suffering work overload; some described bullying and harassment. Morale was low among many groups of staff.
- We found staff shortages, outdated practices, bureaucratic processes, limitations in information systems or use of information.

# Summary of findings

- Staff felt senior managers had insufficient knowledge and experience. Some services had managers in interim roles and staff felt this impacted on their ability to be effective. However staff spoke highly of the support they were given from their direct line managers and were proud of the strong sense of teamwork.
- The trust did not have strong risk management and governance processes at all levels which affected the quality and safety of services. The executives were out of touch with what was happening at the front line.
- There was a top-down culture with senior managers attempting to direct change. Senior managers did not appear to understand what was needed to make necessary changes or to implement their vision and strategies. Staff did not feel part of this process as managers had sought a high number of external reviews.
- The trust recognised the need to work with partners to provide high quality and sustainable services for the island population. However there had been little progress in delivering that vision, so the trust and the wider system were not keeping pace with the actions and improvements needed to meet increasing demand for services and financial pressures.
- The trust did not know whether all front line staff were reporting all incidents and learning from incidents was shared. There was a mixed understanding of the principles of the duty of candour and its application.
- Patient care and safety was affected as all services had teams or wards that were significantly understaffed. Some trust wide key posts were vacant and the trust employed many locum medical staff
- There was inadequate risk assessment of patients and risks were not adequately monitored or managed.
- Key groups of staff were not up to date with safeguarding training. Staff did not always identify or report safeguarding incidents. Safeguarding and 'looked after children' teams were stretched and there were not sufficient monitoring of adult safeguarding.
- The records systems across community services did not support patient safety.
- Care and treatment did not reflect current evidence based practice in all services.
- Staff did not regularly monitor patient outcomes and some services did not participate in national data collection schemes. Outcomes for stroke patients were poor.
- Some staff did not have appropriate competence and skills, particularly in medicine services. Many staff across services did not receive regular appraisal or appropriate supervision.
- Staff did not always seek patients' consent for treatment, observation or examination. Staff awareness of the Mental Health Act (2005) and the Deprivation of Liberty Safeguards was variable and it was not always applied.
- The trust did not plan or deliver services in a way that met people's needs.
- Patients' privacy and dignity was not protected in mental health services wards and acute service escalation beds. Staff did not always report incidents where mental health wards had people of both sexes sharing bathrooms, which is a breach of the regulations.
- Staff did not manage access and flow through services adequately. This led to delays in ambulance handovers and discharge from the emergency department. There were also multiple patient moves for non-clinical reasons across acute services, including end of life care patients and late evening or night time.
- Staff did not plan patient discharge effectively leading to extended length of stays across acute and mental health inpatients services. Staff did not make sure end of life care patients were not discharged in a responsive manner and most were not transferred to their preferred place of death.
- Partnership working between the trust and organisations such as the local authority and hospice was not always effective.
- The trust missed targets in referral to treatment times and cancelled operations.

# Summary of findings

- The trust needs to improve the collation, timeliness and quality of response to complaints, and put in place improved process for sharing the learning that comes from the complaints..
- There was some evidence of staff responding to patients' individual needs and the dementia passport worked well where it was used, but this was not consistent.
- The trust board was not effectively monitoring how the needs of vulnerable patients were being met.
- Staff treated people with dignity, respect and kindness during all interactions. They were compassionate and kind and showed empathy when caring for patients.
- The Mental Health Act Code of Practice was appropriately followed, although the trust was an outlier for second opinion appointed doctor (SOAD) requests, when there were treatment changes for service users.
- There is a systematic review and revision of hierarchical and bureaucratic processes, and clinical business unit leads are supported to work autonomously in the provision of high quality and sustainable and integrated services for patients.
- There are improvements to the collection and use of information to support the monitoring of quality and safety.
- Community records systems are fit for purpose, accessible to staff and support the delivery of safe services for patients.
- There are clear, uncomplicated governance arrangements that support monitoring of quality, safety and performance across all services.
- There are arrangements in place for identifying, assessing and managing risk at all levels and staff are appropriately trained in this.
- The board develops and embeds an effective assurance framework to identify and take early action on any concerns arising in any services.

We saw some areas of outstanding practice including:

- 'Post discharge medicines optimisation support to reduce readmission', known as MOTIVE, resulted in a statistically significant reduction in 30-day readmissions. For every two patients referred by the hospital to the community pharmacist, three admissions per year were prevented.

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

For details of actions for specific services please see the core service inspection reports

Importantly, the trust must ensure :

## Trust-wide

- That the leadership improves at all levels from board to service level.
- that there is an achievable strategic vision and staff are clear of their role and actively involved in delivery of meaningful plans to achieve this.
- Improvements are made to the equality and diversity programme within the trust, so as to ensure equality for all staff and patients.
- Improvements are made to partnership working with the local hospice and local authority, to facilitate effective access and timely flow along patient pathways.
- There is a clear procedure and full range of checks are undertaken prior to the appointment of both

# Summary of findings

executive and non-executive directors as set out in the fit and proper persons regulation of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvements are made to collation, timeliness and quality of response to complaints, and the learning arising from complaints.

On the basis of this inspection, and the overall rating of inadequate, I have recommended that the trust be placed into special measures.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Isle of Wight NHS Trust

The Isle of Wight NHS Trust is an integrated trust providing acute (61%), community (20%), mental health (14%), and ambulance (5%), services to the population of the Isle of Wight. It was established in April 2012, following the separation of the provider and commissioner functions.

The trust is a non foundation NHS trust. The turnover is around £170 million per year.

The Isle of Wight NHS Trust provides services to approximately 140,000 people on the Island, and employs around 2,700 staff. The main trust services are: St Mary's Hospital, a 246 bed general hospital, and Sevenacres unit, mental health beds, located on the same site in Newport. Community health and mental health services are provided across three localities with bases at St Mary's Hospital and clinics and health centres across the island. Woodlands, a mental health rehabilitation unit, is located in Ryde.

The Isle of Wight ranks among the 40% most deprived local authorities in England with 20% children living in poverty. There are worse than average rates for smoking, alcohol consumption and obesity. The life expectancy gap between the most and least deprived areas on the island are 5.4 years for men and 3.8 years for women. There is an increasing population of older people: currently 26% are aged over 65 years (17% England average) and 12% aged over 75 years (8% England average).

There have been some changes at trust board level since the last inspection. The trust chair started in August 2015, the chief operating officer was appointed to the substantive role in August 2015, having joined the trust in February 2015 as interim deputy chief operating officer. The Director of finance took on an additional role as director of human resources in 2015. A director of strategy was appointed in October 2016. The chief executive had been in post since 2012. The director of nursing and workforce was appointed in January 2013, but was on secondment at the time of inspection.

We carried out this focused announced inspection to follow up services that required improvement at our previous inspection in 2014. We also followed up concerns identified through ongoing monitoring of information about the trust. We undertook site visits 22-24 November 2016, and an additional inspection of mental health services 18-19 January 2017.

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

### Acute Services

- Accident and Emergency
- Medical care (including older people's care)
- End of life care

### Ambulance services

- Emergency and urgent care
- Emergency operations centre
- Patient transport services

### Community Health Services

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

### Mental Health Services

- Acute adult inpatient wards, psychiatric intensive care unit
- Community Mental Health Services for adults
- Rehabilitation / long stay wards
- Older Adults inpatient services
- Community Learning Disability Services
- Community Children and Adolescent Mental Health Services

Substance Misuse Services

# Summary of findings

## Our inspection team

Our inspection team was led by:

**Head of Hospital Inspections:** Joyce Frederick and Karen Bennett- Wilson, Head of Hospital Inspection, Care Quality Commission

The team included CQC managers, inspectors, assistant inspector, pharmacist specialist, Mental Health Act reviewers and a variety of specialists including: paediatric emergency nurse consultant, head of nursing emergency

department, divisional director of medicine, consultant geriatrician/stroke physician, palliative care consultant, medical nurses, assistant director child safeguarding, school nurse, health visitor, community services manager, district nurse team leader, occupational therapist, physiotherapist. A consultant psychiatrist, mental health nurses. An ambulance service manager, paramedic, call centre manager, director of nursing, and governance specialist.

## 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?

We used the findings of previous inspection plus ongoing monitoring information to decide which services to inspect

Prior to the inspection we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. This included clinical commissioning groups (CCG), NHS Improvement, and Healthwatch. During the inspection, we also spoke with the local Hospice.

We gave a week's notice of announced inspection of community health and mental health services and trust wide leadership. We carried out an unannounced responsive inspection of acute and mental health inpatient services and ambulance services.

We visited relevant wards and departments at the main site Newport as well as clinics and teams across the Island 22--24 November 2016, and an additional visit to mental health services 18-19 January 2017.

During the visits 22-24 November 2016 we spoke with a range of staff in the departments, wards and teams. These included: in acute services within the hospital, (nurses, support workers, doctors, therapists, consultants, administrative and clerical staff, pharmacists); in the ambulance service, (paramedics, support staff, drivers, call centre staff); in mental health services, (nurses, consultants, junior doctors, therapists, approved mental health practitioners); and in the community health services, (health visitors, school nurses, district nurses, therapists). We spoke with managers at various levels of the trust up to executive and non executive directors on the board. We also spoke with staff individually as requested, held staff drop-in sessions every day and invited them to share their views by email or online.

We talked with patients in the wards and departments, and reviewed comments left in boxes distributed around the hospital. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records 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 at Isle of Wight NHS Trust.

# Summary of findings

## What people who use the trust's services say

- The trust's Friends and Family Test performance was better than the overall England performance in nine of the 12 months between December 2015 and November 2016. In November 2016 trust performance was 95.9% compared to an overall England performance of 95.4%. Between March and September 2016 there was a downward trend in trust performance. This was followed by an improvement in October and November 2016. The response rate of 21.9% was similar to the overall England response rate of 24.2%.
- Results from the Community Mental Health Survey published November 2016 were very poor. The trust performed worse on the areas covering health and social care workers, (listening, time and understanding); organising care; agreeing and reviewing care, (including medicine review); support and well being; overall view of care and services; overall experience. The trust was one of the lowest performing trusts in the country.
- The CQC adult inpatient survey (2016) relates to responses from patients between August 2015 and January 2016. Results demonstrated that the trust had performed within expectations for 9 out of 10 areas of questioning, it performed worse for waiting list and planned admissions. The trust was worse than expected for the questions on information on condition or treatment; explanation of operation or procedure; advice after discharge.
- Healthwatch told us that patients living with dementia and their families had experienced lack of support in the emergency department and the wards. The trust was responding to this but it had taken time to put in place. They told us of concerns raised by patients' families and local care homes about unsafe discharge. Examples included late night discharges, poor or incorrect information to care homes before discharge and delays in discharge summaries to GPs.
- Healthwatch had received concerns about patients not receiving community mental health services and the 'crisis line' failing due to technical issues. Patients were concerned about the capacity of community nursing and lone working of staff at night. They were also aware paramedics in the ambulance service were under huge pressure and stressed.
- Healthwatch told us the majority of feedback from patients and families about the care from healthcare staff was highly positive. They were also positive that trust had recently set up a patient experience group and were trying to address issues but this did not always filter down to the wards and services.
- During the course of the inspection, we spoke with patients and families using services, in person and on the phone. We received comments from patients and the public through comment cards across all areas of the hospital. Patients told us they were treated with kindness and compassion. Most felt involved in decisions and their care and treatment plans, but this was limited in some mental health services. Patients described staff as going above and beyond that which was expected despite being so busy with constant staff shortages.
- Some carers were not satisfied with the lack of (ASD) and ADHD provision in children and adolescent mental health services (CAMHS). In older people mental health services people told us they wanted more activities to do.

# Summary of findings

## Our judgements about each of our five key questions

|  | Rating   |
|--|--|
| <p><b>Are services at this trust safe?</b></p> <p>Overall we rated the safety of the services at the trust as 'inadequate'. For specific information, please refer to the individual core service reports for Isle of Wight NHS Trust.</p> <p><b>We rated safe as inadequate because:</b></p> <ul style="list-style-type: none"><li>• Mental health wards were unsafe and the significant risks had not been identified or addressed. The ambulance station was not secure.</li><li>• All services had teams or wards that were significantly understaffed and this was affecting the safety of patient care. Some trust wide key posts were vacant and the trust employed large numbers of locum medical staff</li><li>• There was inadequate risk assessment or monitoring or managing of risks to patients.</li><li>• Key groups of staff were not up to date with safeguarding training. Staff did not always identify or report safeguarding incidents. Safeguarding and 'looked after children' teams were stretched and there were not sufficient monitoring of adult safeguarding.</li><li>• The records systems in community services did not support patient safety.</li><li>• Staff did not consistently report incidents, there were delays in investigation and staff did not always get feedback or see learning and change arising from incident reporting.</li><li>• Staff were not all aware of the principles of Duty of Candour, and this was not always followed correctly when invoked.</li></ul> <p><b>Environment</b></p> <ul style="list-style-type: none"><li>• We had serious concerns regarding the environment and maintenance of the environment across mental health inpatient wards. For example: unsafe gardens littered with rubbish, poor lines of sight, and patients with access to electrical cupboards, live broken electrical sockets, continually failing personal alarm systems and broken beds. There were un-mitigated ligature points across mental health inpatient service. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The work undertaken by the trust did not identify the majority of ligatures on the wards, and where identified were not mitigated. Staff working on the wards had not been made aware of these risks to patients.</li></ul> | <p><b>Inadequate</b> </p> |

# Summary of findings

- The older people's wards across the trust did not provide appropriate environments for caring for patients with dementia. The trust set up Shackleton dementia ward as a temporary location. The trust had no plans in place during the inspection to move or upgrade the environment for dementia patients. The seclusion room on Shackleton ward (older people's dementia) was unsafe. Dementia patients were being secluded overnight despite the room failing to meet several strict national standards including no two way communication, no toilet facilities, poor visibility and suitable bed. The Seagrove ward seclusion room did not allow free access to toilets and showers for patients.
- The majority of bathrooms across mental health inpatient wards were 'Jack and Jill' in design; patients shared a bathroom accessing from either bedroom. The locking system on these had failed which allowed patients' access to each other's rooms via the bathroom. It also relied on very unwell patients remembering to close two bathroom locks for privacy. The trust were aware that the bathrooms no longer worked. However, the trust board were not aware of the same sex breaches on Shackleton ward where male and female patients shared a bathroom.
- The environments of escalation areas within the acute hospital were not safe. Patients were accommodated in the day surgery unit or discharge lounge which did not provide for safe storage of medicines.

## Duty of Candour

- There was a process in place but it was not fully embedded. The quality administration team had a good understanding of duty of candour, but was not shared by all middle and senior managers or frontline staff.
- Duty of candour training was not mandated for all staff and there was limited awareness amongst front line staff regarding the principles of being open and transparent when mistakes are made.
- There was a requirement within the electronic incident reporting to complete that duty of candour had been addressed. There was evidence of letters summarising conversations between the trust and the patient or relatives, although in some cases whilst an apology was offered the regulation was not fully applied.

## Safeguarding

# Summary of findings

- The acting director of nursing had responsibility for safeguarding across the trust and recognised further work was needed to join up safeguarding across the organisation. There were adult and children's safeguarding policies in place
- The adult safeguarding lead was appointed December 2015 they attended multi-agency meetings on the island but did not attend the safeguarding adults board with the acting director of nursing. They had not received safeguarding supervision since starting in post. A safeguarding practitioner was due to commence in January 2017 and there were plans for administrator support. Clinical business units had safeguarding leads.
- There was a safeguarding children's team which was carrying a vacancy and had demanding workload, particular with the number of reviews required from the safeguarding team (MASH). The team also provided training and children's safeguarding supervision. The trust and CCG were to undertake a joint review of the safeguarding children team. The trust had recently appointed a 'looked after children' (LAC) nurse, as recognised a risk area, however they had a large caseload, more than double the national average. There was a high 'did not attend' (DNA) rate for looked after children which was a concern, but no actions to address.
- There was newly formed and developing joint safeguarding steering group, attended by heads of nursing and some function leads. A safeguarding training strategy was agreed at joint safeguarding steering group, and clinical business units were asked need to release staff for training.
- The trust had a 100% target for staff for mandatory Adult safeguarding level 1 with 83% compliance by October 2016. Level 2 training was provided for front line staff with no target, and level 3 training was for safeguarding professionals only and there was no target. Children's safeguarding training compliance across the trust at time of inspection was 87% level 1, (100% target) 62% level 2 and just 63% level 3 across the trust. There was variability across teams child safeguarding training was just 45% for the medical staff in ED.
- We found there was a significant amount of work to be undertaken in the trust to reinforce and require staff to consistently fulfil their roles and responsibilities in relation to safeguarding adults. There was no assurance that all safeguarding cases were identified, and not all safeguard events were reported properly.
- Mental health ward staff had not reported some safeguarding incidents to the local safeguarding team. This included patient on patient assaults, and not all staff were aware of their

# Summary of findings

responsibility to report this type of incident. The wards held no local record of ongoing safeguarding concerns, once a safeguarding alert and could not advise on the outcome of any alerts made. There was poor communication of safeguarding concerns when patients were transferred between services. Following the inspection we were advised that there had been changes to the trust safeguarding procedures and now all safeguarding alerts went to the trust safeguarding lead.

- The trust had not yet established an adults safeguarding data set; the CCG was supporting them to do this. There was no analysis of themes or trends and the safeguarding lead did not scrutinise incident reports. They did not see reports unless the safeguarding box was ticked, and were not sure that staff knew to submit safeguarding as incidents.
- The CCG reported a relatively low number of applications for Deprivation of Liberty Safeguards (DoLS). The trust had stated that it intends to identify DoLS champions in clinical areas, with the first meeting planned for January 2017.

## Incidents

- Although staff were encouraged to report incidents and received initial feedback via the electronic reporting system. There were ongoing barriers to reporting. We heard of instances where staff did not 'see the point' as they were not confident that it would make any difference. Staff on the older persons' mental health wards were not always reporting incidents in line with trust policy, it was recognised practice to 'bundle' or not report incidents of aggression and violence on older people wards.
- Following external review improvements had been made to investigation and management of serious incidents requiring investigation (SIRIs). However there continued to be two routes for the processing of incidents via the quality assurance lead (reported to the deputy director of quality) and via the risk management facilitator.
- The trust acknowledged that although processes were in place, the management of incidents and SIRIs was not completely embedded in practise across all areas within the trust
- The timely management of reported incidents has historically been a challenge. There were currently 400 open or overdue non SIRI incidents. The trust recently worked with the CCG to close all overdue SIRIs within the 60 day timeframe and this had significantly improved.

# Summary of findings

- There were various mechanisms for cascading learning including a quarterly newsletter sent out via the intranet. A learning lessons log identifying themes, lessons and what went well is shared quarterly on the SIRC page of the intranet.
- The trust was failing to meet targets for reduction of pressure ulcers in the community and acute services. There had been progress in reducing avoidable grade 3 and 4 pressure ulcers in the community through the use of cluster reviews but similar improvement had not been achieved in the acute hospital with an increase in grade 4 reported.
- There was inconsistent evidence of learning from incidents across several services for example in community childrens' mental health and older persons' wards.

## Staffing

- Following inspection in 2014, we told the trust to take action to address staffing levels across services and to review the caseloads in community mental health teams. We found continued serious staffing risks during this inspection. The trust acknowledged that staffing metrics were acute focused and need to develop mental health KPIs to identify hotspots.
- Staffing shortages in community mental health had a significant impact on the quality and continuity of care offered to patients. There were also major staffing concerns across several inpatient mental health wards. The trust had previously carried out a 'safer staffing' initiative, but this had not always resulted in extra staff for a wards 'staffing establishment'. We requested further information on the 'staffing initiative' but were not provided with the information. being recognised.
- The trust had stopped admission to Woodlands ward due to staffing shortages, through sickness and vacancies, and a reduction in the bed numbers down from 11 to eight. Staff reported that the staffing levels had caused a lot of stress and they were unable to facilitate patients' leave due to a lack of staff and felt this was restrictive to the patients.
- Many medical posts were covered by locums and both consultant and junior doctor staffing was insufficient in emergency department and across medical services. There was one part time geriatrician employed at the trust.
- Staffing shortages in ambulance services were affecting staff morale and the service ability to provide a safe service and meet response times.

# Summary of findings

- An acuity tool had been developed but community staffing was not reported to the board and we found shortages in teams and cancelled visits. An acuity tool is used to inform how many staff are required on duty to provide safe care to patients, and to ensure patients' needs are met.
- Senior management teams reported more confidence in nursing staffing in acute services than a year ago. However covering sickness, either long or short term was a challenge for all the ward managers. We found that shortages of appropriately qualified and competent staff, in the emergency department and acute medicine services, were impacting on patient care.
- There was insufficient assurance that staff had completed their mandatory training as the trust did not provide meaningful data.

## Assessing and responding to risk

- We found that patients did not always have risk assessments in place. For example we found across adult community mental health team (CMHT) and community children's' mental health teams did not have assessments in place. Only three of the twelve file reviewed in CMHT had risk assessments and there were no crisis plans in place. When assessments were in place the quality varied across the mental health services and was not always reflective of patients' risks or up to date. There were several different assessment styles in use including paper and electronic versions.
- Many mental health front line staff had not received or were out of date with essential physical intervention training.
- Not all patients on end of life care had an individualised care plan and so risks were not assessed and planned for.
- All staff we spoke with understood the 'The Sepsis Six Resuscitation bundle' and the procedures associated with it. During our inspection of the emergency department we saw that medical staff did not always follow or document the full protocol. We saw two records where patients on this care pathway did not have the "must complete" information filled in.
- We reviewed records for paediatric patients in the emergency department. The paediatric early warning score and sepsis pathway was not recorded for all children.
- In St Mary's Hospital, emergency department data for the months of April to November 2016 showed that almost 53% of handovers took longer than 15 minutes.

## Records

# Summary of findings

- The electronic care records system used in the community services was not fit for purpose and there were concerns with lack of guidance in relation to how staff should complete the records.
- The trust's mixed formats of paper and electronic records created a risk of children safeguarding information being missed. Firewalls on electronic systems prevented staff from accessing records, for example a health visitor visiting a family could not easily see records of over 5 year olds. The CAMHS electronic care records system did not highlight young people who were subject to a child protection plan to alert staff and safeguarding referrals were not clearly recorded.
- The mobile data terminal used to provide ambulance staff with patient information and navigation was unreliable; the system sometimes froze. We raised this as a concern at our inspection two years ago. Although there were plans to upgrade the system, there had been no progress on this since February 2015.

## Infection control

- There was a small infection control team who were mainly focussed on acute services with no capacity to cover community teams. The trust had been unable to appoint a consultant nurse to lead the team so had recently appointed a nurse manager into a development role, they would be supported through 'on the job' infection control training and qualifications. For a considerable period just prior to the inspection, there was one microbiologist working at the trust. For five weeks there was only an on call telephone service from a mainland NHS hospital. The CCG issued a contract query letter and a locum microbiologist was then employed.
- There were no reported cases of MRSA infection and cases of clostridium difficile reduced from the previous year. Incidents of norovirus were well managed through cohorting patients on wards. The services and trust board did not have sufficient information and assurance of information in relation to surgical site infections. We found lapses in infection control practice in some services.

## Are services at this trust effective?

Overall we rated the effectiveness of the services at the trust as 'requires improvement'. For specific information, please refer to the individual core service reports for Isle of Wight NHS Trust.

## We rated effective as requires improvement because:

**Requires improvement**



# Summary of findings

- Care and treatment did not reflect current evidence based practice in all services, particularly mental health.
- The outcomes for people using services was not monitored regularly in many services. Mental health and end of life care services did not participate in national data collection schemes.
- Some staff did not have appropriate competence and skills, particularly in medicine services.
- Staff did not receive appropriate supervision and appraisal rates were lower, in some services.
- There was insufficient psychological therapy in mental health services.
- Many services did not run 7 days a week.
- Patients' consent for treatment, observation or examination was not always sought by staff. Staff awareness of the Mental Health Act (2005) and the Deprivation of Liberty Safeguards was variable and it was not always applied.

However:

- There were some good examples of multi-disciplinary working in services across the trust, but no multi-disciplinary meetings across community services for adults.

## **Evidence based care and treatment**

- National Institute for Health and Care Excellence (NICE) standards were assessed in the emergency department and medicine services but it was not clear this extended to all services. Mental health ward managers did not undertake audits and it was not evidenced how models of care were assessed to ensure that they were NICE compliant. Rapid tranquilisation of patients was not in line with national guidance and legislation.
- Several mental health services were not able to offer or provide a range of appropriate psychological therapies as recommended by the NICE.
- Care did not consistently take account of evidence based practice and guidance priorities of care plans were not routinely completed for patients nearing the end of their life.
- There was an absence of clear, clinical and evidence based pathways with effective outcome measures particularly in community mental health services
- Mental health patient care plans across services were incomplete and on occasion missing. Care plans were not patient centred, personalised, holistic or goal orientated.

## **Patient outcomes**

# Summary of findings

- There were generally positive outcomes in national audits for acute medicine services, but improvement was needed in outcomes for patients using stroke services. Measurement of outcomes through clinical audits in other services was more limited, and in some areas completely lacking.
- Ambulance response times were consistently below expected target. Patient outcomes were not as expected for patients suffering a heart attack, but survival was better than the England average.
- In children's services, not all looked after children (60%) had a full assessment of their emotional needs. Only 20% of looked after children received an assessment taking into consideration additional health needs such as emotional or behavioural problems.
- The hospital standardised mortality ratio ) was as expected and standardised hospital mortality indicators was lower than expected overall and similar to expected at weekends. Mortality and morbidity meetings were chaired by the medical director.
- Stroke services were working on an action plan to improve outcomes for patients, as measured by the sentinel stroke national audit programme.
- Length of stay in acute and mental health services was longer than expected when compared nationally. Discharge planning was not consistent or timely.
- There was a lack of consistent good quality information for services to benchmark outcomes. The trust did not contribute data to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services, collected by the National Council for Palliative Care on an annual basis, to provide an overview of specialist palliative care service activity.
- The trust was not collecting information required as set out in the mental health minimum data set (MHMDS). The MHSDS is a patient level, output based data set which delivers nationally consistent and comparable person-based information for children, young people and adults who are in contact with mental health services.

## Competent staff

- There were lower rates of staff appraisal across some services, and some staff were not receiving appropriate supervision.
- Not all staff had the skills and knowledge required to undertake their role. Nursing staff in acute medicine services did not have key competencies to care for patients.

## Multidisciplinary working

# Summary of findings

- There was effective multidisciplinary working with staff working together to provide patient care in a coordinated way.
- The trust was not providing services seven days a week. For example therapy staff did not work seven days a week so stroke patients were not always able to have specialist assessments within 72 hours. Out of hours specialist palliative care support was only available by phone.
- The multi-agency hub was used effectively to co-ordinate care with other agencies when patients were discharged at the scene as they did not need to attend hospital. There was generally access to support from other teams at the hospital for the physical health and palliative care needs of patients in older people mental health wards. Information was not always provided to the patient's GP in a timely manner. There was a delay in providing discharge letters.

## Mental Health Act

- The Mental Health Act had a compliance mandatory training rate of 89%. There was no evidence that the training had been adjusted to reflect the updated code of practice. We requested further information that was not received.

## Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Patients' consent for treatment, observation or examination was not always sought by staff. When people lacked mental capacity to make decisions, not all staff understood their responsibilities around making best interest decisions. Staff awareness of the Mental Health Act (2005) and the Deprivation of Liberty Safeguards was variable and it was not always applied.
- Mental capacity assessment was always not documented in the DNACPR form, in line with national guidelines. Decisions were not always discussed with patients and/ or their families.
- Data was requested as to the number of staff who had completed training on the Mental Capacity Act but this was not provided.

## Are services at this trust caring?

Overall we found services at the trust were caring and rated this as 'good'. For specific information, please refer to the individual core service reports for Isle of Wight NHS Trust.

### We rated caring as Good because:

- Patients and service users received compassionate care, and we saw that patients were treated with dignity and respect.

# Summary of findings

- Patients, service users and relatives we spoke with said they felt involved in decisions taken about their care, and they received good emotional support from staff.
- Most surveys of patients and people who use the services and friends and families were overall similar to or better than other trusts.

However:

- Community mental health patients were not always fully involved in the planning of their own care. Results from the Community Mental Health Survey published November 2016 were very poor, particularly on the areas relating to health and social care workers.

## **Compassionate care**

- Overall, we observed that staff were kind and compassionate, putting the patient at the centre of care. Patients and their relatives were positive about the caring attitude of staff, their kindness and their compassion. Mental health patients were very complimentary about the staff and their attitudes towards them.
- Patients described staff as going above and beyond that which was expected despite being so busy with staff shortages.
- The trust's Friends and Family Test performance (% recommended) was better than the overall England performance in nine of the 12 months between December 2015 and November 2016. Between March and September 2016 there was a downward trend in trust performance. This was followed by an improvement in October and November 2016. The response rate of 21.9% was similar to the overall England response rate of 24.2%.
- Results from the Community Mental Health Survey published November 2016 were very poor. The trust performed worse on the areas relating to health and social care workers, (listening, time and understanding).
- Data from CQC national surveys for acute inpatients (2016) was similar to other trusts. Patients were satisfied and would recommend the care they had received. The trust was worse than expected for the questions on 'information on condition or treatment; explanation of operation or procedure; advice after discharge'.
- Dignity and respect for patients was maintained at all times during treatment or examination. The trust's 'patient-led assessment of the care environment' (PLACE) audit score for privacy and dignity was 86.7%, the national average of 83.5%.

# Summary of findings

- The trust's quarterly bereavement survey results October 2016 and July 2016 showed approximately 78% of respondents agreed with the statement 'Was their relative/friend treated with dignity and respect'.
- Staff did not take care to ensure privacy and dignity or compassionate care for end of life care patients, and their families and friends when they were moved out of side rooms.

## **Understanding and involvement of patients and those close to them**

- Patients in the majority said they felt involved in their treatment, understood their treatment plans and were able to make their own decisions. Patients said they had been given personalised support, adapted to their ability to take on complex or emotional information.
- Mental health patients told us that they were consulted on care planning with their comments and wishes being taken on board as far as practical. However, the planning rarely followed the care plan format and only one that we spoke with had received a copy of their care plan.

## **Emotional support**

- Patients and their families were supported by staff to reduce anxiety and concern. They felt involved in the decision-making process and had been given clear information about treatment options: they then felt enabled to ask questions of senior medical and nursing staff and be supported to make the decision that was right for them or for their loved one.
- The multi-faith chaplaincy service was available to provide emotional and spiritual support if requested.
- Data from CQC national surveys for acute inpatients (2016) showed a slight reduction in scores (from 7.5 to 7.0) for emotional support from hospital staff.
- There was insufficient psychological therapy in mental health services.

## **Are services at this trust responsive?**

Overall we rated the responsiveness of the services at the trust as 'inadequate'. For specific information, please refer to the individual core service reports for Isle of Wight NHS Trust.

## **We rated responsive as inadequate because:**

- Overall services were not planned or delivered in a way which met people's needs.

**Inadequate**



# Summary of findings

- The wards in mental health services, and acute service escalation beds did not ensure patient privacy and dignity. There were unreported mixed sex breaches.
- There were very high numbers of delayed transfers from inpatient services.
- The access and flow through services was not managed adequately. This led to delays in ambulance handovers and discharge from emergency department.
- There were multiple patient moves for non clinical reasons across acute services, including end of life care patients. There were an unacceptable number of patient moves late evening and night time.
- There were extended length of stay across acute and mental health inpatient services, discharge planning was not timely or effective.
- The processes to facilitate rapid discharge of end of life care patients were not responsive. Most patients receiving end of life care were not transferred to their preferred place of death.
- Partnership working between the trust and organisations such as the local authority and hospice was not always effective.
- There were increasing delays and missed targets in referral to treatment times and cancelled operations.
- Improvement was needed in the collation, timeliness and quality of response to complaints, and the learning arising.
- There was some evidence of staff responding to patient's individual needs and the dementia passport worked well where it was used, but this was not consistent.
- The trust board was not effectively monitoring how the needs of vulnerable patients were being met.

## **Service planning and delivery to meet the needs of local people**

- The trust had an operating plan 2016/17, which described the strategic aims and challenges to delivery of sustainable in the local and national context. This mentioned the internal and cultural barriers within the trust, the importance of relationships with commissioners, and the need to do more for less and 'off load' unsustainable services. There was reference to clinical business unit improvement plans but these were not strategic.
- The trust was expecting that new models of care partnerships would support the trust in being able to meet the needs of local people. Although some of this work had progressed we did not see clear evidence of the working continuing at a pace. There was no evidence of working with the local authority or CCG to reduce the impact of delayed transfers.

# Summary of findings

- It was clear that some executives did not expect the trust to be delivering mental health services in the future and the CCG was reducing funding. However, there had been a neglect of planning for delivery of safe and responsive service to meet the needs of local people.
- The trust was not planning or delivering community mental health services in line with the needs of the population. The trust was unable to describe the demands and capacity of the service, and the impact on patient referrals into, and discharges out of, the service.
- The limited availability of specialised dementia places on the island was affecting the care ward staff were able to provide. The seven beds on Shackleton were generally occupied long-term by patients who remained there until their end of life. As a result of beds on Shackleton being continually occupied, dementia patients were being increasingly admitted on to Afton ward. This was causing difficulties with the patient mix, leading to unrest among patients.
- There were some serious concerns about privacy and dignity on acute and older people mental health wards. For example on Shackleton ward, no curtains, blinds or other appropriate coverings on six of the seven patient bedrooms. There were also no coverings on the windows of the female lounge or seclusion room.
- Male and female patients were accommodated in unsuitable and mixed sex accommodation in temporary escalation areas such as the surgical day unit and the discharge lounge. The breaches of the single sex accommodation requirement, across acute and mental health services were not always recognised or reported.
- Access to the Arthur Webster clinic for patients with learning difficulties was difficult for service users in wheelchairs due to a large heavy door.
- There was no provision or service beyond diagnosis for patients with attention deficit hyperactivity disorder and autism provided by the trust; for example they do not get any psychology input. There was no cover for CAMHS out of hours in the evening and over the weekend; children were admitted to the paediatric ward awaiting assessment.
- The partnership working and relationships between the trust and the hospice were not as integrated as they could be and this affected the planning of end of life care.
- The CEO was a member of the island wide systems resilience group, working with partners on the island towards acute hospital avoidance and improving access and flow through the emergency department (ED).

# Summary of findings

- The trust was using the NHS England 'A&E rapid implementation guidance for local systems' to develop project plans, for example to improve patient flow through the hospital. We found there had been little progress with implementation.

## Meeting people's individual needs

- The wards for older persons' with mental health were not appropriate for promoting the recovery, comfort and dignity of patients. The wards did not take into account the needs of dementia patients; for example lack of space to move around, limited lounge space and access to outside space via a lift situated off the ward and through the hospitals main corridor.
- The trust had a learning disability liaison nurse who supported staff and patients in the emergency department and across the wards. It was not clear that knowledge and understanding was embedded across all staff. We heard of instances where patients with a learning disability were inappropriately referred to the learning disability services from the emergency department when they had physical health needs.
- There was no evidence of the trust monitoring and reporting to the board in relation to meeting the needs of patients with a learning disability.
- Woodlands ward, a rehabilitation ward to support patients' return to the community had a number of restrictive practices in place. There were signs up in the kitchen telling patients what times they could and could not access food. This included cut off times for breakfast, lunch and dinner. However staff said that they would not stop someone from eating and that patients were allowed to access drinks and snacks at any time of the day. One patient reported that staff were inconsistent in enforcing this rule.
- Ambulance staff took the individual needs of people accessing the service into account when providing care and treatment, making adjustments where they could. Staff could access specialist equipment, such as for transporting obese patients. However, staff had not completed specific training on supporting patients experiencing a mental health crisis.

## Dementia

- Dementia care was a quality improvement priority for the trust. A dementia friends patient passport had recently been introduced which allowed families to visit and support patients outside visiting times. Healthwatch told us that families experience was that this was not filtering down to the wards.

# Summary of findings

- Clinical business units were asked to report on actions taken to improve; this was variable in terms of staff training and dementia friends and use of the dementia passport.

## Access and flow

- The trust was managing a high number of emergency admissions and demand for services. There has been limited work on acute admission avoidance. Attendance at the emergency department had reduced by over 20% but there was an increase in admissions with more serious conditions. Within the emergency department 8% of admissions were found to be unnecessary.
- Delays in handover at the emergency department and the service running at maximum capacity meant people could not always access the ambulance service in a timely way. The trust response times were consistently below the expected target and patient outcomes were not as expected for patients suffering a heart attack.
- Between August 2015 and July 2016 the monthly percentage of patients waiting between four and 12 hours from the decision to admit until admission for this trust was consistently worse than the England average. Over the same 12 months, 32 patients waited more than 12 hours from the decision to admit until being admitted.
- The hospital was on red alert working beyond capacity with several escalation areas including the surgical day unit, which affected the running of surgical lists. Daily situation reports report for 22 November identified 10 patients to be moved to day surgery unit overnight. We also found patients accommodated in the discharge lounge overnight.
- Daily bed management meetings were developing but the trust was finding it challenging to get clinicians involved. CBUs and clinical teams did not have ownership of patient flow, it was seen as an external problem across the health and social care economy
- The ambulatory emergency care unit, developed to support reduction in admissions, was not 'ring fenced' and was used as inpatient beds.
- There was a backlog on referral to treatment cancer targets achieved but there was variation over previous months and 31 day wait diagnosis to treatment had decreased recently.
- Cancelled operations for the quarter to September 2016 was 2.2% statistically worse than other trusts in England cancelled operations not receiving treatment within 28 days was 1.4%.

# Summary of findings

- There were extended length of stay across acute and mental health inpatient services; discharge planning was not timely or effective.
- At the time of inspection 64 out of 256 patients in the acute hospital were delayed transfers of care. The chief executive told us there had been occasions when up to 30% of beds were delayed transfers. There were also significant numbers of delayed transfers on the older people mental health wards. The seven beds on Shackleton ward used as long stay led to inappropriate admission to functional mental health ward.
- Access to community mental health services was restricted and beds were closed on Woodlands ward.
- Mental health staff told us there was an issue with inappropriate referrals to mental health beds from emergency department and other wards in acute services.
- CAMHS provided psychiatry 9-5pm, Monday to Friday only. There were examples of children waiting in the acute hospital for an assessment on a Monday.
- There was a policy to limit bed moves for non-clinical reasons but it was not being implemented and we found examples of multiple patient moves for non-clinical reasons, including end of life care patients. The information systems did not allow for easy data collection of non-clinical moves; this depended on a manager manually accessing patient records.
- The trust data for bed moves between April and November 2016 highlighted that 958 patients were moved between the hours of 10pm and 7am. Trust data showed 379 patients were moved three times and one patient moved 11 times.
- There processes to facilitate rapid discharge of end of life care patients were not responsive, and staff were not trained to use the rapid discharge forms. The trust was not monitoring the number of end of life patients who were discharged with fast track rapid discharge in place.
- Most patients receiving end of life care were not transferred to their preferred place of death.

## Learning from complaints and concerns

- There have been longstanding concerns within the trust about the timeliness and quality of complaint handling.
- Staff in clinical business units (CBUs), to whom complaints were assigned, may not have had complaint handling training (but may have had serious incident requiring investigation training) nor was any check made to see if they have the capacity to carry out complaint investigations. The result was investigations lacked rigour and pace.

# Summary of findings

- The recording, monitoring and learning from complaints was inconsistently managed. We found in some areas, community learning disability services and rehabilitation there was no record of complaints made to the service.
- The processes do not support timely responses to complaints. Inexperienced staff in complaints handling did not always direct to the correct service, they were not assertive in following up overdue responses, no deadlines are set or escalation if response not received. There was evidence of failure to pursue root cause
- A high percentage of draft response letters were returned for rework (approximately 40%). The CEO, who signs all letters, also returns a percentage of those, which the patient experience team approves. There were considerable unexplained delays in the cases we reviewed.
- The Board performance report contains little of the detail about complaints: it does not include percentage upheld; the number of return complainants; timeliness of responses; number of current PHSO cases. This is surprising given that timeliness of responses and learning from complaints have regularly been raised as issues at the Board by the Chair of the Quality Governance Committee, which does receive a monthly report with some of the missing metrics above.
- There are no processes for tracking the implementation of recommendations or actions arising from the complaint investigation, or to assess whether actions have been effective. Despite this being a regular concern escalated to the Board there does not appear to be an internal audit planned to provide assurance one way or another
- Despite recognition of concerns in management of complaints there was not an action plan for improvement.

## Are services at this trust well-led?

Overall we rated the leadership of the services at the trust as 'inadequate'. For specific information, please refer to the individual core service reports for Isle of Wight NHS Trust.

### We rated well-led as inadequate because

- Leaders, at senior and executive level, did not always have the necessary experience, knowledge, capacity, or capability to lead effectively. There was no representation or leadership of mental health services at board level.

Inadequate



# Summary of findings

- There was an overreliance on external reviews to solve problems and a lack of understanding of the issues and how to make sustained and lasting improvements. There were delays in decision making and action.
- The operational structure of clinical business units was not fully implemented and was not effective. Clinical business units were not working sufficiently autonomously. Hierarchical and bureaucratic processes were persistent and costly in terms of time and resource.
- The trust leadership had a vision but there was not sufficient action for maximising integration, across the range of services provided. There was not sufficient clarity about how aspirational strategic plans would be delivered in the light of significant challenges.
- The governance arrangements were complicated and not effective to monitor quality and identify risk. The board did not work within an effective assurance framework.
- Risk identification and management was not sufficiently developed across the trust and some significant issues were not identified and appropriately managed. The board was not aware of the quality and safety issues and risks across services.
- There was not a properly resourced and prioritised programme of risk training. There was no risk management action plan.
- Staff morale was low and they were not supported to lead and innovate and drive change. Action was not taken when issues were raised and performance management was not efficient. There was evidence of a hierarchical culture, resistant to change and risk averse. There was insufficient focus on organisational development and improving the trust culture.
- The trust was not ensuring the equality and diversity agenda was delivered.
- The trust was not fully compliant with the requirements of the Fit and Proper Persons Requirement regulation, particularly for non executive directors
- There was insufficient strategic or transformational innovation to improve the quality and sustainability of services.
- The sustainable delivery of quality care was at risk due to financial challenges and reliance on non recurring cost improvement programmes.

However:

- There were pockets of innovation, for example in trust wide pharmacy services.
- There was engagement with people who use services.

## Leadership of the trust

# Summary of findings

- The trust was relatively small in size compared to other acute hospital or combined trusts. However, the services were those necessary for an island population and so the complexity and breadth of services required high calibre and competent leadership to ensure quality and safe care across the trust.
- We found that the senior leadership did not have sufficient capability or capacity to support and move the organisation at a necessary pace, and to ensure quality and safety of services. This was particularly evident for mental health services, but also across the trust.
- There had been changes at trust board level since the last inspection. The chief executive had been in post since July 2012, and the medical director since September 2012. The director of nursing and quality was appointed in January 2013, but was on secondment at the time of inspection and the deputy was acting up to director of nursing and quality role.
- The trust chair started in August 2015, the chief operating officer was appointed to the substantive role in August 2015, having joined the trust in February 2015 as interim deputy chief operating officer. The director of finance, in post since 2007 and took on additional role as director of human resources (HR) training, education and development in 2015. There was no evidence that the board had assessed the capacity or expertise of the director of finance to take on the HR role. Staff raised concerns to us about combining the director of finance and HR role. They felt that this was a barrier to the organisational development and culture change that was needed, some perceived it as a sign the trust did not value staff sufficiently. The trust had undertaken an external review, which had noted a board level HR lead was needed.
- There was no executive director with mental health service expertise on the board. This, along with poor representation of community and ambulance services at board level was highlighted at the previous inspection. Nobody from the community, mental health or ambulance service was represented in the medical director's close team, and there was no representation from mental health services in the quality team. This was of significant concern given the level of safety and quality concerns in mental health services and the lack of board awareness.
- Several staff including senior staff and non executive directors described the executive team as needing to work more cohesively and strategically in their leadership of the trust.

# Summary of findings

Senior leadership and culture was cited as the biggest risk and obstacle to change to the organisation. The CEO recognised the organisation needed to move faster but there was resistance created by executives working in silos.

- Although committed to making improvements to leadership the trust relied heavily on external reviews, some senior staff suggested it was 'almost like they do not trust staff to know the answers'. They described a slow and 'tick box' approach to implementing recommendations, which suggested that the leadership did not understand the issues and so missed the point.
- The trust had six non executive directors (NEDs), including one senior independent director, and two associate NEDs. Two new non executive directors, one with financial experience and the other with marketing and organisational development experience, were expected to broaden the expertise and skills of the board. The NEDs were limited to two year terms of office; vacancies for two more NEDs were imminent as existing tenures came to an end.
- There was evidence of insufficient challenge of executive team by the board. NEDs we spoke with reflected that the board had failed to challenge sufficiently. For example, there was an acknowledgement that despite being unhappy with the cost improvement programmes the Board approved them nevertheless. It looks increasingly that the trust will not deliver the necessary level of savings, so incurring further financial disadvantage (loss of a significant percentage of STP funds). This is a failure of senior strategic leadership which will have further potential adverse consequences for the trust finances and their ability to deliver quality services.
- Some NEDs were being drawn into operational detail when it was urgently needed at strategic level. For example, the chair of the quality governance committee's increased involvement in addressing poor quality in complaints handling.
- Staff across services were frustrated that it appeared no one was making decisions, or when decisions were made that the relevant staff were not consulted or listened to, and were sometimes overruled. Some described constant and confusing changes of managerial direction.
- The Board Assurance Framework included a risk around the capability and capacity of the board. This was added by the NEDs and a lot of the issues related to executive team leadership.
- In November 2015, the trust changed the organisational structure for operational services from two large directorates to five clinical business units structure with triumvirate of leads;

# Summary of findings

clinical director, head of operations, and head of nursing and quality. The aim was to improve clinical leadership and accessibility to the board. The implementation of the new structure was very slow and at the time of the inspection, some CBUs were still at the very early stages of development and leadership. The medicine CBU clinical director and head of operations were recently appointed. The mental health CBU had one healthcare professional covering the clinical director and head of operations posts.

- The trust board were generally in agreement in the change in structure to CBUs. However, the trust had not continued to evaluate and assess the success of the restructuring.
- There were no accountability frameworks with the clinical business units (CBUs) and the operating framework was being developed. There was not yet a clear leadership training framework for the CBU structure; focused work had started, including meeting with CBU leads and providing support. A training needs analysis was still to be completed. There were numerous clinical silos, which were not clinically or administratively integrated.
- Some CBUs covered a diverse range of services and -leaders did not fully understand all the services and risks, or could support integration across primary and secondary care. For example, community services for children (health visiting and school nursing) were within the Ambulance, Urgent Care, and Community CBU. We found there had been insufficient leadership to resolve the on going tension between ED and paediatric unit and so safety concerns for children attending ED persisted. We found differences in capability in local leadership within services for example across community mental health services.
- The surgical CBU was more developed and was embedding clinical leadership, however the team was struggling to get sufficient devolved autonomy from the executive leadership team. We heard decisions had to be signed off in triplicate as nobody agrees.
- A trust wide management development programme had been introduced for first time leaders, it was open to all who had not received previous training, this was not mandatory. There had been considerable work with partners to develop leadership behaviours and associated training. The integrated leadership programme was not due to be introduced until next year.
- In September 2016 NHS Improvement opened an investigation into the trust's strategic leadership, governance and delivery arrangements. This was triggered by concerns relating to persistent poor operational delivery against access standards,

# Summary of findings

poor record of delivering financial plans, slow pace of addressing quality issues and lack of systematic embedded approach to quality improvement and lack of urgency in translating strategic principles into a strategic delivery plan. The investigation found four key areas where rapid improvement was required including addressing weakness in trust leadership and the establishment and effective operationalisation of CBUs.

- The Chair, the CEO and NEDs we spoke with recognised the need for board and CBU development. However, there were no clear plans identifying what was needed and expected outcomes.
- The NHS Staff Survey 2016 identified the trust was similar compared to other trusts for staff reporting good communication between senior management and staff, however this was not consistent across all services. In acute services, the CEO was identified as a visible and communicating with staff and a range of communication mechanisms and newsletters, such as CEO's 'Friday Flame' were well established. However staff from other services told us they rarely saw the executive team.

## Vision and strategy

- The trust encompassed its vision in the strapline, 'quality care for everyone, every time'. Staff throughout the organisation were aware of the trust vision, goals, and quality priorities, diagrammatically presented visually as a 'Quality House'. However some staff groups expressed concern they had not been involved in the development of the trust wide quality priorities.
- The trust has been engaged for some considerable time seeking to determine and deliver a coherent strategy. A written strategy - 2016-2021 Working 'Beyond Boundaries' - to be the preferred choice for sustainable integrated care was agreed by the Board in March 2016. This identified the challenges of a high and growing population of older people, and the strategic priorities included older people's care, dementia, end of life care, community mental health services. However, it was not clear how the strategy would be, or was being, implemented in practice. A lot of the content was aspirational and did not address reality and challenges, for example the significant shortage of geriatricians on the island, shortage dementia care beds in the community.
- The trust also had 16 current major improvement plans, along with an annual business plan and other programmes, notably the vanguard project, My Life a Full Life. However, these were

# Summary of findings

not sufficiently coordinated. The My Life a Full Life project had been in progress for three years but the implementation of plans and locality working across the island was slow, as little progress with integration across trust services.

- Staff told us the strategic direction of the trust was confused and was causing anxiety amongst staff. We found there was no clear shared understanding about what the strategy was and how it would be implemented. Some CBU leads expressed confusion about national, regional changes and how their work was part of My Life a Full Life integration project. There was a 'top down' approach to the development of the strategy.
- Each CBU had a business service improvement plan, these were of varying quality and the newly appointed director of strategy recognised several CBUs needed support in strategic planning.
- The recent investigation by NHS Improvement, September 2016, found weaknesses in the trusts leadership in developing and implementing aligned strategies for delivery of high quality and sustainable services. Along with effective engagement with partners.
- The CEO reported that the latest financial position (showing a significant deterioration) would require difficult decisions which would likely further impact and require changes to strategic priorities and business plans. We did not see responsive position or plans other than that this would be addressed through Island wide systems resilience work and strategic transformation plans (STPs).

## **Governance, risk management and quality measurement**

- Following an external governance review in 2015 the trust had focused on improving governance arrangements. Trust governance arrangements included six board assurance sub committees: Quality Governance; Audit and Corporate Risk; Finance, Investment, Information and Workforce; Mental health Act scrutiny; Remunerations & Nominations, plus the Trust Executive Committee.
- There were a number of committees feeding into the Trust Executive Committee the largest being the Patient Safety, Experience and Clinical Effectiveness Committee (SEE). A large number of sub committees (16) fed into the SEE committee and was becoming unmanageable and the trust was planning to streamline this.

# Summary of findings

- CBU Heads of Nursing and Quality attended and reported into the Patient Safety, Experience and Clinical Effectiveness Committee (SEE), chaired by the medical director or director of nursing. CBU directors attended the Quality Governance Committee.
- Several interviewees, staff and directors told us they believed the governance structures were unwieldy and overly bureaucratic to the point of inertia. The committee structure was complicated, staff were being asked to go to several committees for the same reason with no decision being made. The governance structure had expanded with new issues with no real thought of accountability and focused decision making. It had become self-serving, it existed to be served rather than to serve a purpose.
- Prior to the external governance review the trust had operated a board assurance framework (BAF) that contained 301 risks. This had not been identified as an unusual number of corporate risks by the board. The risk process had been based on an annual survey of, many of which were non clinical and many did not relate to actual clinical, operational and performance risks.
- The BAF was changed following the external governance review (2015). The current BAF had eight risks but these were poor quality. There was no obvious link between actions, progress and actual reduction in risk. Most risks were a considerable way from target with no trajectory or milestones to meet the risk target. There were no clear statements of controls, nor assurances with the columns often left blank.
- The NEDs interviewed could not articulate with any clarity how the BAF assisted the board in strategic risk management, except that they believed that board agendas now had a greater strategic versus operational focus. Sub committee chairs were required to provide a report to each board meeting, including a statement of the level of assurance on topics and concerns. However, these were not linked to the BAF or corporate risk register scores or assessment of risk controls. There was no model of assurance in operation and no supporting accountability framework.
- The executive team lacked real focus on, or understanding of, clinical, operational and performance risks, this was evident from the findings of the core service inspections, not just mental health services.
- There was an inherent lack of understanding of current risk management approaches by staff. Senior staff were not always aware of the current risks and issues, so there was no plan to

# Summary of findings

address them. The governance structure did not provide a clear route to escalate issues of concern and there was no evidence that senior trust managers took account of the views of frontline staff.

- The corporate risk register contained lot of detailed narrative of activity but little detail on risk controls in place and the substantive assurances available. The RAG rating on the risk register was changed based on the actions by staff and not based on the level of risk mitigation. For example, on staffing were rated as 'green' despite staffing pressures still existing in many areas in mental health, community, ambulance and acute services.
- CBU risk registers did not reflect some significant risks in services for example the risks of multiple records in community services for children had not been sufficiently escalated. The need to distinguish between 'issues' identified by staff and risks was also poorly understood across the trust. The risk management strategy and policy did not make reference to 'issues' and how they are related but distinct from risks. Service risk registers were under developed. These were too detailed and reactive, that is, risks were not added until after a problem occurred rather than identifying potential problems and mitigating risks in response.
- Quality of data across the trust was poor and not easily accessible, and impacted on the assurance to the board. CBUs told us they could not always rely on data provided to them.
- Corporate risk management training had started, with approximately 136 staff out of 850 trained. The only member of staff available to deliver the training was the head of corporate governance, who already had a wide portfolio and very few staff. There was also insufficient resource to carry out even a regular sampling of local risk register quality, a significant concern given the poor quality of risk identification and management across the trust. This was evident in mental health services where ligature risks were regularly identified via trust mock inspections and by CQC inspectors, but not by line managers and staff.
- It was not clear why responsibility for corporate and clinical risk management processes was divided between the Head of Corporate Governance and the Quality Governance Team. This unusual approach was not referenced in the risk management strategy policy. We were told the teams worked closely together, for example in management of incidents and SIRIs.

# Summary of findings

However the split was more likely to cause confusion, duplication and/or gaps in risk identification and management, particularly where such a complexity of services across the trust.

- Despite recognition that considerable further improvements were required in risk management delivery, there was no risk management action plan.
- The trust had established a quality governance clinical business unit and there was medical, nursing and AHP representation on the team, but not from mental health. Quality monitoring priorities were identified and represented diagrammatically in the 'house'. CBUs were required to give regular quality reports to the SEE committee on the quality improvements identified in the diagrammatic 'House'. However, there was no standardised format on how this should be presented and SEE minutes evidenced varying levels of assurance from the information provided by different CBUs.
- Mental health staff told us that there was no consultation or consideration of mental health risks or structures in the trusts quality, improvement or governance arrangements. For example, the head of nursing quality reporting systems did not fit the reporting needs of mental health. The quality 'tiles' or priority topics chosen by the trust were not suitable for mental health, staff told us how they make mental health issues fit in to acute reporting systems to try and raise concerns.
- There was a ward accreditation programme in place for acute wards, to measure compliance with fundamental standards, and required actions for improvement. This programme did not extend to mental health wards, and we were told they had a separate accreditation process.
- Governance and assurance was significantly lacking for operational services in particular community, ambulance and mental health services. For example, the executive team was unable to demonstrate that they had sufficient understanding of the risks in community and inpatient mental health services beyond staffing issues. We found insufficient monitoring or assurance that community mental health services were managing risks to patients.
- There was no governance oversight or project management of the business continuity plan (BCP) for community mental health services to ensure its implementation was appropriate or effective. There was insufficient risk assessment, impact assessment or effective monitoring around this. It was not identified and escalated as a significant risk and was not on the

# Summary of findings

corporate risk register. The executive team did not have any oversight of this BCP, they had not requested or received any assurance reports and had not ensured that adequate time and resources were made available to the service

- Mental health service leads had alerted the executive team to the lack of information required as set out in the mental health minimum data set (MHMDS). The MHMDS covers services provided in hospitals, outpatient clinics and in the community, where the majority of people in contact with these services are treated. It brings together key information from the mental health care pathway that has been captured on clinical systems as part of patient care and important for monitoring quality and performance.
- The recent investigation by NHS Improvement, September 2016, also found weaknesses in governance structures and board oversight of performance and risk and escalation processes.

## Culture within the trust

- The trust values: “We care, We are a team, We innovate”, were developed in consultation with staff in 2014. An associated behaviours framework was developed and was being embedded into the appraisal and recruitment processes. Staff were generally familiar with the values. However, it was recognised more work was needed to ensure these were embedded at all levels and all areas of the trust.
- An external review of culture was undertaken February 2015, published to wider staff in August 2015. The review identified that a bullying and aggressive management style was on the increase and there was a risk of sliding into a blame and bullying culture. It reported communication was confused as staff were unsure about how to raise concerns. The organisation was seen as increasingly uncaring towards staff.
- We heard of a general feeling that staff were not sufficiently valued and represented at board level, particularly in the absence of an experienced director of HR. There was a view that the values and behaviours were not always modelled by senior managers and executives. Some staff cited examples of perceived bullying from executive level, undermining what they were trying to do to effect change and improvement.
- The clinical director posts had high turnover, some staff suggested the pressure and blame culture had not allowed them to make decisions. During the inspection and through interviews we found evidence of a culture resistant to change, overly bureaucratic and hierarchical. It took a long time to get anything done, if it was done at all, as the culture was risk

# Summary of findings

averse and staff were not supported to lead and innovate. Several staff of different grades and professions told us concerns were raised to executive level, that they were listened to 'but nothing is done'

- Staff who came to speak with us told us there had been numerous investigations into bullying. When we asked for data we were told there were 10 live employee relations cases related to bullying and harassment (8.2% of all cases) at the time of the inspection, we were not provided with data for the year. The trust was in process of developing an effective KPI for employee relation cases.
- We heard of a culture of subtle bullying from staff working in old fashioned ways and preventing people from doing things, and holding up barriers to change. There was a lack of performance management, so for some it was acceptable not to expect high standards or cooperate. Several staff of different grades and professions told us morale was at the lowest it had ever been, with staff leaving and sickness rates going up.
- Ambulance staff had raised concerns to senior management about the culture, performance management and change was needed. The trust had not taken immediate action but had commissioned an investigation into the culture of the ambulance services, and staff were still not sure of the outcome.
- The trust's sickness rate between June 2015 and May 2016 was mostly higher than the England average of 4%. The trust now benchmarked for specific services and sickness continued above target eg community was 4% with stretch target 3.5%; mental health and LD 5.1% (target 4.5%); ambulance 7.6% target is 5.5%. The highest reason for sickness remained as anxiety, stress and depression.
- The NHS Staff Survey 2015 put the trust in the best 20% of trusts for one question, staff /colleagues reporting most recent experience of violence. It was in the worst 20% of trusts for five questions (including overall engagement score). These included; staff recommendation of the organisation as a place to work or receive treatment, staff motivation at work, recognition and value of staff by managers and the organisation.
- The GMC National Training Scheme Survey 2016, the trust scored "worse than expected" for one out of 15 indicators in four specialities and the same as expected for the remaining specialities.
- There was a general staff perception of an increasing focus on financial outcomes and not patient care and quality.

# Summary of findings

- We heard of initiatives to improve communication, staff health and wellbeing, and staff recognition, but there was no evidence of substantive progress on improving culture since the external review. An education, training and organisational development strategy was in draft. Some staff expressed concerns that progress in achieving organisational development and culture change was too slow, it had been on going over the past four years.
- The trust had recently ratified a raising concerns policy. The listening into action lead was interim Freedom to Speak up Guardian, and the trusts expected to advertise for substantive role during December 2016. There was a nominated NED in post.

## **Equalities and Diversity – including Workforce Race Equality Standard**

- Following external review and HR restructure, the trust decided to move responsibility to the CBUs in an attempt to embed equality and diversity across the organisation. This had not been implemented since the decision 18 months ago; no one had the job role or training to fulfil the role within the CBUs. There was no strategy or trust wide action plan for equality and diversity.
- The former equalities and diversity (E&D) lead no longer held the role but had tried to move the equality and diversity agenda forward and had escalated concerns, with very minimal success. They had used the staff survey and undertaken WRES return themselves, as aware this was a requirement for the trust. They told us 10% of the nursing and medical workforce were from Black and minority ethnic (BME) backgrounds.
- The trust performed poorly in the WRES national data report (using 2015 staff survey data), published 2016. The trust and was fourth worst nationally on the measure re bullying, with 56% BME staff (and 30% white staff) experiencing bullying and harassment. The former E&D lead told us a report was provided to the CEO but it was not clear that the wider board was made aware of results, the director of finance and HR was not aware when asked. The unpublished results of 2016 WRES data, showed improvement from the previous year however disparities continued. Of the BME staff group 74% believed that the organisation provides equal opportunities for career progression or promotion. This was against 84% of white staff. 20% BME staff and 10% white staff reported they experienced discrimination at work from manager or other colleagues.

# Summary of findings

- There was no attempt to corroborate the WRES data. There was no workforce analysis of BME staff, numbers and distribution, or use of incident reporting or whistle blowing procedures, sickness absence, use of grievance.
- The trust had software to collect information against the nine protected characteristics but this was not used so data was not available. At interview the director of HR and finance was not sure level of BME staff in organisation, this data was provided afterwards. They were not aware of the WRES results compared to other trusts.
- We heard of some initiatives to support and welcome overseas nurses and the CEOs stand against post Brexit hate crime on the island that was 94% white British. There had been an attempt to set up a BME staff group, which was abandoned due to apparent lack of interest by the staff themselves. However, we heard from some staff that they were pressured by others who were questioning why they thought they needed something special for BME. This issue had not been picked up by the trust executive team. The Director of HR did not know this and had not explored if a group was required, nor had they spoken to BME groups about this concern.
- The former equality and diversity lead had tried to progress work to ensure compliance with national accessible information standards. They had developed work streams and benchmarking but did not have the role or capacity to progress and this was currently not within anyone's work plan. This was not being progressed or supported by the trust.
- Mandatory training for all staff included equality and diversity issues, and staff were generally aware of the issues affecting patients.

## Fit and Proper Persons

- There was not a clear written policy and procedure in place for Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014), to ensure that directors of NHS providers are fit and proper to carry out this important role. This requirement came into law for NHS trusts in November 2014.

There was evidence of the trust were carrying out fit and proper person tests for all board member posts, retrospectively where needed. However, review of recruitment files highlighted several deficiencies in the processes being followed.

- The recruitment and FPPR checks on executives were carried out by the HR department. At inspection we were told the recruitment of non-executives was carried out by an internal

# Summary of findings

administrator team dealing with provision of support to the NEDs. It was not known what HR experience or qualifications were held by these staff. NED recruitment was not overseen or reviewed by the HR department. There were different process and documentation used for NED recruitment and the information seen did not fully comply with the requirements of the FPPR regulation. For example, different declarations forms and associated guidance was used for executives and non-executives. One of the NED self-declaration forms had attached a guidance sheet with detail about the substance of the declaration the other did not:

- It was not clear whether NEDs were required to declare that they were in good standing with any professional bodies of which they had been or were members. The declaration form did not require it, although the guidance attached to the one signed declaration form did mention professional standing. The trust did not check good standing in anything other than health/care professional bodies, for example, legal or accountancy membership bodies. Good standing in membership in non-health or care professional bodies was not checked nor was this covered in the self-declaration.
- At the time of inspection there was no evidence that references had been sought for NEDS, or any other evidence that checks had been carried out regarding their possible prior involvement with regulated health or care bodies. References had been sought for the executive director. The HR department representative explained that it would fall to the vacancy holder to check the substance of references received and that HR themselves did not check references or seek assurance that the vacancy holder had done so. There was no assurance that references were being checked at all, or appropriately.
- Following the inspection the trust provided evidence of checks and references on NEDs undertaken by NHS Improvement.
- The trust only checked professional standing if current registration was a requirement for the role. So, for example, no check or declaration was required about professional membership for the recent appointment to the Director of Strategy & Planning role (who may or could have been a nurse by background).

## Public engagement

- Public engagement was relatively well developed at the trust overall although it was limited in some services. Public and

# Summary of findings

patient feedback was obtained through national surveys, the Friends and Family Test and comment cards. The hospital also worked with its local Healthwatch and had a range of patient and public forums to obtain patient views.

- The trust also sought views from the trust membership (5600 people), patient council, a patients with disability working group with day to day issues and larger projects such as the design of the Ryde Health and Wellbeing Centre. A patient experience group was chaired by the deputy director of nursing and considered issues raised by these forums.

## Staff engagement

- The trust was in the middle 60% of trusts for response rate to 2016 NHS staff survey. The survey demonstrated some improvement since previous years. However, it was in the worst 20% of trusts for overall engagement score. The quarterly staff Friends and Family test, Q1 2016, identified that 54% of staff would recommend the trust as a place to work (the England average was 62%) and 66% of staff would recommend the trust as a place to receive care (the England average was 79%). Both were a slight improvement on previous quarter, end of 2015 but were below the England average.
- Some groups of staff were less engaged particular in ambulance, community and mental health services. Mental health staff told us they did not feel supported by the trust or engaged in the vision and values. They perceived that there had been a long-term lack of oversight and effective resourcing in mental health services and felt the trust prioritised the physical health services over the mental health services. Several staff referred to mental health as the 'second wave' service. One of the examples provided was the international recruitment drive for nurses, it did not include registered mental health nurses. The trust had stated that mental health nurses were being recruited in the 'second wave'. Staff told us the second wave never happened. The trust later confirmed that there was a recruitment campaign in Dublin, but no staff were appointed.
- Many groups of staff told us their service did not feel part of the trust and their concerns. Mental health staff said they rarely see or had not seen any member of staff above their matron in their service despite the majority of the service being delivered from the same site as the senior managements offices. Community health service staff felt similarly disengaged with the wider trust, citing late notice of meetings or cancellation of visits by executives, to their services. Ambulance staff did not feel that the senior managers understood the issues in their service.

# Summary of findings

- There was no evidence of real engagement and the trust had adopted a tick box approach to the staff survey rather than trust level engagement and support in these areas.
- Five task and finish groups were set up to address themes arising from the staff survey, including a focus on communication. There were a range of newsletters including weekly staff news and monthly team talk (summary of board meeting). A '10 minute team brief', covering 10 items, three trust wide, three for CBU and four for the local services, was started in 2015 but its use was not well embedded across the trust. Evaluation of communications was in progress as a large number of staff (c600) did not regularly use email.
- A bi-monthly staff experience group had been established with a membership of 15 and representatives of mixed staff groups and job roles across the organisation. Work had been ongoing with occupational health to develop training on stress management and initiatives directed at health and wellbeing. There was also a staff partnership forum and a hospital staff management committee for the consultant body.
- The trust had used Listening into Action methodology to engage staff, these sessions were well received but there was not high confidence that changes would be made as a result.
- The trust presented annual awards, which highlighted staff who provided exceptional care, support or customer service over the previous year. A regular employee of the month was also recognized, nominated by a patient or carer.

## **Innovation, improvement and sustainability**

- There was a published quality improvement framework, which identified quality priorities such as reducing incidence of patients harm. The framework was acute services focused and priorities for mental health quality improvement, was lacking.
- The quality team were enthusiastic in their support of quality improvement initiatives, particularly in acute services. There were examples of innovative practices in pharmacy services. 'Post discharge 'medicines optimisation support to reduce readmission' (MOTIVE) was initially undertaken as a local CQUIN (commissioning for quality and innovation). It has been continued as independent analysis of the data the pharmacy department at the trust collected showed significant benefits. There was a statistically significant reduction in 30-day readmissions, and that for every two patients referred by the hospital to the community pharmacist, three admissions per year were prevented. There was little evidence of more strategic transformational quality improvement across the trust.

# Summary of findings

- The CCG had asked for the development of community information systems as a CQUIN, as so concerned about the inadequacy of current systems. The business case had been developed but there was concern the trust would miss the funding deadline if the system was not in place in time.
- NHS Improvement investigation in September 2016 also identified further action was needed to address cultural and behavioural issues which had hindered efforts to devolve powers to CBUs to deliver improvement plans. Consistently applied quality improvement methodology was needed to support sustainable improvement and sustainability, more than a tick box approach.
- The trust was in deficit and had a stretch target for CIPs. The deficit at month 7 was £4.1m, with a projected deficit of £4.6m. The reasons for the current deficit were not achieving non-elective activity, increased costs of additional capacity and extra staffing costs.
- The executive medical director and director of nursing signed off CIPs quality impact assessments. The CIPs did not appear to be connected to the delivery of strategic priorities, and in themselves were not strategic. The trust was 'on track' with CIPs but not in terms of producing efficiency saving. Most of the savings (£4m) this year were non-recurrent, some were due to cost pressures which did not happen, not to improved efficiency. There were a few big efficiency CIPs but these had not produced the expected savings. For example, the theatre utilisation review. However, this initially was planned to bring about £1.3m of efficiency savings but had only turned out to be £140k.
- The trust was an integral part of the My Life a Full Life project and had received additional funding as a vanguard initiative, but the implementation of plans was slow, and so the benefits of integrated working were not yet having a significant impact.
- The trust was part of the Hampshire wide Sustainability Transformation Programme (STP). Ongoing work with the Solent acute hospital alliance and the mental health alliance was essential for the future delivery of sustainable and quality services for the island population. The Chair had worked to improve partnership working and relationships with relevant stakeholders across the island. There had been discussions about integrating services and devolution of budgets but these were initial discussion only. There was general acknowledgement at senior levels of the trust that there was some way to go in ensuring improvement and sustainability and the trust was facing real financial pressures, which would impact on service provision. A turnaround committee had

# Summary of findings

recently been set up to oversee financial turn around and transformation. However, this was at very early stages of planning, some services would need to be provided off the island or shared with other trusts.

- There was an assumption the CCG would provide additional income. However, the CCG have advised there will be no additional investment this year and no further income. The absence and/or withdrawal of ring-fenced funding by the CCG for investing in new services was happening and would impact on the trust plans to improve patient care as outlined in the NHS five year forward view.
- Operational managers were very concerned about these issues and that service impacts were apparently not being considered, and no substantial proposals or plans put forward to address.
- There was evidence of a long-term lack of oversight and effective resourcing in mental health services. Resources had been pulled from critical posts in mental health.

# Overview of ratings

## Our ratings for Isle of Wight NHS Trust

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

## Our ratings for St Mary's Hospital Acute Services

|                               | Safe                 | Effective            | Caring | Responsive           | Well-led             | Overall              |
|-------------------------------|----------------------|----------------------|--------|----------------------|----------------------|----------------------|
| Urgent and emergency services | Inadequate           | Requires improvement | Good   | Requires improvement | Requires improvement | Requires improvement |
| Medical care                  | Inadequate           | Requires improvement | Good   | Inadequate           | Inadequate           | Inadequate           |
| End of life care              | Requires improvement | Requires improvement | Good   | Requires improvement | Requires improvement | Requires improvement |

## Our ratings for Community Services

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

# Overview of ratings

## Our ratings for Mental Health Services

|  | Safe                 | Effective            | Caring               | Responsive           | Well-led             | Overall              |
|--|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Acute wards for adults of working age and psychiatric intensive care units       | Inadequate           | Requires improvement | Good                 | Requires improvement | Requires improvement | Requires improvement |
| Long stay/ rehabilitation mental health wards for working age adults             | Inadequate           | Inadequate           | Good                 | Requires improvement | Requires improvement | Inadequate           |
| Wards for older people with mental health problems                               | Inadequate           | Inadequate           | Good                 | Inadequate           | Inadequate           | Inadequate           |
| Community-based mental health services for adults of working age                 | Inadequate           | Inadequate           | Requires improvement | Inadequate           | Inadequate           | Inadequate           |
| Specialist community mental health services for children and young people        | Requires improvement | Requires improvement | Good                 | Requires improvement | Requires improvement | Requires improvement |
| Community mental health services for people with learning disabilities or autism | Good                 | Good                 | Good                 | Good                 | Good                 | Good                 |
| Substance misuse services  | Good                 | Good                 | Good                 | Good                 | Good                 | Good                 |
| <b>Overall for service</b>   | Inadequate           | Inadequate           | Good                 | Inadequate           | Inadequate           | Inadequate           |

## Our ratings for Ambulance Services

|                                    | Safe                 | Effective            | Caring | Responsive           | Well-led             | Overall              |
|------------------------------------|----------------------|----------------------|--------|----------------------|----------------------|----------------------|
| Emergency and urgent care services | Inadequate           | Requires improvement | Good   | Requires improvement | Inadequate           | Inadequate           |
| Patient transport services         | Requires improvement | Good                 | Good   | Good                 | Requires improvement | Requires improvement |
| Emergency operations centre        | Good                 | Requires improvement | Good   | Good                 | Inadequate           | Requires improvement |
| <b>Overall</b>                     | Inadequate           | Requires improvement | Good   | Requires improvement | Inadequate           | Inadequate           |

# Outstanding practice and areas for improvement

## Outstanding practice

Post discharge medicines optimisation support to reduce readmission” (MOTIVE) was initially undertaken as a local CQUIN. It has been continued as independent analysis of the data the pharmacy department at the Trust collected showed significant benefits. MOTIVE involves pharmacy staff coding each patient on admission to assess what help they will likely need with their medicines after discharge. People with greater needs are actively referred to their community pharmacists for a medicines review;

those with less needs have a phone call from the hospital medicines helpline once they are home to ensure they understand how to use the medicines they have been given. MOTIVE showed that there is a statistically significant reduction in 30-day readmissions, and that for every two patients referred by the hospital to the community pharmacist, three admissions per year were prevented.

## Areas for improvement

### Action the trust MUST take to improve

For actions at service level please refer to core service reports.

### Trust-wide

#### The trust must ensure:

- That the leadership improves at all levels from board to service level.
  - that there is an achievable strategic vision and staff are clear of their role and actively involved in delivery of meaningful plans to achieve this.
  - There is a systematic review and revision of hierarchical and bureaucratic processes, and clinical business unit leads are supported to work autonomously in the provision of high quality and sustainable and integrated services for patients.
  - There are improvements to the collection and use of information to support the monitoring of quality and safety.
  - Community records systems are fit for purpose, accessible to staff and support the delivery of safe services for patients.
  - There are clear, uncomplicated governance arrangements that support monitoring of quality, safety and performance across all services.
  - There are arrangements in place for identifying, assessing and managing risk at all levels and staff are appropriately trained in this.
- The board develops and embeds an effective assurance framework to identify and take early action on any concerns arising in any services.
  - There is effective staff engagement and work to progress organisational development and culture change, so that candour, openness and challenges to poor practice are improved.
  - Improvements are made to human resources processes, including clearly defined and consistent management of poor performance.
  - Staff and service leads are trained and supported in making quality improvements and innovations they identify are needed to support sustained quality services.
  - Improvements are made to the equality and diversity programme within the trust, so as to ensure equality for all staff and patients.
  - Improvements are made to partnership working with the local hospice and local authority, to facilitate effective access and timely flow along patient pathways.
  - There is a clear procedure and full range of checks are undertaken prior to the appointment of both executive and non-executive directors as set out in the fit and proper persons regulation of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# Outstanding practice and areas for improvement

- Improvements are made to collation, timeliness and quality of response to complaints, and the learning arising from complaints.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

#### Regulation

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

How the regulation was not being met:

- The trust did not have assurance that full checks were always undertaken, particularly for non executive directors, to ensure fitness for the role.

Regulation 5

#### Regulated activity

#### Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

How the regulation was not being met:

- Complaints and concerns from patients were not always investigated or responded to in a timely way.

Regulation 16 of the HSCA 2008 (Regulated Activities) Regulations 2014

#### Regulated activity

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

- The provider was not operating effective systems and processes to make sure the board can monitor and assess their services. There was not an effective board assurance model in place.

## Requirement notices

- The provider was not operating effective systems and processes to assess, monitor and improve the quality and safety of all services provided. Governance processes were not effective.
- The provider was not operating effective systems and processes to assess, monitor, and mitigate the risks relating to the health, safety and welfare of patients, staff and any others, across all services. Risks were not identified and/ or appropriately managed and staff were not trained.
- The provider was not operating effective systems and processes to maintain securely accurate, complete and contemporaneous patient records of care and treatment. The records systems in community services were not fit for purpose and a risk to patient safety.
- The provider was not sufficiently seeking and acting on feedback from staff working in services , for the purposes of continually evaluating and improving those services.

Regulation 17 (1); (2)(a)(b)(c)(e)(f); of the HSCA 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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

| Regulated activity  | Regulation   |
|---|--|
| <p>Assessment or medical treatment for persons detained under the Mental Health Act 1983</p> <p>Diagnostic and screening procedures</p> <p>Treatment of disease, disorder or injury</p> | <p>Section 31 HSCA Urgent procedure for suspension, variation etc.</p> <p>We issued a Notice of decision to urgently impose conditions on the registered provider (under section 31 HSCA 2008) as we had reasonable cause to believe a person would, or may be, exposed to the risk of harm unless we did so.</p> <p>The following conditions were imposed for the regulated activity Treatment of disease, disorder or injury:</p> <p><b>Community Mental Health Service</b></p> <p>A.The Registered Provider must operate an effective escalation protocol in community mental health services. This escalation protocol will need to ensure patients are prioritised appropriately in response to service demands and pressures. There should be appropriate governance and leadership arrangements, and appropriate resources and support to the service and staff. The use of the escalation protocol should be on the corporate risk register and there should be clear mitigation and monitoring arrangements. The trust should ensure the escalation procedures are adhered to. The trust must provide the Commission with a report on the escalation protocol.</p> <p>B. The Registered Provider must ensure that every patient who has received a letter, as part of the current action taken under the business continuity plan, is risk assessed and appropriately managed. Each patient must have a documented risk assessment and a clear date for review. The trust must provide the Commission with a report of actions taken.</p> |

## Enforcement actions

C. The Registered Provider must complete the review of the current caseload of each clinician. Each patient must be identified, have a full assessment of their needs and patients should be allocated for CPA according to the set criteria and guidelines. The trust must provide a report to the Commission on this work.

D. The Registered Provider should agree a comprehensive community mental health services improvement plan. There should be the necessary external advice and agreement for this improvement plan. The plan should ensure demands on the service are appropriately escalated, assessed and managed. There should be structures that ensure national guidance and best practice is followed; that promote effective leadership, and review capacity and capability of staff; there should be sufficient resources and support to the service. Staff must be effectively supervised and supported to review their caseloads. The improvement plan should be adhered to and the necessary changes must be implemented at the appropriate pace and urgency. The trust must provide the Commission with a report on the improvement plan and the action taken in response.

E. The Registered Provider must ensure that the Commission receives the following information every two weeks:

- o Number of patients known to the service
- o Numbers of patients who have risk assessment
- o Numbers of patients appropriately identified as requiring CPA
- o Number of patients who are on CPA
- o Number of patients who have CPA review date
- o Numbers of patients identified on the BCP
- o Management outcomes for patients on the BCP
- o Actual and expected caseloads numbers for clinical teams

## Enforcement actions

o Any complaints about the service or incidents involving staff and/or patients of the community mental health service.

F.The first report should be received on 28 December 2016 and every two weeks thereafter.

### **Mental Health Inpatient Services**

G. The registered provider must carry out an urgent assessment of the physical environment on the inpatient mental health wards at St Mary's Hospital. The trust must ensure there is a comprehensive ligature assessment and an action plan to mitigate the risks. The action plan must include a stated time for completion. The assessment must cover all inpatient mental health wards and environments. There should be effective leadership, and the necessary resources and support to ensure changes have appropriate governance, are appropriately supported and are implemented with the necessary pace and urgency. The action plan must be produced by Wednesday 28 December 2016.

H. The registered provider must immediately review its policy and procedures and governance arrangements to ensure there is appropriate assurance to identify, assess, manage, mitigate and monitor all environmental risks to patients' care and safety across all inpatient mental health services. This includes where patient privacy and dignity may be compromised. The governance arrangements need to identify where additional resources and support are required and how staff will be supported to understand what actions need to occur to effectively manage all environmental risks. The trust must provide a copy of the revised governance arrangements by Wednesday 11 January 2017.

I.The Registered Provider must ensure that the Commission receives the following information every two weeks.

- A risk register that includes all environment risks in inpatient mental health services
- The action(s) taken to mitigate the risks

This section is primarily information for the provider

## Enforcement actions

- Risks mitigated through individual patient assessment
- The controls that are in place
- The ongoing dated review and specified actions of how these risks are being managed.

J. The first report should be received on 28 December 2016 and every two weeks thereafter.