DHSC – CQC External Quality Regulation Programme

Manx Care

Assessment Report

Noble's Hospital Estate
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Our Findings

Overall summary

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

We carried out this announced assessment of Manx Care from 3 October to 3 November 2022. The assessment was led by a team of CQC inspectors, supported by a team of specialist advisors, and inspectors from the CQC medicines management and safeguarding teams.

This assessment is one of a programme for the Isle of Man Government's Department of Health and Social Care (IOMDHSC) in order to develop an independent inspection regime of health and social care provided or commissioned by the department and Manx Care.

CQC has no enforcement powers on the Isle of Man. We have not rated services but have made recommendations for improvement.

To get to the heart of people's experiences of care and treatment, we always ask the following 5 questions:

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

These questions form the framework for the areas we looked at during the assessment.

Service overview

Manx Care was established in April 2021 by Tynwald, the Parliament of the Isle of Man, as an arm's length organisation to focus on delivery of health and social care on the island.

It serves a population of 86,000 residents and visitors. In 2019 there were almost 330,000 visitors to the Isle of Man. The Tourist Trophy (TT) motorcycle race alone attracts more than 40,000 during the race fortnight in early summer. The government aims to increase tourist numbers to 500,000 by 2032.

There are 2 hospitals on the island. The main one is Noble's Hospital in Strang, close to the island's capital Douglas, which has 20 wards and 314 beds. It provides services including medical wards, surgical services, maternity and gynaecological services, cancer services, children's services and an emergency department. The other hospital is Ramsey and District Cottage Hospital (RDCH), which has a minor injury and illness unit, an inpatient ward and outpatient services.

Services are divided into the following care groups:

- Medicine, urgent care and ambulance services
- Surgery, theatres, critical care and anaesthetics
- Integrated diagnostics and cancer services
- Integrated women's, children's and families' services
- Integrated primary and community care services.

Each care group has a lead manager, a medical lead and a nursing lead.

Our key findings

- There was an inconsistent approach to mandatory training throughout the hospital. Managers did not always maintain an effective oversight of the training compliance for all staff, and not all staff had completed all required and recommended training for their role. Training systems did not provide managers with details of which staff had completed which training courses, and whilst some managers kept individual logs, this was done inconsistently across services. Systems to ensure all staff remained competent for their roles were not effective, as not all staff received regular appraisals and reviews of their performance.
- Not all staff understood how to protect patients and service users from abuse and avoidable harm. Although staff had training on how to recognise and report abuse, not everyone had completed this to recommended levels for their roles.
- Services did not always have enough staff with the right qualifications, skills, training and experience to keep patients and service users safe. There was an overreliance on bank and agency staff to fill vacancies, and staff often reported feeling pressured to work additional hours and shifts.
- Systems to ensure medicines were safely prescribed, administered, recorded and stored were not always effective.

- Care and treatment were not always based on national guidance and evidence-based practice. Policies and protocols were not always up to date or reviewed regularly. Systems to monitor the effectiveness and quality of care were not always effective, and clinical audits were not always used to improve services.
- Staff treated patients and service users with compassion and kindness. Staff provided emotional support to patients, their families and carers, to minimise their distress and involved them in decisions about their care and treatment.
- Leaders did not always operate effective governance processes across services. Risks that affected staff, the service and patients were not always identified, mitigated or acted upon promptly.
- Not all staff felt respected, supported or valued by managers. Staff were focused on the needs of patients who received care but did not always describe an open culture where they were supported to raise concerns.

We found the following areas of notable practice:

- Manx Care had introduced an electronic beep system, which staff had on their mobile phones. This allowed staff to escalate concerns, request reviews, make other requests and contact staff. All messages were recorded to provide an audit trail.
- Occupational therapists on the stroke unit undertook additional training to assess driving competencies. This allowed staff to help and support patients and allow them to return to driving as soon as it was safe to do so.
- The breast unit had been awarded the Macmillan Quality Environment Mark (MQEM) – a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.
- The integrated cancer service had developed and evolved its ‘skin service’ to serve the patient group better. They had trained 5 GPs across the island to provide treatments for patients, which improved their experience and relieved pressure on the hospital.
- The acute medical unit operated a ‘bridge the gap’ service, which supported patients transitioning into adult services from children’s services or who lived with a learning disability.
- The nursing leadership at ward-level was consistently strong and effective. Ward managers were passionate about developing their staff into the managers of the future.
- Staff shared key information to keep patients safe when handing over their care to others. They used the ‘situation, background, assessment, recommendations’ (SBAR) handover system.
- There was good support and joint working with the thrombolysis team and the Emergency Department (ED) staff.
- The development of the frailty service had already provided positive outcomes for patients.
- Multidisciplinary decision-making and relationships with tertiary centres were effective to deliver safe services.
- Diagnostic services worked to offer patients ‘one-stop’ clinics, whereby patients could see

several healthcare professionals involved in their care during one visit. For example, in the breast screening department, symptomatic patients were able to attend a clinic where a mammogram, ultrasound and physical examination would be undertaken. If clinical evidence suggested a biopsy was required, staff undertook this during the same visit. This avoided the need for patients to attend multiple appointments and helped alleviate any patient stress and anxiety.

- The stroke service was involved in the Sentinel Stroke National Audit Programme. Staff inputted their own data, which was usually completed by a data coordinator.
- The innovative use of telemedicine supported the safe delivery of care and treatment

We found areas where the service could make improvements. CQC recommends that the service:

- **Service-wide:**
  - Improves access to services to ensure patients can access care and treatment when they need it, particularly psychological and neurological specialist support.
  - Improves clinical staffing levels to ensure care remains safe and effective while ensuring staff do not feel pressurised or forced to work additional shifts.
  - Improves the storage, management and oversight of medicines and equipment to ensure all out of date stock is removed and replaced promptly.
  - Improves the culture across the hospital to ensure all staff feel valued and supported.
  - Improves the consistency of equipment cleaning, maintenance and calibration processes.
  - Improves the storage of substances that could cause harm to patients to ensure only authorised staff can access potentially harmful substances.
  - Implements a formalised clinical audit programme supported by the regular collecting and reviewing of patient outcome data.
  - Improves the oversight and management of patient complaints.
  - Develops data sharing arrangements with other departments, services and healthcare providers to ensure staff can access patient care records and treatment information.
  - Improves the storage of confidential patient information to ensure only authorised staff have access to confidential records.

    Improves the completion and oversight of staff mandatory training, including ensuring all staff complete safeguarding training to appropriate levels for their role.
  - Improves the oversight of policies and procedures to ensure all protocols are up-to-date and reflect current guidelines and best practices.
  - Implements a programme of quality improvement and continuous learning.
- **Medical Services:**
  - Improves systems to monitor the completion of the malnutrition universal screening tool (MUST) to ensure patients receive enough food and drink to stay healthy.

- Implements systems to ensure all staff receive effective and regular appraisals.

- **End of Life Care:**
  - Improves systems to identify patients who require end of life care or palliative care in a timely manner.
  - Develops a formalised procedure to ensure that patients identified as approaching the end of their life are appropriately referred to services that can offer a comprehensive and standardised approach to their care.
  - Improves pharmacy staffing levels to ensure patients receiving end of life care are supported in a timely manner.
  - Improves the prescribing, administering and recording of medicines to ensure it is completed in line with hospital policies.
  - Undertakes infection prevention and control audits in all high-risk areas of the hospital, such as the mortuary.
  - Develops policies and processes that are specific to the management of patients requiring end of life or palliative care.
  - Improves the oversight of staff training to allow managers to identify which staff have completed hospice-provided training relevant to end of life care.
  - Develops a service level agreement between services offering end of life care and palliative care to patients.
  - Implements a formalised audit schedule to monitor the quality of end of life care.
- **Urgent and Emergency Care:**
  - Improves the quality of patient care records to ensure comfort rounds are appropriately recorded and evidenced.
- **Ambulance, Air Ambulance and Patient Transport Services:**
  - Improves risk assessment of ambulance activity to ensure that the Emergency Department is alerted to only the most urgent ambulance arrivals.
  - Improves procedures for prescribing prescription-only medicines to ensure all staff have appropriate authorisation to prescribe and administer all required medicines.
- **Surgery, Theatres and Anaesthetics:**
  - Improves access to hospital beds for patients requiring surgery to reduce patient waiting times.
- **Critical Care:**
  - Improves the staffing and training arrangements to ensure there are suitably qualified paediatric nursing staff when children are being cared for in the unit.
- **Diagnostic Imaging:**
  - Improves the displaying of waiting time information in patient waiting areas.
  - Improves patient access to services, particularly DEXA, CT and MR, to ensure patients can access care and treatment when they need it.

- **Outpatients:**
  - Improves the security, storage and oversight of blank prescriptions.
  - Develops and implements a formal chaperone policy.
  - Improves the security of utility rooms to ensure only authorised staff have access.
- **Gynaecology and Termination of Pregnancy Services:**
  - Improves the management and oversight of children being cared for on adult wards to ensure all children are effectively safeguarded.
  - Develops systems to ensure patients are treated and cared for in the correct clinical areas.
  - Improves staffing levels and recruitment processes to ensure all leadership roles are filled, and all role holders have the necessary skills and experience for their role.
- **Maternity**
  - Develops and implements a home birth service.
- **Children, Young People and Neonates**
  - Improves staff training systems to ensure all nursing staff are adequately trained in paediatric resuscitation.
  - Improves incident reporting systems to ensure lessons learned from incidents are adequately shared and discussed to help prevent recurrence.
  - Implements a system to reduce the delay to undertake discharge summaries on the children's ward.
  - Develops a formalised vision for the future of the Children's and Young People's service, supported by a credible strategy.
  - Improves risk management processes to ensure all risks are adequately identified, with clear actions taken to reduce their impact.
  - Improves systems for collecting and reviewing patient feedback from Children's and Young People's services.
- **Community Health Services for Adults**
  - Implements a system to ensure required building maintenance works are promptly identified, reported and rectified, such as the replacement of the flooring in the diabetes centre.
  - Implements a system to ensure all equipment is serviced regularly.
  - Improves treatment policies and protocols to ensure all community services have consistent treatment pathways.
  - Improves risk management processes to ensure all risks are adequately identified, with clear actions taken to mitigate their impact.
- **Community Health Services for Children, Young People and Families**

- Improves systems to ensure children with special needs have access to all required equipment, such as wheelchairs and home aids, and any required adaptations to children and young people's homes is completed promptly.
- Develops treatment pathways that are specific to community services for children and young people.
- Provide additional support, such as respite care, for families with children and young people with multiple care and support needs who received care at home.

We have identified areas we have escalated to the IOMDHSC:

- There were significant shortages of staff across all services inspected, particularly within the emergency department, maternity and neonatal services.
- Medicines were not always stored securely or appropriately, and out of date medicines and equipment was not always identified and replaced promptly. This included resuscitation equipment and trolleys.
- Equipment was not always serviced, maintained and/or calibrated in line with manufacturers' guidance and relevant legislation.
- Not all staff had completed all required training, which included key topics such as safeguarding and resuscitation, and oversight of staff training compliance was limited.
- Governance systems were not always effective, and there was a general lack of oversight of assurance, audits, policies, procedures and protocols.
- There was an organisational separation of Manx Care and Hospice, which meant end of life care was not always delivered consistently across the island.

Medical Services

Overall summary

There are 6 medical wards at Noble's Hospital and 1 at Ramsey and District Cottage Hospital (RDCH). Wards at Noble's Hospital include an acute medical unit, a stroke unit, a frailty unit, and a coronary care unit. The ward at RDCH is a rehabilitation and end of life care ward. There is no medical cover there at night.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

Manx Care was unable to obtain and provide accurate training compliance figures from the electronic training system. This was because the system could only provide the numbers of staff who had completed a course, and this was not representative of the numbers who were required to do so. The data provided also not constitute the full suite of training we would expect all healthcare staff to have undertaken.

Staff did not always receive or keep up to date with their mandatory training.

Managers did not always manage completion of training effectively or alert staff to do it.

Data was collated manually. Figures for January 2022 showed 62% completion but because data included only numbers of staff completing courses it was impossible to see who had done what training.

These issues were common to many services. Where that applies, we cross-refer to this information.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse.

Staff completed safeguarding training to appropriate levels for their role. Data provided by the service showed that as of January 2022, 41.2% of staff had completed children's safeguarding training and 57.7% of staff had completed adult safeguarding training. There was no breakdown of compliance with safeguarding training at care group level. We saw that training numbers were increasing and that there were available dates for training.

Staff on the acute medical unit (AMU) told us that a member of the hospital safeguarding team visited the unit every Monday and Thursday to pick up on any safeguarding issues that had not been responded to. This was positive interaction and support for staff.

Staff gave us examples of when they had concerns about safeguarding and had worked with the safeguarding team to address these concerns.

Boards were used confidentially in the medical wards to highlight any patient with safeguarding issues.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

The wards we visited were visibly clean and had suitable furnishings, which were clean and well maintained. Housekeepers were responsible for cleanliness and cleaning schedules, and we saw good compliance with cleaning schedules.

All wards had side rooms that could be used to isolate patients with infectious diseases or illnesses. Some rooms had systems that generated a negative air pressure within the room to prevent pathogens moving to non-contaminated areas when the door was opened. Personal protective equipment (PPE) was stored outside these rooms.

There were handwashing sinks in all bays on the medical wards and there was signage for handwashing and for donning and doffing of PPE. We saw that staff used PPE but did not always use hand sanitising gel when entering and leaving the wards.

The hospital infection control team visited the AMU every day to see if there were any issues with infection control. The unit carried out commode audits and we saw these were completed satisfactorily.

Hand hygiene audits on 1 ward were at 100% compliance for September 2022, 89% for August 2022 and 100% for July 2022. During the assessment, we saw 1 bay was undergoing a deep clean due to a patient having infectious illness.

Bi-monthly infection prevention and control (IPC) audits were completed across the medical wards. Staff gave examples of where changes had been made as a result of these audits, such as the replacement of rusty medicine trolleys and changes to the storage of bed pans.

All staff were required to complete infection control training as part of their mandatory training and there were IPC link nurses on all the wards we visited.

Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff managed clinical waste well.

We were not assured that all equipment was maintained and serviced regularly. Staff explained that each ward maintained a list of the last service dates for each item of equipment, along with the date when its next service was due. Staff explained they checked these logs on a weekly basis and escalated any overdue services to the hospital's Asset Replacement Team. Daily checks were carried out on resuscitation trolleys across the medical wards and a full check was done every Sunday. However, during our assessment, we identified several items that had exceeded their expiry dates that had not been identified or replaced by the hospital.

There was medical oxygen and suction at all beds on the wards we visited. All beds in the AMU had an observations machine. Patients could reach call bells and staff responded quickly when called.

On the stroke unit, 2 beds had fixed telemetry machines and there were 5 mobile telemetry

machines. The telemetry machines monitored cardiac rhythm to detect any cardiac abnormalities that might have caused or contributed to the stroke. On the day of our assessment, the unit had a delivery of 7 specialist chairs for the use of the stroke patients.

Dirty utility rooms were kept locked to prevent any unauthorised access. On the AMU, we saw there was a Control of Substances Hazardous to Health (COSHH) folder and saw any hazardous substances were stored appropriately.

Clinical waste was in correctly coloured bags.

Sharps containers were dated and not overfilled. There were sharps audits on all wards.

There were day rooms on each ward, which were used for staff training, handovers, and for patient and relative use. All wards had an outside courtyard, which staff said had been invaluable during the pandemic.

Assessing and responding to patient risk

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

The department used the National Early Warning Score (NEWS2) tool, a clinical tool that aims to quickly identify the deterioration of a patient, to assess patients attending the department. We reviewed patient care records and saw NEWS2 scores were recorded and acted upon appropriately and were in line with the hospital's NEWS2 and escalation policy. NEWS2 escalation audits were completed, and the results of the April 2022 audit showed the ward had achieved 75% compliance.

At RDCH, staff explained they had a lower threshold for escalating a patients' NEWS2 score due to no medical cover being available overnight.

There were internal professional standards for the AMU, written by medical staff and senior nursing staff. These included patients being received on the AMU from the emergency department within 1 hour of the decision to admit, and the patient being seen within 30 minutes of arriving on the AMU by a health professional who would take a detailed history, baseline observations and record a NEWS2 and a pain score.

Bedside investigations could be arranged with ward-based phlebotomy, electrocardiograms (ECGs) and cannulation as appropriate. Specific assessments were carried out after 2 hours including full medical clerking, abbreviated mental test score and delirium assessment. Nursing assessments were undertaken within 2 hours of admission to the AMU. This included venous thromboembolism, malnutrition screening tool, oral care, falls care bundle, Waterlow score and pressure areas assessment and activities of daily living including continence.

A consultant medical assessment took place within 4 to 14 hours following admission.

Managers ensured there was always at least 1 nurse on shift who was up to date with their immediate life support (ILS) and blood transfusion training. We noted medical wards had recently rolled out training to nurses for acute illness management (AIMS).

The service used the hospital adult service pathway to manage patients with suspected sepsis, which outlined the 'red flag' sepsis criteria, and the 'Sepsis 6' actions staff should complete within the hour. There was a blood gas analyser on the AMU so blood tests could be expedited.

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

used the ‘situation, background, assessment, recommendation’ (SBAR) tool for all patients on the wards, which provided a comprehensive handover when patients were transferred between clinical teams.

There were board rounds on all medical wards we visited. On the AMU, there were board rounds at 7.30am, 9am, 11.30am, 3.30pm and 9pm. We observed the 9am meeting and saw there was a multi-disciplinary approach to the meeting, which included nurses, doctors, occupational therapists and pharmacy staff. The meeting was well structured with discussions about every patient and their possible discharge date. The consultant allocated doctors to the patient list and there were discussions about diagnostics, pain and medicines. Each patient’s social situations were discussed as appropriate. Staff came together at 11.30am and fed back to the consultant any updated plans for their patients.

The stroke team could access specialist advice from hospital trusts in the UK, including the specialist neurological centre and the hospital trust in Liverpool. This was often used out of hours and at weekends and the service was looking to further develop this support. Where patients required a higher level of care than the hospital could provide, patients would be transferred to England as necessary.

On the stroke wards, there was not always a speech and language therapist to undertake a swallow assessment as these were provided remotely. The nurses were using the Gugging Swallowing Screen (GUSS) - a tool for measuring dysphagia and estimating risk of aspiration. Staff aimed to complete this within 4 hours of admission to the ward.

Staff had a SMART page system on their phones through which they could escalate concerns, ask for reviews, request and contact other staff. All messages were recorded to provide an audit trail.

The Critical Care Outreach Team (CCOT) was a nurse-led service supporting nurses and doctors caring for acutely ill inpatients on other wards throughout the hospital. The team were able to support in the assessment of acutely ill or deteriorating patients on wards and advise on monitoring, investigations and management plans. The role included reviewing patients who had been recently discharged from the unit to a ward bed. As the CCOT did not operate at night, out of hours cover was provided by an on-call medical consultant. Staff from the CCOT used 1 of the hospital’s electronic patient records systems to track patients elsewhere in the hospital, particularly patients’ NEWS2 scores, and would respond if any patients were deteriorating significantly.

We were told of patient safety concerns due to staffing pressures on medical wards, which meant it was difficult for staff on the wards to spot issues and to detect any patients who were deteriorating in a timely manner. They told us senior staff were visible, but they did not always support the team.

On another ward, the critical care outreach team discovered that there was a problem with several the suction machines which were used in the treatment of tracheostomy patients which had not been reported to senior staff. Whilst specialist training had been provided to ward staff, they were not always following the training. This was reported to the ward manager and recorded as a patient safety incident and as an action from this incident it was agreed that tracheostomy patients would remain in the critical care unit.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm

and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. We saw there were shortages of nursing staff and healthcare assistants on most wards visited during the assessment and saw several examples where these staff shortages had impacted the quality and safety of patient care.

For example, the lack of staff on the AMU had resulted in the ward not being able to take patients who required non-invasive ventilation (NIV), which then affected the staffing of the ambulatory care unit. Managers explained how this lack of staff had contributed to an increase in patient falls,

The service primarily used long-term agency staff from the UK to cover any vacancies, although ward managers were often used to make up staffing numbers.

Several nursing staff were acting up into more senior roles to cover staff sickness and vacancies. Staff said they were well supported by senior managers, but some were finding the new roles a challenge.

Physiotherapists, occupational therapists and therapy assistants supported the medical wards. At RDCH, rehabilitation assistants supported the occupational therapists and the physiotherapists.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The AMU had consultant cover Monday to Friday from 9am to 5pm. Outside these hours, the unit was covered by the emergency department medical consultant and the on-call medical consultant.

Prior to the COVID-19 pandemic, 3 consultants worked within AMU. During the pandemic, 2 consultants were redeployed to other areas in the hospital and had not returned to the AMU, which resulted in the current need for locum consultant cover.

Due to the lack of medical staffing, it was difficult to run the ambulatory emergency care (AEC) department as this needed a dedicated consultant to oversee the department and support decision-making. This had an impact on numbers of patients attending the urgent and emergency care department and consequently the AMU.

A member of staff told us they were struggling to complete their continuing professional development and were aware that pathways needed to be updated but they were unable to do so because of staff numbers. The monthly governance meetings that were held with senior ward staff had been postponed because of nursing and medical staff shortages.

At RDCH, medical cover was only provided in the daytime with no medical cover at night.

Records

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

Patient care records were a mixture of paper and electronic notes. Paper records were stored securely at nursing station and in locked trolleys.

We looked at 5 sets of patient care records in the AMU. We saw that risk assessments were

recorded and reviewed when appropriate, early warning scores were documented, medicines were administered correctly, discussions with patients were recorded and all records were legible. All were signed with a few omissions of General Medical Council and Nursing and Midwifery Council numbers.

On the stroke unit, we reviewed 3 sets of patient care records. Records were comprehensive with all risk assessments completed and reviewed. We saw that bed rail assessments had been completed for patients as necessary and that the initial complexity documentation had been completed.

Managers reviewed completed records to assess their quality and identify any areas for improvement. For example, on 1 ward, we saw the ward manager checked the risk assessments for 4 sets of patient records every morning. This followed a complaint from several years ago. The checks included the Waterlow scores, the cannula assessments, oral care and bed rails.

Medicines

The service used systems and processes to safely prescribe and administer medicines safely. There was a good relationship with the pharmacy services to ensure medicines were available. However, medicines were not always stored safely.

We looked at patient medicine records and saw that medicines had been prescribed, administered and recorded in line with hospital policies. The pharmacy team supported and advised all medical wards.

Medicines had been prescribed, administered and recorded in line with hospital policy. The pharmacy team ensured that patients' medicines were clinically checked throughout their stay in hospital. This included a comprehensive medicine history and medicine reconciliation process to ensure medicines prescribed were accurate. Advice on prescribing was clearly documented and followed up by the team. The pharmacy team checked to ensure that patient weights were recorded which is particularly important for calculating weight-based medicines prescribing. Allergies were highlighted and recorded on all medicine charts. Venous thromboembolism (VTE) risk assessment outcomes were recorded on all medicine administration charts. The route of administration was recorded including the reason for prescribing medicines when appropriate.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists regularly reviewed, monitored and provided clinical advice on the best way to administer medicines. This included monitoring and reviewing the effects of medicines administered which included regular reviews for antibiotic prescribing. Advice was written onto the medicine charts as reminders or prompts.

Staff did not always store and manage medicines safely. There were no recent audits available to ensure safe and secure medicine storage. Medicine storage systems were not always secure, and access was not always suitably restricted. For example, during our assessment, we found a utility area had been left unlocked with a drawn-up intravenous medicine left unattended on the workbench and a medicine fridge left unlocked.

Medicine fridge temperature monitoring, to ensure the safe storage and efficacy of medicines, was inconsistent. Although the service had systems to ensure medicines were stored at the recommended room or fridge temperatures, we saw these were not always followed. For example, we reviewed the fridge temperature records for a fridge on 1 ward for September 2022 and saw only 14 temperature readings had been documented.

Emergency medicines were available and stored in tamperproof trolleys or boxes in all areas visited. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe-to-use in an emergency.

Controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely.

Blank prescription pads were stored securely. However, on 1 unit, records were not always kept of the serial numbers of prescription forms when they were issued, which meant staff could not effectively reconcile all blank prescription stock.

Staff learned from safety alerts and incidents to improve practice. There was a system in place for reporting incidents and for receiving medicines safety alerts, although we found staff at ward level did not always receive information on medicine safety incidents. A medicine safety officer was new in post and was in the process of reviewing medicine safety incidents and had written a newsletter to be cascaded to all areas.

The service monitored and audited its use of antimicrobials. For example, staff audited the usage, types, compliance, indication of appropriate types and stop dates of antimicrobials used on AMU. When the audit started, compliance was at 16%, which increased to 77% by August 2022.

At RDCH there was no pharmacy support. All medicines were delivered from Noble's Hospital, including medicines for discharge. These came in bags for individual patients and were stored securely to be given to the patient on discharge. Controlled drugs were stored securely on the ward.

Incidents

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

All staff knew what incidents to report and how to report them. There was an electronic system for the reporting of incidents. There had been no never events in the service from January to August 2022. There had been 1 serious incident in April 2022, which had been investigated and a root cause analysis had been completed with learning for the organisation.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Alerts on the CAS website include National Patient Safety Alerts (from MHRA, NHS England and NHS Improvement and the UK Health Security Agency (UKHSA)), NHS England and NHS Improvement Estates Alerts, Chief Medical Officer (CMO) Alerts, and Department of Health & Social Care Supply Disruption alerts.

We noted from the minutes of the operational clinical quality group in February 2022 that the implementation of CAS Alerts remained an area of focus for care groups. In the minutes of the April 2022 operational clinical quality group, it was stated that recording CAS alerts on the electronic reporting system had commenced in February 2022 and there had been 15 alerts received and cascaded. However, there had been a poor response and targets had not been met since February.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw that duty of candour training was part of mandatory training and we were given examples where the duty of candour had been used. The serious incident log showed the date the duty of candour letter was sent out to the patient or their relatives.

Managers on AMU fed back to staff about incidents on the wards using the minutes of staff meetings and by email. Examples were given on how AMU had changed practices following an incident with blood transfusion bags. There was a serious incident review panel which met every week to review serious incidents and feed back to managers and staff.

However, we saw staff did not always use the incident reporting system to record staff shortages for each shift.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

Manx Care advised CQC that whilst National Institute for Health and Care Excellence (NICE) guidance was applied in some clinical areas, they had limited evidence that NICE guidance was applied universally across the hospital. We were told that positive systems of assurance, monitoring and reporting were not in place. Manx Care’s rationale for this was that whilst clinical practice operates under evidence-based guidelines, there were no formal assurance systems in place for monitoring and reporting.

A previous assessment showed that out of date guidance was in use. We saw hospital policies which had not been reviewed or updated in line with the hospital’s own procedures, and there was no audit system for the medical wards to audit their policies and guidance.

We saw the AMU policy used guidance NICE, the Royal College of Physicians, the British Geriatrics Society and the Society for Acute Medicine, and the guidelines for ambulatory care were based on NICE guidance. One ward, who had appointed a frailty lead who was a physiotherapist, had developed a comprehensive frailty assessment with patient standards based on guidance from the British Geriatric Society and the World Guidelines for Falls.

On the AMU, guidance was available for conditions, which included sepsis, acute gastrointestinal bleeding, venous thromboembolism, acute kidney injury, acute poisoning, diabetic and endocrine emergencies, asthma, transient ischaemic attack, epilepsy, delirium, dementia and mental health disorders including depression and self-harm.

Nutrition and hydration

Staff checked if patients were eating and drinking enough to stay healthy and help with their recovery.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The

service used the Malnutrition Universal Screening Tool (MUST). We saw in the patient care records reviewed during our assessment that this had been completed in all records. Results from the quality dashboard for the medical wards showed that MUST score completion had only reached the target of 95% April 2022, from the period of January to August 2022.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We saw that there were signs by patient beds when fluid intake was restricted.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Face to face speech and language support were limited, however online consultation was available and positive feedback had been provided around this service, there was also access to dietitians. Food supplements were available for patients who needed them.

Four patients said that the hospital food was okay, they had a choice, and it was always hot, although it could be bland. At RDCH, the ward had its own dining room and patients were encouraged to sit at the table if they were able to.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Pain scores taken as a baseline within 30 minutes of admission to AMU. We saw that patients' pain scores were discussed at the board rounds so that pain relief could be managed.

Patient feedback forms included questions about how their pain was managed. On the AMU, 90% of patients said that their pain was well managed, and that staff did everything they could to alleviate their pain.

We saw in the patient care records reviewed during the assessment that pain scores were recorded.

Patient outcomes

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

The service participated in some relevant national clinical audits, including the Sentinel Stroke National Audit Programme.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Performance was reviewed and monitored as part of the divisional governance meetings and the quality dashboards so that staff and management. Action plans were developed to improve care and treatment. The service recorded all inpatient falls per 1,000 days through the quality dashboard. We saw the service's target was ≤ 6.63 falls per 1,000 days, although the service had only achieved this in 1 month from the period of January to August 2022. However, we saw the service consistently exceeded its target of 95% for percentage of patients who had venous thromboembolism prophylaxis between January 2022 to August 2022.

The AMU had completed Commissioning for Quality and Innovation (CQUIN) frameworks for sepsis and venous thromboembolism from NHS England.

There were link nurses on all wards visited for areas including palliative care, infection control, aseptic non-touch technique, tissue viability, dementia, nutrition, safeguarding, diabetes, urology

and smoking cessation.

The frailty service had been set up to identify and support patients in the hospital with frailty needs. The service had reduced the median length of stay on the ward from 21 to 13 days. There had been a reduction in mortality rates from 17% to 6% and readmission rates had dropped by 5% to 25%. The service had set its own guidelines with the comprehensive frailty assessment taking place within 72 hours of the patient's admission.

Neurologists, who were based in the UK, held clinics and did ward rounds every 2 weeks to review stroke patients as appropriate. There was a visiting orthoptist who saw stroke patients as necessary.

There were specialist nurses and advanced nurse practitioners to support services including neurology and gastroenterology.

There was a reconfiguration of the stroke service in north Mersey and the stroke nurse had been involved in these service developments so they could further develop the service on the island.

Competent staff

The service did not always ensure staff were competent for their roles. Managers did not always appraise staff's work performance and there were not always supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We saw there were competency frameworks for staff, including health care assistants, which were completed by staff.

Managers gave all new staff a full induction tailored to their role before they started work. There were induction packs for new staff, as well as buddy schemes and mentorship schemes for staff.

There were education sessions for doctors and nurses on the AMU. Doctors told us the training they received was good. During our assessment, we saw a board round was used to develop junior medical staff and students with challenge and discussion about individual cases.

The junior doctors told us that they had received training in acute kidney injury, chest drains, fluid balance and its importance and how to insert a peripherally inserted central catheter.

The lead nurse on the stroke unit told us they provided training sessions for all hospital and ambulance staff to develop and maintain skills regarding stroke management. There was a training day organised for recognition of stroke and transient ischaemic attack followed by a clinical skills day.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Managers on some wards told us they did not have the time to do staff appraisals due to staffing shortages. Pharmacy staff said they did not receive appraisals or 1-to-1s. However, we saw staff on 1 ward received 6-monthly appraisals.

Multidisciplinary working

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

The medical wards worked with NHS hospital trusts and specialist tertiary centres in England, which included stroke services and long-term conditions services. These relationships were

important as the island could not always provide specialist medical and nursing cover 24 hours a day 7 days a week.

Staff held regular and effective multidisciplinary team meetings (MDT) to discuss patients and improve their care. We saw there was good multidisciplinary care on all wards visited. At the morning board rounds on the AMU, there was a range of staff who were involved in the care and treatment of the patients, including pharmacists, occupational therapists, specialist nurses, doctors, medical students and consultants. We saw that staff from the hospice were involved in the 11.30am meeting and facilitated a same-day discharge for a patient.

There was a frailty lead on ward 6 who was a physiotherapist. They worked with a range of therapists and other health professionals in the identification and management of frailty in patients in the hospital. They were working with primary care colleagues to implement community pathways for patients. There were MDT meetings to support the patients with frailty service, care homes, pharmacists, GP's and allied health professionals.

The stroke wards commissioned appropriate charities to support stroke patients during their hospital stay and following their discharge into the community.

Seven-day services

Most key services were available 7 days a week to support timely patient care.

The medical wards were available 7 days a week and there was good access to diagnostic services.

The thrombolysis service was available 24 hours a day, 7 days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. On the acute stroke unit, there was information about hypertension for staff and patients.

Staff assessed each patient's health when admitted and provided support to help patients to live a healthier lifestyle. As part of the initial patient assessment, patients were provided with information about their lifestyle and wellbeing. Additional support services were available, such as smoking cessation services.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under Manx legislation.

Staff were not provided with training in consent. However, staff demonstrated they understood the principles of consent. Staff told us they made sure patients consented to treatment based on all the information available. We were told by staff that appropriate verbal consent was obtained from the patient prior to any examination or treatment.

Leaders told us that consent was recorded but they did not routinely monitor this, so it was not clear how they were assured that staff gained consent and assessed capacity to keep people safe.

Within the April 2022 minutes of the operational clinical quality group, it showed that there was a lack of assurance regarding compliance with Manx Care's consent to examination or treatment policies and procedures. There was an interim policy for capacity, best interests decisions and deprivation of liberty. This policy was dated for use from 1 June 2022. We saw that there were documents to assess the capacity of patients prior to treatment.

We saw staff on the AMU completed delirium assessments on appropriate patients, which could indicate if the patient had fluctuating mental capacity and was able to make decisions about their care. We saw that some patients had 'do not resuscitate' status in their records. Staff told us that discussions were initiated by junior medical staff but were signed off by a consultant.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw on the AMU that patients were comfortable and call bells were in reach. All patients were appropriately dressed, and privacy and dignity were respected.

At the board round on the AMU, we observed that staff used 'likes to be called' when discussing patients' care.

We spoke to 4 patients on the stroke unit who all said their care had been good, and they had been well looked after.

Emotional support

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

The ward clerk on the acute medical ward dealt with relatives' telephone calls to the ward, keeping them up to date with patients' progress.

Staff told us they worked with charities when patients were admitted to the ward who had pets to ensure appropriate care arrangements were in place.

The neurological nurse had done a quality improvement project to look at the effectiveness of the nurse in meeting individual care needs of the patients. One of the survey questions was about the emotional worries and social concerns of patients.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. At board rounds, the patient's home circumstances were discussed and along with any future care needs. Staff discussed if family members were coping with caring responsibilities.

We saw meetings were held between staff, patients and their relatives on the stroke unit, which could be done by video link if a patients' family lived off the island.

We reviewed 3 patient survey results from 1 ward and saw all were very positive, with 1 patient saying that staff made time for them, and another stating that their care was fabulous. On the AMU, in 92% of the patients surveyed in May 2022 said their care was very good and 7% said that it was satisfactory.

We saw in patient care records there had been advanced care planning and end of life discussions which had involved the patient and their relatives.

Is the service responsive?

We found that this service was responsive in accordance with CQC's assessment framework.

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

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

Managers planned and organised services, so they met the changing needs of the local population.

Wards were spacious with bay areas and side rooms. Some side rooms had systems that generated a negative and/or positive air pressure to support the care of patients with infectious diseases. All wards had safe outside spaces that were adequately maintained.

The AMU took patients from the minor injury's unit at RDCH, primary care, out of hours GP services, the urgent and emergency care department, and from outpatient services. There was a phlebotomy service for the AMU, but all the nurses were trained in phlebotomy to expedite any blood tests. There was no intermediate care service on the island.

The service ran clinics for transient ischaemic attacks 3 days a week and were in the process of increasing this to 5 days a week. Due to a lack of speech and language therapists (SALTs) on the island, swallow assessments were done remotely from the UK. The SALTs would do a swallow and communication assessment following the dysphagia screen, which was completed by the nurses.

Patients who were discharged from the stroke ward were followed up with a phone call 2 weeks following their discharge. They were then reviewed after 6 weeks, and then every 3 months by a doctor or a nurse. The service aimed to discharge patients from the service after 12 months, but this was not always possible due to a lack of community support for stroke patients.

There was a lack of psychological neurological specialist support in both the acute and community services. At the time of our assessment, we saw there was a waiting list of about 4 years, which was impacting on the rehabilitation of stroke patients.

There was a dedicated room for therapists on the stroke unit but no therapy kitchen, which meant occupational therapists had to improvise with a kitchen scenario. They did activities with patients, such as card making, to assess visual perception. Due to limited staffing both in the hospital and the community, there was no early supported discharge service.

The occupational therapists on the stroke unit were being trained to undertake assessments for driving competencies for stroke patients to help them to return to driving as soon as it was safe to do so.

We saw patients with mental health problems were optimised medically on the acute medical

wards and then discharged to a more appropriate setting for their needs with additional support provided by dedicated services for older people's mental health and the crisis team.

At RDCH, staff were trained to do ultrasound scanning for urinary retention, which meant patients did not have to return to Noble's Hospital.

Meeting people's individual needs

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

There was an overall strategic plan for adults with learning disabilities for the hospital services.

Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports.

Wards had appropriate signage for people with living with dementia. Patient information boards indicated those patients with cognitive impairment and learning disabilities. Any communication difficulties were discussed at board rounds.

We saw on the AMU, there was a service called 'bridge the gap' which supported patients who were transitioning into adult services from children's services, or who lived with a learning disability. Patients had access to electronic games, and if medically fit, patients were supported to visit the hospital café.

On 1 ward, we saw games and colouring books were available for patients but there were no structured activities. We saw there was signage by the beds and on doors for patients with hearing loss and additional needs.

Staff told us that they could access translators as necessary.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Patients who were expected to stay in hospital for less than 72 hours were cared for on the AMU. Patients who were expected to stay in hospital for more than 72 hours were referred to an inpatient ward as soon as possible after the initial review.

On each ward, there was a nurse coordinator who facilitated the discharge or transfer of patients to support the flow of patients through the hospital. The access and flow coordinator visited the wards several times a day to check on bed status and we saw there were regular hospital bed meetings.

At the board round on the AMU, all discharge dates and reasons for delayed discharges were discussed.

There was an outlier policy and medical outliers were usually placed in surgical wards. There were named medical consultants for the medical wards.

The service did not always report on all aspects of access and flow, such as delayed transfers of care. This was work in progress for the care group.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service did not always treat concerns and complaints in a timely way. Concerns were investigated and lessons learned shared with staff.

Patients, relatives and carers knew how to complain or raise concerns.

The quality dashboard for the service showed complaints were acknowledged within 2 days, meeting the target of 98%, but the target to meet the first written response was only met in 2 of the months between January to August 2022. On some months, the numbers were as low as 33%.

There was an Independent Review Body for complaints that had not been resolved by the service.

Managers shared feedback from complaints with staff and learnings were used to improve the service. On the AMU, this was done through email and staff meetings. The consultant on the AMU told us they used to discuss complaints at the monthly governance meetings but due to lack of consultant cover these meetings had been cancelled.

We were told how a complaint had changed practice on 1 of the wards, with the outcomes embedded into the routine checks for the ward.

Is the service well-led?

We found that this service was well led in accordance with CQC's assessment framework.

Leadership

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

There was strong and effective leadership at ward manager level. All the ward managers we spoke with were working with their staff to develop them into managers of the future.

We saw services did not always run well, however managers dealt with day-to-day issues including nurse staffing and the ward environment. They had excellent relationships with medical staff including consultants.

All staff said their managers were supportive, capable and approachable. They were always visible on the wards.

Ward managers and coordinators, we spoke with told us the care group managers were supportive and they worked closely with them. They felt involved and their voices listened to. We saw care group managers were visible on the wards and 1 of them had trained as a healthcare assistant to support staff.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a plan and a vision for the future of the services. Senior managers were working with the government to prioritise new services and service improvement.

There was a business case to expand and sustain ambulatory emergency care provision to improve the flow from the urgent and emergency care department, which would be co-located and share staff with the acute oncology service. This would reduce patient numbers in the urgent and emergency care department and be able to provide same day treatments for patients.

Staff and managers were working on the vision for the service, and were involving other stakeholders, such as the NHS trusts within the UK.

Culture

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

There was an open culture on all the medical wards we visited. Staff told us their managers were approachable and they would be happy to raise issues if appropriate. There were staff meetings where staff could speak openly about any issues or concerns.

There was a whistle-blowing policy for the hospital.

Governance

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

There were governance meetings between the care group managers and senior operational managers for the medical wards. Agenda items included incidents, complaints, finance, performance and risk. Managers fed this information back to staff through ward meetings and emails so that all staff received relevant information.

The consultant in the AMU told us there used to be governance meetings for the AMU with membership from staff, which included senior medical and nursing staff, but due to the consultant shortage on the unit these had been suspended. Agenda items at these meetings included mortality, complaints, incidents and performance.

Management of risk, issues and performance

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

There was a risk register for the care group and for the medical wards, which senior managers and senior operational nursing staff were aware of. The main risk was staffing and skill mix, and acuity of the staff on the medical wards. Recruitment was difficult on the island and bank staff were expensive.

The ward manager of the AMU was able to verbalise the risks to the unit, which included not being able to take patients who needed non-invasive ventilation and the staffing of the ambulatory care unit.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was

not always in easily accessible formats. The information systems were secure but not always integrated.

There was a quality dashboard but not all the domains were populated at the time of our assessment. We saw this provided information to staff and managers and saw actions had been taken to improve services.

Staff told us having 3 different patient record systems made their roles more challenging. Staff explained how the systems did not 'talk to each other', which meant staff had to log into different systems to view different aspects of patients' care records. We were told the introduction of 1 integrated system would improve data collection and gathering.

All staff undertook General Data Protection Regulation (GDPR) training as part of mandatory training. We saw that computer screens were not visible to patients on the wards.

The boards containing patient information had doors that could be closed following the board rounds.

Engagement

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

A senior member of staff told us both paper and electronic staff surveys have been undertaken in the last 12 months to enable leaders to focus on staff wellbeing. Staff told us of listening events that had been run by their CEO, which staff spoke positively of.

There was excellent working with partner organisations that supported the service to deliver care and treatment to the patients on the Isle of Man.

Patient stories were becoming more embedded at board meetings. Leaders told us Manx Care Advice and Liaison Service (MCALS) were working with the care group on how they could engage better with service users.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

In order to improve recruitment, Manx Care developed a preceptorship package which has been shortlisted for a nursing journal award twice. This was a year-long programme with a protected day each month for training and supervision. This programme was open for all newly qualified staff, and those coming from overseas or from an area which was not providing acute healthcare, such as nursing homes.

We saw that quality improvement projects had been completed by staff.

All the junior doctors on the medical wards completed a quality improvement project.

End of Life Care

Overall Summary

Noble's Hospital provides acute care to patients admitted to their services. It works in collaboration with The Hospice, Isle of Man to provide care for those requiring end of life or palliative care. The hospital offers essential nursing care and has a mortuary service, viewing facilities and chaplaincy service.

Ramsey and District Cottage Hospital (RDCH) provides nursing facilities for those requiring end of life or palliative care that were medically stable.

The end of life pathway is provided as part of the medicine main core service. Where arrangements are the same, we have reported findings in the medical services report. We requested data in relation to end of life care from both the medical services core service at Manx Care and The Hospice, Isle of Man.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

Safeguarding

Staff did not always understand how to protect service users from abuse. Staff had training on how to recognise and report abuse but not everyone had completed it.

Not all staff completed safeguarding training to appropriate levels for their role. Data provided by the service showed that as of January 2022, 41.2% of staff had completed children's safeguarding training and 57.7% of staff had completed adult safeguarding training. There was no breakdown of levels of safeguarding training at care group level. We saw that training numbers were increasing and that there were available dates for training.

Staff training figures were provided for safeguarding children level 3 but did not demonstrate what percentage of the workforce had completed training.

Manx Care planned to introduce a specific integrated safeguarding team for children and vulnerable adults which would work with external agencies such as the police through daily safeguarding huddles. The approach had been supported by the Safeguarding Board and was due to be implement by June 2023.

Staff had access to hospital-wide safeguarding policies and procedures. These were accessible via the hospital internet.

Cleanliness, infection control and hygiene

The service managed control infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

Wards that provided end of life care to patients and their families were visibly clean and hygienic. Hand washing and hand hygiene was observed as being followed. Cleaning schedules were in place and being followed.

Toilets were available for visitors, which were visibly clean and hygienic. The mortuary was clean and free from any odours. Fridges were visibly clean and cleaning schedules were in place.

Infection prevention and control (IPC) audits were not taking place in the mortuary area. Staff told us these had not taken place for a while and audit data provided did not include mortuary IPC. This posed an infection prevention risk particularly if the deceased had an infectious disease as there was no process in place to ensure cleaning was taking place to an appropriate standard.

Hand hygiene audits took place on medical wards. Hand hygiene audits on 1 ward were at 100% compliance for September 2022, 89% for August 2022 and 100% for July 2022There were bimonthly IPC audits across the medical wards.

Personal protective equipment (PPE) such as face shields, gloves and aprons were available for use by staff in relevant areas.

The multi-faith rooms were visibly clean, tidy and well maintained.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes, staff took precautions and actions to protect themselves and patients.

The design and layout of the wards at the hospital meant there was a good number of single rooms on wards.

The deceased viewing suites were clean and tidy. There was 1 deceased viewing suite which was separated into 2 parts to meet the needs of people viewing either an adult or child. These were located through a separate entrance next to the mortuary which led to a waiting area. The first viewing area was a children's viewing suite where families would have close viewings with their child, in either a cot or Moses basket. This had a glass partition, which was curtained so that these could be opened giving view of the adults' viewing room. This gave the option for families to view their loved one through the glass screen or gave access to the body for close viewing through a door. Viewings were never conducted for more than 1 family at a time.

The mortuary was located on the hospital site on the lower ground floor of the building. There was a concealment trolley for transporting bodies from wards to the mortuary. There was a separate entrance to the mortuary for hearses. The design of the mortuary met best practice guidance and allowed for circulation and had adequate space for movement of equipment.

Fridge and freezer temperatures were checked daily, and staff were aware of the acceptable ranges. If temperatures went outside of the acceptable range, the system alarmed.

A swipe card system was being installed on mortuary doors to enhance security. A key system was staying in place alongside the new system to ensure there was a failsafe for entry in the event of power failure.

At RDCH, nurses or facility staff transported the deceased to the mortuary. Patients were advised to request viewings of the deceased through the funeral services as they were unable to offer a viewing facility.

Medical wards used the syringe pump drivers. These were serviced annually, or sooner if a fault was identified, by an external company. Nurses were responsible for checking that syringe driver services remained in date.

On RDCH, the manager told us equipment needing service or maintenance was sent to Noble's Hospital. We saw that the syringe drivers had been recently serviced.

Dirty utility rooms were kept locked to prevent any unauthorised access. On the AMU, we saw there was a Control of Substances Hazardous to Health (COSHH) folder and saw any hazardous substances were stored appropriately.

Clinical waste was in correctly coloured bags.

Sharps containers were dated and not overfilled. There were sharps audits on all wards.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, staff did not always identify and quickly act upon patients at risk of deterioration.

The department used the National Early Warning Score (NEWS2) tool, a clinical tool that aims to quickly identify the deterioration of a patient, to assess patients attending the department. We reviewed patient care records and saw NEWS2 scores were recorded and acted upon appropriately and were in line with the hospital's NEWS2 and escalation policy. NEWS2 escalation audits were completed, and the results of the April 2022 audit showed the ward had achieved 75% compliance.

At RDCH, staff explained they had a lower threshold for escalating a patients' NEWS2 score due to no medical cover being available overnight.

Senior staff told us that timely recognition of patients nearing the end of their life was challenging and there was no formal process in place to monitor and determine when a person may require palliative or end of life care. This resulted in patients inappropriately receiving diagnostic and therapeutic interventions up until death. This had not been identified as a clinical risk and there was no audit in place. There was no specific palliative care team or clinical lead for end of life care at the hospital.

The service used the hospital adult service pathway to manage patients with suspected sepsis, which outlined the 'red flag' sepsis criteria, and the 'Sepsis 6' actions staff should complete within the hour.

Staff shared key information to keep patients safe when handing over their care to others. Staff used the 'situation, background, assessment, recommendation' (SBAR) tool for all patients on the wards, which provided a comprehensive handover when patients were transferred between clinical teams.

There were board rounds on all medical wards we visited. There was a multidisciplinary approach to handover meetings which included nurses, doctors, occupational therapists and pharmacy. We observed 1 meeting and saw this was well structured, with discussions about every patient and their possible discharge date. The consultant allocated doctors to the patient list and there were discussions about diagnostics, pain and medicines. Each patient's social situations were discussed as appropriate. A representative from the hospice was present at the meeting and a discharge to the hospice was discussed and agreed for that afternoon. Several patients were

moved to speciality wards following the meeting.

Nurse staffing

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

Leaders told us that there was no designated palliative or end of life care team but that end of life care was delivered by the clinical team responsible for the patient.

The service did not always have enough nursing and support staff to keep patients safe. We saw there were shortages of nursing staff and healthcare assistants on most wards visited during the assessment and saw several examples where these staff shortages had impacted the quality and safety of patient care.

For example, the lack of staff on the AMU had resulted in the ward not being able to take patients who required non-invasive ventilation (NIV), which then affected the staffing of the ambulatory care unit. Managers explained how this lack of staff had contributed to an increase in patient falls,

The service primarily used long-term agency staff from the UK to cover any vacancies, although ward managers were often used to make up staffing numbers.

Several nursing staff were acting up into more senior roles to cover staff sickness and vacancies. Staff said they were well supported by senior managers, but some were finding the new roles a challenge.

Physiotherapists, occupational therapists and therapy assistants supported the medical wards. At RDCH, rehabilitation assistants supported the occupational therapists and the physiotherapists.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Leaders told us the service had access to the hospice's medical staff for inpatients on the end of life pathway that were unable to be moved to the hospice inpatient unit. This staffing included a junior doctor and 3 hospice physicians., An on-call rota was in place that comprised of 3 hospice physicians, a consultant and GP, who were supported by specialist palliative care advice provided remotely from a third party in the UK, and an on-call paediatric consultant.

Staffing

There was no specific end of life care team. End of life care was the responsibility of the clinical team caring for the patient and was reflected in the overall staffing figures.

The mortuary staffing team had a staffing establishment of 3 and were fully staffed.

The pharmacy team were short-staffed and were using 2 locum pharmacists and had 5 vacancies available.

Records

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

Patient care records were a mixture of paper and electronic notes. Paper records were stored

securely at nursing station and in locked trolleys.

We looked at 2 patient care records on the frailty ward. We saw that risk assessments were recorded and reviewed when appropriate, medicines were administered correctly, discussions with patients and families about end of life were recorded, and all records were legible. All were signed with a few omissions of General Medical Council and Nursing and Midwifery Council numbers.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Medicines were not always prescribed, administered and recorded in line with hospital policy. Venous thromboembolism (VTE) risk assessment outcomes were recorded on all medicine administration charts. The route of administration was recorded including the reason for prescribing medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists regularly reviewed, monitored and provided clinical advice on the best way to administer medicines.

Staff did not always store and manage medicines safely. There were no recent audits available to ensure safe and secure medicine storage. Medicine storage systems were not always secure, and access was not always suitably restricted

Medicine fridge temperature monitoring, to ensure the safe storage and efficacy of medicines, was inconsistent. Although the service had systems to ensure medicines were stored at the recommended room or fridge temperatures, we saw these were not always followed. For example, we reviewed the fridge temperature records for a fridge on 1 ward for September 2022 and saw only 14 temperature readings had been documented. Emergency medicines were available and stored in tamperproof trolleys or boxes in all areas visited. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts. However, staff at ward level did not always receive updates or information on medicine safety incidents.

The service monitored and audited its use of antimicrobials. For example, staff audited the usage, types, compliance, indication of appropriate types and stop dates of antimicrobials used on AMU. When the audit started, compliance was at 16%, which increased to 77% by August 2022.

At RDCH, there was no pharmacy support. All medicines were delivered from Noble's Hospital, including medicines for discharge. These came in bags for individual patients and were stored securely to be given to the patient on discharge. Controlled drugs were stored securely on the ward.

The service had its own supply of end of life drugs and staff carried a 'just in case' box if undertaking a home visit. The hospital worked closely with the hospice at home team to arrange medications for people where necessary.

Controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely.

Pharmacist staff told us that the organisational separation of Manx Care and the hospice made it difficult to be assured of consistent medication handling for end of life care across the hospital,

hospice and community. Some staff were employed across organisational boundaries to mitigate this risk. For example, 1 pharmacist was employed for 1 day a week at the hospice supporting inpatient services, and 3 days a week at the hospital.

Anticipatory medicines were not always prescribed, administered and recorded in line with hospital policies. Guidance was available in the hospital's Care of Dying policy, but pharmacy staff told us these were sometimes prescribed inaccurately or inappropriately due staffing pressures in the pharmacy team.

Incidents

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

All staff knew what incidents to report and how to report them. There was an electronic system for the reporting of incidents. There had been 1 serious incident and no never events in the period from January to August 2022.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Alerts on the CAS website include National Patient Safety Alerts (from MHRA, NHS England and NHS Improvement and the UK Health Security Agency (UKHSA)), NHS England and NHS Improvement Estates Alerts, Chief Medical Officer (CMO) Alerts, and Department of Health & Social Care Supply Disruption alerts.

We noted from the minutes of the operational clinical quality group in February 2022 that the implementation of CAS Alerts remained an area of focus for care groups. In the minutes of the April 2022 operational clinical quality group, it was stated that recording CAS alerts on the electronic reporting system had commenced in February 2022 and there had been 15 alerts received and cascaded. However, there had been a poor response and targets had not been met since February.

Staff understood the duty of candour. Duty of candour training was part of mandatory training. The serious incident log showed the date the duty of candour letter was sent out to the patient or their relatives.

Managers at RDCH told us how they recorded all patient pressure areas using the electronic incident system.

There was a serious incident review panel which met every week to review serious incidents and feed back to managers and staff.

However, we saw staff did not use the incident reporting system to record staff shortages for each shift.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service did not always provide care and treatment based on evidence-based practice. Staff protected the rights of patients in their care.

The service followed the policies of The Hospice, Isle of Man. This included their policy on the 'care of dying adults in the last days of life', which was informed by guidance issued by the National Institute for Health and Care Excellence (NICE).

Leaders told us they were unaware of any internal clinical protocols or policies for end of life care within the service. The service depended on end of life care services from the hospice and could not give assurance that end of life care delivered on medical wards was standardised or consistent.

There were no audits in place to measure the quality of end of life care offered to patients within the acute hospital.

The service did not offer a specialist end of life care or palliative team for those requiring specialist levels of support.

The service did not provide evidence of working towards any standards or accreditation in end of life care.

The mortuary manager was developing legislation with the Isle of Man Government to ensure that processes around the disposal of human tissue and organ donation were followed. This was being built using existing legislation from England and Scotland.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The service used the Malnutrition Universal Screening Tool (MUST). We saw in the patient care records we reviewed during our assessment that this had been completed in all the records. Results from the quality dashboard for the medical wards showed that MUST score completion had only reached the target of 95% April 2022, from the of period January to August 2022.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We saw that there were signs by patient beds when fluid intake was restricted.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and there was access to dietitians. Food supplements were available for patients who needed them.

At RDCH, the ward had its own dining room and patients were encouraged to sit at the table if they were able to.

Pain relief

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

Staff offered palliative care patients symptom management in the form of syringe pumps and followed the hospice's policy for this.

Patients were referred to the hospice for specialist palliative care input, which included symptom management.

The acute oncology team advised on symptom control for patients with cancer who were approaching the end of their lives.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. The service had not been accredited under relevant clinical accreditation schemes.

The service participated in some relevant national clinical audits.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers did not monitor waiting times to make sure patients could access end of life services when needed and received treatment within agreed timeframes.

The frailty service had been set up to identify and support patients in the hospital with frailty needs. The service had reduced the median length of stay on the ward from 21 to 13 days. There had been a reduction in mortality rates from 17% to 6% and readmission rates had dropped by 5% to 25%. The service had set its own guidelines with the comprehensive frailty assessment taking place within 72 hours of the patient's admission.

Staff were not aware of specific mechanisms for monitoring the quality of end of life care delivered within the acute hospital. However, this was an element of the mortality review process.

Managers monitored the quality of end of life care provided through mortality review process. Approximately 30% of inpatient deaths were reviewed. However, the reviews were conducted by the clinician responsible for the care of the patient and therefore this was not independent. Leaders told us the learnings from these reviews were centred around too many inappropriate admissions to hospital for end of life care but could not provide information on how this was being addressed.

The service collaborated with a UK service for oncology advice or for those with cancer who were approaching the end of their lives. Staff from the UK service felt the relationship was beneficial to patients receiving appropriate and safe care on the island. However, the relationship was largely dependent on individuals and relationships needed to be developed between teams to ensure a consistent approach for patients.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We saw there were competency frameworks for staff, including health care assistants, which were completed by staff.

Managers gave all new staff a full induction tailored to their role before they started work. There were induction packs for new staff, as well as buddy schemes and mentorship schemes for staff.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Managers on some wards told us they did not have the time to do staff appraisals due to staffing shortages. Pharmacy staff said they did not receive appraisals or 1-to-1s. However, we saw staff on 1 ward received 6-monthly appraisals.

Staff had access to The Hospice, Isle of Man Scholl Academic Centre, which provided training courses in breaking bad news, communication skills, symptom management, advanced care planning, care of dying, palliative care and syringe pump training. However, data provided did not reference which staff had completed courses specific to end of life.

Staff told us there was limited formal training for medical staff in palliative care. A consultant for the hospice presented once per rotation on the junior doctor education programme.

Multidisciplinary working

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

The medical wards worked with NHS hospital trusts and specialist tertiary centres in England, which included stroke services, oncology services and long-term conditions. These relationships were important as the island could not always provide specialist medical and nursing cover 24 hours a day 7 days a week.

Staff held regular and effective multidisciplinary team meetings (MDT) to discuss patients and improve their care. We saw there was good multidisciplinary care on all wards visited. At the morning board rounds on the AMU, there was a range of staff who were involved in the care and treatment of the patients, including pharmacists, occupational therapists, specialist nurses, doctors, medical students and consultants.

There was a frailty lead on ward 6 who was a physiotherapist. They worked with a range of therapists and other health professionals in the identification and management of frailty in patients in the hospital. They were working with primary care colleagues to implement community pathways for patients. There were MDT meetings to support the patients with frailty service, care homes, pharmacists, GPs and allied health professionals.

Ward 6 was to have a dedicated social worker to support patients and their discharges.

Manx Care worked with the hospice team to provide support for symptomatic care at end of life and supported certain MDT meetings to identify any potential admissions and provide any palliative care advice.

The service sought end of life and palliative care advice from the hospice for patients that were already known to them or could make a referral for any new patients using the service. This included advice for medical and nursing teams, support for families and carers, and the coordination of services. There was no formal arrangement in place between the hospital and hospice, and advice was provided on an ‘as required’ basis, which could reduce the continuity of care or consistency of information given.

The service had introduced a ‘CHART’ team in the community. This team comprised of a geriatrician, frailty specialist and pharmacist and was created with the intent to reduce emergency department (ED) attendances and increase appropriate prescribing. Their aim was to visit nursing homes to provide care plan reviews, medicines reviews, and advanced care plans across the

island.

Seven-day services

Most key services were available 7 days a week to support timely patient care.

The medical wards were available 7 days a week and there was good access to diagnostic services.

Patients were referred to hospice if they required specialist palliative care input. The team would attend wards and give advice on end of life care for patients known or referred to them. The acute oncology team advised on symptoms control for cancer patients who were approaching the end of their lives. Both teams provided a 7-day service.

Health promotion

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

Staff assessed each patients' health when admitted and provided support to help patients to live a healthier lifestyle. As part of the initial patient assessment, patients were provided with information about their lifestyle and wellbeing.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw on the AMU that patients were comfortable and call bells were in reach. All were appropriately dressed, and privacy and dignity were respected.

At RDCH, patients receiving end of life care were allocated a healthcare assistant or nurse to sit with them until relatives were present to ensure that no one passed away alone.

Emotional support

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

The ward clerk on the acute medical ward dealt with relatives' telephone calls to the ward, keeping them up to date with patients' progress.

Staff had access to training on breaking bad news and communication skills, provided by The Hospice, Isle of Man Scholl Academic Centre.

The end of life care team was unable to give details of how people's holistic, spiritual and

emotional needs were managed, apart from access to chaplaincy services. The service had a chapel that catered for multiple faiths, which people could use at any time.

Patients' loved ones were given a bereavement pack which contained information to support them in their time of grief. This included information about practical matters, such as funeral arrangements, registering death and visiting the deceased, as well as bereavement support. The leaflet used sympathetic language and offered the service's condolences.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. At board rounds, the patients' home circumstances were discussed and along with any future care needs. Staff discussed if family members were coping with caring responsibilities.

Staff facilitated meetings with patients and their relatives. This could be done face-to-face, or by video link if the patients' family did not live on the island.

In patient care records where advanced care planning and end of life discussions had taken place, these involved patients and their relatives.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

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

The service did not always plan and provide care in a way that met the needs of local people and the communities served.

The acute medical wards were based at Noble's Hospital, along with support services which included diagnostics, specialist nurses and allied health professionals.

RDCH and the hospice took medically optimised patients for palliative and end of life care. However, the system to identify when these transfers were appropriate was not effective. Staff told us there was a lack of standardisation regarding end of life care across the island, and there was no palliative care service within the acute hospital. Access to these services externally relied on individual staff visiting the hospital wards to identify patients that may require palliative or end of life care.

Wards were spacious with bay areas and side rooms. Some side rooms had systems that generated a negative and/or positive air pressure to support the care of patients with infectious diseases. All wards had safe outside spaces that were adequately maintained.

Due to a lack of speech and language therapists (SALTs) on the island, swallow assessments were done remotely from the UK. The SALTs would do a swallow and communication assessment following the dysphagia screen, which was completed by the nurses.

Meeting people's individual needs

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

There were comprehensive patient assessments that included individual care plans. The service had introduced the comprehensive geriatric assessment admission proforma, which included prompts to complete advanced care plans where necessary.

Wards had appropriate signage for people living with dementia. Patient information boards indicated those patients with cognitive impairment and learning disabilities. Any communication difficulties were discussed at board rounds.

Staff told us they could access translators as necessary.

Access and flow

People could not always access the service when they needed it and received the right care in a timely way.

Staff told us the timely recognition of patients approaching the end of their life was a challenge. Staff explained the service did not monitor how effectively patients who were approaching the end of their lives were identified and had identified this lack of audit as a clinical risk.

Timely referral to hospice services did not always take place, particularly when patients were not already known to the hospice them. The hospice provided a comprehensive service for palliative and end of life care patients in a timely way when patients were already known to the hospice, but slow identification of patients approaching the end of their lives and an informal referral system to hospice care resulted in patients not receiving timely end of life care. For example, in 1 patient care record, we saw they were admitted to hospital on the Friday, but the decision to make a referral to the hospice had not been taken until Monday due to lack of consultant cover over weekend, and sadly the patient had passed away by the time staff had contacted the hospice.

Staff told us they were concerned about the inconsistent approach to end of life care. There were specific services for the provision of end of life care on the island, but no robust system to refer to them from the acute hospital and no specialist end of life or palliative care service within the hospital. A nurse consultant from the hospice had piloted a formalised outreach service to identify patients appropriate for hospice referral on wards, but due to resources this did not continue. Timely referral depended on staff recognising the approach of end of life care and making a telephone call to the hospice team, or the nurse consultant from the hospice making regular visits to the hospital to identify deterioration themselves.

The service had introduced the long length stay ward round to improve identification of patients with complex needs who resided on the ward for over 21 days These ward rounds were not recorded, and we saw no data to support this had improved recognition or referral times for patients.

On each ward, there was a nurse co-ordinator and one of their roles was to facilitate discharge or transfer of patients to support the flow of patients through the hospital. The access and flow coordinator visited the wards several times a day to check on bed status and we saw that there were hospital bed meetings in the mornings and afternoons.

Staff told us that rapid discharge of patients when their preferred place of death was their home was a challenge due to a lack of funding for continuing care at home and a perceived risk aversion to deaths in the community.

There was an outlier policy and medical outliers were usually placed in surgical wards. There were named medical consultants for the medical wards.

The frailty service had been set up to identify and support patients in the hospital with frailty needs. The service had reduced the median length of stay on the ward from 21 to 13 days.

There was an emergency department end of life care algorithm (flow chart) which included prompts for anticipatory medicines, preferred place of care and death, resuscitation status and discussions with family. As this was developed by the hospice team, the service was unable to routinely monitor compliance due to lack of compatibility with electronic system.

The service had introduced the CHART team in community visiting nursing homes to provide clinical support with the intent to reduce emergency department attendances. The introduction of the team was in its infancy and there was limited information to support whether this had decreased emergency department attendances or increased advanced care plan completion.

Nurses at RDCH were aware of how to access the out of hours emergency response and would call an ambulance if a patient required transfer to Noble's Hospital.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service did not always treat concerns and complaints in a timely way. Concerns were investigated and lessons learned shared with staff.

Patients, relatives and carers knew how to complain or raise concerns.

The quality dashboard for the service showed that complaints were acknowledged within 2 days meeting the target of 98% but the target to meet the first written response was only met in 2 months from January to August 2022. On some months the numbers were as low as 33%. There was an Independent Review Body for complaints that had not been settled.

Managers shared feedback from complaints with staff and learning was used to improve the service. On the acute medical unit, this was done through email and staff meetings. The consultant on the acute medical unit told us that they used to discuss complaints at the monthly governance meetings but due to lack of consultant cover these meetings had been cancelled.

We were told how a complaint had changed practice on 1 of the wards with the outcomes embedded into the routine checks for the ward.

Is the service well-led?

We found that this service was well led in accordance with CQC's assessment framework.

Leadership

Leaders had the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Patients requiring end of life or palliative care did not receive care from a specialist team and there was no clinical lead for end of life care. Representatives from the medical services core service of the hospital that had relevant interests were considered leads for end of life care. This included 2 consultant geriatricians and a physiotherapist frailty lead. Staff were unable to identify leaders for end of life care.

There was strong and effective leadership at ward manager level. Ward managers were working with their staff to develop them into managers of the future.

We saw that services were well run, that managers dealt with day-to-day issues including nurse staffing and the ward environment. They had excellent relationships with medical staff including consultants. All the staff said that their managers were supportive, capable and approachable.

Ward managers and coordinators told us the care group managers were supportive and that they worked closely with them. They felt involved and that their voices were listened to. We saw that the care group managers were visible on the wards and one of them had trained as a health care assistant and worked shifts on the wards.

Vision and strategy

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

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There was a plan and a vision for the future of the services. Senior managers were working with the government to prioritise new services and service improvement.

There was a business case to expand and sustain ambulatory emergency care provision to improve the flow from the urgent and emergency care department which would be co-located and share staff with the acute oncology service. This would reduce patient numbers in the urgent and emergency care department and be able to provide same day treatments for patients.

Staff and managers were working on the vision for the service, and were involving other stakeholders, such as the NHS trusts within the UK.

Culture

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

There was an open culture on all the medical wards we visited. Staff told us their managers were approachable and they would be happy to raise issues if appropriate. There were staff meetings where staff could speak openly about any issues or concerns.

There was a whistle-blowing policy for the hospital.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.

There were governance meetings between the care group managers and senior operational managers for the medical wards. Agenda items included incidents, complaints, finance, performance and risk. Managers fed this information back to staff through ward meetings and emails so that all staff received relevant information.

There was no service level agreement in place with the hospice or RDCH to formalise the

arrangement that patients receiving care in the hospital would be referred and receive treatment. This led to untimely referrals of patients and inconsistent care for patients approaching the end of their lives.

Quality of end of life care was not specifically monitored but was addressed within the mortality review process. Findings had been identified, but we did not see actions taken to improve services and minimise inappropriate admissions to the hospital for end of life care.

Leaders were not aware of clinical protocols or policies for end of life care. The hospital relied on the local hospice to provide end of life care, but the slow identification of patients approaching the end of their lives meant patients were still receiving care within the hospital until their death. The service could not give assurance of a standardised approach to end of life care across all wards.

The service did not have an audit schedule that addressed areas specific to end of life care. There were no patient record audits to identify whether documentation such as advanced care plans (ACPs) or do not attempt cardiopulmonary resuscitation (DNACPRs) had been completed.

The service did participate in benchmarking audits against other specialist palliative care units, such as in the use of continuous subcutaneous infusions for symptom control and was found to perform similarly to other specialist units.

There was no governance process in place to monitor whether staff had completed training relevant to end of life and palliative care through the Hospice.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

There was a risk register for the care group and for the medical wards, which senior managers and senior operational nursing staff were aware of. The main risk was staffing and skill mix, and acuity of the staff on the medical wards. Recruitment was difficult on the island and bank staff were expensive.

There was no formal process in place to monitor and determine when a person may require palliative or end of life care resulting in patients inappropriately receiving diagnostic and therapeutic interventions up until their death, which had not been identified as a clinical risk.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was not always in easily accessible formats. The information systems were secure but not always integrated.

There was a quality dashboard but not all the domains were populated at the time of our assessment. We saw this provided information to staff and managers and saw actions had been taken to improve services.

Staff told us having 3 different patient record systems made their roles more challenging. Staff explained how the systems did not ‘talk to each other’, which meant staff had to log into different systems to view different aspects of patients’ care records. We were told the introduction of 1 integrated system would improve data collection and gathering.

All staff undertook General Data Protection Regulation (GDPR) training as part of mandatory

training. We saw that computer screens were not visible to patients on the wards.

The boards containing patient information had doors that could be closed following the board rounds.

Engagement

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

A senior member of staff told us both paper and electronic staff surveys have been undertaken in the last 12 months to enable leaders to focus on staff wellbeing. Staff told us of listening events that had been run by their CEO, which staff spoke positively of.

There was excellent working with partner organisations that supported the service to deliver care and treatment to the patients on the Isle of Man.

Patient stories were becoming more embedded at board meetings. Leaders told us Manx Care Advice and Liaison Service (MCALS) were working with the care group on how they could engage better with service users.

The hospital had informal engagement arrangements with RDCH and the hospice for end of life care provision. Members of the hospice attended certain MDTs, but there were no formalised engagements to ensure that patients were receiving consistent end of life or palliative care across the pathway.

Learning, continuous improvement and innovation

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

We saw that quality improvement projects had been completed by staff.

All the junior doctors on the medical wards completed a quality improvement project.

Urgent and Emergency Care

Overall summary

The urgent and emergency department is at Noble's Hospital and sees about 150 to 160 patients every day. The department has 14 patient areas across the majors and resuscitation areas.

We visited the minor injury and illness unit (MIU) at the Ramsey and District Cottage Hospital (RDCH). The unit sees an average of 37 patients every day, rising up to 50 patients on some days, which is about 40% of the emergency department attendance across the island.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

Not all staff received and kept up to date with their mandatory training. The service had a target of 95% for compliance with mandatory training but had not achieved this in all areas. Numbers had increased since the pilot assessment in June 2022.

Managers monitored mandatory training and alerted staff when they needed to update it. Since the pilot assessment, a local dashboard had been developed to enable monitoring. Staff were paid if they completed mandatory training in their own time.

In the minor injuries unit at RDCH, we saw that staff had completed their mandatory training, including immediate life support and paediatric basic life support, where training rates where 100%. Staff were given time to complete their mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse.

The service had rolled out level 3 safeguarding training for children and young people since the pilot assessment. At the time of this assessment, 11 members of staff had completed the training with dates booked for training in October, November and December 2022.

The safeguarding team had spent a week in the department working with the staff, and a member of the safeguarding team attended the daily safety huddle.

Staff had started to receive training specific for their role on how to recognise and report abuse. Resources had been rolled out to staff including an exploitation checklist, an adult safeguarding liaison form and a child safeguarding folder. Staff had been signposted to further resources online.

Staff told us that safeguarding had improved, and a junior doctor said they had received good advice from consultants when needed.

We conducted a review of 12 records in the department and saw

Children and young people who were receiving statutory support due to their vulnerability were flagged appropriately on the emergency department (ED) system. We saw these were in place on several records and where appropriate it had instigated contact with the agency involved. This supported early identification and alerting of partner agencies.

There was a system to support community practitioners being made aware of children attending the ED. The safeguarding named nurses facilitate the sharing of information through the electronic care record and we saw examples of the ED staff highlighting the young person would benefit from health visitor/school nurse input. This is recognising the onward care and early help that community staff can offer.

We were told safeguarding nurses were visible in ED and offered support on complex cases and facilitating sharing of information with partner agencies for children identified with benefitting from additional support. For example, staff highlighted a case where a children at risk referral was made as a result of maternal behaviour, but not accepted as children were not exposed to the behaviour. The nurse had a good insight of mother's vulnerability and provided good advice and support.

The recording of the children's and young people's voice, and whether they had been seen on their own, was variable. The assessments were not clear on whether the child or young person had offered their perspective of why they were there or what had happened. Seeking the child's view adds meaning and context to the assessment.

The ED records did not offer consistency on recording if the young person was seen on their own, which was particularly relevant when consideration was being given to the risk of exploitation. For example, a young person was seen for overdose and self-harm, and an agreement was given by the young person for child sexual exploitation (CSE) trigger tool to be completed with a parent present, but it was not recorded if this was their choice.

The electronic ED triage and assessment tools supported practitioners to consider safeguarding and record multi-agency involvement. However, tools such as CSE risk assessment and referrals were not seen attached to the ED record, although they were reported as completed in the record and the safeguarding team had knowledge of their completion. This meant the ED record of care was not offering a full evidence base of activity undertaken to safeguard the child.

The records did not always show a level of professional curiosity within the free text that would inform assessment and the decision making of the level of concern for the children. For example, a young person who had attended the ED after taking an overdose, was not asked any questions about what had happened in the interim or where the medicines where sourced from. A second example was a young person who had anxiety and had fainted who was brought in by an ambulance, but the records did not note if pregnancy had been considered.

We saw that parental responsibility and attending adults was consistently recorded but the recording of the child's family structure (genogram) in ED was a deficit. Although it is possible to record this as free text it is not being undertaken, this means that the child may not be seen within the context of the family unit.

Children attending in mental health crisis had access to child and adolescent mental health services (CAMHS) input between Monday to Friday, and the adult rapid assessment team out of hours. This was a gap in service and was leading to children being admitted to the ward for monitoring until CAMHS could respond to the request for their specialist input. ED did not have an

identified room that was modified and safely adapted during their time in the department. This was not offering a child focused approach.

Children leaving the department before being seen were not managed under an agreed protocol to ensure a consistency in approach. This did not support identifying the child's need and potential vulnerability. For example, a young baby had been registered at the ED, but had left and went to RDCH. It was not clear if the department knew this or what they would have done if they had not been there when called.

We were told there is no chaperone policy, although patients including young people are asked if they would like one. This was a shortfall in supporting a consistent approach to patient choice and their safety, which we raised with the head of safeguarding during our assessment.

In the MIU at RDCH, there was a safeguarding link nurse, and all staff were working through their level 3 training for safeguarding children. We were given an example where there had been several children who had self-harmed, and the nurses shared this information with the safeguarding team and the school.

There was a safeguarding folder available, and staff were aware of safeguarding processes. Staff could ring the on-call duty social worker in working hours or via ambulance control out of hours service for advice referrals. There were safeguarding alerts on the system.

Managers told us Disclosure and Barring Service (DBS) checks were carried out on all staff centrally by the human resources team. These checks help to prevent unsuitable people from working with vulnerable groups. We were not able to corroborate if all staff had a DBS check.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

The ED appeared visibly clean and well maintained. Hand washing facilities and personal protective equipment (PPE), such as gloves, face masks and plastic aprons were readily available throughout the department. All staff were bare below the elbow. However, we observed that staff did not always wash their hands or use alcohol gel before or after providing care and treatment to patients.

We observed staff using barrier nursing principles for a patient admitted with diarrhoea.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned. We saw that staff were using green stickers to indicate that equipment had been cleaned.

We observed staff cleaning equipment after use and most equipment appeared visibly clean. Staff showed us that an item of equipment identified at the last visit as being visibly dirty had been replaced.

Hand hygiene compliance was included as part of the quality dashboard but there were no results shown. As part of the department action plan, the service was to review infection prevention control audits in the department.

The MIU at RDCH was visibly clean and tidy and well maintained and all staff had completed their

infection prevention control training. The curtains around the bays were clean and there were hand washing facilities available.

There was evidence of daily checks and cleaning. Linen was stored correctly in a cupboard off the floor. There was a PPE trolley and appropriate hand hygiene posters including posters for COVID-19 symptoms. Hand gel and soap dispensers were full. Green stickers were in use for clean equipment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

There were 14 patient areas in the majors and resuscitation area.

In April 2021, the design, footprint and internal infrastructure of the emergency department was added to the risk register as it was deemed to be a risk to patient safety, staff welfare and operational inefficiencies in the work force.

The design of the department meant that patient areas were not visible from the nurses' or doctors' stations.

Following the pilot assessment and in view of the risk to patients, plans had been drawn up to make structural changes to the department to incorporate additional services including a same day emergency care service. Consideration needed to be given to where services were relocated to for the duration of the building works and the prioritisation of the phases of the changes.

The department did not have an appropriate ligature-free room. There was a ligature-free space risk assessment scheduled for 12 Oct 2022 and the issue had been raised with the Director of Infrastructure.

Daily equipment checklists were not always completed in full. We found out of date equipment on the airway trolley, the blood trolley and the resuscitation trolley. There were missed checks in August for the main resuscitation trolley for 5 days and in September for 6 days. In majors, there were 11 missed checks in September. We escalated this to managers at the time of the assessment.

Areas of the ED that had been cluttered with equipment had been cleared since the pilot assessment and we observed areas were less cluttered.

We were told that these were the proposals for equipment checks and services. Each ward within the medicine, urgent and emergency and ambulance service care group had their documented list of equipment that required maintenance. This included the date it was last serviced and when the next service was due and who by. This was also recorded on the equipment itself. Each area would have at least one individual responsible for maintaining the list and equipment on a weekly basis. This list would also be kept with the hospital asset replacement officer who would update a central list. Any equipment that was due for renewal would be flagged up to the asset replacement team.

Waste was stored in an unlocked room but was segregated and the appropriate waste was in the correct areas. Fluids were stored in unlocked rooms. Sharps boxes were not overfilled and were signed and dated.

We saw substances, which in the UK would fall under the Control of Substances Hazardous to Health (COSHH) regulations, were now stored in the dirty utility room which had been fitted with a

digital lock.

There was a relative's room with comfortable seating and in a quiet area of the department.

There was no scanner in the department for scanning bladders, which staff said led to delays in treatment.

There was no separate waiting area for children as this had been reallocated for use by suspected or positive COVID-19 patients. This meant children and young people had to wait in the adult waiting room. There was a designated children's cubicle in the main ED. Emergency paediatric equipment was available, which included an emergency trolley. We noted that appropriate guidelines were laminated and attached.

The staff room in the department was too small for the numbers of staff who may have used it at any one time.

In the MIU at RDCH, there were 3 cubicles - 1 with a chair and 2 with trolleys. There was a room with a door and staff could do eye tests in this room. The bays had medical oxygen and suction.

The resuscitation trolley was checked every day. There was an expiry date checklist on top of the trolley as a visual prompt for when items were going out of date.

Hazardous substances were not left out in the sluice and were stored correctly, and sharps boxes were not overfilled and were signed and dated.

At the MIU at RDCH, we saw that there was some out of date stock including surgical gloves, biotabs (a disinfectant product) and lidocaine (a local anaesthetic). There was no central ordering for stock and 3 different forms were needed. This led to delays in receiving stock and staff overstocked to avoid running out of items. There was no stock rotation.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and removed or minimised risks. Staff did not always identify and act upon patients at risk of deterioration.

The ED used the National Early Warning Score (NEWS2) tool, a clinical tool that aims to quickly identify the deterioration of a patient, to assess patients attending the department. We found NEWS2 scores were not always completed in a timely manner and not always acted upon in line with best practice. During our visit, we saw that a patient with a NEWS2 score of 6 whose score was overdue review by 1 hour.

The ED had an electronic board which logged all patients in the department and contained key information such as time of arrival, NEWS2 scores and tests patients were waiting for.

There was a clear policy in place for NEWS2 in the ED. We were not assured that the policy was always followed by all staff.

Patients who self-presented to the ED were booked in by receptionists and then triaged by a nurse in a room off the main waiting room. Triage was completed using the Manchester Triage System (MTS), which included recording patients' observations using NEWS2. MTS is a globally recognised assessment tool used for triage in urgent and emergency care departments and by the ambulance service. In the patient care records, we saw all patients had a NEWS2 score completed on arrival in the ED.

Staff did not always complete individualised risk assessments for patients to ensure they managed

risks such as pressure damage, falls or malnutrition in a timely way. Patients could spend a long time in the department on a trolley and in England patients should have a skin assessment within 6 hours of arriving in the department. We did not know if there was a policy for completion of skin assessments in the emergency department. Falls assessments were not completed for patients over 65 years of age. We tracked 5 patients from the emergency care department to the acute medical unit and saw these risk assessments were completed in a timely way.

The ED had introduced a sepsis tool using the 'Sepsis 6' principles. Staff had worked to reduce blood culture contaminants as this had proved to be a problem. There was a trigger on the patient alert system for staff when they should consider sepsis.

In the action plan, we saw there was a pressure areas risk assessment being developed, and the emergency department was working with the frailty lead to agree suitable tools for the risk assessment of falls.

One of the consultants was working on venous thromboembolism risk assessments using guidance from the Royal College of Emergency Medicine. There was an electronic bleep system that staff had on their phones that they could escalate concerns, ask for reviews, request and contact other staff. All messages were recorded to provide an audit trail. Staff really liked the system.

Patients who had to spend the night in the ED were transferred from a trolley to a bed.

There was a red phone in the emergency department and every incoming ambulance was telephoned through to the department.

Staff shared key information to keep patients safe when handing over their care to others. They used the 'situation, background, assessment, recommendations' (SBAR) handover system.

There were handovers for medical staff twice a day, which were structured and standardised. There were also separate nursing handovers.

Patients in the department could be monitored from the intensive care unit and the coronary care unit.

If patients returned to the ED with the same problem, staff sought advice from a consultant. This followed an incident where there was a delay in a patient diagnosis. We saw that this was raised at the safety briefing in the ED.

A mental health triage form for adults and children had been developed to be completed at triage. This risk was automatically triggered on the electronic system.

Staff told us that the paediatric staff were very responsive when support was requested from the staff in the ED. There was a medical emergency team in paediatrics.

In the MIU at RDCH, patients reported to reception and waited to be called in for treatment. There was no triage system, and the patients were not in view of any clinical staff. The receptionists would inform the MIU staff if there was anyone with chest pain or who looked poorly but there was no standard operating procedure or training for this. We found the average time to clinical assessment was 12 minutes in May, 14 minutes in June and 19 minutes in July.

The ambulance service had a list of conditions that could be treated at the MIU at RDCH could treat. If these criteria were not met the person, would need to go to the ED at Noble's Hospital to ensure patients received the right treatment in the right location.

MIU staff at RDCH told us that they had a good relationship with the ED and if they had any concerns they could ring and speak to somebody in the ED for advice.

We saw that there were sepsis screening tools including one for children under 5 years of age and one for children aged 5 to 11 years of age. There were charts available and guidance for the recording of paediatric early warning scores.

There was a sepsis drawer, and the sepsis tool were attached to the drawer. The unit had no laboratory facilities so any patient suspected of having sepsis would have their bloods taken and then would be transferred by ambulance to the ED at Noble's Hospital.

There was a daily safety huddle for the staff where agenda items included incidents, equipment issues and new policies were discussed.

The MIU at RDCH had X-ray facilities from Monday to Friday and reports were usually back within 48 hours or sooner.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Manx Care told us that there were currently no conventions in place for monthly reporting of safe staffing levels and no convention in place for publishing nursing staffing levels on the hospital website. In addition, Manx Care was unable to provide vacancy, sickness and staff turnover rates for the ED. This information was included on the quality dashboard but there was no data available on the dashboard we saw.

All staff told us there was not enough registered nurses or support staff employed in the department. Staff told us the required staffing levels were 7 registered nurses (RNs) and 2 care support workers (CSWs) on a morning, 8 RNs and 2 CSWs on an afternoon and 5 RNs and 2 CSWs overnight.

On the day of the assessment, the service was short of 3 registered nurses for days and 2 for the night shift. There were recruitment adverts out for 2 band 5 nurses and 9 applications had been received. There were several nurses waiting to start in the department on were being onboarded or were currently supernumerary to numbers for induction.

There was an advert out for a senior nurse which was a new post for the department. There were several internal applicants for these posts. Adverts were due out for CSWs and a temporary band 7 post.

We saw that staff returning to work and new starters were supernumerary in the staffing numbers. We spoke with a member of staff who was a new starter. They told us that they were 2 weeks into their supernumerary period and were completing their competency booklet from the Royal College of Nursing.

There was a nurse consultant who worked 50% of their time in teaching and 50% in the department teaching and working with staff in their development.

The MIU was fully staffed with 6 band 6 nurses and 1 band 7 nurse, who was an advanced nurse practitioner.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe. The department had 3 full time emergency medicine consultants and 2 locum consultants. The consultants, which included covered the department from 8am to 4pm Monday to Friday. Overnight support was provided by a foundation year 3 (F3) and a speciality (ST) doctor. The service was looking to increase the night staffing with 2 speciality doctors. At weekends, medical cover was provided by 3 foundation year 3 speciality doctors and 2 foundation year 2 doctors.

There were no paediatric emergency consultants employed in the department. The department relied on paediatricians from the children's ward for children who were seriously ill. We were told the paediatric ward medical staff were very responsive.

There were 2 consultant job posts, and the job descriptions were with the Royal College of Emergency Medicine for approval. One job was for a consultant in emergency care and pre-hospital care and the other was for a consultant for adult and paediatric emergency care. The locum consultant staff said they were interested in the permanent posts.

There was an advert out for a speciality doctor and there was interest in the post with 2 adverts.

There were 11 middle grade staff both locum and substantive posts.

There was a business case to increase the number of F3 doctors from 4 to 8. There was a plan for an ST4 doctor to be recruited.

Locum doctors tended to have long placements on the island and were given a full induction by the medical staff. They were part of the ED workforce.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Staff did not complete patient care records in line with the standards required by their registering bodies, such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC).

We reviewed 10 sets of patient records; 5 sets were back tracked from patients on the acute medical unit from patients who had come through the urgent and emergency care department and 5 were patients who were in the department at the time of the visit. We saw that risk assessments were not completed. NEWS2 scores were recorded on admission but not always followed up in the appropriate time frame. All records we looked at were signed and dated appropriately.

Staff did not always record comfort rounds for patients, although we did see that they took place. The service was producing a comfort rounding document to make this easier for staff to record.

As part of the CQC action plan, the service was going to identify best practice for record keeping and to work with other clinical directors to support this work across the hospital.

We observed computer screens with patient information were visible in patient facing areas.

In the MIU at RDCH, we looked at 5 patient records. The records were of a good standard although staff were not consistently using their NMC number when signing paper documents.

They were not always recording the second checking of electrocardiograms and X-rays. All paper documents were scanned into the electronic patient record.

Medicines

The service had systems and processes to prescribe and administer medicines safely. There was a good relationship with the pharmacy service to ensure medicines were available. However, medicines were not always stored securely or safely.

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines advice and supply from pharmacy was available and staff knew the routes to obtain medicines out of hours if required.

Staff did not store and manage all medicines securely or safely. On entering the ED corridor, there was a cupboard at floor level which was open with the contents visible. It contained intravenous (IV) fluid bags which were not securely stored and were easily accessible.

The clinical utility room used for medicines storage was locked and secure with access only to authorised staff who had key card access. However, there was limited workspace to prepare and manage medicines primarily due to the chaotic and cluttered storage of medicines. On the work bench, there was a pile of medicines which included loose strips of medicines not in their original container, patients' own labelled medicines and boxes of stock medicines with no coordinated and safe storage. This increased the potential risk of a medicine error, or a medicine not being located. The reason given was that new shelving had been installed and there was not enough space for all the medicines. In a back corner of the room was a plastic bag containing 2 patients' own labelled medicines as well as various loose strips of unlabelled medicines. The floor space was also limited due to 2 large boxes delivered from pharmacy containing medicines that had not been opened and put away. On raising this with staff, immediate action was taken to clear and tidy the whole room.

A chemotherapy extravasation box was available, but it had expired in December 2021 and had not been checked or replaced.

Medicines required in an emergency were available and expiry dates checked were in date. They had a tamper-evident seal to ensure they were safe. Staff recorded weekly safety checks on medical gases, emergency medicines and equipment to ensure they were safe to use if needed in an emergency.

Medicines and controlled drugs (CD) were stored securely. Checks were undertaken and recorded by 2 staff, twice a day. An up to date policy for the management of CDs was available. Random checks of CDs showed that they were within date and stock balances were accurate.

The medicine fridge in the clean utility room was locked and secure with authorised staff access only. Records of medicine fridge temperatures were available, but for September 2022 there were only 4 readings documented. One nurse explained that if they were out of range then they would report it to estates, but it was not clear how they would know if the fridge temperature was within a safe range with only 4 readings taken. The medicine fridge in the trauma unit used for storing anaesthetics was locked and secure. We found only 1 temperature recording had been documented out of 5 days in October 2022. Fridge temperatures were not recorded daily because many of the medicines stored including insulin and vaccines are required to be maintained within a safe range as part of the cold chain.

Blank prescription pads were stored securely within the CD cabinet. Records were kept of the

serial numbers of prescription forms when they were issued which would help identify any prescriptions lost or stolen.

In the MIU at RDCH, staff told us that there were no regular visits from pharmacy and that staff did all the checks themselves. Any stock came from the hospital at Noble's Hospital. We saw that medicines were stored securely and that all cupboards and rooms were secure. We saw that there were 3 out of date vials of lidocaine (a local anaesthetic). We made staff aware of this at the time of the assessment.

The vaccines fridge was locked, and temperature checks were undertaken daily. We found there had been 6 missed checks since 1 January 2022. We looked at the CD book, cupboard and CD checks and everything was in order. Any medicines to be disposed of were signed out by 2 members of staff, placed in a sealed bag and returned to Noble's Hospital.

Staff had all completed the medicines management training which was done every 2 years.

All patient group directions (PGDs) were all on the intranet and we checked 4, which were in date. All policies and access to the British National Formulary were on the intranet. We found that the PGDs were limiting the staff's ability to be able to treat some patient groups. For example, if a patient was allergic to penicillin, then there was no alternative PGD, and the patient would have to go to their GP.

Three of the nursing staff were non-medical prescribers. We saw that allergies were recorded on the patient records.

Incidents

The service did not always manage patient safety incidents well. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers did not ensure that actions from patient safety alerts were implemented and monitored.

As part of the action plan following the pilot assessment, a piece of work was underway focused on incident reporting. This involved the use of the electronic reporting system and linking this into the culture workstream so that staff would be comfortable to report incidents. The information from incidents would be used to improve patient care and safety.

While staff knew how to report incidents, we were not assured that all incidents were declared. This included shifts when there were not enough staff. There was a safe board for staff in the ED which had information for staff, and we saw at the morning safety briefing that incidents were discussed.

There was a serious incident review group and there was GP membership of the group.

We were given 2 examples of where things had gone wrong in the department and how practice had changed following these incidents.

A local incident standard operating procedure was being developed and circulated round the department for review as part of the CQC action plan. There were also actions in place so that any actions and lessons learned about incidents and complaints would be displayed in the department. An incident management standard operating procedure was to be circulated for review.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

We did not have assurance the CAS alerts were read and followed up. This information was part of the minutes of the operational clinical quality group on 10 May 2022.

Staff received training on the duty of candour.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

Prior to the previous assessment, Manx Care advised that they had limited evidence that the National Institute for Health and Care Excellence (NICE) guidance was applied universally at the hospital, but that NICE guidance was applied in some clinical areas. We were also told that positive systems of assurance, monitoring and reporting were not in place. Manx Care's rationale for this was that whilst clinical practice operates under evidence-based guidelines, there were no formal assurance systems in place for monitoring and reporting.

During the previous assessment, we saw out of date guidance in use. We also saw hospital policies which had not been reviewed or updated in line with the hospital's own procedures.

During this assessment, we saw there were trauma pathways in place, and these were easily accessible. There was a consultant lead for the Royal College of Emergency Medicine audits, but sometimes there were not enough patients to qualify for the audit.

The departmental action plan included a committee for clinical guidelines and standard operating procedure assessment and a clinical pathways group. Draft terms of membership, terms of reference and membership were to be agreed.

The service had appointed a lead business manager following the previous assessment. They were working to consolidate all the data sources with a repository for all documentation from the department. They were working with the senior managers to develop terms of reference for all the groups developed following the pilot assessment and were populating the action plan.

The MIU at RDCH was using guidance from the Resus Council for adult tachycardia, adult bradycardia and anaphylaxis. They were using up to date guidance from NICE for the treatment of deep venous thrombosis.

Nutrition and hydration

Staff could not evidence that they gave patients enough food and drink to meet their needs and improve their health.

During our visit, we saw that sometimes staff provided patients with food and drinks if they were experiencing long waits in the department, but this was not consistent for all patients. We did not see comfort rounds documented in-patient care records.

Staff did not complete malnutrition risk assessments in ED. We were told these were completed when patients were admitted to a ward.

As part of the department action plan, 1 of the actions was to ensure nutrition and hydration was documented in the patient care records. The service was developing a standard operating

procedure for nutrition and hydration. There were no dates in place for these actions.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. In the patient care records we reviewed, we saw that at triage staff assessed people's pain and scored it. A pain score of 1 to 10 was used with 10 being the worst pain ever experienced and 1 being no pain.

In all the patient care records we saw the pain score had been documented and, in most cases, analgesia was given and reassessed.

We saw in the MIU at RDCH, staff used smiley faces to assess pain in children. We saw in the patient care records that all pain charts had been completed.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment.

At the previous assessment, Manx Care told us that there were no formal systems for assessing positive outcomes. However, some negative outcomes were identified through the mortality review process, complaints, serious incidents and patient feedback. At this assessment, we found clinical assurance auditing remained limited and did not cover all areas where there may be a risk to patients' safety.

The service was collecting some information about their outcomes and dashboards were being developed for the department. As part of the department action plan, a patient safety and quality group was due to be set up. Draft terms of membership, terms of reference and membership were to be agreed.

Staff told us that there was excellent access to diagnostic services for ED patients.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance.

At the pilot assessment, Manx Care told us that appraisal data was not held centrally, therefore there was no assurance system to ensure staff received timely, effective appraisals of their work or clinical supervision.

As part of the department action plan, an education and clinical supervision had been set up with draft terms of reference, terms of reference and membership to be agreed. Role specific training needs were being identified and a training policy developed.

Junior doctors and medical students told us they were always asked to work to their competency level, they had training in practical skills and there was simulation training every week. They said that the departmental training was good and there were sometimes additional sessions. They said that teaching sessions never got cancelled.

Doctors and nurses described induction processes as good, and a newly qualified nurse showed us they were working through their competencies.

All staff said they needed training in paediatric nursing and medicine. There was training booked

for nurses in paediatric nursing between January and March 2023.

There was a nurse consultant whose role had changed since the previous assessment. They were now involved in training the advanced nurse practitioners for 50% of their time and doing mentoring, training and skills development and checking competencies with the ED staff for the other 50% of their time. They were also an independent prescriber.

In the MIU at RDCH, we saw that staff were working through their competency booklets. The manager told us that they had sent out the appraisal documents to all staff and had completed 50% of the appraisals and were waiting for the other staff to arrange a date for their appraisals. Staff had all completed additional training for their roles.

The manager told us that there were opportunities for staff including advanced nurse practitioner courses and non-medical prescribing courses.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

The pilot assessment had highlighted a disconnect between the nursing staff and the medical staff and part of the department action plan was a staff engagement forum to try to improve the culture and working relationships in the department. This was work in progress.

There were several separate discipline handovers which took place. MDT handovers were more limited. Nursing staff held handovers at 7am and at each shift change. Medical staff held a handover at 8am and there was an all-staff departmental briefing at 9am where safety incidents and other key messages were discussed.

We saw that there was good support from the thrombolysis team during the assessment. The ED staff told us that the paging system ensured a prompt response from the team.

The staff told us that they always got a good response from colleagues, when they required additional support, especially out of hours.

A member of staff from pharmacy visited the department each day to check the medicines and restock when needed.

The children's safeguarding team had recently started visiting the department to review all children and young people's care records each day.

At the MIU at RDCH, we were told there was good multidisciplinary working with the other departments in the hospital. The service could refer to the physiotherapy and occupational therapy service on site. Staff told us that if the orthopaedic surgeons were doing their clinics (Tuesday to Friday) they would see patients from the MIU in their clinics. The dermatologists would also see patients.

Seven-day services

Key services were available 7 days a week to support timely patient care.

The ED was open 24 hours a day, 7 days a week.

The MIU at RDCH was open 8am to 8pm, 7 days a week.

Health promotion

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

Following the pilot assessment, changes were being made to 1 of the electronic patient care record systems to add a tick box system for health promotion. Patients could also be referred to the smoking cessation service.

At the MIU, there health promotion leaflets and staff could refer patients to the smoking cessation services.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

We saw that staff were caring towards patients and took time to interact with patients.

We saw that staff closed curtains in cubicles when they were treating patients. A patient with diarrhoea was admitted to the ED and staff maintained their dignity before they were moved to another ward.

There was to be a patient feedback board in the department. Compliments were collected by the hospital, so we were unable to attribute any of them to the ED.

In the MIU at RDCH, the desk had been lowered at reception as patients had complained it was too high and there was no privacy.

In the MIU, 97% of patients had said they were very satisfied with the privacy of their consultation. Patients were also asked if they were treated with dignity and respect and 90.5% said that they had all the time and 9.5% said that they had most of the time.

Emotional support

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

We observed when a patient was visibly distressed that a member of the nursing staff went to console and reassure them. They then went to find out what was happening to the patient.

The nursing competencies included communication with patients and respecting confidentiality.

We spoke with 2 patients in the department. Both were positive about their care and treatment and received explanations about what was happening and how long it might take.

The service had miscarriage care packages so that staff in the department could support women who had suffered a miscarriage if there was nobody available from obstetrics and gynaecology to support them. This was rolled out during our assessment, and we saw that staff were made aware of the care package.

Understanding and involvement of patients and those close to them

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

The department had a relatives' room, which had tea and coffee making facilities. This room was used for relatives and carers who were distressed or who needed a quiet space. The room was in a quiet area of the department and appropriately furnished and decorated.

We did not see in the patient record that there had been interactions between patients, families and carers but when we were in the department, we saw that this was happening, and that staff were explaining issues and care with patients.

We saw that staff were contacting relatives on behalf of patients for more information and to give explanations and reassurances to them.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

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

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

At the pilot assessment, we were told how managers planned and organised services to meet the needs of the local population. When we spoke with staff and leaders, they were able to tell us about the needs of the local population and how they adapted services to meet this need.

Managers recognised the service was busier from 1pm to 6pm and attempted to increase staffing in line with the increased acuity. However, this was not always possible due to gaps in the staffing establishment.

There was no dedicated porter for the ED and no chute system to get samples to the laboratory. Staff had to take patients to the wards and to diagnostics which meant that they had to leave the department for periods of time.

The island held the TT motorcycle race every year and the population of the island increased significantly during this period. We did not see any plans for how the department could flex to meet any increase in activity.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems.

Medical staff did not have a consistent uniform and locums were wearing scrubs with identification of the NHS trust of their permanent employment. Patients were not always aware who the doctors were.

The MIU at RDCH was open from 8am to 8pm 7 days a week, although staff said the service usually ran late. There was a reception from 9am to 5pm and at 5pm a healthcare assistant took over so that the desk was staffed.

Meeting people's individual needs

The service was not always inclusive and did not take into account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services.

The service could not add a flag to the electronic patient care records to identify patients living with dementia or learning disability unless they had a confirmed diagnosis. Therefore, the hospital was not able to provide data on the number of patients admitted who had a learning disability, dementia or severe sensory loss, such as hearing or sight loss.

Patients could reach call bells and staff responded quickly when called. Usually, staff were based in their area of responsibility in the department.

Staff could get help from interpreters or signers when needed. Staff told us this service was accessible through the hospital switchboard. Laptops in the department had been upgraded to include an application for basic sign language.

Staff supported patients living with dementia and learning disabilities. However, we did not see any initiatives or equipment for these vulnerable patients. One of the nursing staff told us they were the lead for learning disabilities in the ED.

There was a patient engagement group planned as part of the department action plan.

Access and flow

People could not always access the service when they needed it and receive the right care in a timely way.

The department had nowhere to stream patients to when they arrived in the department. This was due to staffing levels and infrastructure issues. There was no clinical decisions unit, and GP streaming and ambulatory care run by the medical staff were short staffed so ran in limited hours between Monday to Friday. The department was trying to run a medical acute care unit, but this often had to close due to staffing. There was a business case for infrastructure changes and permanent staffing for a same day emergency care centre and ambulatory care as part of the department. This would help to improve flow through the department.

It was planned there would be an acute oncology nurse based with the service as some patients were presenting in the ED with cancer symptoms. They would also be able to manage ongoing symptoms without the need to admit patients.

When the department was busy, the service would offer free transport to the MIU in RDCH, but managers said that there was limited uptake of this service.

The service had developed a live dashboard, so they were aware of how long patients had been in the department and if they received care within agreed timeframes. These figures were taken from the quality dashboard from September 2022.

The average time between arrival and triage was 25 minutes in May, 22 minutes in June and 23 minutes in July. The target time is 15 minutes.

The average time between arrival to clinical assessment was 65 minutes in May, 67 minutes in June and 80 minutes in July. The target time is 60 minutes.

The average time between arrival to clinical assessment for category 1 and 2 patients was 48 minutes in May, 44 minutes in June and 53 minutes in July. The target is 10 minutes.

The speciality time between the first speciality request and decision to admit was 98 minutes in

May, 102 minutes in June and 109 minutes in July. The target was 120 minutes.

The transit time between the decision to admit and admission was 111 minutes in May, 132 minutes in June and 107 minutes in July. The target was 60 minutes.

The hospital had a target that no patients should spend more than 12 hours in the ED. We saw that in May there were 88 patients who spent more than 12 hours in the department, 70 in June and 27 in July.

The average total time spent in the ED was 257 minutes in May, 261 minutes in June and 245 minutes in July. The target is 360 minutes.

In the MIU in RDCH, the average time between arrival to clinical assessment was 12 minutes in May, 14 minutes in June and 19 minutes in July. The average total time spent in the department was 47 minutes in May, 66 minutes in June and 56 minutes in July. The target is 360 minutes.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. However, there was limited evidence that lessons learned were shared with all staff.

We did not see any information about how to raise a concern displayed in the department. Senior staff told us how they managed complaints at both formal and informal levels.

There were 34 complaints for the ED and the ambulance service from January 2022 to August 2022.

We were not assured that themes of complaints were identified and that any learning was used to improve the service.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

Leaders did not always have the skills and abilities to run the service. They had not always managed the priorities and issues the service faced. The current leaders were both visible and approachable in the service for patients and staff. They had started to support staff to develop their skills and take on more senior roles.

This was work in progress following the pilot assessment. The service had acted promptly and appointed an associate director of nursing to the department. They were based in the department and were very visible. They were working with the lead consultant and the care group manager for medicine, urgent care and ambulance services. The care group manager was visible in the department and sometimes worked a shift as a healthcare assistant.

The department had been working on an action plan following the pilot assessment. There were several sections to the plan including governance and leadership, clinical, health and safety, metrics, communications, capacity, capability and culture and clinical pathways. Each section had various sub sections.

There were 3 medical consultants who provided leadership for the middle and junior medical staff. The feedback from the junior doctors and the medical staff was positive about the medical leadership.

It was noted by senior managers there had been no role models for the nursing staff and a significant under investment in staff.

The lead nurse/matron for the department had been appointed into a lecturer practitioner role and there was an advert for an 8A lead nurse position in the department who would provide leadership for the nursing staff and support the development of future leaders. There were several internal applicants for the role at the time of this assessment.

The associate director of nursing to the department had a background in leadership development and as part of their role was reviewing the senior nursing roles and responsibilities in the department.

One of the band 6 nurses was to complete a transformative leadership programme.

There was strong and effective operational leadership in the MIU at RDCH. Staff enjoyed working there and there was low staff turnover.

Vision and strategy

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

The care group manager said the action plan went beyond the pilot assessment and the action plan and was the vision for the future of the service. There had been 2 staff engagement events following the pilot assessment to engage staff in the development of the department for the future.

The action plan was detailed with key delivery milestones, start and end dates, the owner of the action and the red, amber, green rating. It had not been fully populated at the time of the assessment and was being managed by the business manager for the department.

Culture

Staff did not always feel respected, supported and valued. The service did not have an open culture where patients, their families and staff could raise concerns without fear.

Following the pilot assessment where it was noted that the culture was poor in the department, the service had organised 2 engagement events for staff to try to identify the cultural issues affecting the department. There were also informal social events. There was inconsistent attendance at these events.

Following the engagement meetings, several themes had been identified and groups were to be established to follow up in these themes. One of these groups was a staff engagement forum. As with all the groups set up, staff representation from across the department were needed so that there was buy in from the ED workforce.

The assistant director of nursing in the department told us that they were trying to lead a fairer no blame culture. They were developing workshops to support psychological safety and working with the Freedom to Speak Up team.

The monthly staff meetings were being restarted and there was cultural support, human factors training, ongoing work on care values and a team charter in development. This was on the safe board in the main ED corridor.

We spoke with medical staff and medical students. They were positive about working in the

department and had good learning experiences.

One member of staff said there was a blame culture in the department and that they were really frightened about doing anything wrong. Another told us that staff were demoralised and there had been some toxic relationships, but these were improving. Another told us that liked the department and were considering taking a permanent position.

Following this assessment, the workforce and culture team from the hospital were to spend a week in the department to further support staff in the development of a more positive working culture.

The culture in the MIU at RDCH was very positive, and staff enjoyed working there. Staff said that they felt supported in the team and that the team supported each other.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

The governance processes were not robust. This meant the department and senior leaders had limited oversight and were unable to be assured the department was providing safe and effective care and treatment.

Following the pilot assessment and the action plan that was developed, there was a section on governance and leadership which had 3 sections governance structure, leadership and support and risk management. This was work in progress.

The action plan governance structure had several committees, quality improvement (audit), patient safety and quality, clinical guidelines and assurance, education and clinical supervision, staff engagement, urgent and emergency care patient engagement group, medicines and equipment and the urgent and emergency care board. Draft terms of reference had been circulated and the membership had been agreed for each committee but at the time of the assessment the groups had not met.

There were plans to reinstate the monthly staff meetings in the department so that information could be communicated to staff.

The emergency care board had the care group leads as part of the membership and it included the senior nurses from the ED and the minor injuries unit. There was also representation from the ambulance service and the appropriate medical wards. There was a set agenda including finance, learning from incidents and complaints and staffing.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events. Staff did not always contribute to decision-making to help avoid financial pressures compromising the quality of care.

Staff had been reluctant to report incidents, but this had been identified and work was ongoing to strengthen the reporting culture in the department. This could pose a challenge to how risks were identified, investigated, actions taken to prevent reoccurrence and lessons learned shared with the staff involved and the wider organisation.

The department was further developing dashboards so that information was more widely available to all staff. However, the Manx Care Quality Dashboard was reviewed and key indicators for the department were not always fully populated. Therefore, it was not always possible to get an overall picture of the departments performance and where improvements were needed.

There was not an effective audit programme for the department. This was part of the action plan and would provide information so better manage patient safety and care and support staff development.

There was training on risk and risk management for all band 6 and 7 nursing staff. This was mentioned at the safety meetings and was on the safe board in the department. The risks in the department were part of the safe board information so that staff were aware of them.

The care group manager and the senior medical and nursing staff were able to verbalise the main risks to the department. These included staffing and acuity/skills, timely access to care and infrastructure of the department.

There was no security in the department and the administration staff had been threatened on occasion and had stopped wearing name badges with their surnames on them to reduce the threat of victimisation. Staff were encouraged to report incidents of threatening behaviour, and this was supported by the nursing and medical staff.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was not always in easily accessible formats. The information systems were secure but not always integrated.

At the previous assessment, Manx Care told us that from an information and business intelligence perspective they knew data collection in many systems was inconsistent.

The quality dashboard was not fully completed for all performance metrics for the ED.

Staff spoke of the difficulties they experienced due to them using 3 systems for patient care records.

Engagement

Leaders and staff had actively started to engage with staff. There were plans to engage with the public to plan and manage services. They did not always collaborate with partner organisations to help improve services for patients.

Following the pilot assessment, there had been 2 engagement events to capture their thoughts and ideas about how the service needed to change. Not all staff had attended the events.

Both paper and electronic staff surveys had been undertaken in the last 12 months to enable leaders to focus on staff wellbeing. In addition, the chief executive officer had held listening events.

There had been a social event that had been funded by the consultants to try to meet informally to support culture change.

As part of the action plan there was to be a patient engagement group. Terms of reference and membership had been agreed.

Patient stories were becoming more embedded at care group meetings. Leaders told us Manx

Care Advice and Liaison Service (MCALS) were working with the care group on how they could engage better with service users.

Learning, continuous improvement and innovation

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

All the staff were committed to providing a good service to their patients. They were working with managers to improve the service to provide the safest care that they could.

Quality improvement was one of the governance committees established from the action plan. There was a nurse who was doing a quality improvement course which would support the department in the future. The quality improvement group had met on 27 September 2022 to agree their proposed quality improvement projects and prepare a report to the board.

Ambulance, Air Ambulance and Patient Transport Services

Overall summary

The Isle of Man Ambulance Service carries out urgent and emergency responses for all types of 999 calls for the population of 86,000 people on the island. It has 21 vehicles operating from 2 sites with 42 whole time equivalent (WTE) members of staff. The service has 4 ambulances on duty during the day and 3 at night, each of which are usually staffed with a paramedic and an emergency medical technician or emergency care assistant. The service is supported by 3 senior paramedic officers from its headquarters and a duty officer.

The transport of patients from the Isle of Man is undertaken by a government department and not the ambulance service. Patient transport services are run as a separate entity with separate governance systems.

A fixed wing aircraft carries out emergency transfers to the nearest hospital speciality, 24 hours a day, 365 days a year. This aircraft completes approximately 500 journey per year and employs 4 substantive staff and 13 bank staff.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the ‘mandatory training’ section under Medical Services on page 8 for issues common to many services.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse. Compliance with safeguarding training for children and young people for levels 1 and 2 was 93% in January 2022, and for adults for levels 1 and 2 was 64%. We saw that training numbers were increasing and there were available dates for training.

Staff were able to give examples of where they had concerns about safeguarding and had worked with the safeguarding team to address these concerns. Safeguarding concerns were initially emailed or telephoned, and a safeguarding team were available in office hours to provide advice and support if needed. Outside of office hours, the on-call manager and the on-call safeguarding team would provide advice and guidance.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned.

Ambulances were visibly clean and had suitable furnishing, which well maintained. A dedicated deep clean team worked hard to ensure that each vehicle underwent a deep clean every 6 weeks.

Cleaning records were up to date and demonstrated all areas were cleaned regularly. The scheduling of the vehicle cleaning was done electronically meaning that staff could access the information when needed and plan for the vehicles down time in advance.

A decontamination policy was in place and set out individual responsibilities and accountabilities. The policy was in date and followed best practice guidance.

An electronic spreadsheet demonstrated what chemicals, such as chlorine-based disinfectants, had been used and when.

Staff followed infection prevention and control principles, including the use of personal protective equipment (PPE) and hand hygiene protocols. PPE was readily available on each ambulance and in the storeroom.

Clinical waste, including used sharps, were stored securely and disposed of regularly.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff managed clinical waste well.

The design of the ambulance station environment did not follow guidance. The ambulance station and ‘make ready’ building was the old boiler room for the hospital. The garage was unable to house the ambulance vehicles due to its small size. Staff told us repeated heating problems were experienced, and the car park was not big enough to accommodate staff and service vehicles. The locker room was shared between male and female staff, making changing at the start and finish of shifts difficult. In addition, a large defunct sealed gas pipe and storage unit sat in between the ambulance station and the make ready building, which was used as the main thoroughfare for service staff. Steps and paving slabs directly outside of the fire exits for both buildings were loose and uneven, and large number of weeds and trees were growing from the uneven slabs which his posed a serious risk to staff and visitors. A business case had been submitted for new accommodation, which had been approved in principle by Manx Care for the 2023/24 budget but was yet to be finally approved by the Department of Health and Social Care.

Ambulances underwent 6-weekly safety testing, which was completed by the fleet services of the government who were also responsible for the servicing of the vehicles. No feedback was received from these inspections and therefore the service did not have oversight to what safety issues may have been detected and repaired. Managers told us that, despite the 6-weekly safety inspection, several tyres that had less than the legal minimum tread depth had been detected by the service. No formal service level agreement was in place at the time of the assessment

Stretchers and equipment, such as defibrillators, underwent annual service inspections and staff carried out daily safety checks of specialist equipment.

Managers could demonstrate how the servicing of the plane was completed at every 100 hours. A service level agreement was in place, which set out key accountabilities and responsibilities. Equipment was serviced by the electronic & biomedical engineering department (EBME) based in the hospital. An asset register was in place for the air ambulance equipment meaning that the service could plan for its replacements and track servicing, faults and repairs.

Assessing and responding to patient risk

Staff did not always complete or update risk assessments for each patient or remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

999 calls were received by the emergency operations centre (EOC) where a call handler answered the call. The EOC was a joint operation with the police and fire services and was staffed by 4 dual call handlers/dispatchers, a police officer and a supervisor. We saw staff had no specific ambulance or clinical expertise. Call handlers prioritised 999 calls into 1 of 5 categories using the Advanced Medical Priority Dispatch System (AMPDS) system. A business case for change had been developed to introduce a clinical triage system, as well as improved quality assurance and audit of calls.

All calls were manually allocated to ambulance crews by radio, where patient details, call details and call priority information was passed. There were 4 dual crewed ambulances (DCAs) planned in the daytime and 3 DCAs planned overnight.

Clinical support stopped in the evening and was only available overnight via the on-call manager, who was frequently called out. This meant there was a gap in support and created the potential for clinical risk.

At the time of the assessment, there was no pathway in place for patients suffering from a heart attack to receive primary percutaneous coronary intervention (PPCI), where a stent is inserted into an artery to remove a clot. Instead, clot busting medicine was administered to the patient. Work to create a PPCI pathway had begun and was in the process of being discussed at the clinical oversight meetings. According to the National Institute for Health and Care Excellence (NICE), PPCI is the preferred coronary reperfusion strategy due to its increased effectiveness over clot-busting medicines.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them to the emergency department appropriately.

A conveyance policy containing protocols for the treatment and transportation of children between the age of 1 and 5 was in place. This included the face-to-face assessment of all children , the mandatory conveyance to hospital of children under the age of 1, and shared decision-making with the on-call emergency department consultant or out of hours GP for all children between the ages of 1 and 5. This was in place in recognition that clinicians had not yet received specific in-depth training in the assessment of young children.

The service had recognised there was no clinical support within the service for babies born before the arrival (BBA) of the ambulance service. In addition, there was no community midwife on the island. In response, the service had stocked neonatal bag valve masks (BVMs) for resuscitation on the ambulances, which it previously did not have. In addition, quick reference cards had been placed on all vehicles for emergency procedures such as the management of a breach birth, umbilical cord prolapse, and how to complete an ‘appearance, pulse, grimace, activity and respiration’ or ‘APGAR’ score.

Staff were able to telephone a senior paramedic officer for advice. During the assessment, we listened to an advice call from a double technician crew with a patient who did not wish to be conveyed to the hospital. The call included the consideration of the available options, the assessment of the patient’s capacity, consideration of their package of care, and any history of safeguarding concerns.

Staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough staff to keep patients safe. At the time of the assessment, the service had 22 employed paramedics and 6 bank paramedics. There were 13 Institute of Health and Care Development (IHCD) technicians and 8 emergency care assistants. The service had struggled with the recruitment of staff, which resulted in high staff vacancies and additional pressures on existing staff.

Staff worked a pattern of 4 12-hour shifts, followed by 4 rest days. Three additional 'standard overtime' shifts, which were above and beyond working hours, were automatically built into an 8-week rota. This posed a risk that staff did not receive adequate rest between shifts, as well as creating staffing challenges over peak times, such as Christmas and summer holidays.

Rotas were created manually by team leaders. However, the rotas could be accessed and altered by anyone which created a risk for the service. This risk was recorded on the service's risk register, and in response, the service was in the process of moving to an electronic rota platform. As this platform was designed for nurses, the service was in the process of checking and amending it for its own needs. It was envisaged this risk would be closed by the end of the financial year.

Records

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

Patient care records were all paper based. They were comprehensive and completed appropriately and staff could access them easily. A copy of the record was shared with the hospital.

Records were stored securely in designated folders, and off the vehicles they were filed securely.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored securely.

Processes and policies were in place, which detailed how medicines should be prescribed and administered. An up-to-date Ambulance Medicine Policy was available, which was detailed and comprehensive.

There were up-to-date Patient Group Directions (PGDs), which are written instructions for the administration of authorised medicines to a group of patients. A standard framework was used for all PGDs which involved the Medical Director, a pharmacist and a paramedic. This meant that medicines were administered to patients by staff with the legal authority to do so. However, we did note the service did not have a PGD in place for 1 medicine used as pain relief. We raised this to the service who advised a PGD would be implemented.

Paramedics had access to the JRCALC (Joint Royal Colleges Ambulance Liaison Committee) pocketbook on their electronic tablets, which provided information on care protocols and medicine formularies.

Staff followed systems and processes to prescribe and administer medicines safely. Medicine

records seen were accurate and up to date. However, there were no medicine disposal records for destruction.

The administration of medicines to a patient were recorded, which included using a date and time stamp at the point of administration.

Staff did not always store and manage all medicines and prescribing documents safely. We found that medicine security and access did not always ensure safe practice. For example, the key to the medicines room was a standard universal key, which meant it was not possible to determine who could access the base medicine storeroom. There was no medicine key register or log to record who had the keys, including records for the return of keys. Keys for the medicine cupboards were stored in a keypad lock with code number access, but the code number has not been changed in over 2 years.

Medicine security issues had already been identified by the head of ambulance service, who had undertaken improvements with an ongoing plan to improve overall medicine storage, security and distribution. We were shown improved window security with bars on the window with an opaque covering to hide viewing into the room from outside.

Medicine stocks were appropriately stored and managed in line with local standard operating procedures, including regular rotation of stock and checks to ensure medicines had not expired.

There was a clearly defined process for the distribution of medicine bags to ensure medicines were available to administer at each location. Medicine bags were tagged and sealed to ensure medicines were available when needed and fit for use.

Medicine rooms temperatures were monitored to ensure medicines were stored within the recommended ranges. An electronic logging system alerted staff to any temperature variations so that action could be taken.

Medical gases were stored safely and securely.

Incidents

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

Incident reports were completed electronically via a central system which meant the service could track and monitor themes and trends, as well as collate important data such as near misses and serious incidents. A total of 221 incidents had been reported by the service between October 2021 and October 2022. Of these, the top themes related to staffing due to the vacancy factor within the service, information technology issues and delays in treatment.

Road traffic incidents also featured heavily. Nine road traffic incidents had occurred between February and September 2022, which correlated with the level of advanced driver training offered to staff. The service had deviated away from the industry standard, struggled to get qualified driving instructors onto the island, and staff were not supported when involved in a road traffic incident by a senior paramedic officer with additional driver training skills.

An upward trend in the reporting of incidents was being realised at the time of the assessment, around 8 incidents per month.

One serious incident had occurred between October 2021 and October 2022 relating to a delay in treatment. The incident had been discussed at the weekly serious incident group, which is represented by the head of the service, and an initial 72 hour review and a more in depth root cause analysis had been undertaken.

Feedback to staff from serious incidents was done by individual face-to-face discussion. Feedback from less serious incidents was automatically sent to the reporter following investigation via the electronic incident reporting system and staff bulletins.

Staff understood duty of candour and knew to apologise when things went wrong. Formal duty of candour was undertaken in writing and prompts on the electronic incident reporting system meant that the investigation could not be progressed until duty of candour had been undertaken. During the assessment, we reviewed a formal duty of candour letter which had been sent in January 2022.

Patient safety alerts were shared with the service from the dedicated patient safety team within the wider organisation. These alerts were cascaded to all staff via email, and bulletins. Staff told us about a recent alert relating to a fault with a cannula which had been actioned by the service.

Senior paramedic officers within the service carried out investigations of the reported incidents including root cause analysis investigations for more serious and complex incidents.

Is the service effective?

We found that this service was effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Quarterly resuscitation and trauma committees were represented by the service, and evidence-based care and treatment came from the JRCALC guidelines, all staff could access via a smart phone application. This meant that real time updates, cautions and contraindications were available to all staff.

A patient group direction working group for the wider organisation considered important updates, such as those from the NICE and the British National Formulary. This was represented by the service and information cascaded to staff via clinical bulletins.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. A visual pain score was available for patients who were unable to communicate their pain verbally.

Patients received pain relief soon after requesting it. During the assessment, we saw that staff administered and recorded pain relief accurately.

Patient outcomes

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

The service carried out monthly local audits including major trauma and patient report form audits.

The service monitored the response times of patients suffering from an acute stroke. In August 2022, out of 29 cases, the average response time was 34 minutes and call-to-hospital time was 1 hour and 7 minutes.

The clinical director for the care group periodically reviewed the clinical management plans of patients, including those in cardiac arrest.

Competent staff

The service made sure staff were competent for their roles. Managers had not appraised staff's work performance or held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. This included a 3-day induction, followed by supernumerary period of at least 4 shifts. Each recruit was allocated a team leader to support them in their development and act as a point of contact for support and guidance. All newly qualified paramedics were assigned a mentor for a 2-year period to ensure continuity of information, support and guidance.

The service was registered to provide accredited training for emergency care assistants. At the time of the assessment, staff were trained in first response emergency care (FREC) which was a recognised qualification in emergency care. The service had a mixture of legacy Institute of Health and Care Development (IHCD) technicians, FREC and paramedic staff members

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals ran from January each year, but at the time of the assessment, appraisals and clinical supervision were being undertaken sporadically due to the breadth and volume of work the team leaders were undertaking. All the air ambulance staff had an in-date appraisal, and 6 informal meetings took place each year with the staff to identify training needs, strengths, weaknesses and concerns.

Professional registration and disclosure and barring service (DBS) checks were completed by the human resources team in the wider organisation. The business manager kept a local record to demonstrate that all checks had been completed and staff were registered and had undergone appropriate DBS checks. The next round of professional registration checks was due in August 2023, and DBS checks in January 2023.

Training courses on the management of trauma had been provided to staff which all staff had completed. This involved a face-to-face learning covering 'HOT' trauma (hypovolaemia, oxygenation, tension pneumothorax/tamponade).

Air ambulance staff completed a 2-day air ambulance skills training day course, as well as undertaking 3 buddy flights and an observed structured clinical examination (OSCE). Staff completed a further 4 OSCEs per year Coastguard flight awareness training, along with blood transfusion and intermediate management of unwell patients training, had been undertaken by all staff working for the air ambulance.

Multidisciplinary working

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

The service was able to access and refer patients into some other services, such as GP services and diabetic services However, at the time of the assessment, no formal multidisciplinary meetings were being undertaken.

The service was working hard to improve multidisciplinary working with peers across the wider ambulance landscape. Links had been forged with the Association of Ambulance Chief Executives (AACE) in the UK, and the service was represented at several of national workstreams, such as the AACE infection prevention and control, national ambulance service medical director (NASMeD), national directors of operations (NDOG) and quality governance and risk directors (QGARD) workstreams.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

At the time of the assessment, we did not see any best interest decisions being made for patients unable to consent to their own treatment or transport.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

We observed that staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness and felt reassured by their care.

Staff followed the service policy to keep patient care and treatment confidential, including by being discreet when discussing patient with members of the visiting team.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff could describe how they had supported patients who became distressed in an open environment.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff explained what they were doing and involved patients, their carers and relatives so they understand what was happening, but they felt part of the decision-making about their care and

treatment.

Staff talked with patients, families and carers in a way they could understand including by not using in-depth medical terminology which patients, relatives and carers may not understand.

Patients and their families could give feedback on the service and their treatment, and those we spoke with during the assessment gave positive feedback about the service.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

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

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

At the time of the assessment, the service was in the process of developing a shared memorandum of understanding between each emergency service to enable co-responding to serious trauma and cardiac arrests.

Tri-service working was in place for training and management of trauma on the island.

Work around timely access to services featured heavily in meeting the needs of the local people.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. Carers and relatives could travel with patients and communication cards meant that staff could help patients to understand what was happening.

Translation services were available through a telephone-based translation company.

The service had specialist equipment such as ramps, hoists and electronic raising chairs, so that patients with mobility issues could be cared for and access the service easily.

Access and flow

People could not always access the service when they needed it to receive the right care in a timely way.

Managers monitored waiting times and access to services for patients. A trend graph of the mean call cycle time for category 1 and 2 calls demonstrated an average time of 1 hour 40 minutes in August 2022. Average turnaround times at hospital were 27 minutes, but we saw this was an increasing trend, with 12 occasions in August 2022 where turnaround times exceeding 60 minutes. Managers told us that work was being undertaken to change the computer aided dispatch (CAD) system to improve services. This is software used to triage and deploy ambulance resources. In addition, the service was awaiting on the outcome of a funding request to permanently recruit and train telephone triage clinicians into the emergency control centre to enable the signposting of certain emergency calls.

The air ambulance service monitored access to its service. Between April 2021 and March 2022, 51% of the 420 transfers undertaken were for patients to receive cardiac treatment, 10% for

trauma treatment and 7% for neurological treatment.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. When they did complain, an acknowledgement and follow up letter was sent to the patient, as well as an accompanying telephone call. Face-to-face meetings could be arranged if the patient wished, meaning they could be included in the complaint process.

The service treated all concerns and complaints seriously. All complaints were reviewed by the head of the ambulance service, and feedback and learnings were shared with staff individually or by bulletin to improve the service.

Staff understood the policy on complaints, which set out roles and accountabilities, and knew how to acknowledge them. No complaints were outstanding at the time of the assessment.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

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

Leaders worked hard to achieve good patient outcomes and understood the issues that affected the service, such as staffing retention, recruitment, lack of finances and the historical set up of service delivery. Leaders made changes to the service to support their staff and allow them to take on more senior roles. For example, the service was in the process of creating defined leadership roles with clear lines of accountabilities, following concerns being raised over the job descriptions for certain roles.

The out of hours leadership for the service was by an on-call manager. We saw the service was in the process of restructuring their leadership model to include 24-hour leadership support supported by a consultant paramedic. At the time of the assessment, a draft structure had been created and was awaiting approval from the government group.

Due to the low numbers of staff, training and education was difficult, At the time of the assessment, all managers were working towards an accredited first line leadership qualification, in addition to coaching, mentoring and regular 1-to-1 meetings with the service lead.

Vision and strategy

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

The service had a vision for what it wanted to achieve. However, this was not always supported by

the wider organisation and by the challenges faced by services run by different agencies. This meant it was struggling to turn their vision into credible action. The vision was focused on sustainability of services and was aligned to local plans and requirements within the wider health economy. However, due to lack of funding could not be implemented.

We saw the service was struggling to meet the current demand on the service, with challenges reported by the service including recruitment and staffing challenges, unsuitable building estate and aging vehicles and equipment.

In addition, at the time of our assessment, we saw the mandate for Manx Care at the time of the - assessment meant that transformation had effectively been paused and a 1 year strategy was not feasible to implement. The service had created a 3-year strategy, which included a demand and capacity analysis. The current conversion rate of patients transferred to the emergency department was 80%. Work to improve the percentage of patients treated on scene had been hampered as paramedics were not trained in minor illness management, collaboration work with primary care networks had been paused until April 2023, and clinicians with advanced practice working in the emergency control centre had not yet been approved.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. Not all staff felt able to raise concerns without fear. However, the service was actively working to improve this and create an open culture.

The service had recognised that equality and diversity was not promoted in daily work. No equality and diversity policy or strategy was in place and there were no senior female clinical leaders. The newly appointed head of ambulance services had created 4 developmental leadership positions to strengthen the management structure and support in the timely response of daily issues. This vision for this role was that it would also diversify the leadership team.

Role modelling of behaviours, which inspectors saw during the assessment, demonstrated the service was working hard to create a culture focused on the needs of the patient.

Collaboration with trade unions took place in the form of the joint ambulance consultative committee. In addition to trade union and management, elected staff members took part in this committee. Staff told us that a recent change to the staff meal break policy meant that urgent rather emergency calls were held so that staff could receive a break. Prior to this, staff were working without a break for in excess of 10 hours. The service had access to a specialist human resources team member 1 morning a week.

There were systems in place for staff to raise concerns externally to the service. Staff told us that no formal whistleblowing policy in place and staff did not always feel confident in raising concerns anonymously.

Managers were working closely with the organisation’s human resources and culture project teams to shift the perception of a culture of blame to that of a blameless and open one. Leaders within the service were attending training sessions on softer non-clinical skills, such as dealing with conflict, absence management and supporting staff members. This work was planned to feed into the future vision of the service. Newly implemented values had been introduced into the service in January 2022 and work was ongoing to promote the use of these values in every day.

Governance

Effective governance processes throughout the service and with partner organisations were not always in place. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Policies and standard operating procedures for the service were ratified by the senior management team of the care group, which included the clinical director. Following this, they were escalated to the urgent and emergency care board, the patient safety and quality committee, the executive committee and the clinical advice group, which had board member representation. A policy template for all new policies was in place, which helped improve consistency. Operating procedures for 999 responses, helicopter landing and vehicle breakdowns were present.

A strategic airbridge oversight committee had been set up, although it did not appear to have any terms of reference in place at the time of the assessment. Key challenges, such as the national shortage of clot-busting medicines, were examples of discussions taking place.

A senior leadership team framework was held twice a month, which included the head of the ambulance service, business manager and senior paramedic officers. Incidents, complaints, vehicle and equipment and infection prevention and control were standing agenda items in these meetings. A risk register and policy review were undertaken at every other meeting to track actions and mitigations and review newly identified risks.

Leaders from the service attended the clinical oversight group and the performance groups led by the chief executive of the wider organisation. A winter plan for the service was presented by the head of the ambulance service at the September meeting, along with the proposed 3-year strategy, next steps to transformation and the staffing challenges.

Information was shared with staff via clinical and operational bulletins. Examples of recent bulletins issued at the time of the assessment including later flow monitoring, recognition of life extinct updates, and an updated mortuary process.

The lack of governance and data sharing, such as routine performance and outcome data between patient transportation services upon island, meant the service was not able to fully assess the effectiveness of their service.

No third party arrangements were in place between community first responders and patient transport staff, which meant the service did not have oversight of staff training, education and recruitment.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff had started to contribute to decision-making to help avoid financial pressures compromising the quality of care. However, they did not always have effective plans in place to cope with unexpected events.

Non-emergency patient transport services were not completed by the island’s ambulance service, as these journeys were contracted out to an external third party.

The patient transport service for the island was ran by the local bus company. The service had no control over the running of the patient transport service and no assurance around safeguarding processes, staff training and education, suitability of recruitment, servicing of equipment and vehicles and infection, prevention and control practices. An historical unsigned service level

agreement was the only available document to new leaders within the service. Staff that we spoke to within the emergency ambulance service gave examples of patient transport journeys being undertaken on school and educational buses due to lack of dedicated patient transport buses. The service was unable to provide information to demonstrate whether this was or was not the case due to lack of oversight and governance processes in place between the 2 organisations.

The service did not always have effective plans in place to deal with unexpected events. Each year, the island hosted a TT motorcycle racing event, which resulted in the island's population increasing from around 85,000 to 135,000 people. The service worked closely with other agencies to manage this increase in demand, including NHS ambulance trusts from the UK, police, fire and other government departments. However, there was no safety advisory group meeting in preparation for the event. We saw leaders had not completed formal major incident training, and staff working on helicopters during the event had not undergone any formal training.

In addition, the service did not have access to major incident equipment or specialist trained staff such as specialist operation response teams (SORT). These teams deal with complex and challenging incidents, such as falls from a cliff, accessing difficult terrain and working in coastal areas. At the time of the visit, the service was working to source key pieces of equipment, such as life jackets and throw ropes for its staff members and was working in collaboration with the fire service and coastguard teams to set out the service's responsibilities in responding to such incidents.

The service had a risk register in place, which was electronic and linked to the incident reporting system. At the time of the assessment, 11 risks sat upon the register, which all had mitigations in place and actions to reduce the level of risk. The risk register for the service fed into care group's register. The service was working with a risk manager for the wider organisation at the time of the assessment

A business case for a new ambulance hub had been submitted and approved by Manx Care and was awaiting final approval from the Department of Health and Social Care.

The service was in the process of developing a cost improvement plan to better manage demand, but this was still in its infancy at the time of our assessment. The service had moved to an NHS supply chain, rather than buying from private providers. A review of all equipment was being undertaken at the time of the assessment and an external audit recently highlighted stock rotation as a strength. Seasonal activity was considered in the stocking of consumables to help leaders manage financial pressures and their impact.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was not always in easily accessible formats. The information systems were secure but not always integrated.

Information management was difficult due to the paper-based system. Satellite navigation system updates were done manually from information provided by the power company on the island. This was time-consuming and meant the systems were not updated in real time.

The service used smartphone mapping applications to help find remote or difficult locations.

The service was unable to access data fleet management, volunteer staff and equipment, which meant they were reliant on individuals sharing information. There was no electronic place for

documents, policies and procedures within the service, which meant updates were not archived centrally.

An electronic dashboard had been created by the service to track training and development. Information from this dashboard was submitted into the wider organisation each quarter to support organisational oversight of training delivery.

No electronic hospital arrival screen (HAS), which tells the hospital which ambulances are en-route, was in place. HAS systems allow hospitals to manage their resources effectively, as well as monitoring arrival-to-handover times. As there was no electronic system in place, the ambulance service telephoned the hospital each time a patient was conveyed regardless of severity of illness. This put additional pressure on both ambulance and emergency department staff.

Engagement

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

Work with local schools and road policing teams was undertaken to educate the children and young people around the dangers on the road.

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

Post-incident debriefing sessions for staff had been implemented for staff attending critical and upsetting incidents.

Public engagement sessions to introduce the service to councils on the island took place in June 2022. The service presented its position, as well as direction of travel, including the clinical workforce and activity levels.

The service attended the public Pride event on the island and provided vehicles and staff to interact with members of the public. Leaders told us this was important to understand how the service was perceived. The emergency service annual conference was attended by the service, who set up a stand to showcase their work.

A staff survey in response to the TT motorcycle race was undertaken to seek opinion on how well planning and execution had gone. This meant that staff were involved in decision-making around event management.

Learning, continuous improvement and innovation

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

The service was working hard to make continuous improvements, and since the new leadership team had been in place, many changes and improvements had been identified and made. Areas of risk had been identified and work was ongoing to overcome them. The ‘make ready’ team had doubled in size and refined how it tracked its schedule. Other changes included ambulance crews carrying neonatal bag valve masks (BVMs) to improve the emergency care of new-born babies and working to establish a co-responding scheme to cardiac arrest calls with other emergency services.

Surgery, Theatres and Anaesthetics

Overall summary

There are 5 surgical wards at Noble's Hospital. At the time of our assessment, 1 ward was being used for waiting list initiative elective surgery undertaken by an external independent healthcare provider. We did not assess this service. We visited the 4 wards run by Manx Care, which have 71 beds in total, the pre assessment unit and the 6 theatre suite.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in all key skills to all staff and make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

The most up-to-date compliance levels shown on the quality dashboard received during the assessment were from January 2022. At this point, the overall training compliance for the care group was 57%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse.

Prior to the recruitment of a safeguarding lead at the start of 2021, training in both adults and children's safeguarding was not in line with 'Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' or the 'Adult Safeguarding: Roles and Competencies for Health Care Staff' guidance, which we were told were recognised on the Isle of Man. This concern was out of the control of staff working in the care group.

Adult safeguarding training compliance was reported as 51% for the care group in July 2021 and 54% in January 2022. Children's safeguarding training compliance was 20% in July 2021 and 32% in January 2022. However, during the reporting timeframes, the training courses were not in line with the intercollegiate documents.

We asked Manx Care to provide the most recent compliance, and this was reported as 73% for adult training and 31% for children's training. However, during the reporting timeframes, the training courses were not in line with the intercollegiate documents.

Despite the training concerns, staff knew how to make a safeguarding referral and who to inform if they had concerns. We heard examples when they had identified adults at risk and how they had worked with other agencies to protect them.

Managers told us Disclosure and Barring Service (DBS) checks were carried out on all staff centrally by the human resources team. These checks help to prevent unsuitable people from working with vulnerable groups. We were not able to corroborate if all staff had a DBS check.

Cleanliness, infection control and hygiene

Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, the service did not use systems to identify and prevent surgical site infections. Staff did not always do all they could to control infection risk well.

Most areas we visited appeared visibly clean and well maintained. Hand washing facilities, alcohol gel and personal protective equipment (PPE), such as gloves, face masks and plastic aprons, were readily available throughout all the wards and departments. On our visits to the wards and departments, we saw staff washing their hands or using alcohol gel before and after providing care. Staff were bare below the elbow and used PPE consistently.

Each area completed monthly infection, prevention and control (IPC) audits such as compliance with hand hygiene and catheter care. Hand hygiene compliance was included as a metric on the quality dashboard, but no results were shown from August 2021 to the date of our assessment. During a meeting with the management team, we were advised these results were populated by the IPC team on a separate dashboard.

We looked at some local audits and found these were predominantly positive, with hand hygiene compliance at 95% or above.

The shower room on 1 ward was not fit for use and could have posed a potential infection risk for surgical patients. We were told following a leak, remedial work had been undertaken but for more than a year the shower area had been left in an unfit state. We escalated this to senior managers and were told work to make the area safe would be undertaken.

On another ward, we highlighted to staff urine samples had been left in 2 toilets. In 1 room, 1 sample was seen, and, in another room, there were 2. It was unclear how long these samples had been left in these areas.

The incidence of various infections, including Clostridium Difficile, Methicillin-resistant Staphylococcus aureus (MRSA) and Pseudomonas aeruginosa were part of the data set for the quality dashboard.

We were told the care group did not collate data on surgical site infections (SSIs). This meant there could be missed opportunities to identify concerns and prevent further surgical site infections. However, in the minutes of the surgery, theatres, critical care & anaesthetics audit meeting on 27 July 2022, it stated there had been a process for monitoring SSIs prior to the global COVID-19 pandemic, which had been paused but was due to restart.

We saw some portable fans with blades, which are no longer used in hospitals in England. This is because this type of fans has been linked to cross-infection in some health and social care settings. Dust and debris can accumulate within the internal body of the blades of fans and can provide a reservoir for microorganisms. The fans we saw were dusty. We saw some fresh flowers on 1 ward, and a member of the management team confirmed both fans and flowers were not in line with the infection prevention and control policy.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. In some areas staff did not always manage clinical waste well.

Most wards consisted of bays with 4 beds and some single side wards. The layout of bay areas did not always follow best practice guidance to prevent the risk of cross infection. This was due to

there being limited space between patients' beds and chairs.

On 1 ward, we were told staff had difficulty accessing pressure-relieving mattresses for patients at risk of developing pressure damage.

The theatres consisted of 6 theatre suites, a large reception and staff areas. All areas we visited appeared clean and well maintained. The areas were spacious and uncluttered.

On some wards, we saw some products not being stored appropriately. This included sachets of powder to thicken urine and chlorine-based cleaning products. These products can pose a risk of patient harm, and some were known to have caused deaths when ingested.

The medical equipment we looked at was not always appropriately serviced or calibrated. Some items showed evidence of recent servicing, portable appliance testing (PAT) and calibration, whilst others had stickers attached which appeared to show the last checks had been carried out more than 2 years ago.

Daily equipment checklists were not always completed in full. On some emergency resuscitation trolleys, we saw some gaps in suction machine and defibrillator checks.

We saw sharps disposal bins, which did not have assembly details completed and temporary closures were not always in place. This posed a risk of harm to patients, especially children or people at risk of self-harming.

On each ward, we looked at a selection of at least 40 single use items such as needles, syringes, dressing packs and wound dressings. We found all items were in date and it was evident stock rotation systems were in place on each ward.

Patients could reach call bells and staff responded quickly when called.

Assessing and responding to patient risk

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

Staff used a recognised tool to identify deteriorating patients and escalated them appropriately.

All surgical patients were assessed in the pre-operative assessment unit. This resulted in a standardised approach and staff being able to view the assessment on the electronic patient care record. If any concerns were highlighted at the pre-operative stage, patients would be referred for review, for example by cardiology and then referred back once they were deemed medically fit for surgery. The manager had implemented a system of 'medically suspending' patients on the electronic system to ensure these patients were not lost in the system.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

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

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed these regularly, including after any incident. Shift changes and handovers included all necessary key information to keep patients safe. Staff also held regular 'huddles' throughout the day. Key patient safety information was shared during these, for example if a patient was at risk of falling.

The quality dashboard contained data relating to the number of patients who had developed pressure ulcers whilst in hospital. This showed 25 patients developed pressure damage from December 2021 to August 2022. Sixteen of these were category 2 or above.

The safety thermometer was a measurement tool used in health care, which focused on the most common harms to patients. Staff told us the safety thermometer was completed by the patient safety team at the hospital. Data relating to this was displayed on the quality dashboard. This showed harm free care for the care group was above the hospital target of 95% in 11 of the 13 months from August 2021 to August 2022.

Information provided in the quality dashboard showed the care group had a target of less than 6.63 patient falls per 1,000 bed days. In the 11 months from August 2021 to June 2022, this target was met in September, October and November 2021 and in March 2022. No data was available on the dashboard from June 2022 onwards.

The hospital target for all eligible patients having venous thromboembolism (VTE) risk assessment within 12 hours of decision to admit was 95%. From the quality dashboard, this was achieved in 6 of the 13 months from August 2021 to August 2022. The percentage of adult patients having VTE prophylaxis prescribed met or exceeded the 95% target in 11 of the 13 months during the same time period.

The World Health Organisation (WHO) Surgical Safety Checklist was developed with the aim of decreasing errors and adverse events, and to increase teamwork and communication in surgery. The 19-item checklist has gone on to show significant reduction in both morbidity and mortality and is now used by many surgical providers around the world.

In theatres, we did not see a paper copy of the WHO checklist being used. We did see a pre-operative checklist from the ward areas, which was checked again when the patient arrived in theatre. We discussed this with senior staff who told us the WHO checklist was well embedded and used consistently. We were initially told the paper form was completed, scanned on to an electronic record keeping system and the original destroyed. Later, we were told the checklist was completed fully online.

A member of staff who told us there was a pilot in use for the checklist. However, the quality dashboard showed audit data relating to the use of the WHO 5 steps to safer surgery checklist. This showed from August 2021 to August 2022, there had been predominantly 100% compliance with the team brief, time in, sign out and time out elements.

In March 2022, the brief remained at 100%. However, there was a slight deterioration in the sign in (93%) and the sign out and time out both at 98%.

In April 2022, the performance deteriorated slightly to 97% for the brief, 95% for the time in and sign out and 92% for the time out.

From August 2021 to February 2022, the debrief performance was consistently low ranging from 37% to 65%. This improved from March 2022 to August 2022, when it ranged between 78 to 96%, except for June 2022 when it dipped to 56%.

Following our visit, an audit undertaken in October 2022 was shared. This showed predominantly positive compliance with all aspects of the WHO checklist. Where performance had dipped below 100%, actions were taken to prevent reoccurrence.

There were boards to display patient safety data outside each ward. The board included the

number of falls, pressure damage, 'you said, we did' for the previous month. Also included was the planned and actual staffing for that day. On all wards, other than the day procedure suite (DPS), the boards were not completed.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Manx Care told us there were currently no conventions in place for monthly reporting of safe staffing levels and no convention in place for publishing nursing staffing levels on the hospital website.

At the time of our visit, the surgical wards and theatres had 13.4 whole time equivalent (WTE) band 5 vacancies, 4.67 WTE band 6 vacancies and 2 WTE band 7 vacancies. There were also 4.4 WTE healthcare assistant vacancies.

The care group did not collate turnover levels. The care group sickness report showed the overall level of sickness as being 9.2% sickness rate, compared to 10.1% during 2021.

Overall, the staffing establishments meant there were enough nursing and support staff to keep surgical patients safe. However, due to vacancies and sickness, staffing numbers were sometimes less than the planned numbers. In addition, having frail elderly medical patients on the surgical wards was impacting on the acuity levels of the wards leaving them potentially unsafe. A senior member of medical staff told us the increasing numbers of medical patients on surgical wards had led to an 'exodus of nursing staff'.

Some managers talked about recent staffing crises; however, they confirmed recruitment had improved which included some transfers in from other services, newly qualified staff and some overseas recruitment.

In February 2022, a business case had been submitted to increase staffing in the pre-assessment clinic for the unit to offer more clinic slots in a safe and effective way. Clinics were being overbooked to accommodate the required activity. We were told this could pose a risk to patient safety, for example if test results were not seen. There had been no outcome from the business case at the time of our assessment.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift but were not always able to meet these. During our assessment, wards were safely staffed. We were told bank and agency staff were used to fill roster gaps. Where staff worked in areas with which they were familiar. More senior managers told us an electronic roster system would be implemented in November 2022 which would support with staffing and flatten out peaks and troughs of high and low numbers of staff.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

We asked to see the data relating to staffing vacancies, turnover and sickness specifically for

medical staff. We were told the care group did not collate turnover levels. The overall care group sickness report showed the level of sickness for the as being 9.2% sickness rate compared to 10.1% during 2021. Medical vacancy rates were not provided.

Some medical staff told us they relied on locum and agency staff to fill gaps in the rosters. Recruitment of permanent staff was a priority, but it was recognised it was sometimes difficult to attract people to move to Isle of Man.

The service always had a consultant and an associate specialist on-call during evenings and weekends. Junior medical staff felt they were supported, and on-call staff came into the hospital when they were needed.

Records

Staff kept detailed records of patients' care and treatment. Paper records were clear, up-to-date and stored securely. Electronic records were not always easily accessible to all staff providing care and computer screens were not always locked when not in use.

We reviewed 5 sets of patient care records. Staff completed patient care records in line with the standards required by their registering bodies, such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC). We found all entries were signed, dated and timed.

We saw evidence that comfort rounds were completed. Comfort rounds (also called intentional rounding) are a way staff in hospitals can offer supportive care at regular times during the day and evening.

We were told staff encountered some issues due to there being 3 electronic record systems which did not "talk to each other".

We saw some computer screens, with patient identifiable data on display. These should be locked when not in use. However, paper records were stored securely in locked trolleys.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

In theatres, we found all medicines were stored securely. Stock levels were clearly displayed on the medicine cupboard doors. A pharmacist completed a stock check in theatres and staff were able to order medicines if required.

Daily temperature checks were completed for medicine fridges in theatres and the anaesthetic rooms. Controlled drugs (CDs) were managed in line with policy. We looked at the register and found all entries had 2 signatures. Twice-daily CD checks were in place. However, we found some out of date medicines, some of which had expired more than 12 months ago. These were immediately escalated to staff during our assessment.

On the surgical wards, medicines had been prescribed, administered and recorded in line with hospital policy. The pharmacy team ensured that patients medicines were clinically checked throughout their stay in hospital. This included a comprehensive medicine history and medicine reconciliation process to ensure medicines prescribed were accurate. Advice on prescribing was clearly documented and followed up by the team. Allergies were highlighted and recorded on all medicine charts. Venous thromboembolism (VTE) risk assessment outcomes were recorded on medicine administration charts, which included the reason for prescribing any medicines. The route of administration was recorded, including the reason for prescribing medicines when

appropriate.

Weights of patients were not always recorded on patent medicine administration records which is important for calculating weight-based medicines prescribing.

Patients were able to self-administer their medicines following a risk assessment. An agreement assessment was also completed, and medicines stored in a bedside locker.

Pharmacists regularly reviewed, monitored and provided clinical advice on the best way to administer medicines. This included monitoring and reviewing the effects of medicines administered which included regular reviews for antibiotic prescribing. Advice was written onto the medicine charts as reminders or prompts.

Medicine charts seen were up to date and completed accurately. This included documenting reasons if a medicine had not been administered which ensures an accurate medicine history is available.

There were no recent audits available to ensure safe and secure medicine storage. Medicine storage systems were not always secure, and access was not always suitably restricted. For example, a clean utility door on a ward for access to medicine storage was not locked and there were boxes of intravenous fluids which were accessible.

The service ensured that medicines were stored at the recommended room or fridge temperatures. However, the process for checking temperatures was not always followed. For example, on 1 ward for September 2022, there were only 19 medicine fridge temperature readings documented. It was of concern that fridge temperatures were not recorded daily because medicines are required to be maintained within a safe range.

Emergency medicines were available and stored in tamperproof trolleys or boxes. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely.

Blank prescription pads were stored securely. However, on 1 ward, records were not always kept of the serial numbers of prescription forms when they were issued which would help identify any prescriptions lost or stolen.

There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts, we found staff at ward level did not always receive updates or information on medicine safety incidents. The Medicine Safety Officer was new in post and was in the process of reviewing medicine safety incidents and had written a newsletter to be cascaded to all areas.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents, however lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information. Managers ensured actions from patient safety alerts were implemented and monitored.

Staff knew what should be reported as an incident and how to use the electronic reporting system. Some staff still viewed the system being used as a blaming tool, but they confirmed incident reporting was encouraged.

The care group had declared 13 serious incidents (SI) in the 13 months from August 2021 to August 2022. Staff spoke positively about a SI meeting that had been implemented by the chief nurse. Seventy-two-hour rapid review reports were created for any incidents deemed to have caused moderate harm or above. These were reviewed through this meeting and an investigating officer assigned.

There had been no never events in the care group in the 12 months prior to our assessment. Staff were not aware of any shared learning from never events that had occurred in other services.

Incidents were an agenda item on the newly implemented care group clinical governance meeting. We saw that themes were discussed, and it was recognised that the group were not utilising outcomes for learning and development. It was suggested that reimplementing safety crosses to target falls, pressure sores, drug errors and collation of outcomes would support using negative data to improve care.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Alerts on the CAS website include National Patient Safety Alerts (from MHRA, NHS England and NHS Improvement and the UK Health Security Agency (UKHSA)), NHS England and NHS Improvement Estates Alerts, Chief Medical Officer (CMO) Alerts, and Department of Health & Social Care Supply Disruption alerts.

We noted from the minutes of the operational clinical quality group in February 2022 that the implementation of CAS Alerts remained an area of focus for care groups. In the minutes of the April 2022 operational clinical quality group, it was stated that recording CAS alerts on the electronic reporting system had commenced in February 2022 and there had been 15 alerts received and cascaded. However, there had been a poor response and targets had not been met since February.

On the quality dashboard, 8 alerts had not been met in line with the target of zero in February 2022 when the process was introduced. However, from March to August 2022 the data showed all alerts had been managed. Ward managers we discussed this with had a good understanding of the process and the actions to take if the alert related to their areas.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service could not always evidence or be assured they provided care and treatment based on national guidance and evidence-based practice.

Staff told us they followed the National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidance relevant to the service. However, we heard and saw several standard operating procedures and policies were out of date.

Senior managers acknowledged more work was needed to ensure all policies, clinical guidelines and standard operating procedures were up to date. It was unclear if there was a standardised process for the review, updating and ratification of documents.

Some policies we were sent before and after our assessment were out of date and had remained so for several years. For example, the consent policy was last reviewed in May 2014 and had a review date of 2017.

Policy review, approval and ratification was part of the agenda for the newly implemented clinical governance meeting. The minutes of the October 2022 meeting showed 4 policies had been reviewed and ratified.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Compliance with completion of the malnutrition universal screening tool (MUST) for the care group was poor, ranging from 57% to 83%. The dashboard showed the target of 95% was not met in any of the months from December 2021 to August 2022. However, we saw these completed in the patient care records we reviewed.

Due to a lack of speech and language therapists (SALTs) on the island, swallow assessments were done remotely from the UK. Patients waiting to have surgery were not left nil by mouth for long periods. However, fasting times were not audited to ensure oversight of this.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain and gave pain relief in line with individual needs. Patients told us they received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Staff told us patients with complex pain would be referred to the pain team.

Patient outcomes

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

Local audits were undertaken by the IPC team and ward managers, such as hand hygiene, catheter care, falls and pressure risk assessment completion. We reviewed some audit folders and found the results to be predominantly positive.

Some patient outcome data was also being collated, we were told recent studies on patients with pancreatitis and Colo-rectal cancer had been completed.

The hospital submitted data to the National Emergency Laparotomy Audit. We asked the hospital to provide any action plans created as a result of any recommendations following national audit outcomes, but this was not received.

We were told the hospital submitted data to the National Joint Registry (NJR). The National Joint Registry records, monitors, analyses and reports on performance outcomes in joint replacement

surgery in a continuous drive to improve service quality and enable research analysis, to ultimately improve patient outcomes.

We looked at the data on the NJR website and found surgeons on the island performed approximately 50% fewer primary hip and knee operations than surgeons in the UK. Surgeons on the Isle of Man performed around a tenth of number of hip and knee revisions compared to UK surgeons.

Operation Type	Operation Subcategory	Procedures Recorded for this Hospital	National Average
Hip Primary	-	311	606
Hip Revision	-	5	56
Knee Primary	Total knee replacement	231	554
Knee Revision	-	5	44
Total		552	1260

Patient improvement measures were not able to be seen on the NJR website. However, 90 Day mortality and revision rates for hip and knee surgery patients were in the 'as expected' range and in line with the England average.

Data from the National Hip Fracture Database (NHFD) showed 85% of patients who broke their hip had surgery on day of, or the day after, admission. This was in line with the national standard in England. In addition, 100% of patients had a physiotherapist assessment and were mobilised out of bed the day after surgery.

Anaesthetic staff told us data was submitted to the National Audit Projects (NAP). NAP study anaesthesia-related complications of low incidence that are potentially serious for patients and important to patients and anaesthetists.

The service did not monitor performance against the risk of readmission for elective or non-elective care.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance to provide support and development. However, at the time of our visit high numbers of staff had not had a yearly appraisal.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, at the time of our visit 68% of staff had not had an appraisal within the last 12 months.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

We were told team meetings did not always take place. However, daily huddles had been implemented and these were documented for staff could not attend.

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

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. They worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

We saw positive examples of MDT working during our assessment and noted care records also showed evidence of an MDT approach to care.

Seven-day services

Most key services were available 7 days a week to support timely patient care.

Consultants led daily ward rounds on all wards. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

Most key services were available 7 days a week, such as radiography. The routine hours for pharmacy were Monday to Friday 8.45am to 5.15pm. A Saturday service for urgent orders was available 9am to 12.30pm. The pharmacy was closed on Sundays and some bank holidays. However, an on-call pharmacist was available 24 hours a day.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients confirmed they had been given health promotion advice and leaflets by staff.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff were discreet and responsive when caring for patients. We observed staff taking time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. One patient told us staff's kindness and compassion were "excellent". Another said the staff were "brilliant" and "attentive".

Patients told us staff took actions to maintain confidentiality.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We heard 2 positive examples of this from ward.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients consistently told they felt safe.

Specialist services such as the mental health team and psychologists were available if required. Staff told us the specialists were responsive when contacted.

Patients told us staff checked on their wellbeing and comfort regularly.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw discussions about care and treatment were clearly documented in care records.

Staff talked with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff supported patients to make informed decisions about their care.

Patients gave consistently positive feedback about the service.

The service had developed an action plan relating to friends and family test (FFT), which included monthly measurement and monitoring of the feedback, improving uptake of the survey by inpatients and improving the visibility of the results.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

Service delivery to meet the needs of local people

The service planned care to meet the needs of local people and the communities served. It also worked with others in the wider system and other organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Due to increasing waiting lists following the global COVID-19 pandemic, the organisation has commissioned an independent external care provider to support with reducing waiting lists. Work had been completed on ophthalmology, orthopaedic and general surgery lists and more work was planned to continue to reduce the time people were waiting for surgery.

Not all surgical procedures could be undertaken by Manx Care. The hospital worked closely with tertiary centres in the UK to manage the care and treatment of people who needed treatment

elsewhere.

We spoke with the manager of the pre-assessment service who described the improvements that had been made since 2018. We were told pre-assessment used to be disjointed but the unit was now responsible for all pre-operative assessments which had led to a more effective, standardised and streamlined pathways for patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, we saw limited facilities for people living with dementia or a learning disability.

Staff had access to a mental health crisis team which were based on the hospital site. We were told this team was usually very responsive. If they were not able to attend, they would offer support and advice via the telephone.

Staff and patients could get help from interpreters or signers when needed. Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff mostly made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs.

We were shown 'this is me' paperwork which was used when people living with dementia or learning disabilities were admitted to hospital. One ward manager told us people usually had this completed prior to being admitted, and due to the size of the island, they often knew the person and their likes and dislikes. However, if the person was admitted without the paperwork and were unable to express their needs, staff would complete a 'this is me' document with the help of families and carers.

Wards were not always designed to meet the needs of patients living with dementia. We did not see equipment such as orientation clocks, and wards were not decorated in line with the recommendations from organisations specialising in dementia care. In addition, staff told us that during the COVID-19 pandemic, some equipment such as material distraction aids had needed to be removed. However, staff told us about activities that were used to support, such as dominoes and playing cards. One ward manager told us they had used some metal pipework, which had been helpful to patients, and some patients helped with small jobs such as folding plastic bags. We were told the dementia specialist nurses were responsive if staff needed support.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with the hospital's standards.

We were told the service did not monitor waiting times in line with the England national performance indicators, such as the 18-week referral to treatment. However, this was being introduced soon. At the time of our visit people were waiting a long time for both diagnostics and surgery. This included cancer patients who were not being seen in a timely manner.

The integrated performance report (IPR) provided for the November 2022 board stated inpatient and day case waiting list numbers were continuing to reduce as a result of the restoration and recovery activity for orthopaedics and ophthalmology. However, it was also recognised that access

to the surgical bed base due to medical outliers continued to challenge theatre efficiency and utilisation which was resulting in late starts to operating lists whilst beds were sourced for elective inpatients and also on the day cancellation of patients or entire elective list cancellations. This meant other surgical speciality waiting lists were increasing.

The IPR showed the number of patients waiting for their first consultant led outpatient appointment had increased and the average wait was 49 weeks. In addition, more than 4,500 patients had waited more than 52 weeks.

The cancer 2-week-wait performance was 46.5% in September 2022, against a threshold of 93%. The cancer 31-day performance was 74.5% against a threshold of 96%, and the 62-day cancer performance was 22% against a threshold of 85%.

Managers held a bed meeting each morning and afternoon where they reviewed bed availability, planned admissions for surgery and the status of patients with medical conditions who were being cared for on surgical wards on surgical wards. These patients are known as medical outliers.

Staff told us cancellations frequently occurred due to there being no beds available on the day of surgery. This situation was predominantly due to medical outliers in surgical beds. We were told the discharge coordinators and the access and capacity team were responsive and supported staff to expedite discharges, but delayed transfers of care were often out of the control of hospital teams. These could be due to delays in setting up domiciliary care packages, a lack of care home beds in the community and patients being reluctant to be transferred to the rehabilitation ward at RDCH.

We raised concerns about the numbers of medical outliers on the surgical wards during our assessment and noted the numbers did decrease during the week we were onsite. Following our assessment, we met virtually with the senior managers for the care group, who told us the current position was better than it had been for a long time, but they recognised there was more work to do. It was acknowledged as a key risk for the care group. However, more plans were being put in place to manage this. These included:

- Daily reminders sent to medical staff via a text to remind them to review all patients who were medical outliers.
- The implementation of red-to-green days. Red-to-green is a simple initiative that helps turn patients' 'red days' into value-adding 'green days' which help to facilitate a safe discharge from hospital. A red day is when a patient does not receive an intervention to support their pathway of care. For example, a planned diagnostic is not undertaken.
- Spot purchase beds.
- Utilising the full bed base at RDCH.

Following our assessment, we were sent an outlier’s policy. This was created 13 October 2022 and appeared to be in draft form. Therefore, it was unclear if prior to our assessment staff had any guidance to support the management of outlying patients.

We were told reduced therapy staffing levels also impacted on delayed discharges.

We looked at the delayed transfers of care (DTOC) document provided by Manx Care which was reported by ward area. This showed there were low numbers (10) of DTOCs reported for the surgical wards. Staff on surgical wards reported the majority of their DTOCs were medical patients, therefore it was clear if the surgical wards were reporting the medical patient DTOCs

given the low numbers shown.

Theatre utilisation was part of the quality dashboard. This showed variable usage between October 2021 and February 2022, however there was no set target shown. The highest utilisation was 85% in November 2021 and lowest was 62% in October 2021. In addition, to this some staff told us some surgeries took longer than expected and therefore the activity was lower than it could have been.

We asked Manx Care for more up to date data and were provided with a report which showed theatre utilisation of between 74% and 86% from April 2022 to September 2022. The table below shows number of cancelled sessions and the reasons for the cancellations.

Month	Scheduled sessions per month	Cancelled sessions due to Bank Holiday or PSF	Cancelled sessions due to surgeon	Cancelled sessions due to anaesthetist	Cancelled sessions due to theatre staff	Cancelled sessions due to other reason	Cancelled sessions due to combined anaesthetist & theatre staff
April	175	13	5	19	2		1
May	150	14	2	13			3
June	237	16	3	5	1		1
July	201	12	3	4	1		
Aug	253	9	2	9	2		
Sept	186		2	7	1	7	

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. We saw information on how to raise a concern displayed in all areas we visited.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

The quality dashboard showed the number of complaints received each month for the care group and the performance against the hospital policy for the management of complaints.

The number of complaints received from September 2021 to August 2022 was 140.

The care group performed well on the target of an acknowledgement being sent within 2 working days. However, they failed to meet the first written response within the agreed response time every month in the same time period.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

Several ward managers were new to post but appeared to have the skills and abilities to run the wards. Other more senior staff were experienced and supported the newly recruited managers. All managers in the service were visible and approachable in the for patients and staff.

The senior team for the care group consisted of clinical and divisional operational leadership. This included an associate director of nursing, surgical and anaesthetic clinical leads and a care group manager.

We noted during our discussions with ward managers some were relatively new to post. More senior leaders recognised there had been managerial changes on some wards, and they had put measures in place to ensure newly appointed staff were supported. This included daily catch ups on all wards. The senior team were also compiling a ward manager guide and ensuring training was available for them for example on HR policies and practices.

Nursing staff told us their immediate line managers were visible and supportive. They told us some of the executive team were less visible but spoke positively about the chief executive officer (CEO).

Senior medical staff told us the medical director was supportive and had a good relationship with the medical team for the care group.

Vision and strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action which had been developed with all relevant stakeholders.

The care group did not have a documented vision or strategy. We discussed this with senior managers who told us this was due to Manx Care being a relatively new organisation.

We were told the services had been in a difficult systemic position due to changes in the Isle of Man government and there being a new policy for the islands health and social care.

Leaders recognised they needed to align with external partners to ensure the service met the needs of local people but told us there was currently a lack of guidance on what was needed and therefore they had focused on maintaining safety.

Leaders told us they had created a documented plan for care group with key deliverables in April 2022. We reviewed this and found this was a comprehensive plan for the delivery of the services.

A Manx Care strategy was needed before care group plans could be made to aligned to the organisational strategic vision. Leaders felt they had some focus on where they needed to deliver.

One ward manager told us their vision for the care group was the have a better surgical pathway with the introduction of a surgical admissions unit, which they felt would streamline the pathway and could help prevent cancellations on the day of surgery.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were helpful and friendly in all areas we visited. We were made to feel welcome, and staff were keen to tell us what it was like to work at the hospital. Staff spoke positively about the

support for their health and well-being. Staff were proud of the care they provided and spoke positively about team working.

A ward manager talked about the development of staff, creating a learning environment and encouraging staff to be link nurses. They were passionate about wanting staff to feel valued and involved in the development of ward initiatives.

Staff told us they would be able to raise concerns with their managers if they needed to.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. However, some processes were developing and staff at all levels were becoming clearer about their roles and accountabilities.

Senior managers told us governance processes were being implemented to ensure effective systems for risk management and safety were in place. We were told there had been siloed systems previously. The aim was to have 1 holistic meeting covering all of governance and safety. The next steps would be to gain maturity of the processes and to drive the board to ward assurances.

We looked at a range of governance meeting minutes and found not all agenda items were discussed. For example, in the surgical triumvirate meetings held in August, September and October 2022 and saw key issues such as health & safety, mandatory training, incidents, complaints, the risk register, finance, cost improvements, waiting lists, transformation project updates and intervention & recovery were nearly always documented as not discussed.

It was recognised that staff “had been through a lot” in recent years and there was a degree of “change fatigue”. Senior leaders felt it was key for wards to own and drive their own assurance mechanisms.

Safety huddles and debriefs had been implemented 3 times a day. It was felt these were helpful for staff and site managers, to gain a better understanding on any issues affecting patient safety.

We raised that we had noted a lack of information available on the quality dashboard. We found there was a suite of performance metrics however the evidence of compliance (or noncompliance) was inconsistently displayed. We were told some data, such as IPC hand hygiene audit compliance, was collated on to a separate dashboard. This meant there was no single method of oversight and assurance. It was not clear if this had been escalated.

Senior leaders acknowledged they were not where they needed to be in terms of oversight and assurance due to the systems being relatively immature, but they felt processes were developing and there had been improvements.

Management of risk, issues and performance

Leaders and teams did not have embedded systems in place to manage performance effectively. However, ward managers recognised their local risks and senior leaders were developing more robust systems and processes.

The senior leadership team for the care group told us risks had previously been managed at care group level and it was therefore difficult to see a holistic organisational view of shared risks.

From the minutes of the newly implemented clinical governance meeting, we saw that the triumvirate were tracking 8 key risks at care group level. All these risks were rated as extreme but

with the mitigating actions in place were currently graded as high risk.

The electronic reporting system was being used for risk management and these were being more closely tracked. However, it was recognised there was still more work to do to ensure robust systems and processes were in place and these become embedded as business as usual.

A project lead had been identified and they were rebuilding the risk management structure. The senior team told us that by 19 October 2022 all managers would have undertaken risk management training. This was being undertaken using what was already established as risks on the reporting system.

Risks would then be reviewed through the holistic governance meeting that had been implemented and fed up to board.

The most up to date information from the electronic reporting system showed the key risks for the care group as being ward-to-board performance, workforce, delivery of isolated service, financial sustainability, mandatory training compliance, management of assets and the surgery, orthopaedic and sub speciality medical on call.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was not always in easily accessible formats. The information systems were secure but not always integrated.

Senior leaders told us the governance of data required more investment. This was for several systems, including personnel, record keeping, reporting and finance. Clarity was needed about how systems should be used so the organisation could start building ‘one source of truth’ for assurance and oversight. However, the governance structure and strategy needed to be in place for teams to start the work effectively.

Leaders told us that a huge amount of work done in last 2 years to build a system and they felt more time was needed. Due to Manx Care being a relatively new organisation, it was felt some areas were “still a piece of someone else’s puzzle”.

Some of the systems we would normally see under the control and governance of a healthcare provider in England remained under a service level agreement with an external agency, such as the human resources system.

Staff told us having 3 different patient record systems was not helpful. The systems did not “talk to each other”, which meant staff had to log in to different systems to view different aspects of patients care records. We were told the introduction of 1 integrated system would improve data collection and gathering.

The electronic reporting system was being developed for use as a risk management tool, but this still needed to become embedded.

Engagement

Leaders and staff actively and openly engaged with each other and there was some patient engagement. They collaborated with partner organisations to help improve services for patients.

A senior member of staff told us both paper and electronic staff surveys have been undertaken in the last 12 months, to enable leaders to focus on staff wellbeing. In addition, the CEO has held

listening events. A manager told us these appeared to be well received by staff, an open dialogue was achieved, and staff said they felt listened to.

Through the post pandemic restoration and recovery work, it had been highlighted that waiting times for surgery needed to be managed. Prior to the introduction of the external company being in place to provide waiting list support, meetings were held with service areas that would be affected. In addition, the organisations communications team had put together information and sent it out to patients.

Patient stories were becoming more embedded at board meetings. Leaders told us Manx Care Advice and Liaison Service (MCALS) were working with the care group on how they could engage better with service users.

Learning, continuous improvement and innovation

All staff appeared to be committed to continually learning and improving services. Leaders encouraged innovation.

In order to improve recruitment, Manx Care developed a preceptorship package which has been shortlisted for a nursing journal award twice. This was a yearlong programme, with a protected day each month for training and supervision. This programme was open for all newly qualified staff and those coming from overseas or from an area which was not providing acute healthcare, for example nursing homes.

One ward manager was passionate about developing teaching opportunities on their ward. They wanted to create a teaching section for each surgical speciality.

The care group had developed a safer surgery pathway document to support the patient journey. We reviewed this and found it to be a comprehensive document which included all aspects of the pathway from preadmission to discharge.

An audit of the operating department was undertaken from 21 to 23 September 2021 as part of the process for Accreditation from the Association for Perioperative Practice (AfPP). Following this several recommendations were identified. The care group had created an action plan which we reviewed and found all actions completed. A further review had taken place just before our visit, we did not see the outcome of this, but we were told the initial feedback was positive.

Critical Care

Overall summary

The Critical Care Unit has 6 beds and provides all intensive care and high dependency services on the island. This includes major post-operative conditions, anaesthetic complications, major trauma, head injuries, spinal injuries, burns, general medical, surgical, obstetric and paediatric emergencies. The service provides intensive care, high dependency care, non-invasive ventilation, isolation facilities, pre-operative resuscitation, post-operative care and stabilisation of patients prior to emergency transfer to off-island specialist facilities.

The unit admitted 224 patients from 1 April 2021 to 31 March 2022, of these 116 were patients with medical conditions, 78 were surgical patients, 5 were gynaecology patients and 25 fell under the category of other.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the ‘mandatory training’ section under Medical Services on page 8 for issues common to many services.

The most up-to-date compliance levels shown on the quality dashboard received during the assessment were from January 2022. At this point the overall training compliance for the care group was 57%.

Staff on the unit told us they were up to date with most training, but basic and intermediate life support training had been difficult to access.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse.

Prior to the recruitment of a safeguarding lead at the start of 2021, training in both adults and children’s safeguarding was not in line with ‘Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff’ or the ‘Adult Safeguarding: Roles and Competencies for Health Care Staff’ guidance, which we were told were recognised on the Isle of Man. This concern was out of the control of staff working in the care group.

We asked Manx Care to provide the most recent compliance, and this was reported as 73% for adult training and 31% for children’s training. We found during the reporting timeframes; the training courses were not in line with the intercollegiate documents.

Despite the training concerns, staff knew how to make a safeguarding referral and who to inform if they had concerns. We heard examples when they had identified adults at risk and how they had worked with other agencies to protect them.

Managers told us Disclosure and Barring Service (DBS) checks were carried out on all staff

centrally by the human resources team. These checks help to prevent unsuitable people from working with vulnerable groups. We were not able to corroborate if all staff had a DBS check.

Cleanliness, infection control and hygiene

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

The critical care unit appeared visibly clean and well maintained. Hand washing facilities, alcohol gel and personal protective equipment (PPE), such as gloves, face masks and plastic aprons, were readily available throughout the departments. We observed staff washing their hands or using alcohol gel before and after providing care. Staff were bare below the elbow and used PPE consistently.

Each bed space had a different coloured individual notes and equipment trolley. We were told these created a visual reminder to staff to decontaminate their hand and change their PPE if they needed to move between bed spaces.

One side ward could be used to isolate patients with an infectious disease or those who were immunocompromised. This was because it could be used with positive or negative air pressure. In a positive air pressure isolation room, the air pressure is higher than in the adjoining areas. Therefore, positive pressure isolation prevents airborne pathogens from entering the room to avoid the air becoming contaminated and potentially affecting an immunocompromised patient. A negative air pressure prevents pathogens from flowing to adjoining, non-contaminated areas when the door to the room is opened. We saw this being used during our assessment to care for a patient with an infectious disease.

Staff told us patients were being routinely swabbed for COVID-19 and other respiratory conditions prior to being admitted to the unit. The unit manager explained this meant they could immediately isolate patients if necessary and prevent the risk of cross infection.

The unit completed monthly infection, prevention and control (IPC) audits such as compliance with hand hygiene and catheter care. Hand hygiene compliance was included as a metric on the quality dashboard, but no results were shown from August 2021 to the date of our assessment. During a meeting with the management team, we were advised these results were populated by the IPC team on a separate dashboard.

We looked at some local audits undertaken in August and September 2022 for hand hygiene, bare below the elbow and catheter maintenance and found these were predominantly positive, with compliance at 92.5% or above.

The incidence of various infections, including Clostridium Difficile, Methicillin-resistant Staphylococcus aureus (MRSA) and Pseudomonas aeruginosa were part of the data set for the quality dashboard.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The critical care unit had 6 beds. There was a 4 bedded bay and 2 side wards. The bed spaces in the bay and the side wards were big enough to accommodate all the equipment required to care for a level 3 patient. Most equipment was provided via ceiling pendants, which meant floor space

was not compromised.

We looked at a selection of more than 50 single use items such as needles, syringes, dressing packs and wound dressings. We found all items were in date and it was evident a stock rotation system was in place.

We looked at the emergency trolleys on the unit, which included the resuscitation trolley, the airway trolley and the pacing trolley. We saw a few gaps in the daily checks but these were predominantly completed each day and after use.

Relatives' facilities on the unit included a sitting room, with an adjacent toilet and interview room. The interview room was not in use as it was being used as a storeroom. There was also an overnight stay room which was located off the unit. All these areas were bright and airy and had appropriate furnishings. Information for relatives was available and complimentary tea and coffee was available.

During our assessment, we found the door to the dirty utility room open and chlorine-based cleaning products were not locked away. We also saw chlorine-based cleaning tablets in the isolation side ward anteroom, which were not in a locked cupboard. These products can pose a risk of patient harm.

The medical equipment we looked at was not always appropriately serviced or calibrated. Some items showed evidence of recent servicing, portable appliance testing (PAT) and calibration, whilst others had stickers attached which appeared to show the last checks had been carried out more than 2 years ago.

We noted all infusion pumps at patient bedsides were out of date for servicing. We were told this was because the equipment was being replaced as the pumps were no longer serviceable. The new pumps had been received but the manufacturer needed to set them up for the department and this had been delayed. We were told this had been added to the risk register.

When we asked about other out of date devices. It was not clear if there was a robust process in place for the service and maintenance of equipment. It was also not clear who was responsible for arranging maintenance. We highlighted the only electrocardiogram (ECG) machine in the unit was out of date and saw the following day this had a 'job' sheet attached showing maintenance had been requested. We then noticed a second machine which was also out of date. A member of staff told us the second machine did not belong to the unit and all ECG machines were the responsibility of cardiology.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed these regularly, including after any incident. Shift changes and handovers included all necessary key information to keep patients safe.

Within the patient care records we reviewed; we noted a comprehensive aide memoire which was used for the handover of post-operative patients from theatre to the unit. This included the 'World Health Organisation (WHO) 5 steps to safer surgery' checklist and a full assessment of the patient's airway, breathing, circulation, disability (including neurological assessment), medical needs, surgical issues and moving and handling.

All records had a full list of all documentation required for all patients including risk assessments and requirements for discharge.

We also saw clear guidance at each bedside for medical handovers for in and out of hours admissions from the medical assessment unit.

National Institute for Health and Care Excellence (NICE) clinical guidelines states early recognition and treatment of delirium can reduce hospital stays and complications. All patients were assessed for delirium in the records we reviewed.

Staff also held regular 'huddles' throughout the day. These were documented and used the Intensive Care Society guidelines. Key patient safety and operational data information was shared during these, for example patient acuity levels, if a patient was at risk of falling, needed isolation, was ready for discharges and any planned admissions. Operational data included nurse coordinator, named nurse for each patient, staffing and any outstanding tasks.

The unit had link nurses for several risk specialities, this included tissue viability, infection prevention and control, falls and end of life care.

Patients in the hospital were assessed using the National Early Warning Score (NEWS2) tool – a clinical tool used to help identify deteriorating patients.

The critical care outreach team (CCOT) was a nurse-led service supporting nurses and doctors caring for acutely ill in-patients on other wards throughout the hospital. The team were able to support in the assessment of acutely ill or deteriorating patients on wards and advise on monitoring, investigations and management plans. The role also included reviewing patients who had been recently discharged from the unit to a ward bed.

Staff from the CCOT used 1 of the electronic patient care records system to track patients, elsewhere in the hospital and would respond if any patients were triggering on their NEWS2.

The quality dashboard contained data relating to the number of patients who had developed pressure ulcers whilst in hospital. This showed 25 patients developed pressure damage from December 2021 to August 2022. Sixteen of these were category 2 or above.

The safety thermometer was a measurement tool used in health care, which focused on the most common harms to patients. Staff told us the safety thermometer was completed by the patient safety team at the hospital. Data relating to this was displayed on the quality dashboard. This showed harm free care for the care group was above the hospital target of 95% in 11 of the 13 months from August 2021 to August 2022.

Information provided in the quality dashboard showed the care group had a target of less than 6.63 patient falls per 1,000 bed days. In the 11 months from August 2021 to June 2022, this target was met in September, October and November 2021 and in March 2022. No data was available on the dashboard from June 2022 onwards.

The hospital target for all eligible patients having venous thromboembolism (VTE) risk assessment within 12 hours of decision to admit was 95%. From the quality dashboard, this was achieved in 6 of the 13 months from August 2021 to August 2022. The percentage of adult patients having VTE prophylaxis prescribed met or exceeded the 95% target in 11 of the 13 months during the same time period.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

We asked to see the data relating to staffing vacancies, turnover and sickness specifically for nursing staff. We were told the care group did not collate turnover levels. The overall care group sickness report showed the level of sickness for the as being 9.2% sickness rate compared to 10.1% during 2021.

The unit did not meet all the guidelines for the provision of intensive care services (GPICS) for registered nurse staffing. In addition, at the time of our visit there was 2.5 whole time equivalent (WTE) band 7 posts, 0.9 WTE band 6 and 2 WTE band 5 vacancies in the critical care and the outreach team.

GPICS state there must be a supernumerary (a member of staff that is not rostered to deliver direct patient care to a specific patient) senior registered nurse who provides the supervisory clinical coordinator role on duty 24 hours a day in critical care units with 6 or more beds. Units with fewer than 6 beds may consider having a supernumerary clinical coordinator to provide the supervisory role during peak activity periods, such as early shifts.

GPICS state the recommended nurse to patient staffing ratio for level 3 patients is 1 nurse to 1 patient. For level 2 patients, it is 1 nurse to 2 patients. The registered nurse establishment on the unit was for 4 level 2 and 2 level 3 patients. This meant the planned number of 4 registered nurses on each shift was in line with GPICS. However, we were told that when the number of level 3 patients increased it was difficult to increase the staff numbers. Staff who were supernumerary such as the unit manager and coordinators were often required to work in the numbers.

Children were cared for in the unit, but we were told there was no nursing staff with a paediatric critical care qualification. We were told when a paediatric patient was in the unit, staff from the paediatric department in the hospital would support with their care.

The CCOT were available from 7.15am to 9.15pm each day. Overnight this role was undertaken by the clinical night manager.

We reviewed the staff moves log and noted registered nurses had been moved to support other areas on 46 occasions from 1 August 2022 and 3 October 2022. On 6 of these occasions, staff logged that the critical care unit had been left without safe staffing levels.

GPICS states that each critical care area should have ward clerk/receptionist cover 7 days per week and a data clerk or dedicated time allotted to a suitable member of staff for data entry to a nationally recognised audit programme (such as ICNARC) and responsibility for the validation of these data. The Intensive Care National Audit and Research Centre (ICNARC) advise that “a unit with approximately 600 admissions a year need 1 full-time member of staff (or equivalent) to keep up with the demands of validation within the prescribed timescales for active participation”. From 1 April 2021 to 31 March 2022, the unit admitted 224 patients.

The unit had a part time ward clerk who worked Monday to Friday between 8am and 1.30pm. This meant nursing staff were required to do administrative jobs outside of these hours.

The unit had no data input clerks. Data for ICNARC was submitted by a member of the CCOT but due to workload and staffing constraints the data inputting had been delayed.

The unit did not have dedicated allied health professionals in line with GPICS. However, they had access to all specialities to support the patients being cared for on the unit, including physio and occupational therapists, pharmacy, dieticians, speech and language therapists and Microbiologists.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The unit did not meet all the guidelines for the provision of intensive care services (GPICS). The GPICS second edition 2019 states “there must be a designated clinical director or lead consultant for intensive care medicine (ICM), an ICM must be immediately available 24 hours per day, 7 days per week, be able to attend within 30 minutes and must undertake twice daily ward rounds”.

We were told medical staff retention was difficult, prior to the COVID-19 global pandemic there had been 17 anaesthetists employed by the hospital. Of these, 13 were consultants and 4 were speciality doctors. At the time of our assessment, the hospital had 10 permanent WTE and 2 part-time anaesthetists. Of these, 4 were Fellows of Intensive Care Medicine (ICM). In addition, the hospital used 5 regular locum staff.

The unit did have a lead ICM, but they did not have enough numbers of ICMs to provide 24-hour, 7 day cover each week. Alternative cover was provided by anaesthetists. ICM or anaesthetist cover was provided from 8am to 6pm each day. Outside of these hours and overnight, there was a first on-call anaesthetist resident in the hospital and a second on-call who was within 30 minutes of the hospital. Due to the size of the unit and the hospital, the first on-call anaesthetist was also designated to cover emergency theatres, the emergency department and obstetrics. In the event of high acuity in the unit or elsewhere in the hospital, the second on-call would be asked to attend the hospital immediately.

We asked to see the data relating to staffing vacancies, turnover and sickness specifically for medical staff. We were told the care group did not collate turnover levels. The overall care group sickness report showed the level of sickness for the as being 9.2% sickness rate compared to 10.1% during 2021.

Medical vacancy rates were not provided.

Records

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

We reviewed 4 sets of patient care records. Staff completed patient care records in line with the standards required by their registering bodies, such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC). We found all entries were signed, dated and timed.

In the unit, all paper care records were stored together in 1 folder. We saw these were well organised and easy to navigate. We saw the results of a critical care quality standards documentation audit completed by the network, which showed the unit had scored 96% to 99% for their record keeping.

We were told staff encountered some issues due to there being 3 electronic record systems which

did not “talk to each other”.

We saw some computer screens with patient identifiable data on display in patient facing areas. These should be locked when not in use.

Medicines

The service had systems and processes to prescribe, administer and store medicines safely, however some of these processes were not always followed.

We looked at patient medicine records and saw most medicines had been prescribed, administered and recorded in line with hospital policies. However, there were some medicine records where it was not always clear what had been administered. For example, 1 medicine chart did not detail the route of administration for how medicine prescribed should be administered. Changes made to prescribed medicines were not always dated on medicine charts. For example, the dose of 1 medicine had been altered on a medicine chart which had not been dated. It was therefore not possible to determine what dose had been given to the patient over a 2-day period. This information is important for a clear audit trail for patient safety and clinical records.

Pharmacists regularly reviewed, monitored and provided clinical advice on the best way to administer medicines. This included monitoring and reviewing the effects of medicines administered which included regular reviews for antibiotic prescribing. Advice was written onto the medicine charts as reminders or prompts. Advice on prescribing was clearly documented and followed up by the team. Allergies were highlighted and recorded on all medicine charts. Venous thromboembolism (VTE) risk assessment outcomes were recorded on medicine administration charts, which included the reason for prescribing any medicines.

There were no recent audits available to ensure safe and secure medicine storage. Medicine storage seen was safe and secure with access only to authorised staff. Medicine stores seen were and neat and tidy.

The service ensured medicines were stored at the recommended room or fridge temperatures, but the process for checking temperatures was not always followed. The medicine room felt warm, but there was no room thermometer available to check and record the room temperature to ensure medicines were stored within a safe temperature range. The medicine fridge temperature was monitored daily by an electronic data logger. The available temperature records were within a safe range. The medicine fridge would alarm if it went outside the safe temperature range.

Emergency medicines were available and stored in tamperproof trolleys or boxes in all areas visited. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs CDs) were stored safely and securely with keys held separately from all other medicine keys. Daily checks were undertaken by staff, and pharmacy staff undertook audits to ensure safe management of CDs.

There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts, however staff at ward level did not always receive updates or information on medicine safety incidents. The Medicine Safety Officer was new in post and was in the process of reviewing medicine safety incidents and had written a newsletter to be cascaded to all areas.

Weights of patients were not always recorded on patent medicine administration records which is important for calculating weight-based medicines prescribing.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents, however lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information. Managers ensured actions from patient safety alerts were implemented and monitored.

The care group had declared 13 serious incidents (SI) in the 13 months from August 2021 to August 2022. Staff spoke positively about a SI meeting that had been implemented by the chief nurse. Seventy-two-hour rapid review reports were created for any incidents deemed to have caused moderate harm or above. These were reviewed through this meeting and an investigating officer assigned.

Staff on the unit told us they were encouraged to report incidents and learning from incidents in the department were shared by team leaders and through the huddles.

There had been no never events in the care group in the 12 months prior to our assessment. Staff were not aware of any shared learning from never events that had occurred in other services.

Incidents were an agenda item on the newly implemented care group clinical governance meeting. We saw that themes were discussed, and it was recognised that the group were not utilising outcomes for learning and development. It was suggested that reimplementing safety crosses to target falls, pressure sores, drug errors and collation of outcomes would support using negative data to improve care.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Alerts on the CAS website include National Patient Safety Alerts (from MHRA, NHS England and NHS Improvement and the UK Health Security Agency (UKHSA)), NHS England and NHS Improvement Estates Alerts, Chief Medical Officer (CMO) Alerts, and Department of Health & Social Care Supply Disruption alerts.

We noted from the minutes of the operational clinical quality group in February 2022, the implementation of CAS Alerts remained an area of focus for care groups. In the minutes of the April 2022 operational clinical quality group, it was stated that recording CAS alerts on the electronic reporting system had commenced in February 2022 and there had been 15 alerts received and cascaded. However, there had been a poor response and targets had not been met since February.

On the quality dashboard, 8 alerts had not been met in line with the target of zero in February 2022 when the process was introduced. However, from March to August 2022, the data showed all alerts had been managed. The unit manager had a good understanding of the process and the actions to take if the alert related to their area.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service could not always evidence or be assured they provided care and treatment based on national guidance and evidence-based practice.

Staff followed the National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidance relevant to the service. However, we heard and saw several standard operating procedures and policies were out of date.

Senior managers acknowledged work was needed to ensure all policies, clinical guidelines and standard operating procedures were up to date. It was unclear if there was a standardised process for the review, updating and ratification of documents.

We looked at some of the documentation used in the department and noted some were in date for review, but many were not. For example, the food charts had a review date of August 2024, but the variable rate intravenous infusion chart had been due for review in 2021.

Some hospital policies we were sent before and after our assessment were out of date and had remained so for several years. For example, the consent policy was last reviewed in May 2014 and had a review date of 2017.

Policy review, approval and ratification was part of the agenda for the newly implemented clinical governance meeting. The minutes of the October 2022 meeting showed 4 policies had been reviewed and ratified.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Compliance with completion of the malnutrition universal screening tool (MUST) for the care group was poor, ranging from 57% to 83%. The dashboard showed the target of 95% was not met in any of the months from December 2021 to August 2022. However, we saw these completed in the care records we reviewed.

Specialist support from staff, such as dietitians and speech and language therapists, were available for patients who needed it.

Pain relief

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

Staff assessed patients' pain and gave pain relief in line with individual needs. Patients told us they received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Staff told us patients with complex pain would be referred to the pain team.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The unit was part of the Cheshire and Mersey critical care network. A critical care network is a group of critical care units from a designated area, who work together to promote the highest quality of care for people who require critical care. It also promotes clinical engagement and collaboration to ensure safe and effective services are available for critically ill patients throughout the patient pathway. It will also provide guidance on service standards to ensure equity of the care patients and their families and loved ones receive.

In England, critical care services routinely submit patient data to the Intensive Care National Audit and Research Centre (ICNARC). The unit also submitted data for ICNARC through the network. ICNARC provides patient outcome data on several key performance indicators for patients who have spent time in critical care units. We were shown the report for patients on the unit between 1 April 2021 and 31 March 2022 which showed the unit scored positively for most of the quality indicators. They were within the predicted range for the following:

- High-risk admissions from the wards.
- High-risk sepsis admissions from wards.
- Unit acquired blood infections.
- Out of hours discharges to a ward (not delayed)
- Non-clinical transfers to another unit.
- Unplanned readmissions within 48 hours.
- Risk adjusted acute hospital mortality (all patients). *
- Risk adjusted acute hospital mortality (where the predicted risk less than 20%). *

* Risk-adjusted measures consider the differences in the case-mix of patients treated)

The unit was an outlier for delayed discharges and discharges to home. We saw an action plan to address these had been implemented and the actions were either completed or on track.

GPICS recommends that a member of staff or a data clerk (for bigger units) is available for data input such as for ICNARC. On the unit the data was inputted by a member of the CCOT. However, due to workload and staffing pressures the inputting of data was behind schedule.

Within the unit there was a critical network board which showed various care bundles. However, it was not clear if the data displayed was for the network or for the unit.

The specialist nurses for organ donation (SNOD) from the UK who had links to the island audited all deaths that occurred within the unit to ensure 100% of potential donors were referred to the service. This information was submitted as part of the units ICNARC data.

Competent staff

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

The unit manager kept a log of staff appraisals. We saw this during our assessment and found

most staff (93%) had received an appraisal within the last 12 months. We were told the manager appraised the band 7 registered nurses and the band 7 staff had a team of more junior staff who they were responsible for appraising.

Most staff had a 6-week supernumerary period when they joined the critical care team. If it was recognised more time was needed this would be allocated, but if staff had previous experience in critical care, they may not need the full 6 weeks. This was determined on a 1-to-1 basis. Staff were given 12 months to complete the step 1 of the critical care step competency framework. This was in line with GPICS which states all nursing staff appointed to intensive care must be allocated a period of supernumerary practice to enable achievement of basic specialist competence.

All registered nursing staff completed the step competencies, but at the time of our assessment, the number of registered nurses who have a post-registration academic programme course in critical care nursing did not meet the GPICS standard of 50%. The unit manager told us this was due to retention issues following the COVID-19 global pandemic. At the time of our assessment, 38% of staff were trained to the required standard. The unit manager told us they had liaised with an English university to arrange a ‘part virtual’ post-graduation course for staff on the unit. This had been agreed and 3 staff were currently undertaking the course. Once these staff had completed the course, the unit would be compliant with GPICS.

GPICS states “each critical care unit must have a dedicated clinical nurse educator responsible for coordinating the education, training and continuing professional development framework for intensive care nursing staff and pre-registration student allocation and this should equate to a minimum of 1.0 whole time equivalent (WTE) per 75 nursing staff”. The unit was not big enough to meet the standard for a WTE dedicated clinical nurse educator and there was no funding for this post. The unit manager told us they had received funding from the network for a service improvement lead, but this had now stopped. Despite this, the manager continued, where possible to allocate 0.3 WTE hours to a member of staff to undertake the service improvement and clinical educator role.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. They worked across health care disciplines and with other agencies when required to care for patients. We saw positive interaction with professionals from other disciplines when they were visiting the unit, for example, radiology and pharmacy staff.

An MDT ward round took place each day at 11am. We observed the ward round and saw staff of all grades and disciplines interacted positively with each other. We also noted the consultant provided good support and teaching to the junior medical staff. The consultant also sought confirmation all staff present were happy with the plan of care agreed.

We saw positive examples of MDT working during our assessment. This included a coordinated approach between different staff disciplines and teams to support a scan under anaesthesia. We noted care records showed evidence of an MDT approach to care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Most key services were available 7 days a week, such as radiography. The routine hours for pharmacy were Monday to Friday 8.45am to 5.15pm. A Saturday service for urgent orders was available 9am to 12.30pm. The pharmacy was closed on Sundays and some bank holidays. However, an on-call pharmacist was available 24 hours a day.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the unit.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff were discreet and responsive when caring for patients. We observed staff taking time to interact with patients and those close to them in a respectful and considerate way. Patients and their families said staff treated them well and with kindness.

All interactions we saw between staff and the patients they were caring for were positive. Staff always maintained people's privacy and dignity using screens. Staff spoke compassionately to the patients including those who were unconscious.

Patients told us staff took actions to maintain confidentiality.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We heard 2 positive examples of this from 1 ward.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs

Emotional support

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

The unit had a calm atmosphere, staff were helpful and respectful to patients, their families and carers and each other. Patients told us staff regularly checked on their wellbeing and comfort.

Staff gave patients and those close to them help, emotional support and advice when they needed

it. Patients consistently told they felt safe.

We saw information displayed about how to contact the hospitals chaplain. Staff told us they would contact the patients preferred chaplain if requested.

The staff had access to SNODs from the UK who would support families with organ donation.

The CCOT leaflets included information about groups which were available to support patients and their families after their critical care experience. This included relevant telephone numbers and online resources.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We saw discussions about care and treatment were clearly documented in care records.

Staff talked with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff supported patients to make informed decisions about their care.

Patients and their families gave consistently positive feedback about the service. The service had developed an action plan relating to friends and family test (FFT), which included monthly measurement and monitoring of the feedback, improving uptake of the survey by inpatients and improving the visibility of the results.

We spoke with 1 relative who told us the staff were wonderful. They had been kept fully up to date with the care of their loved one.

The department had a range of resources to support adults and the children of patients in the unit. This included booklets for children different age groups. The booklets explained what happens in the unit, how critical illness can affect people and what to expect in terms of feelings following discharges.

The unit were also able to provide mementos, such as locks of hair or handprints in memory boxes, for bereaved relatives.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

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

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

The service was planned to meet the needs of the local population.

Post-intensive care syndrome (PICS) is made up of health problems that remain after critical illness. They are present when the patient is in a critical care unit and may persist after the patient returns home. These problems can involve the patient's body, thoughts, feelings, or mind and may affect families. Patient diaries can help the patient understand what happened whilst they were critically ill and can be helpful in their recovery. Staff, patients and their families were encouraged

to complete diaries provided by the unit. All disciplines of staff completed information in these to support the patient's recovery following discharge.

The service provided a follow up clinic in line with GPICS standards. This was also in line with the NICE best practice guidance. Clinics were held monthly and led by a consultant in conjunction with nursing staff and a member of the CCOT. Patients were offered follow up at 8 weeks post discharge and could have as many follow up appointments as were necessary. Patients were referred to other services following their discharge from the unit, based on their individual needs

The care group was able to support magnetic resonance imaging (MRI) under anaesthesia. Previously patients requiring these scans would have needed to be transferred off the island to the UK. However, charitable donations had enabled them to purchase equipment to perform these scans in the hospital.

We spoke with staff about mixed sex accommodation breaches (MSA). MSAs occur in critical care when a patient is deemed fit for discharge, is in a mixed sex environment and is not discharged within 4 hours of being declared medically fit. Staff told us this does happen on the unit, and these were reported. Staff said they would use the side rooms if they were available and always use screens between the beds in the bay area.

Staff had links to SNODs in the UK if organ donation was taking place. The on-call SNOD would travel to the island if necessary.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, we saw limited facilities for people living with dementia or a learning disability.

Staff had access to a mental health crisis team which were based on the hospital site. We were told this team was usually very responsive. If they were not able to attend, they would offer support and advice via the telephone. We found sometimes they would not see the patient until they were medically fit.

Staff and patients could get help from interpreters or signers when needed. Staff on the unit told us this service was accessible through the hospital switchboard. Staff also told us they had access to electronic tablets which could be used for people with hearing difficulties.

Staff mostly made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. However, in the critical care unit we did not see any adaptations for patients living with dementia, those with a learning disability or for those who had been ventilated, such as orientation clocks which are designed to support people in those circumstances by showing the day, date, time and if it was night or day.

The unit did not have a lead doctor or SNOD. However, they had links to SNODs in both England and Wales. If an organ donation patient was identified, the link SNOD would support the person's family, either remotely or they would travel over to the island if necessary.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted and treated in line with national standards. However, people were not always discharged in a timely manner.

People could access the unit when they needed to and the service had a contingency, to use theatre recover, if they needed additional beds. However, we were told delayed discharges from the unit were a concern. One of the consultants had prepared a paper which was being presented the week after our assessment. We were told delays were sometimes due to there being a reluctance from other areas to enable patients to be stepped down from the unit.

The unit did not have any non-clinical transfers out of the department. These are transfers made for non-clinical reasons and can often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers. If capacity issues arose in the hospital, the contingency was to utilise the theatre recovery area until a bed became available on the unit.

ICNARC date showed there had been no unplanned readmissions to the unit from 1 April 2021 to 31 March 2022. This is a positive indicator; however, it was unclear if delayed discharges resulting in longer lengths of stay for medically fit patients, were positively impacting on this indicator. The length of stays more than 24 hours were 31.7% for the unit. The England average for a similar unit was 18.6%.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. We saw information on how to raise a concern displayed in the unit and the relative's room.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

The quality dashboard showed the number of complaints received each month for the care group and the performance against the hospital policy for the management of complaints.

The number of complaints received from September 2021 to August 2022 was 140.

The care group performed well on the target of an acknowledgement being sent within 2 working days. However, they failed to meet the first written response within the agreed response time every month in the same time period.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

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

The senior team for the care group consisted of clinical and divisional operational leadership. This

included an associate director of nursing, surgical and anaesthetic clinical leads and a care group manager.

Nursing staff told us their immediate line managers were visible and supportive. One member of staff described the lead nurse for critical care as a good, strong leader. They told us some of the executive team were less visible but spoke positively about the chief executive officer (CEO).

Senior medical staff told us the medical director was supportive and had a good relationship with the medical team for the care group. We observed supportive interactions between senior and more junior medical staff.

Vision and strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action which had been developed with all relevant stakeholders.

The care group did not have a documented vision or strategy. We discussed this with senior managers who told us this was due to Manx Care being a relatively new organisation.

We were told the services had been in a difficult systemic position due to changes in the Isle of Man Government and there being a new policy for the island's health and social care.

Leaders recognised they needed to align with external partners to ensure the service met the needs of local people but told us there was currently a lack of guidance on what was needed and therefore they had focused on maintaining safety.

Leaders told us they had created a documented plan for the care group with key deliverables in April 2022. We reviewed this and found that this was a comprehensive plan for the delivery of the services.

Manx Care recognised a strategy was needed before care group plans could be made to aligned to the organisational strategic vision. Leaders felt they had some focus on where they needed to deliver.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were helpful and friendly in the unit. We were made to feel welcome, and staff were keen to tell us what it was like to work in the unit.

Staff spoke positively about the support for their health and well-being. Staff wellbeing sessions had been arranged for staff in the unit. These had been planned due to the concerns about morale as a result of the global COVID-19 pandemic and staffing issues which were described as a "hard slog".

Staff were proud of the care they provided and spoke positively about team working. On the unit there was a 'compliment and positivity' board. Thank you cards from patients and their families were displayed on the board as well as messages between staff. We observed caring interactions between staff during our assessment. Staff told us they felt respected and valued.

Staff said they would be able to raise concerns with their managers if they needed to. Junior staff were confident to raise any concerns with more senior staff.

We heard about 1 example of a period of conflict between staff and how this was resolved

amicably.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. However, the processes were developing and staff at all levels were becoming clearer about their roles and accountabilities.

Senior managers told us governance processes were being implemented to ensure effective systems for risk management and safety were in place. We were told there had been siloed systems previously. The aim was to have 1 holistic patient safety and governance. The next steps would be to gain maturity of the processes and to drive the board to ward assurances.

Managers recognised staff “had been through a lot” in recent years and there was a degree of “change fatigue”. Senior leaders felt it was key for wards to own and drive their own assurance mechanisms.

Safety huddles and debriefs had been implemented 3 times a day. It was felt these were helpful for staff and site managers, to gain a better understanding on any issues affecting patient safety. On the unit, they used the Intensive Care Society huddle guidelines, which included ‘BOSH’. This stood for ‘has everyone had a break, was everyone okay, who were the sickest patients and did anyone need any help’.

There was a suite of performance metrics on the quality dashboard, but the evidence of compliance (or noncompliance) was inconsistently displayed. We were told some data, such as IPC hand hygiene audit compliance, was collated on to a separate dashboard. This meant there was no single method of oversight and assurance. It was not clear if this had been escalated.

Senior leaders acknowledged they were not where they needed to be in terms of oversight and assurance due to the systems being relatively immature, but they felt processes were developing and there had been improvements.

Management of risk, issues and performance

Leaders and teams did not have embedded systems in place to manage performance effectively. However, ward managers recognised their local risks and senior leaders were developing more robust systems and processes.

We were told the key risks for critical care were staffing, equipment and finance. From the minutes of the newly implemented clinical governance meeting, we saw that the triumvirate were tracking 8 key risks at care group level. All these risks were rated as extreme, but with the mitigating actions in place were currently graded as high risk.

The senior leadership team for the care group told us risks had previously been managed at care group level and it was therefore difficult to see a holistic organisational view of shared risks.

The electronic reporting system was being used for risk management and these were being more closely tracked. However, it was recognised there was still more work to do to ensure robust systems and processes were in place and these become embedded as business as usual.

The most up to date information from the electronic reporting system showed the key risks for the care group as being ward-to-board performance, workforce, delivery of isolated service, financial sustainability, mandatory training compliance, management of assets and the surgery, orthopaedic and sub speciality medical on call.

A project lead had been identified and they were rebuilding the risk management structure. The senior team told us all managers would have undertaken risk management training by 19 October 2022. This was being undertaken using the current risks on the reporting system.

Risks would then be reviewed through the holistic governance meeting that had been implemented and fed up to board.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was not always in easily accessible formats. The information systems were secure but not always integrated.

Senior leaders told us the governance of data required more investment. This was for several systems, including personnel, record keeping, reporting and finance. Clarity was needed about how systems should be used so the organisation could start building 'one source of truth' for assurance and oversight. However, the governance structure and strategy needed to be in place for teams to start the work effectively.

Leaders told us a huge amount of work done in last 2 years to build a system and they felt more time was needed. Due to Manx Care being a relatively new organisation it was felt some areas were "still a piece of someone else's puzzle".

Some systems we would normally see under the control and governance of a healthcare provider in England remained under a service level agreement with an external agency, such as the human resources system.

Staff said the 3 different patient care record systems were not helpful. The systems did not "talk to each other" which meant staff had to log in to different systems to view different aspects of patients care records. We were told the introduction of 1 integrated system would improve data collection and gathering.

The electronic reporting system was being developed for use as a risk management tool, but this still needed to become embedded.

Engagement

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

A senior member of staff told us both paper and electronic staff surveys have been undertaken in the last 12 months, to enable leaders to focus on staff wellbeing. In addition, the CEO has held listening events. A manager told us these appeared to be well received by staff, an open dialogue was achieved, and staff said they felt listened to.

Patient stories were becoming more embedded at care group meetings. Leaders told us Manx Care Advice and Liaison Service (MCALS) were working with the care group on how they could engage better with service users.

Staff on the unit were supporting a student nurse during our assessment. We saw they offered teaching at every opportunity and made the student feel relaxed and comfortable in the environment.

Learning, continuous improvement and innovation

All staff appeared to be committed to continually learning and improving services. Leaders encouraged innovation. However, we saw limited examples.

In order to improve recruitment, Manx Care developed a preceptorship package which has been shortlisted for a nursing journal award twice. This was a yearlong programme, with a protected day each month for training and supervision. This programme was open for all newly qualified staff and those coming from overseas or from an area which was not providing acute healthcare, such as nursing homes.

Integrated Cancer Services

Overall summary

Integrated Cancer Services is primarily located at Noble's Hospital. The hospital currently delivers some cancer surgery and chemotherapy, otherwise known as systemic anti-cancer therapy (SACT), treatments to patients on the island.

Patients are seen by oncologists based in the UK who prescribe treatments, which are then delivered on the island by experienced nursing and pharmacy teams. Patients also have video consultations with oncologists based in the UK.

At Noble's Hospital, the service has an Oncology Day Unit at Noble's Hospital where patients receive their chemotherapy infusion treatments, and a breast cancer unit. At Ramsey and District Cottage Hospital (RDCH), there is a skin service, which treats skins cancers

The service has fostered links with a UK-based Cancer Alliance network and utilises their cancer pathways, protocols and training.

Is the service safe?

We found that this service was safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

Some staff said face-to-face training was difficult to access due to staffing concerns and training was sometimes cancelled.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse. Prior to the recruitment of a safeguarding lead at the start of 2022, training in both adults and children's safeguarding was not in line with 'Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' or the 'Adult Safeguarding: Roles and Competencies for Health Care Staff' guidance, which we were told were recognised on the Isle of Man. This concern was out of the control of staff working in the care group.

Managers told us most staff had completed level 1 training for safeguarding adults and children but not all appropriate staff had completed level 3 training for adults and children and young people. We did see that staff training numbers were increasing and there were available dates for level 3 training.

Staff gave us examples of where they had concerns about safeguarding and had worked with the safeguarding team to address these concerns. Staff said they would email or telephone the safeguarding team if they needed any advice and support.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

Cancer service departments we visited were visibly clean and had suitable furnishings which were well-maintained. Nursing staff and housekeepers were responsible for cleanliness and cleaning schedules throughout departments. We saw there was good compliance with cleaning schedules.

Hand washing facilities, alcohol gel and personal protective equipment (PPE), such as gloves, face masks and plastic aprons were readily available throughout all the cancer departments.

Throughout our visit, we saw staff washing their hands or using alcohol gel before and after providing care. Staff were bare below the elbow and used PPE consistently.

All staff completed infection control training as part of their mandatory training and the service had links to the IPC team in the hospital.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw green 'I am clean' stickers were used to indicate when equipment had been cleaned.

Spill kits were available in the department where chemotherapy was administered, these kits could be used to clean areas if cytotoxic chemicals were spilt. Cytotoxic is the term used to describe chemotherapy medicines, which prevent the rapid growth and division of cancer cells. Staff were trained in the management of blood and cytotoxic spills. The fluid used in the spill kits was in date.

Environment and equipment

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

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

The design, maintenance and use of facilities, premises and equipment followed UK national guidance. The breast unit had recently been awarded the Macmillan Quality Environment Mark (MQEM). This is in addition to the oncology day unit (ODU) that had already received the MQEM award. The MQEM is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.

The breast unit was a fully integrated diagnostic breast specialist service that provided all examinations and tests necessary to diagnose both benign and malignant tumours. Benign tumours tend to grow slowly and do not spread. Malignant tumours can grow rapidly, invade and destroy nearby normal tissues, and spread throughout the body.

The ODU was previously part of the main hospital but had been recently refurbished to service the specific needs of patients receiving cancer treatments. The ODU had a separate entrance and car park from the main hospital. This meant patients who had weakened immune systems could feel safer entering the building. During the COVID-19 pandemic, all patients attending the ODU would ring the reception from their car and would wait to be invited into the department when staff were ready to see them.

The ODU had 2 open plan bays used for chemotherapy or SACT treatment. There were 2 individual rooms that could be used for oncology patients who became acutely unwell while receiving treatment. These could also be used for patients who preferred to be on their own rather

than the open plan bays.

There were fire exit signs and fire extinguishers throughout the department. All fire exits and doors were kept clear and free from obstructions.

Staff were trained to use equipment. Records showed staff had received up-to-date training on various pieces of equipment and were considered competent to use them. The majority of equipment training was undertaken by manufacturers' representatives. We saw records of equipment servicing with due dates for completion and completion dates recorded.

Staff completed daily checks of emergency equipment, such as resuscitation trolleys, across the oncology department we visited. Intravenous fluids were not always stored securely on the resuscitation trolleys. The cardiac arrest box and anaphylaxis boxes were secured with a tamper-evident seal with expiry dates attached.

Fridge temperatures were checked and recorded every day, and we saw they were within the correct range.

Patients in the ODU who were receiving SACT treatments could reach call bells and staff responded quickly when called.

There were keypad locks on the clean and dirty utility rooms, meaning unauthorised people could not access them. We looked at a selection of single use items across the department such as needles, syringes, dressing packs and wound dressings. We found all items were in date and it was evident stock rotation systems were in place.

Assessing and responding to patient risk

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

Staff were competent when faced with any specific risk issues. Clinical staff within the oncology department completed an acute illness management (AIM) Course. Staff throughout the department used a recognised tool to identify deteriorating patients and escalated them appropriately. Staff of all grades throughout the assessment demonstrated a good understanding of how, when and who to escalate if a patient was to deteriorate.

We observed a situation in the ODU where a patient had an unexpected and adverse reaction to their treatment. The response from staff within the ODU was immediate and the hospital crash team arrived swiftly to provide additional support.

Patients underwent a pre-chemotherapy assessment 2-to-3 days before they started treatment. They were provided with contact details for the triage nurse and a red card outlining any symptoms they might experience that would suggest sepsis.

Staff completed risk assessments for each patient on admission/arrival using a recognised tool, and reviewed this regularly, including after any incident.

Clinical nursing staff within the oncology department had completed training and competency assessments to administer antibiotics. This was done under a patient group direction (PGD). A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. This meant patients who were admitted with suspected sepsis could start intravenous antibiotics without delay.

The service had 24-hour access to mental health liaison and specialist mental health support if

staff were concerned about a patient's mental health.

Shift changes and handovers included all necessary key information to keep patients safe. All staff in each of the departments we visited throughout our assessment attended a daily huddle led by the senior nurse on duty. The huddles included an overview of their department to discuss and identify a variety of quality and safety issues, patients attending for clinics or treatment and staffing.

Nurse staffing

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

Managers adjusted staffing levels daily according to the demands of service and clinics. When extra clinics were added, managers used internal bank staff to fill these shifts. Managers attempted to limit their use of external bank and agency staff, if using agency workers, they requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the department. We spoke with both new and bank staff who confirmed the induction process was comprehensive and met their needs. We spoke with agency nurses who had been supplied by off-island agencies. The nurses spoke highly of the process to bring them to the island and how they had been supported, such as with travel costs and accommodation.

The number of nurses and healthcare assistants generally matched the planned numbers and rotas. Managers held weekly clinical utilisation meetings and these meetings determined if there was an increased need for staff. Senior staff within the department told us they would take on clinical roles if they had staffing gaps.

The oncology day unit had 3 vacancies, 2 for registered nurses and 1 for an advanced nurse practitioner. The service was hoping to recruit an additional 2 registered nurses to help support the increased clinical workload.

Medical staffing

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

Medical staff were managed by their specific care group rather than cancer service. As such, there was no specific staffing data for medical staff in cancer services.

At the time of our assessment, the main challenge was due to no full-time oncologist based on the island. Pre-pandemic, the service had oncology consultants from a UK NHS trust visiting the island to hold oncology clinics. However, this arrangement stopped during COVID-19 restrictions and had not started again.

Cancer services across the hospital faced a significant challenge in attracting medical staff to the island to support clinics. Many clinics were supported by locum doctors who only came to the island for a limited time. This created a significant challenge for managers in attempting to locate suitably qualified doctors.

For example, there was a lack of a full-time consultant dermatologist on the island. A

dermatologist is a medical doctor who specialises in treating the skin, hair, and nails. Some cancers of the skin are usually treated by a dermatologist. The skin service was therefore supported by a visiting consultant dermatologist.

Records

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

The hospital used an electronic care records system and only authorised staff could access these with a secure password through the centre's online system. There were some paper records, and these were stored securely.

There were processes in place for sharing of information and staff with appropriate access could access patient information. All patient care records were stored in a single system, which included referral information, the outcome of multi-disciplinary team meetings and an ongoing treatment record. The system produced discharge summaries for GPs.

The cancer service on the Isle of Man was linked to a UK NHS cancer service and had access to their electronic patient care record system. This ensured all patient care records could be accessed by clinicians both on and off-island. Any handwritten patient notes were digitally scanned and uploaded into the electronic care record.

Medicines

The service had systems and processes to prescribe and administer medicines safely. However, there was no ward-based specialist oncology pharmacist due to pharmacy staffing and resources.

Prescribing for chemotherapy was undertaken by a chemotherapy specialist team based at a UK NHS cancer service.

There was a good working relationship between the oncology team and pharmacy team. The oncology team were very complimentary of the support they received from their pharmacy colleagues. They said pharmacy colleagues "bent over backwards to help". Pharmacy staff attended daily huddles held by oncology teams and relevant meetings wherever possible to discuss treatment protocols.

However, due to the lack of a ward-based pharmacist and pharmacy staffing issues, chemotherapy treatments were sometimes delayed. Nursing staff commented that they "would like a pharmacist more permanently on the ward".

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The chemotherapy unit delivered vascular, injectable and oral systemic anti-cancer treatments, otherwise known as systemic anti-cancer therapy (SACT). SACT is any drug treatment used to control or treat cancer. The drug treatment types may include chemotherapy, immunotherapy, targeted therapy, hormonal therapy or a combination of these.

SACT prescriptions were reviewed and screened by a pharmacist to ensure the dose was correct based on all available blood results.

The service used a combination of SACT, as defined by a UK NHS specialist trust, with regimens which were tumour specific. There was a process for off-protocol treatments and off-licence requests.

The cancer lead nurse or clinical educational support for chemotherapy was responsible for the education of their staff in the prevention, identification and management of extravasation. Competencies were assessed every year.

Staff stored and managed medicines safely. Medicines were stored safely and securely in a locked room with access only to authorised staff. The service ensured that medicines were stored at the recommended room or fridge temperatures. Medicine fridge temperatures were recorded daily.

Emergency medicines, including a chemotherapy extravasation kit, were available and stored in tamperproof trolleys or boxes in all areas visited. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs (CDs), which are medicines requiring more control because of their potential for abuse, were stored safely and securely. Nursing staff held keys for the CD cabinets. Daily checks were undertaken by nursing staff and pharmacy staff undertook audits to ensure safe management of CDs.

Prescription pads were stored securely. However, records were not always kept of the serial numbers of prescription forms when they were issued. This is not considered best practice as this measure would help identify any prescriptions lost or stolen.

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with hospital policy. There was an electronic system for the reporting of incidents and staff could describe how to use it.

We asked the service to provide us with details of any incidents relating to cancer services, but they did not provide any data for us to review.

Staff understood and could describe duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff were able to explain how duty of candour related to their role and clinical practice.

Is the service effective?

We found that this service was effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice in all areas. Staff protected the rights of patients in their care.

Manx Care advised CQC they had limited evidence that National Institute for Health and Care Excellence (NICE) guidance was applied universally at the hospital, but that NICE guidance was applied in some clinical areas. We were also told that positive systems of assurance, monitoring and reporting were not in place. Manx Care’s rationale for this was that whilst clinical practice operates under evidence-based guidelines, there were no formal assurance systems in place for monitoring and reporting.

Staff told us they followed guidance and standards from a range of sources including NICE and

the United Kingdom Oncology Nursing Society relevant to the service. We saw several standard operating procedures and policies were out of date. However, they did reflect NICE guidance. For example, the consent policy was last reviewed in May 2014 and had a review date of 2017.

Senior managers acknowledged more work was needed to ensure all policies, clinical guidelines and standard operating procedures were up to date. It was unclear if there was a standardised process for the review, updating and ratification of documents.

Policy review, approval and ratification was part of the agenda for the newly implemented clinical governance meeting. The minutes of the October 2022 meeting showed 4 policies had been reviewed and ratified.

The service used recognised cancer alliance pathways and protocols. They accessed these through their links with a UK NHS specialist NHS trust hospital.

Nursing staff had competencies from a linked UK NHS specialist trust for the areas in which they worked, such as in the infusion bay. We saw new nursing staff working their way through their competencies, which were then signed off by the registered nurse training them.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their treatment plan.

Patients completed a nutritional assessment as part of the pre-assessment process before starting chemotherapy, and this formed part of their patient care record.

Patients could bring their own food into the hospital if they were going to be there all day. Refreshments were provided by the hospital where required and there were drinks machines and cafés for patients at the hospital.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Pain was monitored as part of the holistic management of the patient. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered and recorded pain relief accurately. Staff had access to pharmacy and medical support throughout the departments if a patient required additional input or advice. Patients told us, and we saw, they received pain relief soon after requesting it with little delay.

Staff asked patients on arrival and before commencing treatment if they were feeling well and if they were in any discomfort during their treatment.

Patient outcomes

We were unable to assess weather staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The unit was part of the UK-based cancer alliance. We were not provided with any data to support patient outcomes, but we were told data was fed to the UK cancer alliance for collaboration.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers and staff together identified any training needs and gave staff the time and opportunity to develop their skills and knowledge. Managers and staff described finding time for development was challenging due to staffing levels and increasing workload pressures.

Managers made sure staff received any specialist training for their role. Staff described how they could access role-specific training through a UK NHS specialist cancer trust.

The COVID-19 pandemic had restricted the ability of staff to travel to the UK to attend training courses. Some courses were being run virtually, which had helped, but managers and staff described this as a challenge.

Staff had their competences defined at induction, checked and updated at their annual appraisal meetings. Managers gave all new staff a full induction tailored to their role before they started work. Staff underwent an induction process to ensure they were confident and competent in performing within their role. We spoke with new and agency staff who described their induction and training, and we complimentary of the process and level of information.

Clinical staff working within chemotherapy services were required to complete a SACT training course, followed by a competency workbook. This ensured all staff were competent to administer any cytotoxic chemotherapy followed with annual update.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings (MDT) to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health and or depression.

There were no oncologists based on the island. Patients were seen virtually by UK-based oncologists, who prescribed their treatment. Patients then received their treatment at Noble's Hospital. There was a mixture of approaches to MDT meetings. For example, staff at the hospital had local MDT meetings and UK oncologists joined online meetings. For other MDTs, patients were discussed at off-island MDTs, with local staff attending virtually.

All MDT meetings followed the UK-based cancer alliance protocols.

All outcomes of MDTs were recorded in the electronic patient care record. As part of the referral process for SACT treatment, there needed to be an outcome from an MDT recorded in patient care record.

All oncology patients on the Isle of Man were receiving identical treatment recommendations and

protocols as those in the UK. Patients had their care pathway reviewed by relevant consultants based on individual cancer diagnosis. UK oncology consultants prescribed cycle 1 of treatment, with Isle of Man advanced nurse practitioners and/or pharmacists prescribing subsequent cycles under the direction of UK-based consultant oncologists. Almost all adult outpatient chemotherapy/SACT treatments were delivered at the hospital.

MDTs during COVID-19 continued throughout the pandemic using online meetings or over the telephone. MDT attendances did not appear to be robust, and we observed 1 meeting where the relevant oncologist did not attend the call.

Inpatient chemotherapy/SACT treatments were given at a UK NHS specialist cancer trust.

Seven-day services

Key services were available 7 days a week to support timely patient care.

The cancer service provided clinics routinely between 9am and 5pm between Monday and Friday. However, due to increased demand, there were occasional evening clinics and some weekend clinics provided in various specialities.

Out of hours oncology emergencies were managed through the emergency department. There were arrangements and links that facilitated the use of the emergency hotline of a UK NHS specialist cancer trust. Clinicians at Noble's Hospital would use the UK NHS specialist cancer trust protocols and work under the direction of the UK-based oncology team.

Health promotion

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

The oncology service had relevant information promoting healthy lifestyles and support in patient areas. We saw patient information displayed in clinics across outpatients.

There were strong links with Macmillan Cancer Support, a cancer charity, who provided a range of support leaflets and information to patients.

This included guiding patients and carers to support services, information on conditions, smoking cessation and drink awareness.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

SACT treatment could not proceed until the relevant consultant oncologist had obtained consent from the patient. This was required to be recorded in the electronic patient care record before medications could be prescribed.

If patients wanted to withdraw their consent during treatment, this would have to be documented on the electronic patient care record.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

In all oncology departments we visited, we saw staff taking time to interact with patients and those close to them in a respectful and considerate way. Staff greeted patients and introduced themselves. Staff genuinely cared about their patients, and patients were pleased to see faces they recognised.

Patients were offered a holistic needs assessment to understand their needs outside their cancer treatment. This enabled staff and the service to tailor care to the patients' needs as a whole and not just to treat their diagnosis.

Staff told us patients had personalised management of their treatment from the beginning to the end of their pathway – this was documented in a booklet called 'your cancer treatment'. Staff followed policy to keep patient care and treatment confidential.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All patients said staff treated them well and with kindness.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were aware of the life-changing impact of a cancer diagnosis and cared for patients in a supportive manner.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave patients and those close to them help, emotional support and advice when they needed it.

There was a quiet room available with seating for patients to use if they were anxious or worried when visiting the department. Staff told us these rooms were available to patients as needed. Staff used these rooms for private discussion with patients and for patients who had received bad news to provide privacy if they were distressed.

Patients' individual needs and preferences were always reflected in how their care was delivered. Patients' physical and psychological needs were regularly assessed and addressed, including nutrition, hydration, pain relief and anxiety.

Staff could describe how they supported patients who had exhausted treatment options and were moving onto a palliative pathway. They would have the conversations with the patients and their relatives and provide appropriate support. Some patients had been attending the hospital for a long time.

Specialist nurses were available to provide additional care and support for patients. They supported their colleagues with training and emotional support.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked

with patients, families and carers in a way they could understand, using communication aids where necessary.

When a patient attended the hospital for their pre-assessment visit, the hospital would involve relatives in some of the discussions with patients wherever possible, so they were aware of the issues for patients who had taken SACT.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. We spoke to patients who were positive about their experience, despite the nature of their diagnosis and treatment.

Is the service responsive?

We found that this service was responsive in accordance with CQC's assessment framework.

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

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

Facilities and premises were appropriate for the services being delivered. The oncology services were spread around different departments at the hospital. Patient areas were comfortable and social distancing was in place for staff and patients. Patients were quickly moved from the main waiting room to sub-waiting areas so they could begin their treatment. Refreshments and water were available through the clinics for patients.

Most cancer clinics were located at Noble’s Hospital, with support services including diagnostics, specialist nurses and allied health professionals.

The island skin cancer service was located at RDCH. There was a combined operating theatre and treatment room where clinicians could perform skin cancer treatments. The skin service had commenced training of 5 GPs with extended interest in dermatology. These GPs would manage routine skin cancers within their own practices across the island, referring complex cases to the skin service. This was designed to take the skin service closer to the patient and to reduce the demand on the secondary care skin service.

Radiotherapy treatment was delivered at a UK NHS trust who had close connections to the Island. This meant patients requiring radiotherapy did have opportunity to be seen in person by oncology medical team prior to treatment.

There were 2 sites used for off-island treatment; 1 delivered radiotherapy treatment and the other inpatient chemotherapy and SACT.

Paediatric chemotherapy SACT was delivered at specialist paediatric UK NHS trust.

The service minimised the number of times patients needed to attend the hospital by ensuring patients had access to the required staff and tests during their visit. There were virtual consultations with off-island clinicians. This reduced the need for patients to attend departments or travel to the UK unnecessarily.

Services across the hospital faced a significant challenge in attracting medical staff to support clinics. Many services were supported by locum doctors who only came to the island for a limited time. This could be a few days, weeks or occasionally longer, depending on the contract agreed

with that individual. This created a significant challenge for managers in attempting to locate suitably qualified doctors.

Managers monitored and took action to minimise missed appointments. Managers ensured patients who did not attend appointments were contacted.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports.

Staff recognised and considered the needs of patients when they were accepted for treatment. A comprehensive needs assessment was completed for every patient before they started any treatment. This was documented in a booklet called 'your cancer journey' which each patient held.

There were quiet rooms available which could be used for patients who may be anxious or where patients required a quieter room than the waiting room. Additional time could be provided in the clinic for patient appointments if required.

The ODU had 2 individual rooms with beds for acute oncology patients. They could also be used should patients become unwell or if they preferred to receive their treatment in a quiet room rather than the open plan bay.

Staff discussed the individual needs of patients at the daily huddle. For example, we saw staff discussed the mobility issues of a patient attending during our assessment. Staff transferred the patient from their wheelchair to a bed in the privacy of one of the individual rooms before moving them to the treatment bay to commence their treatment.

The service had information leaflets available in languages spoken by the patients and local community. There was a wide range of patient information available to patients including information about wigs and the side effects of the cancer treatments.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

The hospital worked with local charities and could signpost patients to complementary therapies during their chemotherapy treatment.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Manx Care cancer service said they benchmarked performance against the UK national targets. Managers monitored waiting times and we requested data to demonstrate their performance, but this information was not provided.

Managers said that despite inconsistently achieving the UK cancer national targets, the hospital was using all available resources through the pandemic to ensure they clinically prioritised patients through their tracker to ensure patients were able to access the services.

Progress and performance for each cancer speciality was overseen at weekly performance and

planning meetings.

Cancer waiting times are a key performance measure and many aspects of the cancer pathway are currently covered by several different UK national standards. There are currently 8 main operational standards for cancer waiting times and 3 key timeframes in which patients should be seen or treated as part of their cancer pathway.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments, treatments or operations cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Due to the COVID-19 pandemic, the hospital was having to make decisions to ensure that patient safety was a priority. Cancer treatment was considered a priority and the hospital continued to provide treatment throughout the pandemic. Priority meetings took place on a regular basis to ensure all patients waiting to be treated were discussed and those who urgently needed to be treated were contacted and treated as soon as the hospital capacity would allow.

Learning from complaints and concerns

Feedback and the ability to raise concerns about care received was being developed. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Complaints were recorded at hospital level, so we did not know how many complaints were attributed to the oncology department.

Patients, relatives and carers said they knew how to complain or raise concerns if they needed to.

Managers told us they shared feedback from complaints with staff and learning was used to improve the service. However, we did not see any evidence to confirm this happened.

Due to the lack of data, we were not assured that themes of complaints were identified and that any learning was used to improve the service.

Is the service well-led?

We found that this service was well led in accordance with CQC's assessment framework.

Leadership

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

Leaders had the skills and abilities to run the service. Each department had a local leader. Each lead within the departments held a daily morning huddle, which was a structured and documented meeting aimed at resource and capacity planning. This included problem-solving any immediate issue, learning from incidents and complaints and key messages/alerts for that day. We saw each leader had oversight of their department.

The leaders had the skills and abilities to run the service. We saw evidence they understood and managed the priorities and issues the service faced. Staff felt supported by both their immediate line managers and the senior leadership team. Staff we spoke with were proud of the work that they carried out.

Senior leaders and staff worked effectively within the UK-based cancer alliance network.

Staff felt leaders encouraged them to develop and felt supported to apply for senior roles. Staff told us they received regular learning sessions for their personal development.

Vision and strategy

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

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a plan and a vision for the future of the services. Senior managers were working with the Manx Care to prioritise new services and service improvement.

Staff said their biggest vision was to improve the cancer services, improve their national target and to be the best in what they do. Cancer services priority was to improve the 62 cancer GP referral and screening standards, and to be able to increase access to treatment for patients.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt respected, supported and valued. Staff throughout the oncology departments were focused on the needs of patients receiving care.

The oncology service had an open culture where patients and their families could raise concerns without fear. Staff were encouraged to report concerns and incidents, and they confirmed to us they were happy to do so.

Staff told us they enjoyed working at the hospital and they were not afraid to raise issues or concerns. They said they were listened to, and action was taken if appropriate. Staff spoke positively about the support for their health and well-being.

Staff showed compassion and care for the roles they performed and the people they cared for. It was clear there was a genuine commitment from staff to improve the service.

Some staff told us of a good team working culture, staff helped each other. Staff told us morale was positive and they were proud to work at the hospital.

Through our conversations and observations, it was clear staff were focused on the needs of patients living with cancer.

Governance

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

Historically, cancer services' governance had been lacking. For example, staff described that prior to 2018, governance for the skin service was absent. However, we were told a local MDT had been established with links to specialist skin MDTs based in the UK and this had greatly improved governance.

Cancer services on the island engaged with a UK-based Cancer Alliance. Teams described 'shared governance' where oncology-related incidents and complaints were managed via shared investigations between the island teams and oncology teams based in the linked UK NHS cancer trust. We were told oncology teams based in the linked UK NHS trust conducted SACT 30-day mortality investigations for Isle of Man patients under their care.

Leaders described how the cancer team hold 'cancer performance days' twice a year with oncology teams based in the linked UK NHS trust, where they explore current challenges, relationships between services and MDT optimisation.

Management of risk, issues and performance

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

There was a risk register for the service.

The main themes of incidents within cancer services were around patients missed diagnosis and delays to treatment. The hospital was continually working on improving their MDT meetings with regular peer review, improving systems to ensure they were appropriate and that pathways were in place to prevent any delays for patients in the cancer journey.

The key challenge and risk for the service is that there is no oncologist based on the island and at Noble's Hospital. Prior to the COVID-19 pandemic, a UK-based oncology consultant would visit the island and conduct 'general' oncology clinics. This provided oncology medical expertise on-site, although there was a risk patients were being seen by consultants not specialists in their cancer. Post-pandemic, no oncologists visited the island and patients were seen virtually.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was not always in easily accessible formats. The information systems were secure but not always integrated.

Although the service collected reliable data and analysed it, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Staff had access to information relating to risk management, information governance and how to raise concerns. Staff were knowledgeable about the hospital incident reporting process.

The information systems were integrated and secure. Staff had access to up to date, correct and comprehensive information on patients' care and treatment in line with their roles and responsibilities. The cancer service on the island was linked to the cancer service based at a UK-based NHS trust who had access to their electronic patient record keeping system. This ensured all patient records could be accessed by clinicians both on and off-island. Any handwritten patient notes were digitally scanned and uploaded into the electronic record.

Meeting minutes were made available to staff if they were not able to attend meetings, which allowed all staff to keep up to date with changes.

Staff followed the hospital information governance policy. Staff undertook General Data Protection

Regulation (GDPR) training as part of mandatory training. We saw computer screens were not visible to patients or visitors.

Engagement

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

Both paper and electronic staff surveys have been undertaken in the last 12 months to enable leaders to focus on staff wellbeing. In addition, the CEO has held listening events. We were told these appeared to be well received by staff, an open dialogue was achieved, and staff said they felt listened to.

There was excellent working with partner organisations that supported the service to deliver care and treatment to the patients on the Isle of Man.

Patient stories were becoming more embedded at board meetings. Leaders told us Manx Care Advice and Liaison Service (MCALS) were working with the care group on how they could engage better with service users.

Learning, continuous improvement and innovation

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

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

The skin service had developed a ‘hub and spoke’ model for increasing primary care activity and focusing on referring only complex cases to secondary care. This involved training 5 GPs to have an extended role in dermatology. The skin service had developed additional services to manage the gap in consultant cover. For example, minor surgery was performed by suitably trained clinical nurse specialists and GPs (with extended roles). The service was about to roll out tele-dermatology photography clinics for suspected skin cancer on the 2-week pathway. It was anticipated this would greatly improve the waiting times for that patient cohort.

The skin service told us how they are planning to commence a skin cancer patient support group within the next 12 months.

Diagnostic Imaging

Overall summary

Diagnostic imaging services are primarily located and provided at Noble's Hospital. Ramsey and District Cottage Hospital (RDCH), based on the north of the island, has facilities for plain X-ray and is due to have a bone-density (DEXA) scanner installed.

Services provided at Noble's Hospital include X-ray, fluoroscopy, computerised tomography (CT), magnetic resonance imaging (MRI), obstetric and non-obstetric ultrasound, breast imaging and interventional radiology.

Most services are provided 7 days a week, the exception being X-ray at RDCH, which is a week-day service. X-ray and CT facilities are available 24 hours a day through the emergency department at Noble's Hospital.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

Some staff said face-to-face training was difficult to access due to staffing concerns and this meant their training was sometimes cancelled.

Safeguarding

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

Prior to the recruitment of a safeguarding lead at the start of 2021, training in both adults and children's safeguarding was not in line with 'Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' or the 'Adult Safeguarding: Roles and Competencies for Health Care Staff' guidance, which we were told were recognised on the Isle of Man. This concern was out of the control of staff working in the care group.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Sonographers told us they had undertaken additional training in identifying those at risk and signs of female genital mutilation (FGM).

Staff followed safe procedures for children visiting the department. The department did not have a

dedicated paediatric waiting area, as everyone waited in the same area. When children came to the department from the emergency department, they waited in emergency department as they had dedicated paediatric areas. Access to the emergency department paediatric waiting area was restricted by secure doors. Staff told us how they would call children through when radiographers were ready for them. This measure meant children were kept safe from risks in the environment.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

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

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

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

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment and rooms between patients. They knew what products they would use and explained how these would change depending on the clinical need.

Staff working in ultrasound said they cleaned all equipment after use. There were 'I am clean stickers' on mobile equipment, such as ultrasound scanners and blood pressure gauges.

Staff used an aseptic technique when cannulating patients for contrast procedures, which followed infection prevention guidance.

Environment and equipment

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

The design of the environment generally followed national guidance. The setting enabled staff to observe and monitor patients waiting. There were changing facilities for patients who were required to change for certain scans or procedures.

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

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

Resuscitation trolleys were stored in a place easily available to all staff and trolleys. Trolleys were colour-coded to differentiate between paediatric and adult equipment. Staff carried out daily safety checks of specialist equipment. Staff told us resuscitation trolleys were checked in 2 ways; the full trolley was checked monthly and resealed with a numerical tag and records supported this, whereas the defibrillator, suction equipment and items not stored within secure drawers were checked daily. Records showed equipment checks had been performed and there were areas to record if equipment was replaced.

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

There was appropriate PPE available for prevention of infection. Some lead aprons and body coverings (used to protect the body from exposure to radiation) in the main department and at RDCH did not appear to show if they had been checked for safety. This meant there was no audit trail and staff were not aware of the condition and integrity of all protective equipment.

The service had suitable facilities to meet the needs of patients' families. Due to restrictions on the numbers of people attending hospitals in response to the COVID-19 pandemic, patients were asked to attend appointments alone, or if they needed support, they could bring carer. Staff understood that some patients may need additional support.

The service had enough suitable equipment to help them to safely care for patients.

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

Equipment service and maintenance contracts were in place and Manx Care medical engineering supported the service for non-radiation checks and repairs. Examples of engineer reports were provided.

We were told that equipment and money had been donated to the service by patients or families of former patients. These were gratefully received and enabled the service to access state of the art imaging equipment to improve services. However, this also brought challenges regarding maintenance and servicing contracts as some items were non-standard or required specialist engineers that brought additional financial burdens.

Assessing and responding to patient risk

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

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

Staff completed risk assessments for each patient on arrival, using a recognised tool and reviewed this regularly, including after any incident. Staff spoke with patients before undertaking a radiation exposure to ensure exposure was justified. The department used a 3-point identification check with patients before undertaking an imaging procedure. In controlled areas there were 'PAUSE

and check' posters that prompted staff to verify information before exposing patients to ionising radiation. We observed most staff carried out checks on patient ID prior to imaging.

Staff knew about and dealt with any specific risk issues. Patients who may be pregnant were asked about the possibility of this before undertaking procedures and this followed local policy. There were posters on display regarding pregnancy that alerted patients to notify staff if they believed they may be pregnant.

Patients from wards attended with notes detailing any additional requirements, and these were also communicated verbally by staff from the ward.

When patients were given intravenous contrast, they were given advice to follow if they became unwell after leaving the department. Staff received additional training on administering intramuscular adrenaline and had undertaken both deteriorating patients and anaphylaxis simulation training, which were repeated yearly or sooner if necessary.

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

There were Radiation Protection Supervisors (RPS) working in the department and radiation-controlled signs gave contact details for them. An RPS is appointed for the purpose of securing compliance with the Ionising Radiation Regulations 2019.

The hospital had a radiation safety policy, which met the Isle of Man's Health and Safety at Work Inspectorate criteria. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with ionising radiation undertaken in the hospital was safe as reasonably practicable.

There were radiation protection supervisors for each modality to lead on the development, implementation, monitoring, and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) Regulations 2019. Staff demonstrated safe working methods to record patient doses for radiation.

All imaging procedures and protocols had risk assessments that had been undertaken by senior staff and radiation protection advisors.

Staff wore dosimeters (small badges to measure radiation) to ensure they identified and accurately recorded any exposure to higher levels of radiation than was considered safe. The dosimeters were then sent for testing by a specialist external organisation, with results showing they were all within the safe range. MRI safety was monitored and managed by a medical physics expert from an external specialist provider and a specialist radiologist was on site.

Staff shared key information to keep patients safe when handing over their care to others. When inpatients were identified as vulnerable, a member of ward staff accompanied them. The department used an electronic image requesting system that alerted staff to individual patient risks, such as pacemakers and previous contrast reactions. Images and reports were made immediately available to all referrers and clinicians. Previous images and reports were also available to help staff check previous findings for clinical checks and comparison.

The service employed radiologists and radiographers and used external teleradiology services for reporting on imaging. The teleradiology service was used to report on a wide range of images and provided this service 7 days a week. When imaging indicated an urgent clinical response, the service had a pathway to communicate this and avoid delayed treatment.

Staffing

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

The service had enough radiographers and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of radiographers and healthcare assistants needed for each shift.

The external teleradiology service reported all plain film X-rays, apart from children under 12 months and images of the head and neck. These images were always reported on by consultant radiologists. A consultant radiologist reported on breast images and carried out ultrasound scans and biopsies.

Staff told us there were continuous vacancies in the general X-ray department that took several months to fill. However, there were generally low staff turnover rates across the hospital and low sickness rates.

The number of radiographers and support staff matched the planned numbers. There were generally enough staff in the service, and when staffing numbers fell below those needed, managers were able to use bank and agency staff to maintain safe levels. The service had low rates of bank and agency staff. Managers made sure all bank staff had a full induction and understood the service.

Medical staffing

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

The radiology staff did not always match the planned number of staff. The service had taken measures to recruit into vacant posts. Recruitment to these posts had been hampered and delayed due to travel restrictions imposed by the COVID-19 pandemic.

Although there was a shortage of radiologists, the service had enough medical staff to keep patients safe. Radiologists reported all CT and MRI studies and specialist X-rays including all head and neck images and examinations of babies. The external teleradiology service reported all other plain film X-rays. The shortage of all modality radiographers is a nationally recognised problem within the UK.

All radiologists and some radiographers were able to access images from home and report them remotely. Home reporting stations had been set up during COVID-19 restrictions so that staff could continue to work when they could not access the department.

Records

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

Patient referrals, reports and images were stored electronically, and all staff could access them easily at any time and from any location.

When patients transferred to a new team or department, there were no delays in staff accessing their patient care records. The record system was accessible and reliable, and images could be viewed and reported on remotely by all registered clinicians.

Staff used radiology information systems to log scanning requests, and these were then vetted by senior staff to ensure they were justified. Staff reviewed previous imaging in the hospital undertaken on a patient to inform their decision when justifying exposure.

When reporting was undertaken by the teleradiology service, they were able to access the imaging system directly and report within it, so images did not need to be sent.

Records were stored securely. Staff accessed records using their own login and password.

Medicines

The service did not always store medicines safely or securely.

During the assessment, we did not see any audits relating to the safe and secure storage of medicines. After our assessment, the service provided audit data on a dedicated audit tool for medicines, but the audit data only included information delaying to September 2022. Results showed compliance had generally been achieved, with areas for improvement identified.

The medicine storage seen was safe and secure with access only to authorised staff. However, there were boxes of contrast media stored in an unlocked cupboard in the 'dirty utility' room in the radiology department in Noble's Hospital, which stored cleaning equipment and materials. We escalated this to staff and immediate action was taken to remove and store appropriately.

The service ensured that medicines were stored at the recommended room or fridge temperatures. Medicine fridge temperatures were recorded daily.

Emergency medicines were available and stored in tamperproof trolleys or boxes in all areas visited. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs (CDs), which are medicines that require more control because of their potential for abuse, were stored safely and securely with CD keys stored and held separately from all other medicine keys. Daily checks were undertaken by staff in radiology and pharmacy staff undertook audits to ensure safe management of CDs.

Incidents

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

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

Staff understood duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw duty of candour training was part of mandatory training

Staff reported serious incidents clearly and in line with hospital policy. Incidents reportable under Ionising Radiation (Medical Exposure) Regulations 2019 were reported appropriately and investigations contained action plans.

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

Is the service effective?

We found that this service was effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and relevant guidance. Radiation protection supervisors for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) Regulations 2019.

The external teleradiology service audited the quality of reports they produced. The department held imaging discrepancy meetings with the reporting service where reporting incidences or concerns regarding quality were discussed, which meant the department could respond and monitor quality. Staff told us not all modalities had been invited to the discrepancy meetings due to historic issues with the service. Staff said this was being addressed by the local leadership team.

We saw reviews against Ionising Radiation (Medical Exposure) Regulations 2019 and learning shared to staff through team meetings and training. The hospital had a radiation safety policy, which met with guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with ionising radiation undertaken in the hospital was safe as reasonably practicable.

Nutrition and hydration

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Patients were provided with information before fasting scans that detailed how long patients should do this for. Water was available in all waiting areas. Staff told us how they would provide patients with a small snack if they felt unwell.

Staff ensured patients requiring CT examination using contrast were sufficiently hydrated prior to their procedure.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain during interventional procedures and gave pain relief in line with

individual needs and best practice. Patients received pain relief soon after requesting it.

Referring staff prescribed pain relief, and nursing staff or medical staff administered and recorded pain relief accurately.

Patients attending from home who required regular pain medicines were advised to bring these to their appointment.

Patient outcomes

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

The service participated in relevant clinical audits, which included ‘success rate of guided CT’, ‘bone density scan accuracy’ and ‘MRI lumbar spine for cauda equina’. The department provided evidence to show they were fully compliant with the World Health Organisation (WHO) checklist for diagnostic imaging.

All audits we reviewed had a clear frequency indication, and this was monitored by the governance lead. Actions from audits were followed up in the next audit report.

The breast screening department had worked hard to clear their backlog following suspension of the service during COVID-19. Time between screening invitations had returned to 2 years and first invitations were sent in the month of when patients turning 50.

The service used the National Breast Screening Programme (NHSBSP) quarterly performance indicators to monitor performance of the service and mammographers against NHSBSP standards and the yearly data set of outcomes.

The service supported the National Alliance action plan and provided women with a single diagnostic assessment reducing attendance and patient anxiety.

Managers and staff used the results to improve patients' outcomes. Staff carried out bone density (DEXA) scans at Noble’s Hospital to check overall bone mineral density and following hip replacement surgery to check bone growth around the operation site. Referrers could then act on the results and make changes to patient care and treatment. However, the DEXA scanner had an intermittent fault which meant it had to be taken out of service in July 2022. The service had attempted to get the scanner repaired but unknown to the service, the maintenance contract had expired. Prior to the scanner failing, there were no waits for scans, and they carried out approximately 120 scans per month.

A new DEXA scanner was due to be installed in RDCH in the week following our assessment.

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

Managers used information from the audits to improve care and treatment. They shared and made sure staff understood information from the audits. Information from audits was presented at monthly meetings for discussion of action and improvement from them.

Consultant radiologists and reporting sonographers attended discrepancy meetings, undertook quality checks, and double reported (an independent report was carried out by a second member of the team) 20% of images in line with the departmental discrepancy policy. Staff also double

reported 5% of outsourced images.

Competent staff

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

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

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

Managers did not consistently support staff to develop through yearly appraisals of their work. Managers told us they did not always have time to do all staff appraisals due to staffing shortages. While appraisals did not always happen, managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they could discuss training needs with their line manager outside of the appraisal process and were supported to develop their skills and knowledge.

The service had developed a training programme for radiographers with a university based in the UK. This would enable the service to develop its own staff base and provide development opportunities.

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

Radiographers carried out a yearly audit to demonstrate proficiency. We reviewed competency framework for different modalities, including MRI and CT Head.

Managers made sure staff received any specialist training for their role, such as in administering of intramuscular adrenaline.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Managers told us multidisciplinary meetings were held virtually across the hospital and they attended these. These meetings supported managers in planning services that fluctuated in capacity, such as interventional radiology. Radiologists would routinely attend MDT meetings to provide specialist knowledge on imaging. This would be particularly beneficial when a patient was being discussed in an oncology MDT meeting.

Patients could see all the healthcare professionals involved in their care at one-stop clinics. In the

breast screening department, symptomatic patients were able to attend a clinic where a mammogram, ultrasound and physical examination would be undertaken. These clinics were staffed by mammographers and a specialist doctor. If clinical evidence suggested a biopsy was required, this would be undertaken at this visit. Staff gave patients in this clinic clear guidance on when they would receive results from these tests. This service removed the need for patients to attend for multiple appointments and reduced stress in patients as they were able to have tests performed at the same time reducing anxiety around diagnosis.

The service supported staff to undertake extended roles, such as radiographer reporting. This would help the service to develop their offering in this area and improve services for patients.

Seven-day services

Key services to support timely patient care were not available 7 days a week.

Staff could call for support from doctors and other disciplines. The service operated a full imaging, dental X-ray and screening service during the week. However, imaging services on weekends and out of hours were restricted to emergencies only.

The service did not operate an interventional radiology service during weekends and on bank holidays due to staffing numbers.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle such as for patients attending for gastrointestinal imaging.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the Consent on page 18 for issues common to many services.

Consent documents were completed, and they gave patients details of the procedure and risks associated. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain X-rays. In some general cases, this was inferred consent. Specialty medical staff obtained consent for any interventional procedures in writing before attending departments and for biopsy procedures.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our assessment we saw staff interacted with patients in a way that demonstrated empathy and good levels of care.

Radiographers took time to speak with patients during procedures and made sure they were fully

informed about what would happen. Mammographers in the breast screening unit took time to have detailed and compassionate conversations with patients to ensure distress was minimised.

Patients said staff treated them well and with kindness. In the main waiting area, patient feedback had been posted. This feedback was positive in nature and praised staff for their care. Staff at reception gave clear and simple instructions to patients on where they needed to go.

Reception staff respected patient privacy when they were checking personal details on arrival for their appointments, although glass screens to protect people from infections sometimes made this more difficult.

Staff in all departments were caring and compassionate to patients. We saw positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.

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

Staff told us they could access translation services if required and generally these requirements would need to be known in advance. Patients were entitled to a chaperone on request and efforts would be made to provide one that was of the same gender. For imaging procedures where the procedure involved an intimate area, staff worked in pairs to provide this as a standard and staffing allowed for this.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. MRI staff would support patients suffering from claustrophobia and anxiety. CT rooms were equipped with calming equipment such as ambient lighting and ceiling images.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing care before, during, and after procedures and showing consideration to patients' emotions, allowing them time to ask questions or comply with requests.

Staff were aware some positioning could be uncomfortable and allowed patients to be independent or made adjustments where possible.

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff told us they felt valued and supported in their role enabling them to provide high quality care. Patient feedback confirmed this was happening.

Patients gave positive feedback about the service. Feedback on display was mostly positive in nature, and many of the comments praised short waiting times and caring staff. We were told patient surveys had stopped due to the pandemic, but these had resumed in January 2022 after restrictions had been removed. The service provided data which demonstrated a comprehensive series of 16 questions were asked. Responses across the questions were mainly positive.

Is the service responsive?

We found that this service was responsive in accordance with CQC's assessment framework.

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

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

The service planned and provided care in a way that met the needs of local people and the communities served. The service provided imaging services to the wider hospital and a walk-in service following GP referral. The service had a main imaging area with 2 CT scanners, 2 MRI scanners, ultrasound, interventional radiology and plain film imaging. There was a bone density scanner, but at the time of our assessment, the scanner was out of service and a new scanner was due to be installed the following week.

The breast screening unit carried out the cancer screening service for the entire population of the island and symptomatic screening clinics.

Managers planned and organised services, so they met the changing needs of the local population. Facilities and premises were appropriate for the services being delivered. The amount of imaging equipment in the department provided easy access to imaging, and staff were able to book non-urgent appointments relatively easily and at short notice.

The main imaging area was signposted clearly and close to the main entrance. There was a walk-in service for plain film imaging.

The service had systems to help care for patients in need of additional support or specialist intervention. All imaging equipment was labelled to clearly demonstrate weight bearing limits, and risk assessments were in place for bariatric patients. When a ward patient required additional support, a member of nursing staff attended with them. Posters and leaflets to support paediatric patients were on display in waiting areas.

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

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

Meeting people's individual needs

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

The main waiting area was spacious. There was sufficient seating and a small area with children's toys and books which were clean and well maintained. Sub waiting areas provided adequate seating arrangements. Patients attending departments had access to drinks and snack facilities, a café and a shop.

Patient toilets (including disabled facilities and baby changing) were all easily accessible.

Referrers usually informed departments in advance of patients who may have had additional needs or required additional support when attending for procedures. Reception staff informed radiographers when they had identified if patients attending had any additional needs. Staff could offer an appointment at a quiet time if a patient had a particular need, such as a learning difficulty or dementia, where waiting in a busy waiting area could be distressing. Staff confirmed that priority was generally given to people who required additional support.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Booking staff provided leaflets to patients with their appointment information. If referrers provided information on the language required or any specific patient needs, leaflets would be printed accordingly.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff organised interpreter services for patients who did not speak or understand English.

A poster communicating the risk of radiation during pregnancy was on public display in the main waiting area at the time of our visit. However, this was not available in written in multiple languages.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and targets. All patients who attended from emergency department, or for urgent referrals from clinics, had images completed the same day. If radiographers identified suspicious findings on chest X-rays, they were able to share the image immediately with a radiologist to generate a report or make an instant referral for CT.

Patients were able to attend for symptomatic breast screening and received results of this within 2 weeks of the initial GP referral. When patients attended from internal areas of the hospital, efforts were made to avoid these patients being in the waiting area. This was achieved for emergency patients by calling the patients to attend when radiographers could take them straight in.

However, the service had long waiting lists for routine scans and imaging. We were told waiting lists for CT scans (in particular CTCA, which takes images of the coronary arteries of the beating heart) were around 12 months. The waiting times for MRI scans were approximately 5 to 6 months. Routine referrals for ultrasound scans were approximately 9 to 10 months.

The bone density (DEXA) scanner had been removed from service in July 2022 due to a fault and the lack of a valid service contract. We were told the DEXA service usually scanned in the region of 120 patients per month. The new scanner was not due to be installed until October 2022.

The department did not display waiting times in the waiting area and patients had to ask staff for this information.

Managers worked to keep the number of cancelled appointments treatments and operations low. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within targets and guidance.

A booking team worked with patients and referrers to ensure appointments met agreed timeframes. Appointments were managed according to priority, such as unplanned or emergency care, urgent and routine.

When servicing or equipment failure was being undertaken, patients were moved to other worklists to avoid delays.

The service used an external reporting company for out of hours reporting of CT and MRI examinations. This service provided some support during daytime hours to meet increases in demand and to help meet reporting time targets, although staff told us this still could not meet demand, in particular for CT reporting. There was a service level agreement, quality assurance agreement, and contract written for this.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern in patient areas.

Complaints were recorded at hospital level, so we did not know how many complaints were attributed to the radiology department.

Managers told us they investigated complaints and identified themes. Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The service reported there had been no formal written complaints direct to the service in the 12 months prior to our visit. However, managers said they contributed to complaint responses regarding specialty care elsewhere within the hospital that related to diagnostic imaging.

Managers had a process for sharing learning from complaints with staff and ensuring learning was used to improve the service.

Is the service well-led?

We found that this service was well-led in accordance with CQC's assessment framework.

Leadership

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

There were managers in each department within radiology, most of which were longstanding.

Leaders said they had an open-door policy. Staff described managers as being accessible and approachable. Staff knew who they were and how to contact them should the need arise.

Leaders had knowledge in the area they were working in and used their experience to inform decisions. Where leaders did not have clinical knowledge in an area, they sought input from experienced staff. Staff told us they were able to approach leaders and give insight using their own knowledge of the areas they worked in.

There were regular staff meetings and minutes of these showed discussions of service improvement and shared learning discussion. There were apprenticeships in place to develop and support non-clinical staff though higher education to qualify as radiographic staff.

Vision and strategy

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

Leaders demonstrated a vision for their service and were motivated to improve. The service was aligned with the wider plans of the hospital, to improve services for patients.

Managers were aware of challenges and risks to providing an improved service and had identified and implemented changes to meet some priorities and planned outcomes early, such as investment in additional equipment including a bone density scanner at RDCH.

Radiologists supported the strategy, and although the team was pressured and short of staff due to a shortage of radiologists, they had been able to make some recent appointments and make improvements to rotas to support emergency access to care, timely discharges, and reduce reporting times.

Culture

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

Staff spoke positively and were proud of their workplace. Staff spoke positively about managers and said they were approachable and fair. Interactions between leaders and staff were warm and courteous. Leaders checked in with staff throughout the working day and encouraged them to feed back any issues.

Staff told us they felt heard, and managers respected and valued them. However, some clinicians described how they felt undervalued by the hospital executive team. We were told they felt they had not been listened to regarding service developments they had outlined and recommendations they had made regarding cost savings and staff retention and recruitment.

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

address concerns about unsafe clinical practice.

Leaders showed that when concerns were raised, patients were able to report this. Feedback from complaints was shared among staff and duty of candour had been completed as part of investigations.

Staff knew about their responsibilities for duty of candour and could tell us how this was used in complaints and incident reporting.

Governance

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

Managers described the governance structure and how that was supported by a range of meetings. Staff had monthly meetings following an agenda to discuss a range of issues including complaints and incidents. We were told staff meetings minutes were shared with all staff in the service. Senior managers had a weekly meeting to discuss issues and concerns, this meeting also informed service planning.

The service operated under the integrated diagnostic and cancer services care group of the hospital and attended group meetings for this area. Managers told us how they had developed the storage and access of audit information and followed a quality improvement process to achieve this.

The service used a radiology reporting service and quality of this was monitored at monthly meetings, clinical staff could also inform this meeting by providing details to management. The teleradiology service also provided internal audit reports to the service.

An external provider gave medical physics support and managers were able to contact them when needed. The RPA produced yearly reports detailing areas for improvement and made recommendations the service should take. These actions were given dates of completion and followed up in regular check-in meetings.

There were radiation protection committee meetings attended by the RPA, RPS for each modality, senior managers, and the hospital medical physics expert.

Management of risk, issues and performance

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

Leaders used systems to manage performance effectively. The service used a systematic approach to improve the quality of its services while maintaining standards of care. Staff described the governance structure which they said was effective and promoted staff confidence.

The risk register identified risks which were categorised according to potential impact. These were mainly regarding staffing, ageing equipment, and capacity and demand. The register showed actions taken and any remaining gaps were identified with dates for review. There were plans in place for equipment failure.

Staff managed performance effectively and there was an improving trend for patients waiting for diagnostic tests. Staff monitored performance against key performance indicators (KPIs) and took

action to avoid breaches before they occurred such as provision of additional scanning sessions.

Staff described good IT support and no recent breakdowns or failures in the picture archiving and communications system (PACS). Images were always available to all relevant professionals.

Service leads and managers worked together to provide accurate information. They monitored performance and provided information to the care group leads, along with identified risks and issues for escalation. Service leads reported a good level of support in planning for the future including finance and workforce planning.

The department had RPSs who met regularly, who were supported in their role by deputies. Controlled radiation area signs gave contact names and contact details for radiation protection supervisors.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was not always in easily accessible formats. The information systems were secure but not always integrated.

Access to information systems was restricted to only those who needed it, and this kept patient and confidential information secure. Staff could find all patient information such as diagnostic imaging records including previous images, and reports, medical records and referral letters through electronic records.

All diagnostic images were available securely via PACS to external tele-reporting clinicians.

All staff had access to the hospital intranet to gain information on policies, procedures, relevant guidance, and e-learning.

Engagement

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

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

Both paper and electronic staff surveys have been undertaken in the last 12 months, to enable leaders to focus on staff wellbeing. In addition, the Chief Executive had held listening events. We were told these appeared to have been well received by staff, an open dialogue was achieved, and staff said they felt listened to.

There was excellent working with partner organisations that supported the service to deliver care and treatment to the patients on the Isle of Man.

Patient stories were becoming more embedded at board meetings. Leaders told us Manx Care Advice and Liaison Service (MCALS) were working with the care group on how they could engage better with service users.

Learning, continuous improvement and innovation

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

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

Ceiling images used in CT scanner rooms were reported as being calming for patients. The images projected could be changed and altered to different views.

Outpatients

Overall summary

Outpatient clinics are located at Noble's Hospital and Ramsey and District Cottage Hospital (RDCH). Clinics include trauma and orthopaedics, ear nose and throat services, ophthalmology, audiology, dermatology, urology and pain management. We visited clinics at both sites during our assessment.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in all key skills to all staff and make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

Some staff said face to face training was difficult to access due to staffing concerns and training was sometimes cancelled.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse.

Prior to the recruitment of a safeguarding lead at the start of 2021, training in both adults and children's safeguarding was not in line with 'Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' or the 'Adult Safeguarding: Roles and Competencies for Health Care Staff' guidance, which we were told were recognised on the Isle of Man.

Managers said most staff had completed level 1 training for safeguarding adults and children but not all appropriate staff had completed level 3 training for adults and children and young people. However, we were not provided with specific data to confirm.

Staff gave us examples of where they had concerns about safeguarding and had worked with the safeguarding team to address these concerns. Staff said they would email or telephone the safeguarding team if they needed any advice and support.

We were told there is no chaperone policy, although patients including young people were asked if they would like one. This is a shortfall in supporting a consistent approach to patient choice and their safety the issue was raised with the head of safeguarding while on site.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

Outpatient departments we visited were visibly clean and had suitable furnishings which were well-maintained. Nursing staff and housekeepers throughout outpatients were responsible for

cleanliness and cleaning schedules. We saw there was good compliance with cleaning schedules.

Hand washing facilities, alcohol gel and personal protective equipment (PPE), such as gloves, face masks and plastic aprons were readily available throughout all the outpatient departments.

Throughout our visit, we saw staff washing their hands or using alcohol gel before and after providing care. For example, we saw staff adhering to good infection control procedures when cleaning their hands and preparing equipment prior to giving infusions in the Day Assessment Treatment Unit.

Staff were bare below the elbow and used PPE consistently.

The service had links to the IPC team in the hospital. Managers told us staff completed infection control training as part of their mandatory training, however they could not provide data to confirm this.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw green 'I am clean' stickers were used to indicate when equipment had been cleaned. Blood pressure cuffs were disposable.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Staff completed daily checks of emergency equipment, such as resuscitation trolleys, across the outpatient departments we visited.

There were keypad locks on the clean and dirty utility rooms, but not all rooms were locked during the day or when a clinic was running. This posed a potential risk that unauthorised people could access these rooms and their contents.

In the day assessment treatment unit, there was a cabinet that was used to store hazardous materials. During our assessment, we saw this was not locked and contained items that were not hazardous. This was highlighted to clinic staff during the visit and immediately rectified. non-hazardous items were removed, and the cabinet was locked.

Throughout the outpatient departments, clinical waste was in correctly coloured bags. Sharps containers had been assembled correctly, were dated and not overfilled.

Across all outpatient departments, we looked at a large selection single use items such as needles, syringes, dressing packs and wound dressings. We found all items were in date and it there was effective stock rotation systems in place.

Assessing and responding to patient risk

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

The hospital had a clinical prioritisation system for patients overdue their appointment dates. The hospital had a backlog of patients waiting to be seen. The backlog was in part incurred as a result of the stopping of services during the COVID-19 pandemic. The hospital had implemented risk monitoring systems to help ensure patients were seen in order of clinical need. They were developing strategies to reduce the waiting lists for each clinical speciality.

Safety checklists prior to treatments were used in areas such as ophthalmology prior to intravitreal injections.

There was a hospital-wide pathway and process for the assessment of both adults and children within outpatient clinics who became clinically unwell while in attendance. Staff could describe the pathway, which involved contacting the hospital resuscitation team or emergency service dependent on location.

Staff were aware of sepsis and could describe the signs and symptoms to be aware of. We saw posters on walls to raise awareness of sepsis and staff told us sepsis was included in mandatory training.

Clinical nurse specialists gave patients their contact details so they could escalate any change in their condition or seek advice when they needed to.

There was a standard operating procedure for staff to follow if a patient did not attend their appointment. The standard operating procedure directed clinicians to the hospital policy for safeguarding children and young people. The standard operating procedure stated the clinician must consider whether there was a safeguarding risk for any non-attendance in the case of children and vulnerable adults and then act accordingly in following any concerns up. This involved liaising with the referrer to assess the risk and consider if further actions were appropriate.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Although we were not provided with specific data, managers told us nurse vacancy rates were low and staff turnover rates were low across all outpatient departments.

There is no specific guidance regarding staffing outpatient clinics. Managers used their experience and professional judgement to calculate and review the number and grade of nurses and healthcare assistants needed for each clinic.

Managers adjusted staffing levels daily according to the demands of service and clinics. When extra clinics were added, managers used their own bank staff to fill these shifts. Managers limited their use of bank and agency staff, and if using agency workers, they requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the department.

Where required, managers would fill gaps in shifts and work clinically. However, this would impact on their management time.

The number of nurses and healthcare assistants matched the planned numbers and rotas were refreshed on a weekly basis. Managers held weekly clinical utilisation meetings and these meetings shaped where there would be either an increased need for staff or a reduction if a clinic was cancelled.

Clinical nurse specialists were not all managed by the outpatient departments but had rooms allocated to them when they held clinics. Clinical nurse specialists were overseen by the care group relevant to their specialism.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers constantly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

There was no staffing data for medical staff in outpatients due to medical staff being assigned to their individual speciality rather than the outpatients department.

Records

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

Patient care records were a mixture of paper and electronic records. Administration teams generally prepared notes for outpatient clinics and these usually included a set of patient labels and notes sheet. Patient care records, including the referral letter, were electronic and could be accessed by nurses and doctors via secure password.

Paper notes used in clinic were generally kept at the nursing station and stored securely in locked trolleys.

Staff reported locating historical and scanned documents on the electronic system could be a challenge if staff were not familiar with the filing protocols. This meant that staff who were not familiar with the service may struggle to locate patient information in a timely manner.

Medicines

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

There was limited use and storage of medicines within outpatient departments. There were no controlled drugs stored in any outpatient department.

Emergency medicines were available and stored in tamperproof trolleys or boxes in all areas visited. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Prescription pads were stored securely. However, records were not always kept of the serial numbers of prescription forms when they were issued which would help identify any prescriptions lost or stolen. This is seen as good and safe practice.

Some senior nurses had undergone additional training and were non-medical prescribers. This enabled some clinics, such as the anticoagulant clinics, to be nurse-led. The anticoagulant clinic provided specialised care for patients taking oral anticoagulant medication. Anticoagulant medications help treat and prevent blood clots.

Consultants told us the non-medical prescribers were a great asset and this type of training supported staff retention.

Incidents

The service managed patient safety incidents well, however these were not always reported. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

While staff knew how to report incidents, we were not assured all incidents were declared. For example, some staff said they did not use the incident reporting system to record staff shortages for each shift.

There was an electronic system for the reporting of incidents and staff could describe how to use it. There were no never events in the service from January 2022 to August 2022.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw duty of candour training was part of mandatory training.

The outpatient manager fed back to staff about incidents across outpatients using the minutes of staff meetings and by email.

There was a serious incident review panel which met every week to review serious incidents and feed back to managers and staff. There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts.

Is the service effective?

We found that this service was effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Manx Care advised CQC they had limited evidence that the National Institute for Health and Care Excellence (NICE) guidance was applied universally at the hospital, but that NICE guidance was applied in some clinical areas. We were also told that positive systems of assurance, monitoring and reporting were not in place. Manx Care's rationale for this was that whilst clinical practice operates under evidence-based guidelines, there were only partial formal assurance systems in place for monitoring and reporting on compliance with NICE guidance.

Staff told us they followed or mirrored NICE and Royal Colleges' guidance relevant to the service. We saw several standard operating procedures and policies were out of date but did reflect NICE guidance. For example, the consent policy was last reviewed in May 2014 and had a review date of 2017.

Senior managers acknowledged more work was needed to ensure all policies, clinical guidelines and standard operating procedures were up to date. We were advised a specific project with this aim was underway and standardised processes for policy governance had been recently adopted in January 2022.

Policy review, approval and ratification was part of the agenda for the newly implemented clinical governance meeting. The minutes of the October 2022 meeting showed 4 policies had been reviewed and ratified.

Nursing staff had developed competencies for the areas in which they worked, such as the ophthalmology outpatient department. These were based on NICE guidelines and had been reviewed and updated by relevant nursing teams.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Pain relief was not routinely required in outpatient settings. There were medical staff available in different outpatient clinics for advice should need arise.

Patients who required regular pain relief were advised to bring these medications with them to their appointment.

In clinics where treatments were given, staff told us they assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. For example, in the ophthalmology or infusion clinics.

Patient outcomes

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

Care groups participated in their own speciality audits as required, such as in general surgery and medicine.

Local audits were undertaken by the IPC team and department managers, such as hand hygiene. We reviewed audit folders during our assessment and found the results to be predominantly positive.

We were told there were issues with joined-up care with primary care across the island for the oversight of people who were prescribed anti-coagulation medication. Monitoring required in line with NICE guidance was inconsistently undertaken, as there was limited governance to support who should undertake this activity. We were told monitoring of all patients prescribed with anti-coagulation medication was the responsibility of the hospital. However, a recent audit had identified a large cohort of patients who had been started on anti-coagulation medication in secondary care, but who did not appear to have undertaken the appropriate follow-up monitoring. It was not clear who had clinical oversight of these patients. NICE guidance states patients prescribed DOACs should receive at least annual full blood count (FBC) and liver function tests (LFT). This meant there was a risk that patients may not be receiving recommended diagnostic tests.

There were specialist support nurses in the hospital that staff could access for support and guidance, including palliative care, infection control, aseptic non touch technique, tissue viability, dementia, nutrition, safeguarding, diabetes, urology and smoking cessation.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Managers did not always support staff to develop through yearly appraisals of their work. Managers told us they hadn't had time to do all staff appraisals due to staffing shortages.

While appraisals did not always happen, managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they could discuss training needs with their line manager outside of the appraisal process and were supported to develop their skills and knowledge.

We requested copies of meeting minutes but did not receive them. However, managers said they

made sure staff attended team meetings or had access to full notes when they could not attend. There was the option to attend team meetings virtually if staff were unable to be in the department when they occurred. We were told team meetings had standard agenda items, but we were unable to confirm this.

Clinical educators supported the learning and development needs of staff. Staff had been able to progress within the department by undertaking additional study. For example, managers made sure staff received any specialist training for their role. There was additional training for staff working in areas such as ophthalmology or infusion clinics. These staff needed extra competencies to be able to fulfil their roles.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings (MDT) to discuss patients and improve their care. There was MDT working across the specialities providing outpatient services in all settings. Where required, there were MDT meetings in the specialties. There were specialist registered nurses working in clinics across outpatients to provide care and treatment to patients. For example, staff in orthopaedic outpatients worked with the medical staff and physiotherapy staff to provide care to patients.

There were several nurses led clinics across the hospital. Different staff groups and professionals worked together across the services to provide care, treatment and support to patients.

Dermatology teams told us they offered a service whereby GPs and community nursing teams were able to support patients in the community following training and with guidance from the hospital team. This reduced the need for patients to attend appointments at the hospital.

Seven-day services

Key services were available 7 days a week to support timely patient care.

The service provided outpatient clinics routinely between 8:30am and 6pm between Monday and Friday. However. there were occasional evening clinics and some weekend clinics provided in the various specialities to afford patients the opportunity to attend appointments at convenient times.

The service also added extra clinics to help reduce the waiting list and backlog of patients needing appointments.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw patient information displayed in clinics across outpatients.

This included guiding patients and carers to support services, information on conditions, smoking cessation and alcohol awareness.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the ‘consent’ section under Medical Services on page 18 for issues common to many services.

In clinics where children were treated outside of the paediatric department, staff described how they would discuss the appointment with the child and explain the equipment in the room, so the child was not scared or uncomfortable. Staff were able to contact the paediatric clinic if they needed advice.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Across all the outpatient settings and departments, we visited, we saw staff taking time to interact with patients and those close to them in a respectful and considerate way. Staff greeted patients and introduced themselves. Staff cared about their patients and patients were pleased to see faces they recognised. We saw patient thank you cards for their care and compassion.

Staff were discreet and responsive when caring for patients. Patients said staff treated them well and with kindness.

All patients we spoke with during the assessment told us staff treated them with respect and maintained their dignity and privacy, such as through ensuring clinic doors were closed during appointments and using curtains in treatment rooms.

Chaperones were available and provided as necessary across the outpatient departments. Whilst we were told there is no hospital chaperone policy, patients including young people were asked if they would like one.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

In outpatient settings, there was a quiet room available with seating for patients to use if they were anxious or worried when visiting the department. Staff used these rooms for private discussion with patients and for patients who had received bad news to provide privacy if they were distressed.

Staff described being adaptable to the needs of patients, such as by providing separate waiting areas for distressed or anxious patients, and fast tracking patients through outpatient clinics if they were anxious or phobic.

There were specialist nurses in some clinics who were able to provide care and support for patients. Patients were offered contact details so they could call specialist nurses if they had any questions or concerns.

There were leaflets available throughout clinic areas signposting other emotional support services for patients, such as, local support and listening groups.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us if there was a delay to a clinic, they were informed by the staff running the clinic.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw posters in clinics advertising the friends and family test.

Patients gave positive feedback about the service. We spoke to patients who were positive about their experience.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

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

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

Managers planned and organised services so they could better meet the changing needs of the local population. Outpatient services had reacted to the challenges created by the COVID-19 pandemic by being inventive with ways to contact and treat people using technology and new pathways.

Services across the hospital and outpatients faced a significant challenge in attracting medical staff to support clinics. Many services were supported by locum doctors who only came to the island for a limited time. This could be a few days, weeks or occasionally longer, depending on the contract agreed with that individual. This created a significant challenge for managers in attempting to locate suitably qualified doctors. Furthermore, there was a knock-on impact on administrative staff and patients when clinics were cancelled or re-scheduled due to a lack of staff. There was also an impact on the outpatient nursing and healthcare support teams when clinics were changed or cancelled, as the outpatient nursing team was small and could not always cover additional clinics at short notice.

Many outpatient clinics were located at Noble’s Hospital with support services including diagnostics, specialist nurses and allied health professionals. At RDCH, there was a plain film X-ray room, and the service was about to install a new bone density scanner.

There were facilities for a variety of clinics to be run according to a rota, together with the clinic and treatment facilities for the island’s skin and burns service.

Some outpatient specialities had urgent clinic appointment slots to allow for clinically urgent cases. There was a dedicated administration team which booked and assisted in managing appointments for the specialties.

Where necessary, managers set up additional clinics for specialities with long waiting lists, such as orthopaedics.

The service minimised the number of times patients needed to attend the hospital by ensuring patients had access to the required staff and tests on one occasion. There were virtual clinics, which reduced the need for patients to attend departments unnecessarily by having a consultation over a video link or by telephone.

Managers monitored and took action to minimise missed appointments. Managers ensured

patients who did not attend appointments, or children who were not brought, were contacted.

Meeting people's individual needs

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

Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports throughout their hospital journey. Outpatient areas, such as the cardiology department, had dementia friendly environments which included coloured seating and toilet signage. There was a hospital-wide dementia strategy.

Managers made sure staff, and patients, loved ones and carers, could get help from translators, interpreters or signers when needed.

There were quiet rooms available in outpatient departments, which could be used for patients who may be anxious or where patients required a quieter room than the waiting room. Additional time could be provided in the clinic for patient appointments if required.

Appointment times varied depending on whether the appointment was a new appointment or a follow up appointment and depending on the speciality.

There were a range of patient information leaflets available throughout the department.

There was a newly established Manx Care Advice and Liaison Service (MCALS), which provided advice and support regarding concerns.

Staff said they worked closely with the service that provided patient transport to clinics to help patients access transport to and from their appointment. They would contact transport services if there was a delay in collection or appointments. Staff described how they would always wait with patients until transport arrived to take them home. We were told if there was opportunity to put a short notice clinic in to place this could be difficult organising transport through the patient transport service (PTS) at short notice, which would impact the service.

Letters were sent to patients from the bookings and administration teams following appointments or before appointments.

Access and flow

People could not always access the service when they needed it and received the right care in a timely way.

Waiting times on the Isle of Man were not subject to same reporting requirements in respect of referral to treatment (RTT) as for NHS services in the UK. However, Manx Care was developing a suite of reports in order to align itself with UK RTT monitoring. At the time of our assessment, the development reports and monitoring were still in its infancy. Managers described their ambition to improve outpatient and waiting list reporting to improve the patient experience.

The service often struggled to meet the demand for outpatient appointments due to medical staffing issues. Managers worked hard to mitigate this, but often the issues were beyond their control and frequently had to make difficult decisions to cancel and re-schedule clinics.

Managers told us they monitored numbers of patients on all the waiting lists, waiting times, breaches and people who do not attend appointments (DNAs). Additionally, there was monitoring of the numbers of outpatients overdue their follow up appointment, which was a challenge for the

hospital.

We requested data detailing waiting times for outpatient specialties, but this was not provided.

We were told patients on waiting lists were prioritised based on clinical priority. The hospital used risk stratification protocols to give all patients a risk prioritisation status. Patients were subsequently monitored continuously on waiting lists. Patients at most risk of potential clinical harm if not treated had enhanced monitoring and there were escalations procedures to follow.

Progress and performance for each clinical speciality was overseen at weekly performance and planning meetings.

Learning from complaints and concerns

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

Complaints were recorded at hospital level, so we did not know how many complaints were attributed to the outpatient department.

Patients, relatives and carers told us they knew how to complain or raise concerns if they needed to.

There was an Independent Review Body for complaints that had not been resolved.

Managers told us they shared feedback from complaints with staff. Due to the lack of data, we were not assured themes of complaints were identified and any learning was used to improve the service.

Is the service well-led?

We found that this service was well-led in accordance with CQC's assessment framework.

Leadership

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

Staff were positive about local leadership within their teams and told us team leaders were supportive and available when required. Staff told us they were able to talk to the senior leadership team but reported that the hospital executive team were rarely seen around the departments.

There was a structure for the management of outpatients. There was a senior nursing lead for outpatients covering each site, and each outpatient department had an allocated senior nurse who ran each clinic.

Senior managers were aware of the challenges with waiting lists for outpatient appointments and RTT indicators.

Vision and strategy

The vision and strategy for outpatients was being developed, they were focused on sustainability of services and managers were working to improve services.

A Manx Care strategy was needed before care group plans could be made to aligned to the

organisational strategic vision. Local leaders felt they had some focus on where they needed to deliver. This was discussed with senior managers who told us this was due to Manx Care being a relatively new organisation.

There was a plan and a vision for the future of services. Senior managers were working with Manx Care to prioritise new services and service improvement.

Culture

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

Staff in departments told us there was good teamwork, openness and honesty within their teams. Overall, staff were positive about working in their departments. Staff told us they felt supported and described an open culture.

Staff told us morale was generally good despite all the recent challenges brought about by the COVID-19 pandemic.

Staff were helpful and friendly in all areas we visited. We were made to feel welcome, and staff were keen to tell us what it was like to work at the hospital. Staff spoke positively about the support for their health and well-being.

Staff told us they were proud to work in the hospital. Staff who told us they “loved” their job. Another staff member told us they would not want to work anywhere else. Staff told us they would be happy to have their own family treated at the hospital.

Governance

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

Leaders described governance arrangements for the outpatient departments. Governance meetings and governance issues fed into quality and safety meetings, which were held every week.

We were told that at these meetings incidents and complaints were discussed. Senior staff attended the meetings and then escalated governance issues through this meeting to the performance improvement meetings, hospital management board and the clinical quality board.

Managers described the clinical utilisation group, who supported the work around capacity and demand challenges in outpatients. A breach review meeting, and a planning and delivery meeting were held weekly.

Daily huddles and debriefs had been implemented across the outpatient departments. Staff and managers said there were helpful and enabled them to gain a better understanding on any issues affecting patient safety.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There was a risk register for outpatients. Risks were rated and had actions associated with them. Staff were aware of top risks such as capacity for appointments, staffing, estates and facilities, and

information technology.

Senior managers were aware of the risks as were senior operational nursing staff. The main risk was medical staffing availability. Recruitment on the island for locum and bank staff was also a challenge. Outpatient leaders described difficulties to recruit and retain healthcare assistants.

As most information was at hospital level and not broken down into care groups and departments, it was difficult to have an overall picture of departmental issues and performance.

Information management

The service collected some reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. However, this was not always in easily accessible formats. The information systems were secure but not always integrated.

At the previous assessment, Manx Care told us from an information and business intelligence perspective they knew data collection in many systems was inconsistent.

There was a quality dashboard, but we saw this was work in progress as not all the domains were populated. However, we saw this provided information to staff and managers and saw actions had been taken to improve services.

Staff described challenges in extracting useful and meaningful data relating to outpatient waiting lists. Manx Care were developing a more effective and user-friendly set of reports, but this was in its infancy.

Some staff spoke of the difficulties they experienced due to them using multiple systems for patient care records. For example, patient referral letters, images or scan results and historical patient notes being in different systems or locations.

All staff undertook General Data Protection Regulation (GDPR) training as part of mandatory training. We saw computer screens were not visible to patients or visitors within outpatient settings.

Engagement

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

Both paper and electronic staff surveys have been undertaken in the last 12 months to enable leaders to focus on staff wellbeing. In addition, the CEO has held listening events. We were told these appeared to be well received by staff, an open dialogue was achieved, and staff said they felt listened to.

There was excellent working with partner organisations that supported the service to deliver care and treatment to the patients on the Isle of Man.

Patient stories were becoming more embedded at board meetings. Leaders told us Manx Care Advice and Liaison Service (MCALS) were working with the care group on how they could engage better with service users.

Learning, continuous improvement and innovation

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

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

Gynaecology and Termination of Pregnancy Services

Overall Summary

Gynaecology inpatient services are delivered at Noble's Hospital. The ward has 2 bays, each with 4 beds, and 5 side rooms. The ward was previously only open from Monday to Friday but has recently remained open over the weekend to support general surgery for female patients.

Urogynaecology, post-menstrual bleeding, colposcopy and hysteroscopy clinics are held in a small outpatient department shared with maternity and paediatric services.

The Early Pregnancy Assessment Unit is based on the gynaecology ward. Although the Early Pregnancy Unit is part of gynaecology services at the hospital, it sits within the CQC maternity services assessment framework and has been included in the report for maternity services.

The service also runs clinics for women who needed or wanted a termination of pregnancy. These clinics are held in a separate part of the hospital in the sexual health clinic.

Patients attend the ward as 'ward attenders' for minor procedures or clinical review. Prior to the COVID-19 pandemic, patients attended the ward for gynaecological day surgery, but following the pandemic, the majority of day surgery is performed in the hospital day procedure suite.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

The quality dashboard showed that overall mandatory training compliance for the care group was 74% in July 2021, 70% in January 2022 and 81% in September 2022.

Not all compliance rates met the service target of 85%.

Issues with the accuracy of mandatory training compliance data was mentioned in the minutes of the February 2022 operational clinical quality group. It was also noted in the minutes of the operational clinical quality group from May 2022 there was insufficient monitoring of other mandatory training subjects, as well as role-specific assurances. At the time of our assessment, we did not see that managers had sufficient oversight of all mandatory training compliance to be assured that staff had the skills to perform their role safely. Care group leaders told us that ward managers were responsible for maintaining mandatory training spreadsheets for oversight. However, we saw that the management of this was inconsistent. Following our assessment, we were told that mandatory training data for the care group was held and updated by the business support team rather than ward managers.

Mandatory training compliance was also discussed in the care group Patient Safety and Governance meeting. Low compliance was noted in the meeting in June 2022, and it was recorded that it was individual staff responsibility to ensure training was completed. No actions were identified to support staff to be able to complete the training. Following our assessment, we

were told that staff had been offered time off in lieu (TOIL) or extra pay in order to encourage training compliance.

During our assessment we were told that intermediate life support (ILS) or advanced life support (ALS) were not required to be completed by clinical staff and that no staff had completed this training.

Staff told us they were not provided with protected time to complete mandatory training and therefore it was challenging to complete the required training.

Staff did not complete training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia.

Staff told us that they had not completed any simulated emergencies such as haemorrhage or cardiac arrest.

Safeguarding

Staff did not always understand how to protect service users from abuse. Staff had training on how to recognise and report abuse, but not everyone had completed it.

Adult safeguarding training compliance was 77% for the care group in July 2021 and 88% in January 2022. Children's safeguarding training compliance was 0% in July 2021 and 0% in January 2022. The safeguarding training levels (as outlined in the mandatory training section of this report) were not in line with the 'Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' or the 'Adult Safeguarding: Roles and Competencies for Health Care Staff' guidance, which we were told were recognised on the Isle of Man. Following our assessment, we were told that safeguarding training data had been difficult to capture prior to January 2022 and leaders felt the low compliance figure was due to data inaccuracy rather than non-compliance.

A safeguarding assurance report was shared with the operational clinical quality group in June 2022. Although gaps in assurance were identified, this report did not detail actions being taken to mitigate these risks.

Manx Care had a 'safeguarding children and adults' strategy' dated 2022 to 2025. Staff that we spoke with were not aware of this strategy.

The care group had an average of 7 new safeguarding referrals per month from January to August 2022. We were told by service leaders they did not have any oversight of completed safeguarding referrals unless staff included this in the ward handover.

Staff told us that patients under the age of 18 years were often cared for on the ward. Other than the patients being provided with a side room, staff were not able to tell inspectors what actions were taken to ensure that these patients were safe during their admission. Staff told us they did not consider this to be a risk and they were not able to tell us if there were any policies or guidelines available to support them in keeping these patients safe. In addition, no staff on the ward had completed safeguarding children training. Therefore, it was not clear if staff had the required skills to safeguard young people on the ward.

During our assessment, we escalated our concerns about the safety of children and young people being cared for on adult wards. The hospital leadership team confirmed that in the last 12 months, 3 patients aged 16 years and under, and 3 patients aged 17 years had been admitted to the ward. The leadership team confirmed that the hospital had a policy for the admission of children and

young people, but this was still in draft form and not yet approved.

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We were provided with a copy of the Manx Care safeguarding children guidance and procedures dated 2022 to 2025. This policy did include information about how to make a referral and actions which should be taken if staff have immediate concerns for child safety.

Staff were able to provide examples of safeguarding referrals that had been completed for patients. At the time of our assessment, we saw that a safeguarding concern had been identified on the ward and a referral had been appropriately completed.

Staff demonstrated that they understood how to respond and support women if they suspected domestic violence or sexual assault.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Equipment was not always clean and cleaning records were not always completed. However, the environment was visibly clean.

Cleaning records were not always up to date and did not demonstrate all areas were cleaned regularly. The ward had daily and weekly cleaning checklists for staff to complete. The daily checklist had not been completed for 13 days out of 30 in September 2022, 9 days out of 31 in August 2022 and 17 days of out 31 in July 2022. The weekly checklist had not been completed for 2 weeks out of 4 in September 2022, 3 weeks out of 4 in August 2022 and 2 weeks out of 4 in July 2022. In addition, some weeks that had been completed were only partially completed.

The ward environment had a mix of fabric and disposable curtains in use. We saw a curtain changing checklist on the ward that stated curtains must be changed every 6 months or when contaminated. The record showed the curtains in 1 of the bays and 3 of the side rooms had not been changed since 7 February 2022.

Ward areas were mostly clean and had suitable furnishings which were clean and well-maintained. However, the emergency resuscitation trolley on the ward had a layer of heavy dust on all surfaces and did not appear clean. The children's toys in the ward waiting area were not included in the ward cleaning schedules, although they appeared clean.

We found that all the face masks both in use on the ward, and in storage areas had expired in July 2022. We escalated this during our assessment to senior staff on the ward, and although some masks were removed, later that day we saw that some out of date masks were still available on the ward.

Monthly infection prevention and control (IPC) audits were completed by the hospital IPC team. However, these were not always shared with the ward manager, so they were unable to show inspectors compliance rates, or any actions taken to manage areas of concern. The care group data report for August 2022 showed the ward had achieved 100% compliance in an environmental IPC audit, a hand hygiene audit and a bare below the elbow audit completed in August 2022. These 3 audits had been marked as "not applicable" to the outpatient department or termination of pregnancy clinic area in the August 2022 data report, despite clinical practice taking place in these areas. We requested a copy of the IPC audits for these services, but no information was provided. Following our assessment, we were told that the audits were marked as "not applicable" as the data was not available at the time the report was created.

We reviewed patient care records and did not see any evidence that the service performs any

infection screening at the time of admission, such as for MRSA. Following our assessment, the service provided a copy of their policy for the preadmission screening of patients.

The incidence of various infections, including Clostridium Difficile, Methicillin-resistant Staphylococcus aureus (MRSA) and Pseudomonas aeruginosa was included in the quality dashboard but no data was completed between August 2021 and August 2022 for this care group. However, the ward was closed for a period of time in 2021.

We reviewed the patient care records of 3 patients who had a catheter and only 1 of these patients had a catheter care plan in place to support safe maintenance. Not all patients who had a vascular access device had a cannula care plan in their patient care records to support safe maintenance of the cannula and the ensure the device.

We requested a copy of the IPC policy but were told the hospital did not have an overarching IPC policy. We were provided with a copy of the Manx Care policy for aseptic non-touch technique (ANTT), which was dated March 2021. The policy included relevant information for staff to follow and referenced appropriate national guidelines and other Manx Care policies which staff could refer to.

Some items used in gynaecology services were decontaminated and sterilised for reuse. This contract was managed centrally for the whole hospital. Staff told us they did not have any issues with availability of sterilised equipment. We saw that sterilised equipment was stored appropriately in sealed packaging and with a clear expiry date.

The ward had an IPC link nurse who was responsible for monitoring IPC practice on the ward. They had completed a hand hygiene audit and a catheter care audit in September 2022, which both showed 100% compliance.

During our assessment, we observed staff decontaminating their hands and using PPE appropriately. Hand sanitisation points were readily available throughout the ward and outpatient's clinic.

Cleaning schedules in the outpatients clinics were fully completed, and the environment was visibly clean, tidy and well organised. The curtains in the outpatients clinics were not disposable, but the fabric curtains had been changed in July 2022.

All sharps bins were clearly dated, and the temporary closure mechanism was in use.

Cleanliness was included in the patient survey and the latest results from June 2022 showed that 87% of patients who completed the survey felt the ward was "very clean" and 13% of patients felt it was "fairly clean".

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The ward had a weekly to do list, which included stock checks, stock ordering and replenishment. The weekly to do list had not been completed for 2 weeks out of 4 in August 2022 but was fully complete in September 2022. However, we found out of date stock items throughout the ward environment. In the clean utility, we found an umbilical cord clamp that had expired in December 2019 and an enteral feeding adapter pack that expired in September 2020.

In a clinic room on 1 ward, we found a trolley with numerous of out of date items. For example, we found wound dressings that expired in March 2020 and water for injection that expired in March

2022.

We observed that some substances considered hazardous to health were not stored securely. We saw formaldehyde and chlorine tablets were stored on shelves in the dirty utility and the room was not secure.

The emergency resuscitation trolley was stored centrally on the ward and easily accessible if it was required. The trolley was secured with a tamperproof tag. The trolley contained a stock of relevant equipment and consumables which may be required in an emergency. Equipment on the trolley had recently been safety tested. There was a daily checklist on the trolley for staff to complete, but this was not always completed. The checklist was not completed on 4 days out of 30 in September 2022, 2 days out of 31 in July 2022, but was fully completed in August 2022.

Not all equipment was in date for safety testing and calibration. We saw 11 intravenous pumps in the fluid store on the ward; 3 of these had required testing in January 2022 and 3 pumps had no sticker showing if they had ever been tested. The 2 syringe drivers in the equipment store were due for testing in June and October 2020. We saw a manual sphygmomanometer which was due for calibration in July 2021 and a digital observations machine due for testing in July 2020. We saw equipment which was overdue servicing and calibration in the outpatient's clinic.

The bathroom on the ward contained 2 lifts for aiding people into the bath, which were both due for testing in May 2022. The lamp in the early pregnancy assessment clinic was due for testing in August 2020.

We saw posters on display encouraging staff to check equipment servicing dates before using items in the equipment store, but we did not see any action had been taken to rectify out of date servicing or that this was being effectively monitored. We saw no records of any equipment checks being carried out by staff or that the equipment safety testing was being monitored by leaders.

Women could reach call bells and staff responded quickly when called. Throughout our assessment, we observed staff responding quickly to call bells.

Staff disposed of clinical waste safely. We saw that waste was appropriately segregated and secure whilst awaiting disposal.

The emergency resus trolley checklist in the outpatient's clinic was fully completed, and the trolley was clean and secure.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman. Staff did not always have the skills, knowledge or information to identify and manage risks to medical patients on the ward.

Staff used a recognised tool to identify women at risk of deterioration and escalated them appropriately. We saw evidence of timely and accurate recording of observations and use of the National Early Warning Score (NEWS2) tool. However, observations and NEWS2 scoring was completed using a variety of different paper and electronic systems dependent on the stage of their treatment. This meant that it was difficult to identify trends in observations, and there was a risk that deterioration may not be identified.

Staff spoke openly about how they did not always have the skills and knowledge to care for the type of patients who were often on the ward as medical outliers. We saw patients undergoing gynaecological investigations or procedures were sometimes cared for in other parts of the

hospital by staff without gynaecology skills and experience, which was not in line with Royal College of Obstetricians and Gynaecologists (RCOG) standards.

Staff did not always feel supported by the medical teams responsible for the medical and surgical outliers on the ward and told us how they did not always come to review the patients without being contacted. Staff described how clinical reviews of these patients often took place later in the day when it was too late to request take home medications (TTOs) from pharmacy, which resulted in delayed discharges. However, staff spoke positively of the gynaecology doctors and how they were visible and responsive on the ward.

Leaders told us they held daily safety huddles on each ward. However, we did not see that this took place during our assessment.

Compliance with completion of the malnutrition universal screening tool (MUST) had not been monitored before February 2022. However, the ward was closed for some time during 2020 and 2021. The quality dashboard showed that the target of 95% was not met in February 2022. Although 100% compliance had been achieved in May to June 2022, compliance had deteriorated below the target in July and August 2022, and we did not see that any action had been taken to improve performance.

A hospital wide NEWS2 escalation audit completed in showed a 40% compliance in February 2022, which improved to 75% and 66% in March and April 2022 respectively. This was repeated in March and April 2022 showing compliance rates of 75% and 66%. Some areas for improvement were identified, although we did not see that any action had been taken to improve performance.

We reviewed 4 sets of patient care records and saw that staff completed risk assessments for each woman on admission using recognised tools. However, staff did not always perform pregnancy checks in all women of reproductive age before surgery.

Compliance with the World Health Organisation (WHO) surgical safety checklist was not recorded on the Manx Care Quality Dashboard for this care group from August 2021 to August 2022. Gynaecological surgery was undertaken in general theatres and 100% compliance with the WHO checklist was recorded on the quality dashboard by the surgical care group. We observed care in general theatres and did not see that the WHO checklist was being used. We reviewed records of 3 patients who had undergone gynaecological surgical procedures and did not find any record of a WHO checklist being completed.

Staff demonstrated they were confident in escalating medical emergencies but were unable to tell us if there were any defined care pathways for cancer, acute gynaecological conditions or women requiring urgent terminations.

The service had 24-hour access to a mental health crisis response team for liaison and specialist mental health support.

Staff shared key information to keep women safe when handing over their care to others. We observed nurse handover and saw appropriate information was discussed. The handover documentation was thorough and followed the ‘situation, background, assessment, recommendations’ (SBAR) approach.

Information provided in the quality dashboard showed that the care group had a target of less than 6.63 patient falls per 1,000 bed days. In the 12 months from August 2021 to August 2022, this target was met in 11 months. Data was not recorded for July 2022.

An audit of falls prevention compliance had been completed in October 2022 on 1 ward. The audit included a review of 9 patient care records. All patients had a completed falls risk assessment, but not all risk assessments had been regularly reviewed or updated. All patients had a moving and handling risk assessment and a bed rails assessment. In addition, all patients had a nurse call bell within reach, appropriate footwear and appropriately positioned mobility aids.

The hospital target for all eligible patients having venous thromboembolism (VTE) risk assessment within 12 hours of decision to admit was 95%. From the quality dashboard, this was achieved in 7 of the 12 months from August 2021 to August 2022. The ward was closed for 4 months, and the target was not achieved in 2 of the 12 months.

Arrangements for emergency or life-threatening situations, such as haemorrhage or cardiac arrest, had not been tested.

Following our assessment, we requested information about local safety standards for invasive procedures (LocSSIPs), but no information was provided.

Patients who required surgical termination of pregnancy could choose to be treated at the hospital or off island. Those who attended the hospital were cared for on the gynaecological ward. The service had a dedicated termination of pregnancy nurse who completed follow-up appointments with patients.

Nurse staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients on the ward safe from avoidable harm and to provide the right care and treatment. Managers did not always review and adjust staffing levels and skill mix, to meet the needs of the service users.

The hospital policy for safe nursing and midwifery staffing was due for review in April 2018. This policy stated the planned staffing on ward 4 was 3 nurses and a healthcare assistant (HCA) on an early shift, 2 nurses and an HCA on a late shift, and 2 nurses on a night shift. This was different to the planned staffing levels we were provided with at the time of the assessment. The policy outlined responsibilities for escalation of staffing shortages, which we saw staff enacting during our assessment.

We were told that the staffing requirements for each shift on ward 4 were 2 registered nurses (RN) and an HCA, which was in line with the RCOG recommendations. From 19 September to 9 October 2022, we saw 52% of shifts had no HCAs, 3% of shifts had only 1 registered nurse on shift and only 43% of shifts were fully staffed.

Staff told us the ward staffing was planned as a gynaecology ward. At the time of our assessment, the ward had 6 medical outliers and 2 surgical outliers. Staff told us that the acuity and dependency of the patients was much higher than they were staffed to support, and they often felt the ward was unsafe. Leaders responsible for the staffing of the ward told us that although they knew a staffing review had taken place, they were not involved in this and were not provided with a copy of the review or outcome. Following our assessment, we were told a staffing review had not taken place, but additional staff had been provided to account for the ward moving from being a 5 day service to a 7 day service.

We observed senior staff challenging the decision making when outliers were identified to come to the ward that they thought were inappropriate. However, we saw staff were not always listened to. Staff spoke of examples where patients needed treatment or interventions that the nurses on ward

4 were not trained or competent to carry out. Senior nurses told us how they had escalated their concerns about their ability to care for the patients with the current staffing but that no action was taken. Staff told us how they often felt staffing levels compromised the quality and safety of the care they were able to deliver.

We saw that an incident report had been completed by staff when they were caring for a patient experiencing an early miscarriage and medical patients were brought to the ward without additional staff being provided. Staff reported patient care being negatively impacted.

We reviewed the minutes from a meeting with gynaecology staff and members of the executive team in June 2022. Staff had raised concerns about how the required staffing levels had been measured and they felt the establishment was not correct. Staff had highlighted they felt the ward was unsafe at times, especially at nights and weekends with acutely unwell patients and no resources close to the ward should there be an emergency. Staff told us there had not been a review of the staffing establishment since this meeting and that staffing figures had not changed. Following or assessment, we were told that the executive team welcomed the meeting and recognised that staff were advocating for their patients. We were told leaders were trying to be addressed.

Service leaders told us how staff, including bank, agency and student nurses, were provided with a corporate induction, a Manx Care induction and an induction to the ward. Following our assessment, we were provided with a copy of a checklist that was used to support the induction of staff to ward 4. Although 100% of nursing staff had completed the local workplace induction, only 77% of nursing staff had completed the corporate and Manx Care induction programmes.

Staff vacancies and sickness rates were listed on the quality dashboard. The service had a high nurse vacancy rate. Data provided by the service showed that in April 2022, 29% of registered nurse posts were vacant. We were told at the time of assessment that vacancy rates had not improved. Service leaders told us that more staff had left the ward since the ward had been closed during the pandemic.

No staff on the ward had specialist gynaecological qualifications and at the time of our assessment, and only 6 nurses were considered gynecologically competent. This meant not every shift had a nurse training in gynaecology, which is not in line with RCOG standards. Following our assessment, we were told that wherever possible, a gynecologically competent nurse was made available.

Staffing gaps were being filled with bank staff, which were mainly permanent staff who also worked on the bank.

We observed a nurse shift handover. All relevant information was discussed to ensure that staff were equipped with the knowledge to keep people on the ward safe.

The termination of pregnancy clinic was managed by 1 consultant, an associate specialist and the termination of pregnancy lead nurse. At the time of our assessment, it was not clear how the role of the lead nurse would be covered by an appropriately skilled person in the event of an unexpected absence. We were later told that staff absences in this service were covered by the Integrated Sexual Health Service.

Medical staffing

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

The obstetrics and gynaecology service were delivered by a team of consultants and speciality doctors. The service did not have any junior or training-grade doctors.

On the first day of our assessment, we saw that due to staff sickness, there was only 1 consultant on shift for the whole of obstetrics and gynaecology services. Leaders of the service told us how they considered medical staffing to be a risk but that this did not impact service delivery because staff were working together to fill staffing gaps and to keep people safe.

Data provided by the service showed that in April 2022, the vacancy rates for medical staff was 18%. At the time of the assessment, we were told that some of these vacancies had been filled and that medical staffing was improving. The clinical lead for the service was planning to retire soon but a replacement clinical lead had already been identified.

All medical staff had completed the corporate, Manx Care and local workplace inductions.

Ward rounds were conducted each day during the week with an additional review of patients or ‘board round’ being conducted as part of the morning handover.

Nursing staff spoke positively of the availability and responsiveness of the medical team, despite staffing challenges. The maternity and gynaecology services in the hospital were closely located with offices for medical staff to use. This meant that in the event of an emergency, staff were close by and responded quickly.

Surgical terminations of pregnancy were performed in general theatres and therefore staffed by the surgical care group.

Records

Records were clear and up to date, but they were not always comprehensive, stored securely or easily available to all staff providing care.

Women's care records were not always comprehensive. We reviewed 4 sets of patient care records for gynaecology patients. Not all records were comprehensive. For example, we found not all patients had relevant care plans, and pre-operative assessments were not always holistic. We saw gaps in completion of food and fluid balance charts. In 3 of the 4 patient care that we reviewed, discharge pathways were either not present or not completed.

Records were not always readily available. Inpatient records were stored on a mix of paper and electronic systems. This meant that, at times, it was difficult to see trends in care. For example, not all observations were recorded in 1 place. Pre-operative and intra-operative observations were stored differently to post-operative observations. This meant that it was staff needed to access different systems in order to identify trends or deterioration.

Records were not stored securely. Paper records were stored in a trolley by the nurses’ station. Throughout our assessment, this trolley was left unsecure and unattended for periods of time, which meant there was a risk that notes could be accessed inappropriately.

We did not see any records of patients with mental health needs, learning disability, autism or dementia at the time of our assessment. However, staff were able to tell us that patient passports and ‘this is me’ documents were stored in patient care records to support patients with their individual needs and preferences.

Staff told us that when patients were reviewed by the mental health crisis team, the records were not always comprehensive and did not always support staff to understand next steps or why patients had been discharged by the team.

All initial clinical assessments for terminations of pregnancy were completed by a third-party provider with which Manx Care held a service level agreement. If the patients were then booked in for treatment at the hospital, assessment records were shared so that they could be reviewed as part of the next step of the patient's care.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

There was no ward-based pharmacist on gynaecology wards, although a pharmacist visited the wards when they were able to. This impacted on the provision of an effective medicine optimisation service. Nursing staff explained they were able to contact pharmacy for support or advice when needed.

There was a lack of a medicine reconciliation process to ensure patients prescribed medicines were as up to date as possible. Patients weights were often not recorded on medicine charts. This is important for calculating weight-based medicine prescribing. Venous thromboembolism (VTE) risk assessment outcomes were not always recorded on medicine charts, and VTE reviews were not always undertaken.

Medicine allergies or sensitivities were recorded on all medicine charts seen. This ensures that staff were aware and alerted to prevent the prescribing and administration of medicines causing allergic reactions.

There were no recent audits available to ensure safe and secure medicine storage. Medicine storage systems were not always secure.

Medicines were not always stored in their original containers. On 1 ward, we found 2 loose ampoules of 2 different medicines stored in a medicine cupboard. This increased the risk of the incorrect medicine being picked and administered in error.

The service ensured that medicines were stored at the recommended room or fridge temperatures, and daily checks were recorded to ensure medicines were stored within a safe temperature range.

Emergency medicines were available and stored in tamperproof trolleys or boxes in all areas visited. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs (CDs), which are medicines that require more control because of their potential for abuse, were stored safely and securely with CD keys held by nursing staff. Daily checks were undertaken by staff and pharmacy undertook audits to ensure safe management of CDs.

Prescription pads were stored securely. However, on 1 ward, records were not kept of the serial numbers of prescription forms when they were issued which would help identify any prescriptions lost or stolen.

There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts, but staff at ward-level did not always receive updates or information on medicine safety incidents. The Medicine Safety Officer was new in post and was in the process of reviewing

medicine safety incidents and had written a newsletter to be cascaded to all areas.

Incidents

The service did not always manage safety incidents well. Staff recognised incidents but did not always report them. Managers did not always investigate incidents in a timely manner and take action to reduce the chance if incidents reoccurring. Managers did not always ensure that actions from patient safety alerts were implemented.

Staff knew what incidents to report and how to report them but did not always complete incident report forms due to a lack of time and because they felt action was rarely taken as a result. One member of staff had noted in an incident report in February 2022 that incidents were not getting reported due to time constraints. Another reporter had written they had already reported similar incidents several times and that they were developing a reporting 'fatigue'.

The quality dashboard showed there had been no never events in this care group between October 2021 and October 2022. There had been 1 never event in gynaecology theatres in July 2021. Not all service leaders demonstrated they understood what constituted a never events and were unaware of the never event that occurred in gynaecology services in July 2021.

Managers shared learning from incidents with their staff and across the care group. Staff told us that incidents were included in a monthly newsletter sent out to all staff by the care group. However, not all staff were able to provide us with examples of incidents or learning from incidents within the service, the wider care group or Manx Care.

All staff had completed training in duty of candour. They were open and transparent, but they did not always understand their role in enacting duty of candour.

At the time of our assessment, the gynaecology service had 47 open incidents which were under review. Of the 47 open incidents, 1 was from 2018, 8 were from 2021 and the rest were from 2022.

One of these incidents took place in March 2018 where a patient was not followed up and the level of harm had been graded as "severe". We did not see any evidence this incident had been thoroughly investigated or that any actions had been taken to mitigate any risk. Additionally, senior staff involved in the management of outpatients were not able to tell us if patients who had been referred into the service were adequately tracked or if patients were being seen in a timely manner.

We saw an incident took place in April 2021 where a patient was inappropriately transferred to the gynaecology ward, and nursing and medical staff did not have the knowledge and skills to provide the care the patient needed. This incident was still marked as "being reviewed" on the incident reporting system and staff told us that this was still a frequent occurrence. We saw that there were another 6 incident reports of inappropriate transfers to the ward with a status of "being reviewed".

In August 2022, the most common theme of incidents for the care group was staffing, communication, and medication. However, in the data that we received about open incidents; we saw a theme regarding the inappropriate transfer of patients to wards. There were 9 open incidents about patient falls which had occurred between June and September 2022.

Between October 2021 and October 2022, the gynaecology service had 75 incidents. There were 34 incidents which were still under investigation and 3 of these were from 2021.The main incident themes were patient falls, incidents relating to care delivery and medication incidents.

Manx Care had a policy for incident reporting, investigation and learning which was dated October 2021. This policy directed staff to report incidents using the incident reporting system and had clear roles and responsibilities in relation to reporting and investigating incidents.

The quality dashboard showed that in February 2022, 7 patient safety alerts were “not completed by deadline”. Staff told us safety alerts were managed centrally by the care group and any actions taken were recorded on the incident reporting system.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

Managers did not monitor the service to ensure care and treatment was based on national guidance and evidence-based practice. Policies were not always up to date.

Care group leaders were not able to show us how they were assured that care was safe or effective or that staff followed local policies, evidence-based practice or national guidance. They told us how they “relied heavily” on patient experience as a measure of quality.

Sepsis risk assessment tools were available to staff on the ward, but senior nurses spoke about how they were concerned about the ability of more junior staff to recognise sepsis and that they considered this a risk. We did not see that sepsis recognition or treatment was monitored within the service or care group. Following our assessment, we were told that sepsis performance was discussed at the hospital operational clinical quality group. We reviewed the minutes of these meetings from February, April and May 2022 and did not find any evidence of sepsis being discussed.

In addition, the hospital policy for the management of sepsis in adults was due for review in February 2020. We were provided with a copy of a guidelines for the management of paediatric sepsis, but these were from a paediatric network in England and Wales, and it was not clear if they had been reviewed and ratified as appropriate for use in Noble’s Hospital.

We saw hospital policies that had not been reviewed or updated in line with the hospital’s own procedures. For example, the hospital’s major incident plan was created in November 2017 and minor adjustments were made in April 2018. There appeared to have been no further reviews or updates to the plan in the last 4 years. Within the plan, it was stated that it was the responsibility of the hospital emergency planning team (HEPT) to ensure the plan was reviewed twice yearly. The hospital’s consent to care and treatment policy also had not been reviewed since 2014.

At handover meetings, staff included psychological and emotional needs of women, their relatives and carers.

Patients were provided with the ward telephone number so that they could access support if they experienced problems after discharge. Women who had a termination of pregnancy were given a contact number for the lead nurse for the service. In addition, telephone or face-to-face follow up appointments were scheduled according to the individual needs of the patient.

Sexual health screening and contraception advice was part of the standard structure for termination or pregnancy clinics. However, we did not see that staff were routinely provided with training in sexual health or contraception.

All medical terminations of pregnancy after 20 weeks were referred to a specialist NHS service in England.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health but did not always accurately record intake. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The hospital menu was varied and provided options for those with specialist dietary needs. There was a small shop and café on site, which patients could access.

Staff used a nationally recognised screening tool to monitor women at risk of malnutrition. The malnutrition universal screening tool (MUST) had been completed for all in patients in the notes that we reviewed, and staff had responded appropriately to the risk of malnutrition.

Specialist support from staff, such as dietitians and speech and language therapists, were available for women who needed it. Staff knew how to refer patients to these services and spoke positively of the support they received. No staff on the ward had received training to perform swallowing assessments, but they told us they would contact the stroke ward if they needed support with this out of hours.

An HCA on the ward had been identified as the nutritional link nurse. The HCA spoke passionately about nutrition and hydration and had been completing meal audits annually since 2011. However, the audits and improvement work had not been completed since 2020 due to the COVID-19 pandemic and the closure of the ward. The HCA spoke about their plans to restart the audits and the importance of protected mealtimes on the ward.

Prior to the COVID pandemic, the lounge on the ward was prepared at each mealtime and patients were encouraged to sit in the lounge for their meals rather than remaining in bed. At the time of our assessment, this had not been reinstated but staff were planning to start this again.

Staff supporting patients at mealtimes was included in the patient survey and the latest results from June 2022 showed that 100% of patients who needed help always felt supported.

Staff did not always fully and accurately complete women's fluid and nutrition charts where needed. Our review of records for 4 patients showed that food and fluid balance charts were incomplete in all 4 records.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw that pain was assessed as part of the observations and considered when the NEWS2 score was calculated. Through observation and a review of records, we saw that staff consistently completed care and comfort rounds every 2 hours and that pain was assessed as part of this. In addition, patients had access to call bells, and we saw that staff responded in a timely manner.

Management of pain was included in the patient survey and the latest results showed that 87% of patients felt that staff did all they could to manage their pain. We saw 13% of patients left this question blank.

Pain management advice was provided to women as part of the initial assessment and treatment consultation in the termination of pregnancy clinic.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment and use findings to make improvements and achieve good outcomes for women.

Staff were not able to tells us of any audit activity against NICE or RCOG guidelines for gynaecology or termination of pregnancy services to monitor the effectiveness of care and treatment. When we asked about audit, leaders told us that each service within the care group had its own audit timetable. Senior nurses told us that they were not aware of an audit timetable and that they felt audit was “lacking”.

We saw that the care group had an audit plan for 2022 to 2025 and that audits within the gynaecology and termination of pregnancy services were planned. A clinical lead for audit had been identified for the service, but we were told that audit meetings and audit completion had been delayed by the COVID pandemic, gynaecology ward closure and staffing issues.

Staff spoke about audits that they planned to do, but how the completion of these audits had been restricted by the COVID-19 pandemic and the closure of the ward. We were told about an of TED stocking use had been started but that staff were unable to access the data needed and business intelligence had not responded to a request for support.

Service leaders told us how they did have some links with other services who delivered gynaecology and termination of pregnancy services but that they did not formally benchmark against these services.

The quality dashboard for the service included several key performance indicators that had been identified including length of stay, emergency readmissions within 28 days and the number of discharges taking place before noon. However, all these indicators were either not recorded or noted as “under development” for this care group.

The service did not monitor outcomes for women going through menopause to measure the impact and their experience to improve the service and care provided.

Although the clinical lead for terminations of pregnancy collected some outcome data, such as sexual health screening results, we did not see that any audit was performed or that this data was used to identify areas for improvement or make changes to the service.

The lead nurse for termination of pregnancy was relatively new to the service and was due to attend some specialist training in the next 2 weeks. They spoke passionately about providing a safe and effective service for women and had plans to complete audits and measure quality in the future.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff’s work performance or hold supervision meetings with them to provide support and development.

The service had a gynaecology competency workbook that staff were required to complete in order to be considered competent to provide gynaecology care. However, staff and managers told us the gynaecology day case patients were being redirected to the hospital day procedures suite and the ward was being utilised for outliers and this was impacting on the opportunities for staff to

develop and maintain gynaecology nursing skills. At the time of our assessment, only 6 nurses were considered ‘gynae competent’ and this meant that not all shifts had a nurse who was skilled and experienced in caring for gynaecology patients, which is not in line with RCOG standards.

Staff had not received any training in sepsis recognition or management. A senior staff member told us how staff did not always recognise signs of sepsis other than a raised temperature and that they considered sepsis recognition to be a risk. However, we did not see that any action had been taken to mitigate this risk or to monitor sepsis care. We did not have the opportunity to review any records of patients with sepsis during our assessment.

Staff on the gynaecology ward did not receive training in contraception or sexual health and they told us how they did not routinely offer this advice to inpatients.

Staff did not complete training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia.

At the time of our assessment, managers were not able to show us how appraisals were recorded or monitored. Not all staff thought the appraisal system was effective, staff spoke of having no time for appraisals and training and 1 staff member described the appraisal system as “seriously lacking”. Following our assessment, we were told that all substantive staff on ward 4 had received an appraisal in the last 12 months, but the completion of some appraisals had been impacted by the ward closure throughout the pandemic

The lead nurse for termination of pregnancy was new to the role and had a 2-week training course booked with a service in England to enhance their skills and knowledge.

The medical staff worked across gynaecology and obstetrics. Competency was monitored as part of the GMC annual appraisal and 5-yearly revalidation process.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit women.

Senior nurses in the service told inspectors they did not routinely hold regular multidisciplinary meetings to discuss patients and improve their care. However, nursing staff told us how they had good working relationships with gynaecology medical staff, and they felt well supported by the doctors. We observed staff working well together to benefit the women using the service.

We saw some senior members of staff had access to colleagues from other services within the hospital, such as maternity. However, some staff told us how they often felt isolated, especially when caring for outliers who were acutely unwell.

Not all staff felt that medical staff responsible for outliers on the ward were always supportive. Staff reported experiencing delays in ward rounds and medical reviews for patients and staff often had to chase teams to get them to visit the ward.

Staff were not able to tell us of there were additional services in the hospital to support patients with learning disabilities, autism or dementia.

Women admitted to the hospital were placed under the care of a consultant gynaecologist and the consultants were visible on the ward throughout our assessment.

Nursing staff were able to tell us about a smoking cessation team and a drug and alcohol dependency team within the hospital that they could refer patients to for support, but they told us

these services were rarely used.

Staff told us that they felt well supported by the dietician and pain teams in the hospital which they could refer patients to for support if needed.

Seven-day services

Key services were available 7 days a week but did not always support timely care.

Gynaecology consultants led daily ward rounds on the ward and ensured that patients were reviewed at the weekend. Nursing staff spoke positively of the gynaecology doctors and how responsive and proactive they were. However, staff told us medical and surgical outliers were not always reviewed in a timely manner and medical and surgical teams were not always responsive when asked to come to the ward.

Pharmacy services did not provide take home medications after 3pm on weekdays, which staff told us was an issue if ward rounds for outliers took place later in the day. We were told this sometimes resulted in discharges being delayed until the next day. On-call pharmacy support was available over the weekend.

Staff could call for support from other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

Health promotion

Staff did not always give women practical support and advice to lead healthier lives.

The patient survey asked if staff discussed opportunities to improve overall health. We saw 100% of patients said they had not had a discussion with staff about improving overall health.

We reviewed 4 sets of patient records and found that admission assessments were not always holistic. None of the patients had been provided with health promotion advice or material, and opportunities for health promotion advice were not identified.

Staff on the gynaecology ward were not provided with any training in health promotion, such as contraception or sexual health. Staff did not have access to condoms on the ward so were unable to supply these to patients on discharge from hospital.

Information leaflets were available for patients in the ward lounge. Information leaflets were available in the outpatient's department, but these were in an area out of sight from patients. However, we did observe staff providing patients with relevant information leaflets at the time of their appointments.

The ward environment had a cervical cancer awareness display and menopause information board on the ward corridor.

Prior to the COVID-19 pandemic, ward staff had carried out some work in relation to pyjama-induced paralysis. They had created posters which were displayed throughout the ward and were encouraging patients to get dressed and mobilise during their stay on the ward. This work had been stalled by the pandemic and ward closure.

All women attending the service for an elective termination of pregnancy were offered contraception in line with RCOG guidelines.

Consent

Staff supported people to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support people who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

We reviewed 4 sets of patients care records and found consent was obtained and recorded within the patient care records.

We observed clinical staff performing examinations and delivering treatments on the ward and in the outpatient's clinic. We saw that patients were provided with information to allow them to make an informed decision about their care and provide informed consent.

Women accessing services for a termination of pregnancy were initially assessed by telephone and then face-to-face at their next appointment. Women were provided with information at both assessments to enable them to make informed decisions and ensure they were seeking a termination voluntarily.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. We observed chaperones being present when intimate examinations were performed.

Women said staff treated them well and with kindness.

Staff understood the importance of confidentiality and caring for women in a discreet way. They spoke about how they wanted to provide a service that patients felt able to access with confidence.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude. The termination of pregnancy clinic was held in the sexual health clinic. Staff spoke about how this was a more appropriate setting as being in an outpatient clinic with pregnant women may be upsetting for women seeking a termination.

Staff spoke passionately about how they wanted gynaecology patients to be cared for in an appropriate setting by staff with the right skills. They demonstrated they understood the individual needs of patients relating to gynaecology conditions or procedures and how they felt women should be treated with kindness and compassion by nurses with gynaecology experience. Staff told us how they felt this did not always happen as gynaecology patients were sometimes cared for in other parts of the hospital by staff with no gynaecology experience.

We observed staff displaying a caring and compassionate approach to patients. Despite telling us they were exhausted, and that morale was low, staff were working over their shift time and extra shifts because they were dedicated to delivering safe and high quality care for patients.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. We observed staff in the outpatient's clinic taking the time to

listen to patient concerns and providing care in a respectful and considerate manner.

One patient had left feedback on the patient survey about the curtains around beds being too short and that they did not close properly to allow patients to maintain privacy and dignity. We did not see any issues with this during our assessment.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. However, they did not always feel supported by the service to achieve this.

We observed staff giving women and those close to them help, emotional support and advice when they needed it.

Staff were not provided with training on breaking bad news, but they understood the importance of empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The lead nurse for termination of pregnancy had not received any specific training in counselling. However, they had made links with a local community wellbeing team who women could contact for support. Additionally, the service in England that provided terminations off island also offered a counselling service for women. Women could self-refer to both these services and were provided with the contact numbers at the time of assessment and treatment.

Staff told us how some women would attend the outpatient's clinic for a scan but then would have to come to the ward to see a doctor in the clinic room. Staff felt this was not supportive of women in distress especially in the event of a miscarriage or termination. Staff told is that a business case had been submitted for a bereavement suite for women who had experienced a miscarriage or termination but funding for this had not been supported. Women were able to access the forget-me-not suite, but this meant that women would have to be transferred up to the maternity floor, which for some women could cause further distress. Following our assessment, we were told that the business case had been put on hold due to the increase in bed base on the ward.

Staff told us how the acuity of the patients on the ward often impacted their ability to offer emotional and psychological support to women who needed it.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment and supported them to make informed decisions about their care. We observed staff summarising treatment plans and repeating information if patients did not understand.

Staff talked with women, families and carers in a way they could understand, however staff were not able to tell us if they had access to communication aids or translation services if they needed it.

We saw that patient experience questionnaires had been handed to some patients to complete. However, we did not see that any questionnaires had been handed out since June 2022, so it appeared that this process was inconsistent. There was also a suggestion box in the patient lounge.

Women gave positive feedback about the service. We reviewed 8 anonymous patient experience questionnaires from June 2022. Seven women rated their overall experience as good or very good, and 1 woman rated their experience as satisfactory. Women commented that staff were “knowledgeable”, “understanding” and “caring” and that the care they received was “exemplary”. Women spoke positively of the service they received.

The patient survey included questions about patients feeling involved in decisions about their care and discharge. 87% of patients felt that doctors provided answers to questions when they asked and 85% of patients felt that Nurses provided answers to questions when they asked. We saw 87% of patients felt involved in decisions about their care and treatment, 13% of patients left this answer blank. We saw 100% of patients said they felt involved in decisions about their discharge, but 50% of these said they only felt involved “to some extent”.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

Service delivery to meet the needs of local people

Facilities were appropriate for the services being delivered. However, staff were not always aware of what services were available to meet the needs of patients. Managers did not always take action to ensure women accessed the services that they needed.

Facilities and premises were appropriate for the services being delivered. However, leaders told us that outpatient clinic space was a challenge and that services had to be carefully planned.

Staff could access emergency mental health support 24 hours a day, 7 days a week for women with mental health problems. However, they were not able to tell us how they would seek additional support for patients with learning disability or dementia. In addition, staff did not receive training in how to support patients with learning disability, dementia, autism or mental ill health.

Managers monitored missed appointments. We saw 241 patients had attended gynaecology clinics in August 2022 and 9.1% of patients did not attend their appointment (DNA), and 62 patients had attended colposcopy clinic in August 2022 and 11.4% of patients did not attend their appointment. Clinical staff were able to tell us that secretaries managed appointments when patients did not attend but they were not able to tell us what action was taken to contact the patients or to minimise the number of missed appointments. DNA rates were listed in the monthly care group data report, but no actions to reduce missed appointments were identified and the number of missed appointments was not improving.

Termination of pregnancy services were planned so that women had a choice of where they accessed treatment. Women could seek a termination from the commissioned service in England without needing to contact their GP or local hospital if they preferred not to. All treatment and follow-up support could be accessed through this service.

Meeting people’s individual needs

The service was inclusive and took account of women’s individual needs and preferences. Staff made reasonable adjustments to help women access services but did not always know what services were available to support women.

The ward and clinic environments were designed to meet the needs of women. The ward had a lounge area which women could access if they wanted to access a quiet space away from the

busy ward environment.

Signage within the hospital was clear and easy to follow. The environment was well lit and free from clutter so patients could move around easily without restriction or hazard. Corridors and door frames were wide enough for wheelchair users and disabled toilets were available.

Staff showed they understood how to support patients with learning disabilities and dementia and were knowledgeable about the use of patient passports and 'this is me' documents. However, staff did not know of any specialist support for these patients within the hospital.

The lounge on the ward had information on display about disability networks which patients could access.

Assessments of women seeking a termination of pregnancy were thorough and holistic. The lead nurse for this service was able to demonstrate and understanding of the individual needs of women and how the support provided would be tailored to ensure women were provided with the information and support that they needed.

Women who had a termination of pregnancy had access to a 24-hour aftercare helpline through the commissioned service in England. Women were provided with telephone access to the lead nurse for the termination of pregnancy service and a local community wellbeing service who were able to provide counselling.

Women were given a choice of food and drink to meet their cultural and religious preferences.

Not all staff understood how to meet the communication needs of women with a disability or sensory loss.

Although women could access a variety of information leaflets in the clinic and ward environment, we did not see any leaflets in languages other than English and there was no information on display about accessing information in other languages or formats.

Prior to our assessment, we were provided with a copy of the 'Isle of Man strategic plan for adults with a learning disability' dated 2020-2025. However, during our assessment, staff were not aware of the strategy or any additional support available for patients with learning disabilities.

Access and flow

People could access the service when they needed it and received the right care promptly. However, delays were not always communicated to patients. The service did not demonstrate that waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Staff told inspectors that waiting times were exceeding target standards however, they were unable to show how waiting lists were monitored or any data at the time of our assessment. Following our assessment, we requested referral-to-treatment data (RTT) data for this service but were told the service does not capture any RTT data.

Waiting times in the outpatient's clinic were not always on display. We saw the clinic environment had display boards, which included staff names and waiting times, but during our assessment, these boards were not always completed.

Beds on the gynaecology ward were not ring-fenced and were often used for medical or surgical outliers, meaning that women attending for gynaecological procedures were often cared for in general surgical environments. Staff had formally raised concerns about this with managers, but

they told us that no action had been taken. Following our assessment, we requested the number of outliers that had been on ward 4 in the last 3 months. Data provided by the service showed there had been 68 medical outliers and 72 surgical outliers between 1 August and 31 October 2022.

Patient moves from ward-to-ward were not always made due to a clear medical reason or in their best interest. Staff told us they often challenged decisions about bed moves they felt were clinically inappropriate and did not feel they were always listened to. We saw that staff completed incident report forms about inappropriate patient transfers. During our assessment, we saw that 1 woman was moved from ward 4 to another clinical area within the hospital. When staff challenged this decision and raised concerns with care group leaders, we were told the decision had not been discussed with the relevant clinicians or in the hospital bed management meeting. The woman was later moved back to ward 4 as it was agreed the decision to move the patient was clinically inappropriate.

Staff told us that they had access to a complex discharge coordinator in the hospital and they felt supported with discharge planning to ensure patients were discharged safely. However, during our records review, we saw some gaps in the documentation of discharge planning.

The hospital had a discharge policy, which staff could follow if a woman wished to self-discharge from the hospital. However, this policy was due for review in January 2017.

Although length of hospital stays and delayed transfers of care were listed as indicators on the quality dashboard, these were not monitored for this care group. The dashboard included indicators for waiting times and appointment and surgery cancellations, but data for these indicators was not recorded for this care group

Termination of pregnancy clinics were held every Thursday, but staff told us that they were able to add extra clinics in to ensure that any changes in demand or requests for alternative times could be managed and that women did not have to wait to be seen. We were told that waiting times and time from access to procedure was not monitored.

Learning from complaints and concerns

The collection of complaints data was not always accurate, so it was not clear if the service treated concerns and complaints seriously and investigated them. We saw that lessons learned were shared with all staff.

The quality dashboard showed the number of complaints received each month for the care group and the performance against the hospital policy for the management of complaints. The number of complaints received recorded on the quality dashboard from August 2021 to August 2022 was 19. We found the number of complaints received recorded on the care group data report from August 2021 to August 2022 was 28. The numbers of complaints recorded each month was different in each report. For example, in December 2021, the quality dashboard showed 5 complaints and the care group data report showed none.

Between April 2021 and March 2022, 15 complaints were received about gynaecology services. Of the 15 complaints, 14 were fully or partially upheld. Apologies had been given to complainants and actions plans identified where relevant.

The care group performed well on the target of complaint acknowledgement being sent within 2 working days. However, the first written complaint response was not always sent within the agreed response time in each month between August 2021 and August 2022. Complaints handling was

noted to have improved in the minutes of the Board of Directors meeting in February 2022.

The Manx Care Advice and Liaison Service (MCALS) report in June 2022 showed that there had been 5 contacts about the integrated women, children and families care group in April 2022 and 2 in May 2022. All these contacted related to appointments. The report showed that 77% of queries were resolved on the same working day. The report did not outline if any actions had been identified as a result of any themes or trends.

We did not see any information about how to raise a complaint on display within patient areas but comments from patients were on display the entrance of the ward.

We saw that a monthly care group newsletter was sent out to all staff each month and that this contained information about complaints and compliments. We saw that patient feedback comments were displayed on the board at the entrance to the ward.

We reviewed the minutes from the care group patient safety and governance meeting and found that complaints were discussed.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

Care group leaders understood the issues the service faced and were visible and approachable in the service for patients and staff. However, a key leadership role was vacant and not all senior staff had the skills to perform their role in leading and managing of the service.

The gynaecology and termination of pregnancy service and the care group had a clear leadership structure which staff were aware of, but not all staff knew who the hospital leadership team were and how risks and issues were escalated and managed above care group level.

Staff told us how they felt supported by the care group leaders but not always by the hospital leadership team. They said that care group leaders were visible and understood the challenges that staff face each day, but they did not always see that action was taken to resolve issues.

All leaders understood the challenges that the service was facing in relation to staff recruitment and retention.

Vision and strategy

Staff and care group leaders had a consistent approach to the future of maternity service but there was no formal vision or strategy for the service or care group. The hospital values had been refreshed and we saw that staff understood and demonstrated these values.

During our last visit to Noble’s Hospital in June 2022, we were told that pulse surveys showed that approximately one-third of staff employed by Manx Care did not know the organisation had a set of values. We were told that the values had been refreshed and were had been relaunched in July 2022 and we saw that the values were on display throughout the hospital.

Care group leaders told us how they were working to develop ward 4 into a women’s surgical unit, rather than just a gynaecology ward. Not all staff understood this was the plan for the ward, and staff spoke about how they did not always feel included in the decision-making about the future of the gynaecology ward. We did not see this vision for the service had been formalised, considered

the needs of the patient population, or that a strategy of how this would be achieved had been developed.

The lead nurse for termination of pregnancy and spoke passionately about the future of the service and ideas that they had. They told us how the clinical lead for the service was very supportive of this and that they worked well together for the benefit of women using the service.

Culture

Staff did not always feel respected, supported and valued, but they were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The Isle of Man did not have a 'freedom to speak up' process but did follow the Government's policy on standards for whistleblowing. Staff told us how they felt able to speak up and raise concerns if they had any.

Student nurses told us they felt well supported and had been provided with opportunities to learn. They had a named practice assessor and practice supervisor, which they felt able to talk to if they had any concerns or worries.

The gynaecology ward had been closed for a period throughout the COVID-19 pandemic and staff had been redeployed to support other wards. Staff and leaders told us this had negatively impacted the culture on the ward and had resulted in some staff not returning.

Staff told us that they felt listened to and supported by the care group leaders but did not always feel heard by the executive leadership team or that the challenges on the ward were fully understood.

We saw staff on the ward had collectively written to the executive team in March 2022 raising their concerns about the closure of the ward, and the placement of medical and surgical outliers on the ward compromising the safety of patients. The staff had recognised that many gynaecology patients were being cared for in other areas of the hospital and that this was not in line with RCOG standards. Staff highlighted that the impact on the team had been "devastating". We saw that in response to this letter, executive leaders had met with staff in June 2022. The meeting minutes stated that the director of nursing planned to raise the issue with the senior management team and report back to staff. Staff told us they had received no further updates and had not seen that any action had been taken. Following our assessment, we were told this piece of work was ongoing.

Senior staff told us how some staff were resistant to change the care group leaders were sighted on this resistance and spoke of how they were keen to work with staff to overcome this reluctance and improve services.

Nursing staff spoke positively of the culture within the gynaecology service and how they felt supported by their colleagues. Despite the staff telling us that they were burnout and that morale was low, we observed staff supporting each other and 1 nurse spoke of the "sisterhood" that they felt amongst the team.

Governance

Leaders did not operate effective governance processes, throughout the service. Not all staff were clear about their roles and accountabilities. Staff did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The care group had a clear governance structure and leaders told us they were able to easily

escalate concerns to the executive leadership team via governance meetings. However, it was not clear how this information was communicated to staff. Staff told us how there were no regular team meetings and were unable to show us how they would access minutes from previous team meetings.

A hospital quality dashboard was in place, but this was only partially completed for this care group and sometimes contained conflicting data to the care group monthly data report.

Not all staff were clear about their roles and what they were accountable for. For example, none of the leaders that we spoke with were able to tell us how they were assured that the service was safe and 1 senior nurse that we spoke with demonstrated that they did not understand all of the functions of their role and their part in maintaining oversight of the service.

We saw that out of date policies and guidelines were in use in the service. For example, we saw 2 policies for consent to procedures; 1 which was due for review in 2017, and 1 which was undated. The hospital policy for uniform, dress code and bare below the elbows was due for review in March 2019 and the safe nursing and midwifery staffing policy was due for review in April 2018.

Following our assessment, as part of the data request process, we were provided with some duplicated policies which contained conflicting information and could be confusing for staff. For example, we asked for the chaperone policy. We were provided with 2 different chaperone policies; 1 was due for review in April 2020 and the other was due for review on April 2021.

Following our assessment, we reviewed the Manx Care outlier policy, which was not dated and did not have a review date. This policy stated that “all patients should be RAG [red, amber, green] rated within 24 hours of admission and reviewed daily for appropriateness to outlie”. In addition, the policy stated that “staff should not be put at risk by being asked to care for patients in an environment where there is insufficient staffing” or where “staff do not have the appropriate knowledge or skills for these patients”. During our assessment, we did not see that outliers on the gynaecology ward were ‘RAG’ rated and staff consistently told us they did not always have the skills to safely care for the patients, or the staff numbers required to meet the acuity of the patients.

In November 2021, the integrated medicines optimisation group (IMOG) was established and met monthly to discuss and approve medicines related initiatives across Manx Care.

We reviewed minutes of the IMOG and found these contained limited information. The minutes did not cover any medicines incidents, near misses or learning from incidents. There was some focus on policies but again this was limited. We did not see any information regarding antimicrobial stewardship, VTE, critical medicine prescribing rates or medicines reconciliation.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

Arrangements for identifying, reviewing and managing risks were not robust. Not all service leaders were able to tell inspectors if the service had a risk register. In addition, leaders had different views on what the top 3 risks to the service were. We asked leaders within the service about what they considered to be to top risks to the quality and sustainability of services. The risks identified were not consistent and did not always align to the risks listed on the risk register.

Prior to our assessment we reviewed the risk register for the care group. It was not clear which risks related to which service within the care group and not all risks had a review date. The risk registers also did not include any mitigations which had been taken to reduce the risk. Colposcopy capacity was listed as an extreme risk. Staffing ratios in gynaecology outpatient clinics and the colposcopy database being not fit for purpose were listed as high risks. Gynaecological cytology specimen errors were listed as a moderate risk and had not be reviewed since September 2021. The risk of women not being able to access termination services on the island due to a lack of resourced service was listed as a high risk on the care group risk register and this has not been reviewed since July 2020. The care group data report for August 2022 contained the same version of the risk register.

We were provided with a copy of the risk register action log. This contained conflicting review dates to the risk register which raised concerns about oversight of the 2 documents. This document showed that all risks had been reviewed in September 2022 and mitigations were identified. The risk register was included as a standing agenda item on the care group patient safety and governance meeting agenda.

Throughout our assessment, we were told on multiple occasions that nurse staffing on the gynaecology ward, obstetrics and gynaecology staffing and sepsis recognition were risks to the safe delivery of gynaecology services. None of these were listed on the risk register. In addition, we saw that mandatory training compliance for safety critical course such as basic life support was poor, and this was also not on the risk register.

Information management

The service did not always collect reliable data or analyse it. Staff could not always find the data they needed. Information was not always stored securely.

Patient care records were stored in over a combination of paper and electronic records. We saw this often made it difficult for staff to see full details about patient history of an episode of care. For example, in 1 patient record, we saw observations were recorded using 3 different methods. Intraoperative observations were on a printout in the patient's care notes, post-operative recovery observations were recorded on a paper anaesthetic record and pre and post-operative observations on the ward were recorded electronically. This meant for clinicians to monitor for patient deterioration or improvement, they would need to access all 3 sources of information rather than being able to easily identify trends.

The clinical notes trolley, which was stored in the corridor next to the nurses' station, was open and unsecure throughout our assessment and we observed several times where the nurses' station and notes trolley were left unattended and notes could be accessed without authorisation.

Data collection within the service was ineffective. Not all indicators on the quality dashboard were monitored. Staff told us that systems did not support the collection of data to monitor and improve services and that data often had to be collated manually which was time consuming and open to the risk of human error to misinterpretation. We saw that data collection was not always accurate, such as the number of complaints recorded on the care group quality dashboard was different to the number recorded on the care group data report.

Engagement

The service collected feedback from patients, but this process was inconsistent and not always timely. Leaders did not always demonstrate that they engaged with equality groups, the public or partner organisations to plan and manage services.

The service ran a hospital wide staff survey called 'have your say'. Following our assessment, we requested the results from the most recent survey, but this information was not provided.

A hospital-wide patient survey was handed out to patients on the ward, but this was reliant on certain members of staff rather than being a consistent process, which meant that not all patients had access to the survey. We did not see that any surveys had been handed out since June 2022. Patients rated their overall experience during their hospital stay. We saw 75% of patients rated their experience as "very good", 12.5% of patients rated their experience as "good" and 12.5% of patients rated their experience as "satisfactory". In addition, the June 2022 surveys had not yet been collected and analysed, which meant that any areas for improvement would not be acted upon in a timely manner.

A suggestion box was on display in the ward waiting area/lounge where patients could leave comments or suggestions about the service.

Leaders were not able to tell us of any formal processes in place to engage patient representatives, equality groups or partner organisations in the decision making to shape services and culture. However, we did see that patient stories were shared at the board of directors meeting.

The leaders of the termination of pregnancy service engaged well with the commissioned service in England to improve services for women. Anonymised data was shared with the clinical lead each month, and the lead nurse was travelling over to England to attend training and gain peer support with the development of the services at Noble's Hospital.

Learning, continuous improvement and innovation

Care group leaders wanted to improve and develop services and all staff were committed to providing a safe service. However, staff did not feel they had the time to take part in the development of services or to focus on improvement and innovation. Staff did not receive training in quality improvement.

A senior nurse from ward 4 had been seconded into the role of project lead for a gynaecology cancer pathway service improvement project. Temporary changes to the service were being piloted with a view to more permanent changes being made in the future. The project team were communicating with services from England in order to learn from and share best practice examples. The project was in its infancy, so we were not able to see any outcome data at the time of our assessment, but an action map had been created so that the team had focus and clear goals for achievement.

Staff were not provided with any training in quality improvement and we did not see that all staff had a focus on learning and improving services. Staffing challenges in the service meant that staff had to prioritise takes and service delivery took precedent over service improvement.

Maternity

Overall Summary

The Maternity Unit includes a ward where antenatal and postnatal patients are admitted. The ward has 17 beds in a mixture of 4 bedded bays and single rooms. The ward also has a separate area with 3 rooms converted for use during the pandemic for women who have COVID. There is a separate day assessment clinic and waiting area.

The service had a Forget-Me-Not Suite for women and families who have experienced the loss of a baby, with a double bed, shower room and kitchen area.

The delivery suite includes 4 birthing rooms, 2 pool rooms and a parents' lounge. There is 1 maternity theatre.

Antenatal clinics are held in a small outpatient's department shared with paediatric and gynaecology services. There are 6 consulting rooms, 1 ultrasound room, 1 venepuncture room, 1 seminar room and a parentcraft room for parenting classes.

The Early Pregnancy Assessment Unit is based on the gynaecology ward. Although the Early Pregnancy Unit is part of gynaecology services at Noble's Hospital, it sits within the CQC maternity assessment framework and has therefore been included in this report.

There were 390 babies born in 2022 prior to the assessment, with 46 babies delivered in August 2022, all the babies were delivered in the hospital. 22 of these women had given birth before. 47.8% of women were discharged breast feeding.

In August 2022, the service had:

- 11 planned caesareans
- 11 emergency caesareans
- 4 instrumental deliveries
- 8 episiotomies
- 21 inductions
- 3 water births
- 1 still birth
- Perinatal mortality rate 3.48

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

The quality dashboard showed that overall mandatory training compliance for the care group was

74% in July 2021, 70% in January 2022 and 81% in September 2022.

Not all compliance rates met the service target of 85%.

Mandatory training data provided by Manx Care did not include all specialist training that midwives were required to complete. Leaders told us that midwives were required to complete K2 foetal surveillance package, which included cardiotocography (CTG) training. We did not see that compliance with this course was monitored and when we were provided with mandatory training data, this course was not included. In addition, mandatory training data for medical staff did not include Neonatal Life Support (NLS) or PROMPT. Following our assessment, we were told that compliance with the K2 foetal surveillance package was monitored. However, compliance figures were not provided.

The patient safety and governance report from April 2022 states that obstetric emergency drills were planned bi-monthly and that all staff were required to complete this annually. The report also states that NLS training was planned for September 2022 and that 1 staff member was training to become an NLS instructor to facilitate future courses.

Data provided by Manx Care prior to our visit stated it was unable to obtain and provide us with accurate training compliance figures from the electronic training system for all services within the hospital. They could only provide the numbers of staff who had completed a course not the numbers who were required to do so. In addition, the data provided was not a full suite of the training we would expect all healthcare staff to have undertaken.

This issue was mentioned in the minutes of the February 2022 operational clinical quality group. However, this had not improved at the time of our visit. It was also noted in the minutes of the operational clinical quality group from May 2022, that there was insufficient monitoring of other mandatory training subjects as well as role specific assurances.

Information provided by the hospital stated that this data was extracted manually and therefore may not be accurate. In addition, the mandatory training policy did not represent safeguarding training requirements and therefore these figures may also be inaccurate. The hospital explained that staff absences and vacancies were impacting the ability to achieve compliance.

Mandatory training compliance was highlighted as an assurance gap in the maternity care dashboard report in May 2022 and a newly appointed practice development facilitator had been tasked with focusing on this area for improvement.

Mandatory training compliance was also discussed in the care group patient safety and governance meeting. Low compliance was noted in the meeting in June 2022 and it was recorded that it was individual staff responsibility to ensure training was completed. No actions were identified to support staff to be able to complete the training.

Staff told us they were not provided with protected time to complete mandatory training and therefore it was challenging to complete the required training. We saw that mandatory training was discussed at a maternity ward meeting in August 2022. It was acknowledged that staff shortages were impacting completion and that leaders were trying to incorporate time within working hours but had offered overtime or time off in lieu to those who completed training in their own time. Staff told us that the last 2 PROMPT courses had been cancelled due to staff shortages.

Safeguarding

Staff did not always understand how to protect service users from abuse. Staff had training on how to recognise and report abuse but not everyone had completed it.

No medical staff had completed child safeguarding training, which meant there was a risk that medical staff did not have the skills or knowledge to recognise and respond to safeguarding concerns.

The safeguarding training levels (as outlined in the mandatory training section of this report) were not in line with the 'Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate' guidelines, which we were told was recognised on the Isle of Man.

Staff were unsure if safeguarding training included information about female genital mutilation (FGM) and child sexual exploitation (CSE). This meant there was a risk that staff would not have the skills or knowledge to recognise and respond to FGM or CSE.

A safeguarding assurance report was shared with the operational clinical quality group in June 2022. Although gaps in assurance were identified, this report did not detail actions being taken to mitigate these risks.

Midwives from the service had made an average of 7 new safeguarding referrals per month from January to August 2022.

We requested copies of the hospital adult and child safeguarding policies. We were provided with the Isle of Man Government's interagency safeguarding adults policy dated 2018 to 2020. This policy did not include information about what process staff at Noble's Hospital should follow when making a safeguarding referral. The policy referred to 'internal agency reporting procedures', but we were not provided with a copy of an adult safeguarding policy for Noble's Hospital. We also saw that Manx Care had a safeguarding children and adults strategy dated 2022 to 2025.

We were provided with a copy of the Noble's Hospital policy for safeguarding children in the maternity services, which was due for review in June 2018. This policy did not include information about what action should be taken if staff identify immediate or urgent safety concerns out of hours. However, we were provided with a copy of the Manx Care safeguarding children guidance and procedures dated 2022 to 2025. This policy did include information about how to make a referral and actions which should be taken if staff have immediate concerns for child safety.

We saw that staff in the antenatal clinic took opportunities to speak with women alone to allow women the opportunity to speak with staff about domestic violence or other safeguarding concerns. Staff demonstrated they understood how to respond and support women if they suspected domestic violence or sexual assault.

The service had an abduction policy dated October 2022. The processes outlined in the policy had not been tested so it was not clear if staff knew what action to take if a baby was abducted. However, the maternity unit was secure and could only be accessed by swipe card or by intercom.

Cleanliness, infection control and hygiene

The service did not always control or monitor the infection risk. However, staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Prior to our assessment, we reviewed the Maternity Patient Safety and Governance Service Report from April 2022. The report noted that the IPC audits for the ward area, delivery suite and outpatients had scored 98%, 100% and 100% respectively.

The care group data report for August 2022 included the results of infection prevention and control audits completed within the care group. There were no audits listed for the maternity ward or delivery suite and the outpatient's department had been marked as "not applicable".

We saw that some areas of the maternity unit had fabric curtains and cushions and we did not see that there was a process in place to ensure these were cleaned or replaced when required. Following our assessment, we were told that cleaning procedures and schedules were available, but we were not provided with copies of these documents.

We asked for the incidence of sepsis and other infections within 42 days of delivery. We also asked for the readmission rates for infections in mother and baby. We were told that this information is not currently collected or monitored by the service.

The incidence of various infections, including Clostridium Difficile, Methicillin-resistant Staphylococcus aureus (MRSA) and Pseudomonas aeruginosa was included in the quality dashboard.

We requested a copy of the infection prevention and control policy but were told the hospital did not have an overarching infection, prevention and control policy. We were provided with a copy of the Manx Care policy for aseptic non-touch technique (ANTT) which was dated March 2021. The policy included relevant information for staff to follow and referenced appropriate guidelines and other Manx Care policies which staff could refer to.

Cleaning records within the maternity unit and clinic areas were fully completed and the environment and equipment were visibly clean.

Items used in maternity services were decontaminated and sterilised for reuse. This contract was managed centrally for the whole hospital. Staff told us they did not have any issues with availability of sterilised equipment. We saw that sterilised equipment was stored appropriately in sealed packaging and with a clear expiry date.

During our assessment, we observed staff decontaminating their hands and using PPE appropriately. Hand sanitisation points were readily available throughout the maternity department.

All sharps bins were clearly dated, and the temporary closure mechanism was in use.

The importance of compliance with PPE requirements and COVID-19 testing were discussed at the maternity ward meeting in August 2022.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Not all equipment was in date for safety testing and calibration. We saw an observation machine on the ward which was due to for testing in August 2021. We saw that 2 medical gas cylinders in the maternity theatre both expired in September 2022. Staff had signed to say that these cylinders had been checked daily. When we raised this with staff, they acted very quickly to get the cylinders replaced.

In the forget-me-not suite, we found clinical gloves that expired in October 2021 and lubricant jelly sachets that expired in August 2017. In addition, there was a hairdryer which was due for electrical testing in August 2020.

In the clean utility on the ward, we found needles that expired in October 2021 and suction tubing

that expired in August 2022.

The emergency resus trolleys were stored centrally on the ward and delivery suite and were easily accessible if required. The trolleys were secured with a tamper proof tag. The trolleys contained a stock of relevant equipment and consumables which may be required in an emergency. Equipment on the trolleys had recently been safety tested. There was a daily checklist on each trolley for staff to complete, but this was not completed daily. The ward checklist was fully completed in September and October 2022 but was not fully completed for July and August 2022. The delivery suite checklist was fully completed for July, September and October 2022, but no records were available for August 2022.

The ward and delivery suite also had emergency trolleys for pre-eclampsia and post-partum haemorrhage (PPH) which were fully stocked with appropriate and in date equipment and the trolleys were secure to prevent unauthorised access.

Leaders told us that equipment servicing was managed centrally for the hospital and servicing was automatically carried out, so this was not monitored at a care group or service level. Equipment faults were reported using an electronic system and staff reported that maintenance teams responded quickly to reports.

Staff said they had enough equipment to look after women and babies safely and we saw that all cardiotocography (CTG) machines had recently been replaced.

Community midwives had a stock of equipment which was checked regularly to ensure it was clean and in date. Community midwives that we spoke with did not report any issues with access to equipment.

Waterproof sonic aids were available for use when women were using birthing pools.

Women could reach call bells and staff responded quickly when called.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

We reviewed antenatal records and found that appropriate risk assessments were completed at every antenatal appointment.

We saw evidence of timely and accurate recording of observations and use of the maternity early warning score (MEWS) and that staff responded to and escalated patient care appropriately. Following our assessment, we requested audits of documentation or risk assessments specific to the maternity service. We were told that no audits of completion of pressure ulcer prevention assessments, malnutrition universal screening tool (MUST), MEWS or the new-born evaluation score (APGAR) had been completed in maternity services despite some of this information being recorded on the care group quality dashboard. We were later told that the MUST is not used within maternity services and therefore it is not clear how the service identified the risk of malnutrition in women who used maternity services.

Information provided in the quality dashboard showed that the care group had a target of less than 6.63 patient falls per 1000 bed days. In the 12 months from August 2021 to August 2022 this target was met in 11 of the 12 months. Data was not recorded for July 2022.

The hospital’s major incident plan was created in November 2017 and minor adjustments were made in April 2018. There appeared to have been no further reviews or updates to the plan in the

last 4 years. Within the plan it was stated that it was the responsibility of the Hospital Emergency Planning Team (HEPT) to ensure the plan is reviewed twice yearly.

The service had identified the lack of electronic record of care for pregnant women who are diabetic or develop diabetes in pregnancy as a moderate risk on the care group risk register.

Arrangements for emergency or life-threatening situations such as haemorrhage or baby abduction had not been tested.

In 2021, a review of 20 patients showed that 100% of patients had a WHO checklist in their care records with a sign in recorded. However, 30% of the checklists were incomplete. The 2022 audit showed that 15% of patients had no checklist in their record and 17% of checklists were incomplete. We did not see that any action had been taken to improve this. However, during our assessment, we observed the WHO checklist being used and fully completed.

Leaders also told us that each ward held daily safety huddles known as grand rounds. However, we did not see that this took place during our assessment.

We observed a pre-operative team brief in maternity theatre. All members of the theatre team were present and the physical, psychological and emotional needs of the woman and her partner were discussed.

The service did not offer midwifery-led care.

Midwife staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The hospital policy for safe nursing and midwifery staffing was due for review in April 2018. This policy stated that the planned staffing for each shift was 4 midwives and 1 midwifery care assistant, except for Wednesdays when the early shift required 5 midwives and Tuesday and Thursday when the late shift required 5 midwives. The policy outlined responsibilities for escalation of staffing shortages, which we saw staff enacting during our assessment.

We reviewed planned and actual staffing levels for the 3 weeks in September and October 2022, which included the hospital, outpatients and community midwifes. The planned staffing levels did not match the requirements outlined in the hospital policy for safe nursing and midwifery staffing. We saw 49% of shifts had fewer midwives than planned and some shifts had only 50% of the required midwives. During our assessment, we saw that staff were working extra shifts, and over their shift times to cover staffing gaps. In addition, a senior midwife had worked 19 days in a row in order to provide additional cover for maternity staffing gaps. Following our assessment, we were told that an on call system was used when there were midwife shortages.

We saw that the senior midwives in the service closely monitored staffing levels throughout the day and night to identify any gaps in staffing and take steps to request extra staff or amend planned clinical activity. The home birth service had been withdrawn. In addition, on the first day of our assessment, we saw that the planned caesarean list had been cancelled due to a lack of staff.

During our assessment, we were told that a staffing review had taken using the birth rate plus tool in 2019. We were told that the service required an additional 2 midwives but that this had not been funded.

Staff vacancies and sickness rates were listed on the quality dashboard. However, this information was not recorded for this care group. Leaders told us the maternity service was funded for 36.06 whole time equivalent midwives. At the time of our assessment the service had 11 vacancies. There were also 3 midwives on long term sick and 2 midwives on non-clinical duties. In addition, the service had 3 vacancies for midwifery care assistants.

Service leaders told us they were concerned about their ability to always deliver a safe service given the current staffing levels. We were also told that leaders were concerned because many of the midwives were due to retire soon. Midwifery staff shortages was listed as an extreme risk on the care group risk register.

The Maternity Care Dashboard Assurance Report in May 2022 showed that staffing levels were a concern and that in April 2022 staffing levels were below the 2019 safe staffing standards for 25 days out of 30. This assurance report did not include any information about the actions taken to keep staff and women who use the services safe.

Staffing was identified as the biggest challenge to the service in the patient safety and governance report in April 2022. Actions taken to improve staffing were outlined in the report. It was noted these had not been successful at the time of the report. It was also recorded that staffing had impacted some of the improvement works that had been planned.

We also saw that the maternity business continuity plan dated May 2022 contained information about what action should be taken to manage staff shortages. For example, at times of where the staff shortage was 30% or greater, all training and study time would be cancelled so that staff could be redirected to deliver patient care.

The service had begun to work with Salford University to support midwifery students on the Isle of Man with 100% of clinical placements being completed on the island. One student was currently undergoing that training and another student was due to start in September 2022.

We reviewed staff exit interviews for midwives who had left in the last 12 months and saw staffing issues were noted as a theme.

Service leaders told us how staff, including bank, agency and student midwives, were provided with a corporate induction, a Manx Care induction and an induction to the unit. Although 100% of midwifery staff had completed the local workplace induction, only 85% had completed the corporate and Manx Care induction programmes.

Medical staffing

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

The obstetrics and gynaecology service were delivered by a team of consultants and speciality doctors. The service did not have any junior or training grade doctors. We were told that obstetric consultant cover was provided 24 hours a day, 7 days per week. During on call periods, Doctors were expected to stay within the hospital if they lived more than 15 minutes from the hospital.

On the first day of our assessment we saw that due to staff sickness, there was only 1 consultant on shift for the whole of obstetrics and gynaecology services. Leaders of the service told us how they considered medical staffing to be a risk but that this did not impact service delivery because staff were working together to fill staffing gaps and to keep people safe.

Data provided by the service showed that in April 2022 the vacancy rates for medical staff was 18%. At the time of the assessment, we were told that some of these vacancies had been filled but that recent staffing levels had been affected by unplanned absence. The clinical lead for the service was planning to retire soon but a replacement clinical lead had already been identified.

100% of medical staff had completed the corporate, Manx Care and local workplace inductions Ward rounds took place once daily with multidisciplinary ‘grand round’ also taking place each morning where all patients were discussed, and learning was shared from any complex cases.

Records

Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date, stored securely.

All ante and post-natal care records were stored electronically. All clinical records from labour and birth were recorded on paper.

We reviewed 3 sets of care records and found them to be comprehensive. All documents were dated, timed and signed with an identifiable name. Referrals to specialist services were recorded.

We saw that care records were stored securely throughout our assessment. On the maternity ward, trolleys containing patient care records were stored in a locked room behind the desk.

When women transferred between services such as antenatal services to labour ward, there was no delay in records being accessed.

The electronic system used by the service automatically sent a copy of the discharge letter to women's GPs and health visitors.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

There was no ward-based pharmacist on maternity wards, although a pharmacist visited the wards when they were able to. This impacted on the provision of an effective medicine optimisation service. Midwifery staff explained that they were able to contact pharmacy for support or advice when needed.

There were gaps in the medicine reconciliation process to ensure patients prescribed medicines were as up to date as possible. Patients weights were routinely not recorded on medicine charts. This is important for calculating weight-based medicine prescribing.

Medicine allergies or sensitivities were recorded on all medicine charts seen. This ensures that staff were aware and alerted to prevent the prescribing and administration of medicines causing allergic reactions.

There were no recent audits available to evaluate safe and secure medicine storage, however medicine storage seen was safe and secure.

The service ensured that medicines were stored at the recommended room or fridge temperatures, and daily checks were recorded to ensure medicines were stored within a safe temperature range. Freezer temperatures were monitored daily and were within the recommended range for medicine storage of -10°C to -25°C although it was noted that the freezer required defrosting.

Emergency medicines were available and stored in tamper proof trolleys or boxes in all areas

visited. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency. A post-partum haemorrhage (PPH) emergency box was available stored in the medicine fridge. Although there was a checklist held in the box, the expiry date was not clearly displayed on the outside of the box.

Controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely with CD keys held by midwifery staff. Daily checks were undertaken by staff and pharmacy undertook audits to ensure safe management of CDs.

There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts, however staff at ward level did not always receive updates or information on medicine safety incidents. The Medicine Safety Officer was new in post and was in the process of reviewing medicine safety incidents and had written a newsletter to be cascaded to all areas.

Incidents

Staff were not provided with clear guidance to support them in the recognition and reporting of incidents. However, staff demonstrated that they knew how to recognise and report incidents and near misses. Managers investigated incidents and but did not always share relevant lessons learned from the wider service.

Following our assessment, we requested a copy of the current incident reporting policy. Two documents were provided. The maternity unit had an incidents, complaints and claims guideline which was due for review in April 2021. The policy directed staff to report incidents using the hospitals electronic web-based incident reporting system called ‘PRISM’. At the time of our assessment, we were told that this system had been replaced with a system called ‘Datix’. We saw there was a Manx Care policy for incident reporting, investigation and learning which was dated October 2021. This policy directed staff to report incidents using the Datix system and had clear roles and responsibilities in relation to reporting and investigating incidents.

In August 2022, 37 incidents were reported within the care group and the most common themes of incidents was staffing, communication, and medication. Of the 37 incidents reported, 16 were from the maternity unit.

From July to September 2022, 52 incidents were reported within maternity. 12 of those incidents related to staffing or resource issues, 11 were maternal incidents and 9 were foetal or neonatal incidents.

The Patient Safety and Governance Maternity Report from April 2022 highlighted that there had been a theme of medication errors, term admissions to the neonatal unit and shoulder dystocia sans haemorrhages. This report did not include what action had been taken as a result of these themes.

The quality dashboard showed that there had been no never events in this care group between October 2021 and October 2022.

It was noted in the Maternity Care Dashboard Assurance Report in May 2022 that there had been a positive significant increase in incident reporting in Maternity, it was felt that this was due to staff being encouraged to report incidents including staffing issues.

Managers shared learning from incidents with their staff and across the care group. Staff told us that incidents were included in a monthly newsletter sent out to all staff by the care group. However, not all staff were able to provide us with examples of incidents or learning from incidents

within the service, the wider care group or Manx Care. In addition, we reviewed the minutes of a maternity ward meeting in August 2022 and saw that incidents or learning from incidents was not discussed.

All staff had completed training in duty of candour.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

Managers did not monitor the service to ensure care and treatment was based on national guidance and evidence-based practice. Policies were not always up to date.

Care group leaders were not able to show us how they were assured that care was safe or effective or that staff followed local policies, evidence-based practice or national guidance. They told us how they "relied heavily" on patient experience as a measure of quality.

Staff were completing hourly checks of CTG records using the "fresh eyes" approach. However, this process was not audited, so they could not tell us how they were assured that this was completed.

Leaders told us that women who experienced spontaneous rupture of membranes (SROM) were admitted and antibiotics were administered within 18 hours and induction within 24 hours. However, this was not audited or monitored so leaders could not tell us how they were assured that this was happening for all women.

Leaders told us that a breast-feeding audit had been completed within the maternity service. We requested a copy of this audit, but the information was not provided.

The Patient Safety and Governance Report from April 2022 stated that an audit programme had been formulated and that all midwifery staff were to be encouraged to take responsibility for an audit.

Staff were able to demonstrate how they accessed policies; however, they told us that there were too many policies and many of them were out of date. We saw hospital policies which had not been reviewed or updated in line with the hospital's own procedures. For example, the hospital's consent to care and treatment policy had not been reviewed since 2014.

The hospital policy for the management of Sepsis in Adults was due for review in February 2020. We were also provided with a copy of a guidelines for the management of paediatric sepsis however these were from a paediatric network in England and Wales and it was not clear if they had been reviewed and ratified as appropriate for use in Noble's Hospital.

We requested copies of the hospital maternal and neonatal death guidelines which staff are expected to follow. However, these were not provided.

We reviewed minutes from a maternity ward meeting in August 2022. No guidelines were discussed. Following our assessment, we were told that new guidelines are displayed on the ward rather than being discussed at meetings.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women's nutrition and hydration was monitored throughout and after labour. The hospital menu was varied and provided options for those with specialist dietary needs. There was also a small shop and café on site which patients could access if they chose to.

Specialist support from staff such as dietitians and speech and language therapists were available for women who needed it. Staff knew how to refer patients to these services and spoke positively of the support they received.

Mothers were given information to support them to make an informed choice about feeding their baby and this was documented in maternity records.

Manx Care had a specialist infant feeding team women could be referred to for support or advice if needed.

The fridge used to store expressed breast milk was in a locked room on the neonatal unit. This meant that in order to store or access milk, women would have to ask staff to go to the neonatal unit for them.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff monitoring pain levels and supporting women to make informed choices about pain management.

In August 2022, 39% of labouring women received diamorphine, 39% used Entonox, 32% received a spinal injection, 9% received and epidural and 2% received a general anaesthetic.

Staff told us that women received an epidural within 30 minutes. However, we did not see that this was monitored or audited for compliance.

The service had access to an anaesthetists 24 hours per day, 7 days a week so that women always had a choice of pain relief.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment and use findings to make improvements and achieve good outcomes for women.

Staff were not able to tell us of any audit activity against National Institute of for Health and Care Excellence (NICE) or Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for maternity services to monitor the effectiveness of care and treatment. When we asked about audit, leaders told us that each service within the care group had its own audit timetable. Following our assessment, we requested a sample of clinical audits completed within the last 12 months. We saw no audits had been completed in 2022 but we were provided with some audits from 2021 and a care group audit plan for 2022 to 2025.

The service did not meet the RCOG guidance for the maternity dashboard to monitor clinical performance and governance. The RCOG recommended clinical activity, clinical outcome

indicators and risk incidents, complaints and patient satisfaction. However, patient satisfaction was not included on the hospital maternity dashboard and the service did not always consistently record data on the dashboard.

An instrumental delivery audit completed in 2021 showed that 9.2% of deliveries in 2021 were instrumental which is the below the RCOG guideline standard of 15%. Only 37% of patients had received a single dose of prophylactic antibiotics which is below the RCOG standard of 100%. The audit included actions including staff training that was required. However, we did not see how these actions were being monitored and the audit was not listed on the care group maternity audit plan for 2022 to 2025 for a second cycle.

An audit of post-partum haemorrhages was completed in 2020. The results of the audit showed the incidence of post-partum haemorrhage at Noble's Hospital was double the UK average and that help had been requested in only 62% of cases. Appropriate pharmacological management had been delivered in only 30% of cases. There were inaccuracies or gaps in documentation in 58% of cases and only 65% had been reported to the risk management team. As a result of this audit, an action plan had been created and it was recorded that this audit would be repeated in 1 year. We did not see that the audit had been completed since 2020 and it was not listed on the care group audit timetable for 2022 to 2025.

Women who sustained a 3rd or 4th degree tear during labour were routinely followed up as ward attenders to the gynaecology ward. Staff were unable to tell us if the outcomes of these procedures were monitored to improve experience and care for women. Following our assessment, we were provided with a copy of an audit of third and fourth degree tears completed from 2011 to 2021. The audit showed the incidence of tears during labour was less than the UK average. 100% of women had received postnatal antibiotics. Only 92% of women had received a post-natal follow up, however this was an improvement on results from an audit from 2006 to 2011 when only 25% of women had received a post-natal follow up. This audit was listed for annual completion on the care group audit timetable for 2022 to 2025.

The service had completed a review of the number of babies born before arrival in the last 5 years. There had been 6 planned home births, 4 of which had been supported by staff from the hospital. The other 25 babies born out of hospital were due to rapid labours and were unintentionally born at home, on the way to the hospital or in ED. It was reported that those born in ED "mostly" had a midwife present. The review did not identify the number of births in ED where a midwife was not present, or any reasons for a midwife not being present. Most births before arrival happened between midnight and 7am with no contact with the maternity unit. The report did not include if any areas for improvement had been identified or any actions taken as a result of this review.

We saw minutes for Perinatal mortality review meetings which took place in November and December 2021. No meetings had taken place since this meeting. The minutes showed how external stakeholder views were considered when discussing cause of death and any areas of learning. We saw that actions were identified but as no meetings had taken place since December 2021, it was not clear how completion of these actions was monitored or measured.

We reviewed minutes of a maternity ward meeting in August 2022 and saw that patient outcomes were not discussed.

Leaders told us they did not contribute to any data collection such as the Maternity Services Data Set. They told us how they did have some links with other services who delivered maternity services but that they did not formally benchmark against these services.

During our assessment, we were told that the number of unplanned admissions to intensive care or neonatal intensive care were recorded on the care group quality dashboard. We reviewed the quality dashboard that had been shared with us and this information was not included for this care group. The dashboard also did not include any antenatal screening key performance indicators. Following our assessment, we were told this information was recorded on the maternity dashboard.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

We saw that staff did not have regular appraisals, and at the time of our assessment, managers were not able to show us how this was monitored. Not all staff thought the appraisal system was effective and staff spoke of having no time for appraisals and training. Some staff told us about some professional development opportunities that had been identified but that they were not able to commit to them due to staffing shortages on the unit.

Following our assessment, we requested appraisal rates for all staff in the service but were only provided with appraisal rates for midwives. It was not clear if appraisals were offered or if rates were monitored for medical staff or midwifery care assistants. Appraisal data showed that only 69.2% of midwives had received an appraisal. We saw 18 midwives had received an appraisal, but the 6-month review was overdue for 7 of these midwives. We could see from the information that was provided to us that staffing issues and staff sickness impacted completion of appraisals.

The mandatory training data which was shared with us did not include any compliance rates for training in new-born screening or bereavement.

The medical staff worked across gynaecology and obstetrics. Competency was monitored as part of the General Medical Council (GMC) annual appraisal and 5 yearly revalidation process.

Staff did not complete training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia.

Midwives were frustrated at the lack of midwifery led care and felt that this was resulting in staff becoming deskilled and lacking in confidence.

The service had an induction pack for staff who were new to the service, including bank and agency staff. There was a separate pack for student midwives.

We spoke with a student midwife during our assessment who told us how they felt supported by staff and managers within the service and that staff were proactive in identifying learning opportunities.

The service also had a midwifery preceptorship pathway for new midwives which included a period of supernumerary practice. Staff received pay increases when they had achieved completion of competencies. New staff also attended a Manx Care induction programme with new nurses from across the hospital. Staff attended a training day on 1 day per month, when they would be given training and time for reflection.

Multidisciplinary working

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

Women admitted to the hospital were placed under the care of a consultant obstetrician and the consultants were visible in the maternity department throughout our assessment.

Staff were not able to tell us if there were additional specialist services in the hospital to support patients with learning disabilities, autism or dementia.

Staff were able to tell us about a smoking cessation team and a drug and alcohol dependency team within the hospital that they could refer patients to for support, however they told us that these services were rarely used.

Ante and post-natal clinics were run by obstetric doctors and midwives and supported by care assistants. The service also ran some multidisciplinary clinics such as diabetes clinics.

Community midwives were based in the hospital which enabled them to maintain communication with the acute team.

The maternity unit was adjacent to the neonatal unit and above the paediatric ward which meant that staff could work together to support women following birth and if paediatric or neonatal colleagues were needed in an emergency they were near the maternity unit.

The early pregnancy assessment (EPAU) clinic room was based on the gynaecology ward and the clinic was led by an obstetrics and gynaecology Doctor.

Seven-day services

Some key services were available 7 days a week to support timely care.

EPAU was not available at weekends and senior staff told us how they thought this was required. We did not see that leaders had carried out an assessment to see if this service was needed 7 days per week. Patients who needed to access EPAU over the weekend would attend the ward if it was urgent or be booked into EPAU clinic on Monday if it was non urgent.

Diagnostic services could be accessed for urgent cases during weekends and out of hours.

Obstetrics and gynaecology clinicians were available 24 hours per day, 7 days per week to provide consultant directed interventions.

Health promotion

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

When women attended the antenatal clinic for the first time, they were provided with an electronic link to information that may be helpful. This included health promotion advice but also advice about what to expect during pregnancy and labour. Paper leaflets were also available for patients who could not access information electronically.

A pregnancy passport which had recently been introduced to the service and was provided to all women in the antenatal clinic included information about health and wellbeing during pregnancy such as smoking, mental health and sleep.

The maternity patient survey results in September 2022 showed that 82% of women felt the information provided to them during labour was consistent and 70% of women felt they were given appropriate advice and support at the start of labour.

We reviewed 3 sets of medical care records and saw that women were provided with information to support them to lead healthier lives. They were also provided with information to support them to keep their baby healthy, for example, we saw that community midwives provided information

about delayed cord clamping and baby feeding options.

We did not see that staff received any training in health promotion to ensure they had the skills and knowledge to provide relevant information to women.

Consent

Staff supported people to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support people who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

An audit of instrumental deliveries in 2021 included a review of consent and showed that of the 63 patients reviewed, consent was recorded for all patients. No review or audit of consent had been completed since this review. Leaders told us that consent was recorded but they did not routinely monitor this, so it was not clear how they were assured that staff gained consent and assessed capacity to keep people safe.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff were discreet and responsive when caring for women. They took time to interact with women and those close to them in a respectful and non-judgemental way.

Women said staff treated them well and with kindness.

Staff followed policy to keep women's care and treatment confidential. Staff understood the importance of confidentiality and caring for women in a discreet way. They spoke about how they wanted to provide a service that patients felt able to access with confidence.

We observed staff displaying a caring and compassionate approach to patients. Despite telling us that they were exhausted, and that morale was low, staff were working over their shift time and extra shifts because they were dedicated to delivering safe and high-quality care for patients.

One midwife in the service had written a poem and had provided a copy of the poem to the families of all babies born during the COVID pandemic.

We reviewed the results of the maternity patient's survey. In August 2022, 87% of women felt they were treated with respect and dignity during labour and kindness and understanding during the post-natal period. In September 2022, 100% of women felt they were treated with respect and dignity during labour and kindness and understanding during the post-natal period.

Staff told us that women in a subsequent pregnancy after previously experiencing a bereavement were provided with additional support from the bereavement team.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. However, they were not always provided with the training and knowledge to support them in this role.

Leaders told us that bereavement training was available for staff, but this was not mandatory, and we did not see compliance was monitored. It was recorded in the minutes of the Peri-natal mortality review meeting in November 2021, that the bereavement team had received no formal bereavement training. We did not see that this had been offered or completed at the time of our assessment. Following our assessment, we were told that this training is planned for 2023.

The service had a bereavement team staff by midwives as an additional role rather than a dedicated role; they completed follow up support for women and partners who needed it.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff on the maternity unit supporting women who became upset; privacy curtains were available when needed.

Staff in the antenatal clinic displayed a kind and caring attitude to patients, putting patients who may have been anxious at ease.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients spoke positively of the care they had received in the antenatal clinic and on the maternity unit during and after labour. However, 1 patient told us how they had a poor experience in the EPAU where they felt that medical staff were uncaring, and they overheard staff talking about them. We did not observe any issues with this during our assessment.

We reviewed patient care records and saw that mental health needs were assessed and discussed at every contact. However, as staff did not receive training in mental health needs, there was a risk that concerns may not be appropriately identified or managed.

The maternity unit had a bereavement suite which was designed to be used during or after still birth, unexpected death or abnormality. The room was on a corridor off the maternity ward, which meant that women could still be observed and supported by staff but that they had access to a peaceful and private environment.

Equipment was available to support women and families to spend time with their babies after still birth or death such as cooled cots. Women were provided with memory boxes which included items such as hand and footprint kits. There was also a tree of remembrance painted on the wall of the maternity unit where families could add the name of their baby to a leaf on the tree. A service of remembrance was held annually at the hospital. Women were also given information to support them to make informed choices about burial or cremation following pregnancy loss.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment and supported them to make informed decisions about their care. We observed staff summarising treatment plans and repeating information if patients did not understand.

Staff talked with women, families and carers in a way they could understand, however not all staff were not able to tell us if they had access to communication aids or translation services if they needed it.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. The service carried out surveys to collect women's experience of care

in antenatal, labour and birth and post-natal services. In August 2022, all the women surveyed said they felt listened to and involved in decisions about antenatal care, 93% of women felt involved in decisions about care during labour and that they were given information they required following the birth of their baby. In September 2022, 94% of women felt listed to at antenatal check-ups, 88% of women felt involved in antenatal care decision making, 88% of women said they were spoken to in a way they could understand during labour and 94% felt involved in decisions about care during labour.

The pregnancy passport that was provided to all women included information about how to access support and included prompts for women to consider when creating a birth plan. Women kept these booklets at home and brought them to antenatal appointments where their birth plans were discussed. The passport also included a section where women could share any additional needs, they, their partner or family may have for example, if a translator was needed. We saw that any individual needs were also recorded in patient care records.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

Service delivery to meet the needs of local people

Facilities were appropriate for the services being delivered. However, the availability of some services had been limited due to staff shortages which meant the needs of some women were not always fully met.

Facilities and premises were appropriate for the services being delivered. However, leaders told us that outpatient clinic space was a challenge and that services had to be carefully planned.

A home birth service was not currently available, and leaders said this service had been withdrawn due to staffing availability. Leaders and staff were keen to make this service available again and this was listed as a risk on the care group risk register.

There were specialist midwives within the service including safeguarding and teenage pregnancy. However, these were additional rather than dedicated roles. Leader told us that dedicated roles were not required due to the size of the service. However, midwives told us that staff shortages were making it difficult for them to carry out their specialist roles.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems. However, they were not able to tell us how they would seek support for patients with learning disability or dementia. In addition, staff did not receive training in how to support patients with learning disability, dementia, autism or mental ill health, and not all staff were able to tell us about what systems were in place to aid the delivered of care to patients.

A birth reflection service was offered to all women where they could give feedback on their experience in order to inform how services are improved and developed.

The delivery suite had a family room which would be used by relatives or partners during labour.

Antenatal clinics were held in the hospital but also in 13 GP practices across the island to ensure that women could access a clinic. At the time of our assessment we were told the community service was being ran by hospital midwives working bank shifts. Although there was a focus of continuity of carer in the service, there was a risk that staff shortage could impact the ability to maintain continuity of carer.

Meeting people's individual needs

The service was not always inclusive and did not always meet women's individual needs and preferences.

Not all staff were able to tell us what support was available to meet the information and communication needs of people with a disability or sensory loss. We were also told that there was no interpretation service available for women whose first language was British Sign Language and that family members would be used as interpreters. This potentially put vulnerable women at risk of coercion or manipulation and could be a barrier to domestic violence or safeguarding concerns being disclosed or identified. Following our assessment, leaders told us that the service did have access to a interpreters or video relay service (VRS) when needed.

Due to staff shortages and service demands, leaders told us that women who were assessed as suitable were being discharged from post-natal clinics to health visiting services at 14 days after birth rather than the recommended 28 days.

Prior to our assessment, we were provided with a copy of the Isle of Man Strategic Plan for Adults with a Learning Disability dated 2020-2025 however, during our assessment we did not see that staff were aware of this strategy.

A pregnancy passport had recently been introduced to the service. Each woman was provided with a passport which included a personalised care plan for women to complete. Women were asked to record their preferences for before during and after labour and the booklet included some ideas of things women may want to consider. This pregnancy wallet contained a QR code that women could use to access all this information in other format such as other languages or large print.

Signage within the hospital was clear and easy to follow. The environment was well lit and free from clutter so patients could move around easily without restriction or hazard. Corridors and door frames were wide enough for wheelchair users and disabled toilets were available.

The outpatient's clinic was wheelchair accessible and the ward and delivery suite had rooms which were suitable for wheelchair users or women with mobility issues. The maternity unit and clinic environments were designed to meet the needs of women.

We reviewed patient care records and found that individualised care plans were available for high risk women and women with a multiple pregnancy. We saw that preferred place of birth was recorded in all care records.

Leaders told us that all poor outcomes or unexpected deaths were thoroughly investigated to identify learning and improve services.

Access and flow

Women could not always access the service when they needed it and receive the right care promptly.

In the last 12 months, the elective caesarean section list had been cancelled on 12 occasions due to staffing shortages and unexpected activity such as emergencies.

The clinical lead for the service told inspectors that women with pre-labour spontaneous rupture of membranes were offered antibiotics within 18 hours and induction within 24 hours. However, we did not see that this was monitored to ensure this was happening in practice.

Managers monitored missed appointments. We saw 165 patients had attended obstetrics clinics in August 2022 and 6.8% of patients did not attend (DNA) their appointment. Staff told us that secretary's managed appointments when patients did not attend but they were not able to tell us what action was taken to contact the patients or to minimise the number of missed appointments. DNA rates were listed in the monthly care group data report, but actions to reduce missed appointments were not identified.

Access to services was not monitored by the service. The number of women booked into the service by 12 weeks gestation was not included in the care group quality dashboard or the monthly care group data report.

The service had enough birthing rooms to ensure that women in labour were not in areas not designed for birth.

Managers and staff started planning each woman's discharge as early as possible. Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Specialist midwives supported women dependent on their individual need as necessary. The hospital had a discharge policy which staff could follow if a woman wished to self-discharge from the hospital, however this policy was due for review in January 2017.

Learning from complaints and concerns

The collection of complaints data was not always accurate, so it was not clear if the service treated concerns and complaints seriously and investigated them. We saw that lessons learned were shared with all staff.

The quality dashboard showed the number of complaints received each month for the care group and the performance against the hospital policy for the management of complaints. The number of complaints received recorded on the quality dashboard from August 2021 to August 2022 was 19. However, the number of complaints received recorded on the care group data report for August 2022 from August 2021 to August 2022 was 28. The numbers of complaints recorded each month was different in each report. For example, in December 2021, the quality dashboard showed 5 complaints and the care group data report showed none.

From July to September 2022, 2 complaints were received about maternity services. These complaints were from women who had poor experiences before or during labour. The complaints were being managed by the maternity leadership team but were both still open at the time of our assessment.

The Manx Care Advice and Liaison Service (MCALS) report in June 2022 showed that there had been 5 contacts about the Integrated Women, Children and Families care group in April 2022 and 2 in May 2022. All these contacts related to appointments. The report showed that 77% of queries were resolved on the same working day. The report did not outline if any actions had been identified as a result of any themes or trends.

The care group performed well on the target of complaint acknowledgement being sent within 2 working days. However, the first written complaint response was not always sent within the agreed response time in each month between August 2021 and August 2022. Complaints handling was noted to have improved in the minutes of the Board of Directors meeting in February 2022.

We saw that a monthly care group newsletter was sent out to all staff each month and that this contained information about complaints and compliments. We also saw that patient feedback comments were displayed on the board at the entrance to the ward. However, we reviewed

minutes from the maternity ward meeting held in August 2022 and saw that complaints and learning from complaints were not discussed.

We reviewed the minutes from the care group Patient Safety and Governance meeting and found that complaints were discussed.

We reviewed the minutes from the Board of Directors meetings in February, April and May 2022 and did not see that complaint numbers or themes and trends were discussed.

We reviewed minutes from the maternity ward meeting held in August 2022 and saw that complaints and learning from complaints were not discussed.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

Care group leaders understood the issues the service faced and were visible and approachable in the service for patients and staff. However, some lead midwives had limited time to perform their role in in leading and managing the service due to staff shortages.

Staff told us how they felt supported by the care group leaders but not always by the hospital leadership team. They said that care group leaders were visible and understood the challenges that staff face each day but that they didn't always see that action was taken to resolve issues. All leaders understood the challenges that the service was facing in relation to staff recruitment and retention.

The care group had a clear leadership structure and we saw that processes were in place to escalate concerns via relevant executive safety meetings or by ad-hoc 1 to 1 meetings with executive leaders.

Some lead midwives in the service told us how they struggled to perform their leadership roles because of staffing shortages, and we saw that the Head of Midwifery and the Senior Midwife were working extra clinical shifts and long hours because they were concerned about the safety of the service.

The triumvirate leadership team were invested in developing midwives and had created some leadership development opportunities within the service. However, staff told us that these opportunities were limited by staff shortages.

The service had invested in developing a midwife into a professional midwifery advocate (PMA). This followed the NHS England's advocating for education and quality improvement (A-EQUIP) which was a model for clinical midwifery supervision. Staff who had undertaken their PMA training were required to undertake the role on top of their current workload.

Vision and strategy

Staff and care group leaders had a consistent approach to the future of maternity service but there was no formal vision or strategy for the service or care group. The hospital values had been refreshed and we saw that staff understood and demonstrated these values.

During our last visit to Noble's Hospital in June 2022, we were told that pulse surveys showed that approximately one-third of staff employed by Manx Care did not know the organisation had a set

of values. We were told that the values had been refreshed and were had been relaunched in July 2022 and we saw that the values were on display throughout the hospital.

Staff and leaders spoke passionately about the future of midwifery services and how they wanted to deliver safe care to meet women's needs and preferences. Following our assessment, we requested a copy of the vision and strategy for the care group. We were told that the vision for the future of the service was outlined within the Manx Care Ockenden assurance framework and that a strategy for maternity was currently being drafted following the publication of the Case for an Isle of Man Maternity Strategy by the Royal College of Midwives in August 2022.

Culture

Staff did not always feel respected, supported and valued but they were focused on the needs of patients receiving care. Staff did not always describe an open culture and some staff were fearful of raising concerns.

The Isle of Man did not have a Freedom to Speak Up Process but did follow the Government policy on standards for Whistleblowing. Staff told us how they did not always feel able to speak up and described a "blame culture" within the service. They described how some staff were often reluctant to engage and defensive when things went wrong and that this often meant that lessons weren't identified.

Staff told us how the culture within the midwifery team was supportive and how everyone worked extra shifts to help and support their colleagues to keep women safe. They frequently missed their breaks due to low staffing numbers. We observed staff collectively having refreshments, in the office, while continuing their duties.

Midwives reported that they felt the relationship with the senior medical staff was "hierarchical" and that they did not always feel supported. They spoke of good relationships with the specialist doctors but that they often experienced this being discouraged by consultants.

Senior staff told us how some staff were resistant to change, and care group leaders were sighted on this resistance to change and spoke of how they were keen to work with staff to overcome this reluctance and improve services.

We reviewed the comments of exit interviews of staff that had left in the last 12 months. Some staff described the culture as "difficult" and how communication between staff groups was sometimes poor and that there was a "lack of professional respect". However, positive comments were made about support from managers.

During our assessment, we spoke with maternity staff across a variety of roles and grades. All staff we met were friendly and welcoming. Staff told us they were exhausted. They were visibly emotional when discussing the staffing pressures within the department and did not feel that they were able to do all they could to keep women and babies safe from harm.

Governance

Leaders did not operate effective governance processes, throughout the service to enable them to monitor the safety and performance of the service.

The care group had a clear governance structure and leaders told us they were able to easily escalate concerns to the executive leadership team via governance meetings.

The quality dashboard enabled leaders and clinical teams to compare their performance against national standards in order to identify areas for local clinical quality improvement. However, the

dashboard was not fully completed for this care group and contained some conflicting information when compared to the monthly care group data report.

We saw that out of date policies and guidelines were in use in the service. For example, we saw 2 policies for consent to procedures, 1 which was due for review in 2017, and 1 which was undated. We saw the resus trolleys on the maternity ward and delivery suite both contained Resus Council UK Anaphylaxis guidelines from 2015 and the IOMDHSC Resus Policy which was due for review in August 2017. The hospital policy for uniform, dress code and bare below the elbows was due for review in March 2019 and the safe nursing and midwifery staffing policy was due for review in April 2018.

Following our assessment, as part of the data request process, we were provided with some duplicated policies which contained conflicting information and could be confusing for staff. For example, we asked for the incident reporting policy. We were provided with a local maternity policy and a Manx Care wide policy, which contained conflicting information about how incidents should be reported. We were also provided with 2 chaperone policies; 1 was due for review in April 2020 and the other was due for review on April 2021.

We saw minutes from the most recent Ockenden working group meetings which were in September and November 2021. The service had carried out a self-assessment against the 15 immediate and essential actions highlighted in the Ockenden Report. Several of the identified actions had not yet been completed, although not all had passed their expected completion data. However, the Ockenden working group had not met since November 2021 and therefore it was not clear how improvement and completion of actions was being monitored or measured. Following our assessment, we were told that following an assurance report being presented to the executive board; some work was ongoing, but the actions had been put on hold

Following our assessment, we requested the minutes of the last 2 maternity team meetings. We received 2 different sets of minutes, both dated 5 August 2022. The contents of the minutes were different, so it is not clear which one was a true record of the meeting. In addition, there did not appear to be a standard format or agenda for the meeting and key topics such as incidents, complaints and best practice guidelines were not discussed.

In November 2021, the integrated medicines optimisation group (IMOG) was established and met monthly to discuss and approve medicines related initiatives across Manx Care. We reviewed minutes of the IMOG and found these contained limited information. The minutes did not cover medicines incidents, near misses or learning from incidents. There was some focus on policies but again this was limited. We did not see any information regarding antimicrobial stewardship, venous thromboembolism (VTE), critical medicine prescribing rates or medicines reconciliation.

We requested a copy of the service level agreement that the hospital has with a third-party maternity service in the UK. This information was not provided, and we were told it is currently under review. Therefore, we were not able to see that the service had appropriate service level agreement in place.

We requested evidence of compliance with all 4 aspects of the saving babies lives care bundle, but this information was not provided. Following our assessment, we were told that the saving babies lives care bundle has not been implemented by the service.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

Arrangements for identifying, reviewing and managing risks were not robust. Leaders had different views on what the top 3 risks to the service were. We asked leaders within the service about what they considered to be to top risks to the quality and sustainability of services. The risks identified were not consistent and did not always align to the risks listed on the risk register. Throughout our assessment we were told on multiple occasions that obstetrics staffing was a risk to the safe delivery of maternity services. This was not listed on the risk register. In addition, we saw that mandatory training compliance for safety critical course such as basic life support was poor, and this was also not on the risk register.

Prior to our assessment we reviewed the risk register for the care group. It was not clear which risks related to which service within the care group and not all risks had a review date. The risk registers also did not include any mitigations which had been taken to reduce the risk. Midwifery staff shortages was listed as an Extreme risk, lack of a home birth service was listed as a high risk. The maternity unit not being fully secure, and the lack of an abduction policy had been listed as a moderate risk and this had not been reviewed since November 2021 despite a policy being available at the time of our assessment. The care group Data Report for August 2022 contained the same version of the risk register.

Following our assessment, we were provided with a copy of the maternity risk register. Not all risks were graded and none of the risks had review dates. Some risks had been on the register since 2017 and there was no record on this document that showed the risk had been reviewed since this date. Additionally, some of the risk gradings were different to the care group risk register. For example, security of the maternity unit was listed as a moderate risk on the care group risk register but as a low risk on the maternity risk register.

We were also provided with a copy of the Risk Register Action Log. This contained conflicting review dates to the Risk Register which raised concerns about oversight of the 2 documents. This document showed that all risks had been reviewed in September 2022 and mitigations were identified.

The risk register was included as a standing agenda item on the care group Patient Safety and Governance Meeting agenda.

Information management

The service did not always collect reliable data or analyse it. Staff could not always find the data they needed. Information was not always stored securely.

Data collection within the service was poor. Not all indicators on the quality dashboard were monitored. Staff told us that systems did not support the collection of data to monitor and improve services and that data often had to be collated manually which was time consuming and open to the risk of human error to misinterpretation. We saw that data collection was not always accurate, for example the number of complaints recorded on the care group quality dashboard was different to the number recorded on the care group data report.

Patient care records were recorded on a combination of electronic and paper records. This meant that for clinicians to review a full clinical history they would need to access 2 sources of information rather than being able to easily identify trends.

Throughout our assessment we saw that patient care records were stored securely.

Engagement

Leaders collected feedback from patients and staff but did not actively engage with equality groups, the public and local organisations to plan and manage services.

Leaders were not able to tell us of any formal processes in place to engage patient representatives or equality groups in the decision making to shape services and culture. However, we did see that patient stories were shared at the Board of Directors meeting.

Leaders told us how a Maternity Voice Partnership had been created but that this had been stalled by the COVID-19 pandemic.

The service ran a hospital wide staff survey called 'have your say'. Following our assessment, we requested the results from the most recent survey, but this information was not provided.

A birth reflection service was available and offered to all women. Women were able to reflect on their experience of the maternity services at Noble's Hospital and give feedback to support the development and improvement of services.

Learning, continuous improvement and innovation

Care group leaders wanted to improve and develop services and all staff were committed to providing a safe service. However, staff did not feel they had the time to take part in the development of services or to focus on improvement and innovation. Staff did not receive training in quality improvement.

Staff were not provided with any training in quality improvement and we did not see that all staff had a focus on learning and improving services. Staffing challenges in the service meant that staff had to prioritise tasks and service delivery took precedent over service improvement.

The service had recently developed a personal care plan booklet which was handed to each woman antenatally. We were told that this had been created to improve the experience of women using the service and to ensure they had the opportunity to be involved in decisions about their care. However, this had only recently been implemented in September 2022, so the impact had not yet been measured.

Children, Young People and Neonates

Overall summary

The children, young people and neonatal unit is based across 2 wards at Noble's Hospital. The children's ward has 4 bedded bays, 5 individual side rooms, a 2-bedded room and 2 high dependency beds. Each bay has its own shared toilet facility, with side rooms having en-suite toilets and some shower facilities. There are separate shower and bath facilities for parents and carers.

The neonatal unit is accessible via an intercom system. The unit consists of 9 cots, with 1 intensive care cot, 2 high dependency cots and 6 special care cots. There is also a room for isolation purposes. At the time of the assessment, 5 of the cots had been closed due to shortages of qualified neonatal nurses.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

The quality dashboard showed that overall mandatory training compliance for the care group was 74% in July 2021, 70% in January 2022 and 81% in September 2022.

Information provided by the hospital for showed 83% of nursing staff on the children's ward and 92% of nursing staff on the neonatal unit had completed mandatory training.

Staff told us they did not have time to complete the mandatory training at whilst on duty, but 1 staff member advised they could access the training at home and got time back

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse. Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and adults formed part of the mandatory training programme for staff. Records showed 100% of nursing staff on the children's ward and on the neonatal unit had completed safeguarding adults' level 1.

However, only 24% of nursing staff on the children's ward and 80% of nursing staff on the neonatal unit had received training in safeguarding children and young people level 3 training. This meant that the hospital was not following the 'safeguarding children and young people: roles and competences for health care staff intercollegiate document fourth edition: January 2019' guidance that recommends a minimum of level 3 training for all clinical staff who work with children, young people and/or their parents/carers.

Following the assessment, the hospital advised safeguarding level 3 training commenced in January 2022.

Staff knew who to inform if they had concerns and could access support from the services safeguarding lead if needed. Whilst there was no formal safeguarding supervision for nursing staff, we were told occasional debriefs did happen and the named safeguarding doctor undertook peer reviews of child protection cases seen in the hospital.

The hospital had 2 chaperone policies; 1 had last been reviewed in 2017 and was due for review in April 2020 which had been ratified by the patient safety and quality committee, and 1 that had last been reviewed in 2018 and was due for review in April May 2021.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use control measures to protect patients, themselves and others from infection.

We reviewed patient areas across the wards, as well as utility rooms and treatment rooms. All areas we checked were visibly clean with no clutter in the corridors. The wards had cleaning schedules in place which included all areas. These detailed cleaning to be undertaken on a daily, weekly and monthly basis. We saw the cleaning undertaken by the housekeeping teams were completed daily. However, on the children's ward, we found there were gaps in the cleaning undertaken by the nursing staff in July, September and August 2022. For example, in September there was no record of work surfaces being cleaned for 23 days across the month or the children's room being cleaned from 6-27 on the 29-30 September. The resuscitation trolley should have cleaned weekly, but records showed the trolley had only been cleaned on the 17 September.

Environment audits were undertaken bi-monthly. Over the period March to August 2022, audits were not undertaken consistently. On the children's ward, audits demonstrated compliance of 94% in June. Information for April and August was not available. On the neonatal unit compliance was, 92% April, 89% June, and 95% in August.

Staff followed infection control principles including the use of personal protective equipment (PPE). We noted staff adhered to the hand hygiene, bare below the elbows and hospital uniform protocol in clinical areas. This reduced the risk of infections to staff and patients and was in line with good practice. Sanitising gel was available on at the entrance to the children's wards. On the neonatal unit, handwashing facilities were at the entrance with a notice for visitors to wash their hands when entering the unit.

On the neonatal unit, hand hygiene compliance was 100% for the 6-month period April to September 2022. On the children's ward, hand hygiene compliance was 100% in June, July, and 60% May. There was no information available for April, August or September.

The hospital used 'I am clean' stickers to identify equipment that had been cleaned and was ready for use. We saw equipment had stickers which recorded the date when they were last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

On the children's ward, the resuscitation trolley was easily accessible and emergency drugs were sealed and in date. Drawers were locked and appropriately tagged and sealed. There was evidence of daily checking of the resuscitation trolley. However, the resuscitation policy had last been reviewed in 2017, which meant staff were not following the latest guidelines from the Resuscitation Council's UK, which were issued in 2021. Emergency drug information leaflets were

not dated so staff would not know if they were current or been reviewed recently. Written guidance on resuscitation trolley was not secured or bound but loosely placed on the trolley, which meant the information could easily be misplaced. The defibrillator was overdue for testing and was last tested in May 2022.

Portable appliance testing was not conducted regularly, which meant staff were not assured the equipment was fit for purpose. Across both the children's ward and neonatal unit, 42 pieces of equipment such as oxygen saturation monitors, blood pressure monitors, suction units, respiratory nebulisers, syringe drivers and IV pumps were found not to have been tested regularly. On the children's ward, the baby scales calibration was due in March 2016 and there was no evidence of PAT testing. We saw a button was found to be loose and had wires were sticking out. On the neonatal unit, the transport incubator had a serving label which showed it was last serviced in November 2020. Following the assessment, the hospital provided evidence that transport incubator had been serviced in February 2022. However, the incubator should have been serviced annually.

Both the children's ward and the neonatal unit had milk kitchens, which were accessible with a swipe card. On the children's ward, a random check of baby foods and formula showed food stored was in date. The milk fridge was used to store breast milk. At the time of the assessment, the fridge held 3 bottles, which were labelled with the mother's/baby's name and date the milk was expressed. However, we found that daily temperature checks of the fridge were not being recorded, which meant that mother and staff could not be assured breast milk was being stored at the optimal temperatures of 4°C or lower. Staff advised the lack of checks and recording was primarily down to staffing shortages on the ward.

On the neonatal unit, staff told us that parents were able to access the milk kitchen to collect and store breast milk using a swipe card. We saw that that fridge and freezer temperature were recorded daily and were within the appropriate temperature range. Staff advised that each mother had a separate tray to deposit breast milk, but as there was no oversight, staff and parents could not be assured babies were receiving their mother's milk.

Staff understood their responsibility to ensure they segregated and disposed of clinical waste appropriately. Clinical waste bins were clearly labelled, and we observed that staff kept the rooms used to store clinical waste clean and tidy to minimise infection risk.

The children's ward was accessible via an intercom system. The ward had 2 high dependency unit beds, 5 side rooms and 10 beds in bays. At the time of the assessment, 1 of the beds was out of use due to issues with the floor. The bays and corridors were generally kept clear of equipment.

The children's room was spacious with various toys suitable for all age groups. Staff told us there were enough toys to so they could rotate and cleaned. The room had a side entrance so children who were anxious about coming into the hospital could be brought onto the ward without having to walk through the hospital. Staff told us the toys would distract children and were useful to assist with calming them.

At the time of the assessment, there were 2 patients who had been referred to the child and adolescent mental health services (CAMHS) on the children's ward. However, the ward did not have any dedicated cubicles for patients who presented with mental health needs, which meant children admitted to the paediatric ward did not benefit from a formalised process for assessing any risks within the environment they are admitted too. We did not see evidence of a ligature risk assessment for each child or for the wider ward environment. Following the assessment, the

hospital provided a ‘paediatric inpatient mental health risk assessment & management plan’ proforma for completion on admission to the emergency department.

The neonatal unit was accessible via an intercom system. The unit consisted of 9 cots, with 1 intensive care cot, 2 high dependency cots and 6 special care cots. There was a room for isolation purposes. At the time of the assessment, 5 of the cots had been closed due to shortages of qualified children’s nurses.

On the children’s ward and the neonatal unit, disposable items of equipment were disposed of appropriately in either clinical waste bins or sharps instrument containers. Wards had designated bins and colour coded bags for clinical waste. Sharps bins were not over filled and were dated when they came into use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration. However, not all nursing staff were trained in advanced paediatric life support or paediatric immediate life support.

The hospital was in the process of ensuring staff were trained in advanced paediatric life support (APLS) or paediatric immediate life support (PILS). At the time of the assessment, 7 nurses had been trained either APLS or PILS and another 9 nurses had their training pending in within the next 4-6 months. Although we could see the team were working towards either APLS or PILS, this meant the hospital was not following the guidance from the Royal College of Nursing (RCN) which states “at least 1 nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need”.

Paediatric risk assessments for each patient on admission and allergies were recorded. Staff used a recognised tool to identify deteriorating patients and escalated them appropriately. Patient care records we reviewed showed paediatric early warning score (PEWS) system was being applied to clinical practice and patients were assessed using PEWS. Each chart recorded the necessary observations such as pulse, temperature and respiration, and the frequency of the observations was appropriate. However, staff advised that PEWS was not audited, which meant the hospital could not be assured the documentation was being completed correctly. The hospital had a paediatric early warning scoring policy in place, which had been reviewed in May 2022. Following the assessment, the hospital advised PEWS was audited monthly.

A data request was submitted to the hospital regarding the new-born early warning trigger and tack (NEWITT) policy and audit. However, this was not provided.

We requested a copy of the hospital policy for the management of paediatric sepsis, but we were provided with guidelines from a paediatric network in England and Wales. It was not clear if they had been reviewed and ratified as appropriate for use in Noble’s Hospital.

Nursing handovers were held twice a day between 7.30-8am and 7.30-8.00pm. Handovers were undertaken using the ‘situation, background, assessment, recommendation’ (SBAR) tool to keep patients safe. Staff told us they did not undertake safety huddles between shifts, which meant there was no system in place to ensure staff were kept up to date with patients or highlighted any specific concerns, such as infection risks.

The medical handover was held once a day in the morning. We attended a medical handover, which was consultant-led with consultants and doctors in attendance. Each patient was reviewed, and tasks allocated. Discussions took place about new admissions, nutrition issues and

safeguarding patients. In the evening, the end of day medical handover was written. Nursing and medical handovers were held separately.

Nurse staffing

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

Information provided by the hospital for April 2022 showed the children's ward had 17.2 whole time equivalent (WTE) registered nurses with 5 WTE registered nursing vacancies, and 5 WTE healthcare assistants (HCA). A data request was submitted to the hospital regarding the current vacancies rates for the children's ward and neonatal unit, but no information was provided.

Nursing staff told us the children's ward was very short staffed, and covering the rota required staff to work additional shifts. Staff told us until recently they had been using regular agency staff to cover the vacant posts, but they were no longer able to use them. Senior leaders acknowledged recruitment was an issue and were trying to recruit. Nursing staff told us they could not ensure there were always 2 registered children's nurses on duty, as recommended by Royal of Collage Nursing (RCN) guidance. We requested data for the planned and actual staffing levels on the children's ward between 26h September to 17h October 2022, but this was not provided.

A play therapist was available on the ward Monday to Friday, who also covered HCA duties if the ward was busy and or short staffed.

Information provided by the hospital for April 2022 showed the neonatal unit had 15.6 WTE registered nurses and 4 WTE vacancies. At time of the assessment, the number of vacancies had increased to 6 WTE. Nursing staff told us the neonatal unit was very short staffed, and the unit had reduced the number of cots from 9 to 4 to ensure safe staffing levels. However, during the assessment, staff were being deployed from their normal areas of work such as community nursing teams and play therapy to work on the unit. Staff told us the redeployed staff helped with stocking up and cleaning, as not all staff had the required skills and training to work on the unit to support neonates.

Medical staffing

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

Information provided by the hospital for April 2022 showed across the children's ward and the neonatal unit, the hospital had 4 WTE paediatric consultant posts with 1 WTE consultant vacancy, 3 WTE associate paediatric speciality doctors, 6.85 WTE speciality doctors and 1 WTE foundation year 2 doctor. At the time of the assessment, the vacancy for the paediatric consultant post had been filled. On-call was covered by consultants who covered 1 week in 5.

Medical staff told us managing the rota was not easy as they were very short staffed. The neonatal unit was always covered with an additional doctor 24 hours a day when a baby was in the intensive care unit (ICU), which impacted on staffing levels. During the day, 1 doctor covered the unit.

The service ran a 2-tier rota, with 1 consultant and speciality doctor covering 24 hours a day, with the speciality doctor being on site at weekends. The service always had a consultant on-call during evenings and weekends5. From 4.30pm to 8.30pm, a doctor was on site to cover

emergency department, maternity, the children's ward and neonates. Medical staff advised when covering nights, the doctor would be on shift for 24 hours. The women, children and families integrated care group risk register identified the insufficient level of out of hours paediatric medical cover on wards as a risk. This risk had been open since June 2017. Following the assessment, the hospital advised the risk remains on the register whilst pending a review.

The hospital provided conflicting data. Information provided by the Manx Care showed that paediatrician absence days for the 12 month period October 2021 to September 2022 was 118.5. Information provided for our data request showed paediatricians absence days as 107.5 days.

Ward rounds were consultant-led 7 days per week. Doctors had access to teaching sessions, which included attendance at ward rounds. Doctors felt consultants were supportive and approachable.

Records

Records were clear, up to date, easily available to all staff providing care, but were not always stored securely.

Patient care records were comprehensive, and all staff could access them easily. Paper patient care records were used to document patients' treatment pathway. We reviewed 7 patient care records and saw allergies were recorded, treatment plans were in place, risk assessments were reviewed and saw records were accurate, complete, legible and up to date.

On the children's ward, a whiteboard detailed the patients initials and bed number so they could be easily identified. We observed this was kept closed when not in use to respect patients' privacy and keep patients' information confidential.

Records were not always stored securely. On the children's ward, records were stored in a lockable trolley in the reception area. However, we observed the trolley was not locked and was left unattended when the reception area was left unstaffed, which meant there was a risk that notes could be accessed inappropriately.

Children and young people who were receiving statutory support due to their vulnerability were flagged on the emergency department electronic record system. However, as the children's ward used paper records, it was not clear how a child's or young person's vulnerability would be flagged to medical and nursing staff on the ward or where this would be documented.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff reported a lack of dedicated pharmacy support made this difficult.

The children's ward did not have a dedicated pharmacist time to cover the ward. Staff told us they covered 6 wards, so could not provide a full ward clinical service. The lack of pharmacy support on the children's ward had been identified as a risk on the women, children and families integrated care group risk register, which was opened in November 2021. Following the assessment, the hospital has advised the care group had recently sourced funding for appointment of a dedicated pharmacist.

The monitoring of medicines fridge temperatures daily on the children's ward was inconsistent.

The clean utility where medicines were stored was clean and tidy. Access was via a swipe card for

authorised staff only. Bedside medicine cabinets, which held patients' own medicines, were locked.

We saw controlled drugs (CD) were stored, recorded, and handled appropriately with 2 nurses signing when CDs were being administered. Records showed that CDs were checked twice daily. We conducted a random check of CDs and saw the number of ampoules held and the CD register balanced.

We saw blank prescriptions pads to be used outside the hospital were stored in CD cabinets, with numbers recorded for each prescription issued. This ensured prescriptions could be tracked, as well as ensuring no prescriptions were misplaced or lost.

Medicines issued to patients on discharge (TTOs) were stored in a locked medicine cabinet ready for patients to take home. A record of what had been issued was kept.

We checked 2 prescription charts and saw that information on patient demographics and allergies were complete.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses.

The hospital advised there had been no never events or serious incidents in the last 6 months.

The hospital used an electronic incident reporting system to report incidents including near misses. Staff were aware of how to report incidents. Staff told us they would mainly report staffing levels. It was not clear how learning from incidents were discussed as nursing staff told us incidents were not discussed at handovers, and ward meetings had not taken place since at least May 2022 due to lack of staff.

Medical staff told us incident reporting was a standing item at their meeting and would also be picked up on ward rounds, which provided opportunities to share learning. However, nursing and medical staff reported they did not always get feedback as the incident reporting system would generate a blank response. Following the assessment, the hospital advised there was an open action log on share point for learning. Data provided by the hospital showed in the 7-month period from March to September 2022, the children's ward reported 26 incidents. Of the 26 incidents reported, 96% (25) were categorised as no harm, and 4% (1) was categorised as low harm. The top incident reported over this period was for staff not following policy and procedure. None of the incidents reported were related to staffing issues on the ward.

In the 6-month period from March to August, the neonatal ward reported 17 incidents. Of the 17 incidents reported, 88% (15) were categorised as no harm, and 12% (2) was categorised as low harm. The top incident reported over this period was errors in documentation.

We reviewed the minutes from the women, children and families integrated care group patient safety and governance meeting and found that incidents were discussed.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

Policies, procedures and guidelines were available to all staff via Manx Care intranet system and staff knew how to access them. However, policies could be located on different systems, which meant staff could not always be assured they had access to the most recent version.

Staff working in children and young people (CYP) services had access to a range of policies that had been developed locally. Information provided by the hospital showed that showed 20 of the policies were due for review, and some had not been reviewed since 2014. Twelve policies had no review date at all. Staff could not be assured that the policies, procedures and guidelines had been developed in line with the latest national guidance and referenced current good practice, such as guidance issued by the National Institute for Health and Care Excellence (NICE) and Royal Colleges of Paediatricians. Staff told us there was no hospital-wide process for policy approval. Following the assessment, the hospital advised the paediatric policy working group, who were responsible for ratifying internal policies, were actively reviewing the out of date policies.

The paediatric cancer care pathway was based on UK guidance. Staff undertook patient assessments based on national tools such as PEWS, and nursing handovers used the SBAR tool.

The neonatal unit was working toward level 1 accreditation for the UNICEF 'Baby Friendly' accreditation - an accreditation based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's services.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery.

There were protected mealtimes on children and young people in the inpatient ward. This meant all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal, and staff would assist patients with their meals as necessary.

Patients received information on pre-surgery fasting at pre-operative appointments to ensure patients were ready for their procedure. Patients received fluids up to 2 hours before surgery and food up to 6 hours before. Patients were encouraged to have solid foods on the ward after their procedure.

Pain relief

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

Staff assessed patients' pain using a recognised tool. We saw that pain scores had been recorded in the patient's paper records on the children's ward. The ward also recorded patients' pain score on the electronic PEWS system and assessed this as part of the ward's patient rounding. Staff told us any pain scores of 3 out of 10 or above would be flagged to medical staff who would respond. Patient rounding's are a structured means of promoting patient-centred care, which focuses upon patients' pain, positioning and personal care needs.

The hospital had up-to-date clinical guidelines for the management of acute uncomplicated pain for paediatric patients, which was last reviewed in March 2021.

On the children's ward, we observed patients who were undergoing elective surgery were offered

pain-relieving cream to numb the back of their hands when they had a canula inserted.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment.

The women, children's and families integrated care group did not have a formal audit programme in place. At the time of the assessment, a 3-year 2022 - 2025 core audit plan for the care group had been drafted, but it was not clear if the plan had been ratified.

It was not clear if the hospital was meeting any of the Royal College of Paediatrics and Child Health Care (RCPCH) standards, which sets out 10 key requirements in order to deliver high quality, safe and sustainable acute general paediatric services, as the hospital did not audit its performance against any of the RCPCH standards. This included the RCPCH standard for ensuring every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission.

Staff told us the neonatal unit was linked to BadgerNet, which forms a part of single record of continuous care for all babies within the neonatal services in the UK and was able access data to be able to benchmark their service against other neonatal units.

The hospital provided the women, children's and families integrated care group data reports for the 8-month period from January to August 2022, which reviewed their monthly performance. Although each review included some information on neonatal activity and some of the children's community-based services, it did not include data relevant specifically to the children's ward.

The hospital did not conduct audits on paediatric diabetes, asthma, and epilepsy.

The hospital provided details of 2 local audits undertaken in the CYP services. In January 2021, an audit that looked at the 'contamination of blood cultures in the paediatric department' found the rate of blood culture contamination was 3% - the suggested acceptable rate. In 2020, an audit that looked at 'improving assessment and discharge planning of children admitted with an exacerbation of asthma or viral induced wheeze' was undertaken. The aim was to improve the percentage of patients discharged with asthma action/viral wheeze plans from 67% to 100%. In the period of September to November 2020, 67% (4) patients were discharged with an asthma plan and 67% (16) patients were discharged with a wheeze plan. Action plans were in place to increase the uptake of patients discharged with a plan.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

At the time of the assessment, 13 nursing staff were registered children's nurses, and 3 registered nurses were in the process of completing a pathway for children's nursing.

The competency of medical staff was monitored as part of the General Medical Council (GMC) annual appraisal of their work and 5-yearly revalidation process.

We saw 1 nurse had received an appraisal in the last 12 months. A data request was submitted to the hospital regarding the appraisal rates for medical and nursing staff for the children's ward and neonatal unit. However, this was not provided.

Nursing staff told us there were opportunities for learning and development, but study days were

cancelled due to low staffing levels. Nursing staff had access to a practice development facilitator who worked across the women, children and families integrated care group.

Medical staff told us they had an annual appraisals and job plan reviews. They also had access to teaching sessions.

Multidisciplinary working

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

We saw evidence of multidisciplinary working on the children's wards and neonatal unit between medical and nursing staff. A pharmacist visited the ward Monday to Friday to review new patient medicine charts and to pick up orders and any medicines to take out (TTO).

A play therapist was based on the children's ward. Monday to Friday, however during the assessment the staff member was redeployed to the neonatal unit due to staff issues.

The children's ward and neonatal service worked closely with the safeguarding team, school nurses, health visitors and the community children's team.

Children attending in mental health crisis had access to child and adolescent mental health services (CAMHS), which operated Monday to Friday. Out of hours and at weekends, staff contacted the adult rapid assessment team.

Medical staff told us the neonatal unit had weekly MDT meetings with another hospital in the Channel Islands to discuss cases.

Medical staff told us children with life-limiting conditions, complex and continuing care needed a coordinator to help facilitate MDT meetings with other therapies. The care of children with neurological conditions was coordinated with the palliative care consultant and local pain team.

Health promotion

Staff did not always give patients practical support and advice to lead healthier lives.

We found little evidence of information being available for patients that provided advice on healthy eating, exercise and other information on how to live healthier lives.

On the children's ward, there were no leaflets on display that covered sexual health, chlamydia screening, contraception, illegal drugs, or sexual relationships.

On the neonatal unit, no information was displayed on topics such as sudden infant death syndrome (SIDS), and no advice was available on sleep positions, cot safety and ideal temperatures for babies. Following the assessment, the hospital advised this information was provided on a 1-to-1 basis to all parents and carers prior to the patients' discharge and revisited in the community by health visitors.

Consent

Staff supported patients to make informed decisions about their care and treatment. They did not receive training but demonstrated they knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the 'consent' section under Medical Services on page 18 for issues common to many services.

The hospital’s consent procedures policy was dated from 2014 and was due to be reviewed in 2017. The policy detailed what staff needed to do when seeking consent from parents, children and young people aged 16 and 17 years, and from people where they may not have the capacity to consent. Staff understood the need for parental consent. However, the policy did not reference the use of Gillick competency to assess the competence of a young person under 16 to provide consent to treatment. The Gillick competency and Fraser guidelines help healthcare professionals balance children’s rights and wishes, with their responsibility to keep children safe from harm.

In all the patient care records reviewed, we saw that parental consent had been gained and recorded.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff provided treatment and care in a kind and compassionate way and treated people with respect. Staff were seen to be empathetic and considerate to patients and their parents and carers. We observed positive interactions between staff and patients. For example, curtains were drawn when speaking to parents, carers and their child, which respected their privacy and dignity.

We spoke with 2 children and their parents and carers. Parents and carers all gave positive feedback about the care their child was receiving. One child told us the staff were very nice and friendly. One parent told us “The staff always ask if I have any questions”.

Family feedback was displayed in the neonatal unit. The parental satisfaction survey undertaken in 2021 was completed by 46% (32) of the families, with 100% saying they were very satisfied with their visit to the neonatal unit.

The children’s ward did not use the friends and family test, but senior leaders told us they were developing a range of different satisfaction surveys and feedback methodologies. Following the assessment, the hospital advised the care group was using a feedback app, which is advertised for patients and carers to access.

Emotional support

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

On the children’s ward, parents could visit all day. A parent told us the children’s ward had made a bed available for them, which allowed them to stay overnight with their child.

The children’s ward had a play therapist who provided emotional support and coping mechanisms through play, which included distraction therapy and education. They would assist doctors and nurses by supporting children whilst undergoing treatment.

On the neonatal unit, visitors were limited to parents and grandparents. Parents were able to visit at any time they wished. The nursery operated a 'quiet time' between 1pm and 3pm every day so babies could sleep without any interruptions.

The neonatal family feedback survey 2021 showed 100% of parents said they were involved in the day-to-day care of their baby, such as nappy changing and feeding.

Support was provided to parents to build close and loving relationships with their baby and feed their baby in ways that supported optimum health and development.

Understanding and involvement of patients and those close to them

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

Both parents and carers said staff took time to explain their plan of care to them and their child. They knew the name of the doctors who was oversaw the care of their children. One of the children told us “The doctor explained what was happening and I have met the anaesthetist who explained who would be with me when they take me to and from the theatre”.

On the neonatal ward, the family feedback survey 2021 showed 81% of parents said they were offered the opportunity to attend ward rounds and 100% said they were able to speak to a doctor at their request.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

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

The service did not always plan and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system to plan care.

Staff told us they faced challenges in providing care and treatment for children who presented with mental health conditions. The CAMHS worked 9am to 5pm Monday to Friday and provided an outreach on-call service at the weekend and on bank holidays from 9am to 5pm. Out of hours, staff contacted the on-call adult rapid assessment team. This had not been identified as a risk on the women, children and families integrated care group risk register. Following the assessment, the hospital advised the on-call adult rapid assessment team had a clear pathway identified for women and children.

The paediatric diabetes clinics were held most weeks. Support was available from specialist nurses from Monday and Friday between 9am and 5pm, and from the Children’s ward medical team who provided emergency advice after hours and at weekends.

The hospital had a community children’s team, which children would be referred for follow up following discharge if required. In the period from March to August 2022, a total of 201 children were referred. Staff told us all children under 5 years of age would be referred to the health visiting service who would follow up on children following discharge from hospital.

The neonatal unit had 2 parent and family rooms with a double bed and en-suite, which provided parents a private space where they could stay overnight, or a new mother could start breast feeding.

Meeting people’s individual needs

The service did not always take account of patients’ individual needs and preferences or coordinate care with other services and providers.

Young people aged 16 and above were treated as adults. Medical staff advised there were joint clinics between paediatric and adult services, where required, to facilitate the transition from

children to adult services. It was not clear what arrangements were in place for patients with long term conditions, life-limiting illnesses or complex needs to transition from paediatric to adult services.

There was all day visiting for parents and carers on the Children's ward, and the ward had pop-up beds so a parent or carer could stay overnight. On the neonatal unit, visitors were limited to parents and grandparents only, with parents able to visit at any time. The nursery operated a 'quiet time' between 1pm and 3pm every day to allow babies to sleep without any interruptions. Both the children's ward and the neonatal unit had small kitchens where parents and carers could make hot drinks and heat food.

The hospital catered for patients who required specialist diets. Food was prepared by the hospital's kitchen. Staff could access a range of snacks and drinks for children and young people as required.

The children's ward had an information leaflet about what to expect on the ward for parents and carers. However, this was still in draft, and it was not clear if it had been ratified or was in use on the ward.

Children and young people had access to a play therapist who would support children on ward, in the diabetes clinic, and undergoing MRI scans. The play therapist used therapeutic play for any child or young person with anxieties or fears surrounding their hospital admission and acted as chaperone and advocate for children and young people.

Managers made sure staff, patients, their loved ones and carers could access interpreters when needed. Staff could use a telephone interpreting service for patients whose first language was not English.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Staff told us there was a backlog in discharge summaries on the children's ward. Senior leaders told us about 60% of the discharge summaries had been completed at the time of the assessment, which meant all information needed for patients' ongoing care was not shared in a timely way. Doctors told us the discharge template was not fit for purpose and had been flagged but not actioned. All children leaving the hospital should leave with a discharge letter.

On the children's ward, there were a total of 295 elective admissions in the 12-month period October 2021 to September 2022. Senior staff told us that the hospital was not breaching waiting times for CYP services. However, the hospital did not capture referral to treatment data.

There were 2,794 emergency admissions in the 12-month period from October 2021 to September 2022 on the children's ward, with 35.4% (989) of patients being discharged with 24 hours of admission.

In the period from March to August 2022, there were 44 admissions to the neonatal unit. One baby was repatriated, and 2 babies were transferred off the island to during this period. The hospital had a neonatal unit air ambulance transfer guide in place, which had last been reviewed in June 2020.

The hospital had an up-to-date paediatric high dependency transfer policy dated from August 2022 to cover intensive care unit (ICU) level transfers for children on the island to the UK.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. However, learnings were not always shared with all staff.

The hospital advised there had been no complaints for the children's ward and the neonatal unit in the 3-month period June to September 2022. However, it was not clear how learning from complaints or concerns from across the hospital were shared and lessons learnt were communicated with staff.

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

The hospital had a complaints policy in place which was due to be reviewed in November 2021. Staff told us the process for managing complaints had change and were now handled by the Manx Care Advice and Liaison Service (MCALS).

We reviewed the minutes from the women, children and families integrated care group patient safety and governance meeting and found that complaints were discussed.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, they did not always understand and manage the priorities and issues the service faced.

There was a clear leadership structure. The paediatric wards and neonatal unit came under the women, children and families integrated care group. The care group was led by a care group manager, clinical director, head of midwifery, matron and lead business manager.

At the time of our assessment, the care group director of nursing role was vacant, and we were told that executive leaders had decided not to recruit to this role. Staff told us how they felt well supported by the care group leadership team. However, it was recognised by the inspection team that this gap in nursing leadership had the potential to negatively impact the patients and staff within the care group.

Staff described their immediate managers as accessible. Medical staff were positive about the support they received from consultants, senior colleagues and their peers, who they described as being approachable and supportive. However, there appeared to be a disconnect between the senior management team and staff. Staff felt there was a lack support, there was a perception that staff were not consulted and were left out of the decision-making process, and there was little opportunity for progression.

Vision and strategy

The service did not have a documented vision for what it wanted to achieve or any strategies.

During the assessment, we saw the hospital's core values of 'committed, appreciated, respectful and excellent' were displayed throughout the hospital. However, it was not clear how these values

were incorporated within the women's, children's and families care group. Following the assessment, we requested a copy of the strategy and vision for the care group, but this was not provided.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they did not feel valued or supported by senior leaders. The children's ward and neonatal unit had staffing shortages and staff felt under pressure to work extra shifts. Staff told us they should not have to come to work and feel concerned about safe staffing levels. Medical staff felt senior management were not listening or involving clinical leadership.

On the wards, we observed that staff were supportive of each other. Staff told us there was good teamwork and they were committed to delivering a good service. Staff were enthusiastic about the care and services they provided for patients.

The hospital followed the government's policy on standards for whistleblowing and did not have a 'freedom to speak up' process in place. Managers told us they had an open door policy and staff were encouraged to raise concerns and report incidents. However, learning from incidents was not always shared.

Governance

Leaders did not always operate effective governance processes throughout the service. Not all staff were clear about their roles and accountabilities. Staff did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The women, children and families care group had a clear governance structure. Senior staff told us that escalation from the ward to the board was effective and there were opportunities to escalate through monthly leadership and governance and bimonthly patient safety and governance meetings.

Following our assessment, as part of the data request process, we were provided with some duplicated policies which contained conflicting information and could be confusing for staff. For example, we asked for the chaperone policy. We were provided with 2 different chaperone policies; 1 was due for review in April 2020 and the other was due for review on April 2021.

Management of risk, issues and performance

Leaders and teams did not used systems to manage performance effectively. It was unclear how risks and issues were identified, and actions taken to reduce their impact. Staff did not appear to contribute to decision-making.

The senior leaders told us they understood the challenges that the CYP service was facing in relation to staff recruitment and retention on the children's ward and the neonatal unit and identified this as their main risk. However, this had not been identified on the risk register.

The women, children and families care group risk register identified 22 risks. Data provided showed the risk register was reviewed regularly with review dates. Some risks had been opened since 2017 including the risk to children and young people due to inadequate facilities for care of disturbed children. Three risks had been closed in August 2022, 2 of which related to mandatory training in obstetric emergency and neonatal resuscitation and safeguarding training. The risk

levels for both was still assessed as being high.

It was not clear how risks were identified and escalated to staff. The risk register was included as a standing agenda item on the care group patient safety and governance meeting agenda.

Information management

The service did not always collect reliable data and analysed it. Staff could not always find the data they needed. The information was not always stored securely.

The children's ward and neonatal unit used a mix of paper-based and electronic records. We found paper records were not always stored securely, which meant there was a risk that notes could be accessed inappropriately.

We saw that data collection was not always was completed for all performance metrics for women, children and families care group, and some indicators on the quality dashboard were not monitored. For example, the CYP services were unable to obtain accurate appraisal and mandatory training compliance figures as the data had to be collated manually.

Engagement

Leaders and staff did not always actively and openly engage with patients. The service collected feedback from patients, but this process was inconsistent and not always timely.

There was little engagement within the CYP services when developing and improving services. In minutes of the women, children and families care group leadership governance meeting minutes, patient stories were part of the standing agenda. However, patient stories were not always presented.

At the entrance of the children's ward, there was a display board and suggestion box where parents and carers could leave comments or suggestions about the service. On the board, there was a display which had 'you said, we did' to show how the hospital had responded to comments. For example, 1 patient had said "they liked playing in the playroom with kitchen and dolls", the hospital responded saying "we continue to keep the playroom stocked with toys and arts and crafts". However, it was not clear when the board had been updated as some other information on the board had not been updated since July 2022.

The neonatal unit gathered family feedback following their baby's discharge from the unit. Feedback from families was displayed near the entrance of the unit which covered the 12 month period between January and December 2021. There were 78 admissions on the unit during this period and 46% (32) of families responded, with 100% of families indicating they were "very satisfied" with their visit to the unit. Staff told us that the board was updated annually, which meant new families using the unit were not seeing the latest feedback from parents.

Staff across the hospital had the opportunity to participate in Manx Care staff survey called 'have your say' on shared purpose. Information provided showed the response rate was low with 12% (331) of staff from Manx Care responding. It was not possible to determine if the results were an accurate reflection of staff members' views. However, when asked if "I would recommend the Manx Care as a great place to work", hospital services scored 5.5 out of 8, and when asked if "departments work[ed] well together across the hospital", services scored 3.4 out of 8.

Learning, continuous improvement and innovation

Staff were committed to improving services

The care group was working toward level 1 accreditation for the UNICEF ‘Baby Friendly’ accreditation. Baby Friendly accreditation was based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children’s centres services.

Community Health Services for Adults

Overall summary

Community adult services are provided by the integrated primary and community care services care group (IPCC). These services include diabetes and endocrinology, tissue viability, district nursing, long term conditions coordinators, continence service, Parkinson's nursing, speech and language therapy, community adult services (CATs), dietetics, podiatry, rotational therapy services and first contact practitioners. Community adult services are provided throughout a variety of clinical settings both within Noble's Hospital and RDCH. Some services such as podiatry, diabetes, dietetics and speech and language, provide an 'in reach' to the hospital on the wards.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

Mandatory training completion rates varied across services within the care group. At our visit, we saw spreadsheets for different services which showed an overall low level of compliance with mandatory training. Service leads told us each service group lead was responsible for collating training compliance data and this was done manually. One service lead told us staff may have completed training that was not included on the spreadsheet, and this accounted for the low rates.

There was a comprehensive list of e-learning courses available, but staff were not supported to complete annual training. Service leads did not consistently monitor training and alert staff when they needed to update their training.

Following our visit, we requested the mandatory training completion for all community services. Data provided showed a list of 74 courses without a breakdown of which staff needed to complete specific training courses. The data showed the overall training completion rate for the care group in October 2022 was 35%. The mandatory training policy, reviewed in September 2020, set the minimum target to be attained as 85%.

Mandatory training included courses covering infection control, safeguarding children and adults, fire safety, manual handling and data protection.

We noted that the minutes of the care quality and safety committee dated August 2022 stated mandatory training was to be included on the agenda for all team meetings. We reviewed records of service reports which stated staff were unable to attend training because:

- Courses were only delivered in the morning
- Staff were reluctant to book training because of staff shortages and high sickness rates which resulted in training being cancelled at the last minute
- Personal development plans were overdue
- Teams found the mandatory training matrix was not user friendly. Mandatory training was

not a priority as the issues were highlighted but there was no clear strategy on how improvements should be made.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse.

Staff did not have the appropriate level of training for their role. Service leads told us the appropriate level of training for clinical staff was safeguarding children and adults' level 3. Staff said there were very low levels of training for safeguarding adults' level 3 because courses had not been available for the last 2 years. Staff completed safeguarding level 2 training through e-learning and level 3 face-to-face. Some staff were unsure of the level of safeguarding training they were required to complete.

Following our visit, we requested the data for safeguarding training. Records showed that children safeguarding level 1 was 43%, level 2 was 14% and level 3 was 10%. Completion for adults safeguarding level 1 was 29% and level 3 was 2% We were not provided with the completion rate for adult level 2 training. This was not in line with the 'Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' or the 'Adult Safeguarding: Roles and Competencies for Health Care Staff' guidance documents, which set out the level of training required for different roles.

Staff understood their responsibilities to safeguard patients from avoidable harm and abuse. Staff knew how to raise safeguarding concerns. The safeguarding lead was a named nurse within the community nursing team. Staff gave a range of examples of the types of concerns they would report. Staff said they did not always receive feedback from the safeguarding lead when they had reported safeguarding concerns. They did not discuss any learning following safeguarding investigations.

Managers said Manx Care had updated safeguarding polices across all the services as a part of an overhaul of policies and procedures. Managers understood improvements were required for safeguarding processes and training across the care group. The safeguarding partnership board had a refined structure with a new chair to help to drive these improvements.

We were provided with data which showed the care group reported 25 safeguarding incidents in the previous 12 months. Podiatry staff gave an example where a safeguarding concern was missed. Consequently, a new protocol was implemented to ensure staff recorded both negative and positive safeguarding findings for each patient. Patient care records we reviewed showed these checks were recorded. We did not see records to show this learning was shared with other community teams where a similar protocol could be implemented.

Managers told us Disclosure and Barring Service (DBS) checks were carried out on all staff centrally by the human resources team. These checks help to prevent unsuitable people from working with vulnerable groups. We were not able to corroborate if all staff had a DBS check.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

All clinical staff wore uniforms with short sleeves to ensure they were bare below the elbow, to

perform effective hand hygiene and reduce the spread of healthcare associated infections. Staff followed infection control principles including the use of personal protective equipment (PPE).

The service provided staff with PPE, such as gloves, apron and masks. We observed care provided in peoples' own homes and saw that staff decontaminated their hands and used PPE appropriately. Staff understood the measures they needed to take to prevent the spread of healthcare associated infections, such as the correct use of PPE and good hand hygiene.

Where we observed clinics, handwashing and sanitising were available. There were hand hygiene posters above the sinks prompting staff to decontaminate their hands and instructions on effective techniques. Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment between patients and completed daily cleaning checklists.

Clinical areas were clean and had suitable furnishings, which were clean and well-maintained. All the clinical areas we visited were visibly clean and free from clutter. Storage areas were tidy. Clinic rooms where patients attended for care and assessments were clean and staff decontaminated equipment between patients appropriately.

Information provided by Manx Care showed infection prevention and control (IPC) audits were not completed consistently across all the services within the care group. We were provided with audit data from December 2021 to September 2022 and we observed there were gaps in the data such as no results for August 2022 and no audit results for some community services. Staff said they could not provide the missing audit results because of staff sickness.

The district nursing service completed regular IPC, hand hygiene and inserting catheter care and maintenance audits which showed 96-100% compliance from April 2022 to August 2022. From December 2021 to September 2022, the diabetes and endocrinology, physiotherapy, podiatry and wound management audits showed 95-100% compliance.

Records provided by the service showed 36% of staff completed training in IPC.

There was an IPC lead nurse for community services who collated all the audit results and presented them to the operational patient safety group. Staff said community services had stopped reporting on the number of respiratory infections because of COVID–19 but this had recently resumed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always kept people safe. Staff managed clinical waste well. When providing care in patients' homes, staff took precautions and actions to protect themselves and patients.

District nursing staff carried equipment, such as blood pressure monitors, temperature monitors and weight scales. Nurses were provided with an electronic device to access patient care records and update the care and treatment provided. Staff told us they had all the equipment necessary and did not experience difficulties in accessing equipment.

Staff managed the stock of disposable single use items well. We reviewed the storage of single use devices such as wound dressings, sliding sheets, hoist slings and syringes. We found all equipment was in date, cupboards were well stocked and tidy. Storerooms were well organised and stocked so that staff could easily select the items they required for patient care. The floor was free of equipment which allowed access for cleaning.

Staff disposed of clinical waste and contaminated used sharps such as needles appropriately. We

observed sharps disposal boxes were used in clinics and on community visits to ensure the safe disposal of sharps. There was a process in place for sealing and disposing of full sharps boxes. Waste was disposed of in appropriate bags and disposed of securely. Staff told us some of the buildings in the community were old and they did not have an adequate number of dirty utility rooms.

At the diabetes and endocrinology centre, we observed that 1 section of the building had carpets on the floor. We were told that the entire building was carpeted and when the emergency doctors moved into the building, only a section of the carpet was removed. Clinical rooms should not have carpets but rather floors that were impervious, easily cleansable with curved edges. There was no policy for cleaning the carpets including actions to take if carpets are contaminated with body fluids or spillages. We observed cleaning equipment was stored in the passageway close to a bathroom. Staff said having adequate space within the centre was a challenge.

Staff carried out daily safety checks on most specialist equipment. We observed staff calibrating the blood glucose monitor before carrying out a check on the patient. Most of the equipment we checked had been serviced and had electrical testing, except for 4 blood pressure machines that had not been serviced since October 2020. Staff were unsure of who was responsible for servicing now that the diabetes and endocrinology service had moved from hospital to the IPCC.

The service had enough suitable equipment to help them to safely care for patients. Resuscitation equipment was located on a purpose-built trolley and was visibly clean. Single-use items were sealed and in date. Resuscitation equipment had been checked daily from Monday to Friday and an up-to-date checklist confirmed all equipment was ready for use. We noted the centre was open on the weekend and the checklist was not completed during this time. Staff told us the emergency doctors who used the facilities on the weekend were responsible for checking the equipment.

Assessing and responding to patient risk

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

The service had processes in place to ensure that patient referrals were assessed and allocated to staff in a safe and timely manner. Each service group was responsible for assessing and triaging patients' referrals and arranging appointments based on the urgency of referrals.

Electronic patient care records we checked showed a full patient history, any allergies and risks appropriate to the current care needs. Each patient had a plan of care that was current, tailored specifically to them and their needs and amended and updated at each appointment.

Staff completed risk assessments such as malnutrition universal scoring tool (MUST) and Waterlow pressure ulcer risk assessments. The district nursing service had a quality dashboard which monitored the completion rates for MUST and Waterlow assessments. Records showed that at June 2022, the current cases with MUST scores were between 76-87% and Waterlow assessments 76-86%. We saw that these scores were monitored monthly for each health centre and at RDCH.

Staff discussed patients on their caseloads in the morning and at lunchtime. Nursing staff discussed the care plans in place and planned care interventions. This enabled teams to plan care appropriately and identify complex needs.

Basic life support was a part of mandatory training and records showed that 44% of staff completed it. This was below the 85% target for the care group. We were not provided with an

action plan for improvement.

The service undertook individual risk assessments, where staff had identified concerns about the patient care environment or staff safety. District nursing staff told us lone worker risk assessments were carried out and 2 nurses would attend a patient's home if there was a high risk.

Staffing

The service did not have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed staffing levels and skill mix. There was a reliance on bank and agency staff to fill gaps in the rosters.

The service had a high vacancy rate. Each of the service leads provided information on the vacancies with their service. We were told Manx Care had an ongoing recruitment process and there were challenges with recruitment and retention. Records provided showed there were 43 clinical and administrative vacancies across the care group. Data showed there were positions vacant for each year between 2019 to 2022. The current clinical and service lead vacancies were:

Clinical and service lead roles	Number of vacancies
Senior/registered nurse district nursing (DN)	4
Long term conditions coordinator	2
Parkinson's disease nurse	1
Advanced physiotherapist/physiotherapist/ clinical team leader	7
Physiotherapist rotational	4
Physiotherapist services manager	1
Clinical specialist physiotherapist in respiratory	1
Occupational therapist rotational	1
Senior Therapist	1
Speech & language lead specialist/specialist	2
Clinical specialist	2
Therapy services manager	1
Dietetic support worker/nutrition nurse	3
Specialist podiatrist	3

There were vacancies across most of the services within the care group. Staff gave examples of how the lack of adequate staffing impacted them. For example, the increased workload and the additional responsibility when staff members were on sick leave, particularly long-term sick. At our visit, the diabetes and endocrinology service had 2 members of staff on sick leave. Staff said they were "very short staffed", and it had been difficult to cover the service because they were a small team. Clinics had to be cancelled and patients rebooked because of insufficient staffing.

From September 2021 to September 2022, the care group reported the sickness rate was 7%.

There were some services that had 1 practitioner, such as the cardio-respiratory physiotherapist, continence and wheelchair so these services were not provided when staff were sick or on annual leave which increased patients' wait time. Staff turnover was high in some services and staff said this affected continuity of care because the team was not stable. Staff told us the instability and upheaval were detrimental to the service.

The Parkinson's and progressive neurology clinic were being provided remotely by staff that was not based on the island. The clinic had a locum for a day each week. However, there are times when a face-to-face appointment is required so that staff could observe a patient's swallowing function. It was not possible to do this examination remotely.

Following our visit, we asked the service to provide information on the overall use of bank staff, this was not provided.

We visited the Central Community Health Centre and spoke with 4 members of staff at the community adult therapy and podiatry clinics, 2 of whom were bank staff, and of the 3 musculoskeletal physiotherapists, 2 of whom were bank staff. This meant that some services relied heavily on the use of bank staff.

Staffing was included on risk register, and it was discussed at leadership meetings.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely. However, records were not easily available to all staff providing care.

Community adult services used electronic patient care records, which were password protected. Patient notes were comprehensive. We reviewed patient care records across different service groups and found they were completed appropriately. All the records we reviewed demonstrated the plan of care and treatment for the patients.

The district nursing service completed a record keeping audit in April 2022 to assess areas such as the accuracy, legibility, appropriateness and security of records. The audit showed 100% compliance with the services procedures.

Staff could not always access patient care records easily. Staff explained there were several different IT systems for patient care records and there was no interface between them. All staff told us about the problems they encountered due to there being 3 or more electronic IT systems which did not "talk to each other". This mean staff from different teams did not have access to 1 patient care record allowing continuity and information could not be shared effectively and quickly to provide patient care. Staff spent a long period of time looking for information on the different systems and this was cumbersome. Staff said they did not know when their patients were admitted to hospital.

The district nurses could not access the patient's full medical history and medication without first obtaining consent for each patient care record. Patients did not always know the medication they were taking, and GP referrals were often sparse and did not include medication information or history. Staff told us this impacted their ability to prescribe, although they were qualified and competent to do this, and patient care was delayed.

The diabetes and endocrinology IT system was becoming redundant and was due to be replaced. Staff recorded this on the risk register. Staff said patient care records were handwritten and scanned onto the hospital's IT system which mean hospital staff did not always have access to an up-to-date record. Staff also recorded the same handwritten notes onto the electronic record which mean that patient care records were documented twice.

Staff had access to training in record keeping and 42% completed it.

Medicines

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

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Visits included discussions about medicines; any issues could be discussed with the patient's GP or local pharmacy. Staff told us there were difficulties with local pharmacies. One of the pharmacies was closed and there were delays in the supply of dressings, B12 injections and medications including those for end of life care. Staff advised that some patients did not always get insulin and 1 patient did not have insulin for 2 days due to supply issues.

Staff did not routinely carry medicines with them. Most medicines, including dressings, were prescribed by the patient's GP.

Nursing staff regularly administered insulin to patients. They followed the provider's guidance and policies to ensure it was administered safely and appropriately. Staff used prescription charts and records showed daily checks and administration were completed. This was recorded in the patient care records we checked.

Some staff were trained as non-medical prescribers. Community nursing staff were able to prescribe medicines within the scope of their practice. This would allow the community nursing team to complete health assessments and to treat symptoms early, such as infections, which reduced the need for patients to visit their GP or hospital. The prescriber had completed additional recognised training to be qualified for this role. It was unclear if staff had access to training to update and maintain their prescribing skills.

Incidents

Staff did not always recognise and report incidents and near misses. Managers investigated incidents but did not share lessons learned with the whole team and the wider service.

Staff knew how to report incidents but not all staff understood the criteria of incidents that needed to be reported. Manx Care had an electronic incident reporting system for staff to report incidents. The system alerted managers when an incident was reported, and the named manager allocated a lead investigator for each incident. Some staff were unsure of the incidents that needed to be reported. Staff explained difficulties with the local pharmacy, including patients not getting their insulin on time, no catheters available, queuing for an hour to collect medication and waiting 6 weeks to get pain medication. However, leaders told us these incidents were not being reported on the electronic system so they could provide feedback to the pharmacy.

Records provided by the service showed 22% of staff completed training in incident reporting.

Data provided by the service showed from September 2021 to September 2022, there were 422 incidents reported. Of the incidents reported, they were low or no harm and there were no reported serious incidents. Incidents were categorised into areas such as pressure ulcers, injury, environment, delay in treatment and referrals. There were 88 reported pressure ulcer incidents. For each incident the actions taken was recorded. Staff told us root cause analysis for pressure ulcers was completed by the tissue viability nurse. It was unclear what lessons were learned from the incidents we reviewed because the information was not precise and in some cases this column on the incident log was blank.

There were no reported never events from September 2021 to September 2022. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Learning from incidents was not embedded across the care group. Staff told us learning from incidents was not widely shared and they did not received feedback on incidents they reported once an investigation was completed. Therefore, staff did not feel encouraged to report incidents.

Staff received training on the duty of candour and 81% completed it. Staff understood duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff gave examples of incidents where the duty of candour requirements applied.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service was not able to show that care and treatment was always provided based on the most up to date guidance or evidence-based practice.

We visited 8 patients in their home and observed staff adhere to relevant quality standards. We saw several examples of good practice. Waterlow scores were used to assess patients for risk of developing pressure ulcers and care plans produced for anyone who required them.

Staff gave examples of following published guidelines such as NICE for controlled drugs, diabetic foot problems: prevention and management, and type 1 diabetes in adults: diagnosis and management.

Policies were reviewed through governance processes. Staff told us there was no alerts on the system when policies were due for review, and this needed to be checked manually. We were told Manx Care was in the process of updating the care groups policies and procedures. All the policies were currently not being stored in the same location. Some policies were on the Department of Health and Social Care intranet, and some had been reviewed and were on Manx Care intranet. Staff told us they did not know which policies had been updated and they could not easily find policies.

Following our visit, we asked for examples of pathways from different community services. We were provided with 6 examples from the therapy services. We did not receive pathways from any other community services. There were no cardio-respiratory pathways, and this was recorded on the risk register dated October 2022. We were told in some instances there were no pathways because the staff understood what needed to be undertaken. This meant staff could not be assured they were providing care in line with the most up-to-date evidence-based guidance.

The district nursing service had relevant information displayed on the staff noticeboard such as diabetes care: recognising and treating hypoglycaemia (low blood sugar) and dressing and wound care: pressure ulcer prevention, stages of wound healing and tissue type. Staff said there was a dressings formulary which covered community nursing teams.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery.

People’s nutrition and hydration needs were identified and met through a malnutrition universal screening tool (MUST) which was completed for patients during their initial assessments. Staff completed personal care support plans to identify nutritional care and fluid needs of patients and

how they were to be achieved.

The service referred patients with swallowing difficulties to the speech and language therapy (SALT) service if they had concerns about a patient's ability to swallow food or fluids. The service did not have a speech and language therapist on the island and services were being provided remotely from the UK.

Staff could refer patients to the dietetics service if they required further advice and support with their nutritional needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

We observed patients in the podiatry and musculoskeletal physiotherapist (MSK) clinic being asked about their levels of pain at the start of their appointment and this was recorded in their patient care record.

The district nursing service worked with other organisations such as hospices to provide end of life care that reflected patients' needs. Staff told us hospice at home had taken over most of end of life care, but each district nursing team has 2 syringe drivers at each centre. District nurses prioritised the visit requests for pain relief, and for patients undergoing palliative care. However, pain scores were not recorded. We were not assured that staff could identify patients that required dose adjustments for their pain-relieving medicines or assess the effectiveness of the pain relief as staff did not record pain scores.

Staff could request a review of pain relief if required from the patient's own GP. The service had positive links with GP services. Staff we spoke with told us that they were able to contact the patient's GP to highlight concerns they had about the level of pain patients were experiencing or if they required advice with managing patients' pain.

Patient outcomes

The service did not monitor the effectiveness of care and treatment in many areas. Therefore, they had limited opportunities to identify where improvements were needed or when they had achieved good outcomes for patients.

Community services did not monitor performance to determine the effectiveness of care and treatment. The service did not have an effective audit programme and did not participate in clinical audits which could improve outcomes for patients.

Key performance indicators (KPI) were not routinely monitored for all the community services. Leaders acknowledged more needed to be done to monitor KPIs.

The district nursing service had a dashboard which was used to monitor caseloads, appointments, referrals, discharge, waiting times, failed appointments, medication cases, MUST and Waterlow scores.

We were told that the community adult therapy services completed an audit in August 2022. We were not provided with information on the aims and objectives of the audit. Staff said the results of the audit data were being analysed and any actions would be followed up on.

Leaders said an audit of prosthetic and orthotics was underway. However, staff did not provide information about taking part in the audit.

Competent staff

Staff did not always complete induction and competency checks. Managers did not always appraise staff's work performance. Supervision meetings were not held to provide support and staff development.

Managers gave some new staff a full induction tailored to their role before they started work. All new substantive and bank staff were required to complete an induction within their designated team. Team leaders were responsible for ensuring all new staff had a local induction. Staff were required to complete a corporate induction and data provided by the service showed 54% of staff completed it. The service could not be assured that all staff were provided with the required knowledge from the induction process.

Managers did not support all staff to develop through yearly, constructive appraisals of their work. Appraisal data was not held centrally therefore, there was no oversight to ensure staff received timely, effective appraisals of their work or clinical supervision

Following our assessment, we requested the appraisal completion rate for community adult service. We were provided with the data for 4 services:

- District nursing: 82%
- Dietetics: 85%
- Tissue viability: 38%
- Podiatry: 80%

We were not provided with data for community adult therapies, diabetes and endocrinology, other specialised nursing services, long term conditions coordinators, continence service, and the wheelchair service. Service leads said team leaders were responsible for completing appraisals for the staff they supervised. Some staff told us they had not completed appraisals.

We found inconsistent supervision processes as the service did not have formal supervision embedded across the care group. Some staff reported not having supervision in the previous 2 to 3 years, while other staff said they received supervision in the last year. Staff told us supervision could be informal so there would be no record of the discussions.

Staff are proactively supported and encouraged to acquire new skills. For example, podiatrists received post graduate training in ultrasound, injection therapy, the high-risk foot and ageing foot, while diabetic specialist nurses completed insulin pump training so they could run a clinic on the island and start patients on insulin pump therapy. Physiotherapists received training on neck vascular pathologies so they could identify issues and make appropriate referrals. Staff said they were supported to attend study days and professional conferences.

Multidisciplinary working

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

Community adult services were responsible for the promotion of health and independence in the community.

Staff worked across health care disciplines and with other agencies when required to care for patients. Community adult services provide patients with a range of services including diabetes

and endocrinology, tissue viability, specialised nursing services such as district nursing, long term conditions co-ordinators, continence service, wheelchair service and a Parkinson's nurse.

We observed an example of staff from different teams working well together to aid a patient who had multiple complex needs. Communication between them was good and we saw staff were proactive and focused on the patient's wellbeing for their current recovery and future care needs.

There were joint clinics which had a positive impact on patients. For example, the joint orthotic and podiatry clinic and the joint antenatal and diabetic clinic. Women with gestational diabetes attended the joint antenatal and diabetes clinic every fortnight. This meant that women could receive their care at the same time and same appointment.

There were 2 tissue viability nurses based in the community who worked across both primary and secondary care. For example, the tissue viability nurse came out to review patients with the district nurses when requested on joint visits. Staff said they could ask the tissue viability nurse to view photographs of wounds when urgent advice was required.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff attended multidisciplinary team meetings with a wide range of professionals to discuss patient care in detail and develop appropriate plans of care. For example, continence staff met with other community services as well as staff in Noble's Hospital. Wellbeing hubs facilitated meetings with staff across community services and with social workers.

Staff said they had good relationships with other teams and specialist nurses were available for consultation when required. All the services reported they felt communication and joint working with the district nursing service was good.

Health promotion

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

The service offered physiotherapy and occupational therapy to improve mobility and independence and gave practical advice on how to reduce social isolation and to get patients more active in the community. Patients were encouraged to manage their diabetes care independently, through dietary advice and skills to self-administer insulin. Staff in podiatry provided verbal health promotion advice, such as footwear, insole use and foot care.

Staff discussed self-care with patients and carers including the need for 6-monthly doppler assessment of the patients' legs and application of compression hosiery to prevent the recurrence of leg ulcers. Patients in the continence clinic were provided with health promotion leaflets such as promoting healthy bladders.

Specialist teams provided health promotion advice and support to patients. We observed staff providing information on diet and exercise. We observed a physiotherapist helping a patient with a self-exercise programme which was individualised to their abilities and needs. Physiotherapy classes were available with the objective of building confidence so patients could go to a local gym to continue self-directed exercise with a year of subsidised membership.

Health centres we visited had health promotion information in the waiting areas such as 'eating well with dementia' and 'compression care for leg ulcers'.

Consent

Staff supported patients to make informed decisions about their care and treatment. However, they did not receive training and could not demonstrate they knew how to

support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the ‘consent’ section under Medical Services on page 18 for issues common to many services.

We observed staff gaining patients consent during home visits with the district nursing team and during clinics. All patients surveyed by the community adult therapy team said they were informed and involved in decision making about their care (100%).

Staff did not understand how and when to assess whether a patient had the capacity to make decisions about their care. Staff did not understand how to complete a capacity assessment. Some staff said a capacity assessment was not something they would be required to do, and they would seek advice from a more senior colleague. Staff did not receive training on mental capacity. Staff did not know there was information on mental capacity within the safeguarding policy. This meant that some patients may have consented to care without understanding what they were consenting to and there were no ‘best interest’ decisions documented.

Is the service caring?

We found that this service was always caring in accordance with CQC's assessment framework.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff delivering care in patients’ homes and in the clinics. We saw staff were caring, respectful and had supportive relationships with their patients and those close to them. Their interactions were professional, friendly, and kind. Staff demonstrated an understanding of the importance of treating patients and those who were important to them in a caring and sensitive manner.

Staff provided patient-centred care that went above and beyond. Staff gave examples of working late so that they could provide the patient with their second dose of insulin and starting work earlier so they could complete a sinus pack for a college student.

We observed care at various clinics. Staff reviewed each person’s record before calling them to their appointment. They read the previous consultation record, treatment plan and any updated hospital letters available to them. They spent time at the start of each appointment checking how the patient had been and if there were any changes since the previous appointment.

Staff followed policy to keep patient care and treatment confidential. The staff respected the confidentiality of patients and did not discuss or display confidential information in the hearing of others. Staff shared information appropriately with each other either during handover or within the secure electronic records systems.

Patients said staff treated them well and with kindness. We spoke with patients who were visited at home and patients who attended clinic. Patients said staff were friendly, caring and professional. Patients said, “staff are very kind”, “always friendly and welcoming”, “these people are wonderful, without them I don’t know what I would do”, “really good service, no complaints at all” and “staff are lovely, like friends.” We reviewed patient feedback from letters and thank you cards which were consistently complimentary about the care they received.

Patients gave positive feedback about the service. The district nursing service started a patient satisfaction survey in October 2021. Staff told us there was a low response rate from the south of the island. Questionnaires were given to all patients following a home visit and patients could post their response to the care, quality and safety coordinator. The results were analysed for October 2021 to December 2021 and 99% of patients said the team was responsive to their needs and 98% said the service was easy to access. We were provided with data for January 2022 to August 2022, although this had not been analysed. We reviewed the data and found patients were overall positive about their experience.

Community adult therapy completed a patient satisfaction survey in 2021 where 97% of patients said the service met their expectations and 100% said they would recommend the service to friends and family.

Patient feedback was not collected across all the services within the care group. We did not receive patient satisfaction survey data from any other service within the care group.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the impact that patients care, treatment and condition had on the patient's wellbeing. Staff stressed the importance of treating patients as individuals with different needs. Staff asked patients about their general wellbeing and acted appropriately if any other concerns were noted.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed that staff communicated well with patients and carers. Staff took time to listen to patient's concerns and they offered support, reassurance and advice. Patients were not rushed. We observed a patient that was extremely anxious attending a physiotherapy appointment. Staff spent time talking to the patient about their worries and provided reassurance. They adjusted the care provided so that the patient felt less anxious. The patient told us they were happy with their care at the end of the appointment.

Carers told us they were kept informed of their loved one's care and treatment. They were able to discuss their loved one's care and staff would take time to explain treatment or provide support to them.

Staff said they considered and understood patients cultural and religious needs and adapted their care accordingly.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients were involved in planning and making decisions about their care and treatment. They said staff explained their care in a way they could understand and checked to make sure they understood. Patients told us they felt listened to, respected and that their views had been considered.

Staff talked with patients, families and carers in a way they could understand. Staff ensured patients and carers had enough information to make decisions about their care and the treatment

they were receiving. All patients said they had enough information to help them with their care and treatment, in various formats.

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients surveyed by community adult therapy said they felt the physiotherapists listened to them, explained their treatment and they understood what would happen next.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

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

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the changing needs of the local population. Community adult services provided diabetes and endocrinology, tissue viability, specialised nursing services such as district nursing, long term conditions coordinators, continence service, wheelchair service and a Parkinson's nurse. The allied health professionals included speech and language therapy, community adult services (CATs), dietetics, physiotherapy outpatients, musculoskeletal physiotherapy, podiatry and first contact practitioners. These services were provided throughout a variety of clinical settings inclusive of hospitals and health centres. The care group provided some of these services closer to the patient’s home.

Staff worked with professionals from other teams and organisations to provide effective care for patients. Staff had developed good working relationships with a wide range of other services including GPs, mental health teams, women and children’s service and acute hospital teams. Diabetes, dietetics, podiatry and speech and language provided an 'in reach' to the hospital, such as providing care on the wards. Staff knew who to contact to make relevant referrals.

The service had systems to help care for patients in need of additional support or specialist intervention. There was a joint orthotic and podiatry clinic which meant patients could be assessed and have their custom-made footwear and insoles made on the island. The patient did not need to travel for this treatment, and they received timely care. One patient we observed was referred to the clinic because they were experiencing a lot of pain when they walked. The patient was assessed in the clinic and left 15 minutes later with a custom insole.

There was a lack of administrative support for several community services. Staff said they were using their clinical time to do administrative duties and this time would be better spent on patient care.

Meeting people’s individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service worked closely with the wider

multidisciplinary team for example mental health teams, social workers and GPs to ensure patients in vulnerable circumstances had support.

Systems were in place to identify and monitor vulnerable patients. Staff applied flags to electronic patient care records to identify patients living in vulnerable circumstances. The patient's needs were recorded within their patient care records.

District nursing services were generally provided in patients homes. Staff gave an example of a patient who preferred to be treated at the health centre rather than at home and this was accommodated.

There was a range of equipment available including adjustable height beds, hoists, and walking frames. Therapy staff were able to access equipment in a timely way to support patients being discharged back into the community.

During our visit, we observed services were accessible. Corridors and toilets had ample space to allow for mobilising with staff and the use of mobility aids, including frames and wheelchairs. Bariatric furniture and equipment were available.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service made information available in large print and hearing loops were available to assist patients wearing a hearing aid.

Managers made sure staff, and patients, loved ones and carers could access interpreters or signers when needed. Information on interpreting services was readily available.

Access and flow

People could access the service and received the right care. However, patients did not always receive care in a timely way.

There were referral criteria for community health services. This helped to ensure that the majority of referrals to the services were appropriate. Information provided from the district nursing dashboard showed a high number of failed appointments. Staff said some of these failed appointments were patients who were not house bound and were not present when the team visited their homes. Inappropriate referrals included poor hospital discharge, a lack of information and in some cases no referral.

The service piloted a district nursing liaison service where district nurses visited the hospital twice per week to prevent these referrals. The pilot was discontinued as the scheme did not realise the intended service benefits and the service was deciding the next steps.

Wellbeing partnerships had been created to promote the delivery health and social care services closer to home for the people who needed it. It consists of locally based healthcare professionals who provide coordinated support for people to help them stay well in their own community, through a single point of contact. Staff said these mechanisms would assist in determining the most appropriate referral services for patients.

Each service was responsible for monitoring referral-to-treatment times (RTT), and this was mainly done manually, except for the district nursing service which had a dashboard. Urgent referrals could be seen by the district nurses in a day. Community adult therapy, prosthetics and orthotics produced a monthly report monitoring RTT. For community adult therapy, the RTT for urgent 1 referrals were 3 working days and urgent 2 referrals were 5 days. Other referrals were seen at 15-30 days and routine referrals within 12 weeks. Records provided by the service showed the KPI

was for 80% of all referrals to be seen within their target, but overall, this was 63%. In September 2022, there were 235 unallocated patients waiting for an appointment. There was no action plan to address long waiters.

Managers did not monitor waiting times for all community services and did not make sure patients could access services when needed and received treatment within agreed timeframes. We reviewed the Manx Care integrated performance report dated June 2022. From January 2022 to June 2022, the community adult therapy service did not meet the 80% KPI. The report did not provide KPI data for any other community service. Staff told us musculoskeletal physiotherapist (MSK) had an RTT of 8-9 weeks, podiatry was 4 weeks for urgent referrals and routine referrals should be 8-12 weeks, but this target was often missed. There was a 4-month wait for a continence home visit.

Some services such as therapies (Parkinson's and progressive neurology) and diabetes and endocrinology monitored their caseloads to determine which patients could be discharged so that they could increase their capacity. GPs were referring all diabetes patients to the service, although the service should only treat the type-1 or complex type-2 diabetics. The type-2 diabetic patients on the case load were reviewed and some patients were discharged back to GPs for care. Staff told us the numbers of patients had increased again and another review was undertaken, and patients discharged. Letters were sent to the GP for each patient discharged.

Some staff reported that their caseloads were too high, but patients were sometimes not discharged because other services may not cater for them.

There was 1 cardiac-respiratory physiotherapist, and the service was based at Noble's Hospital. Urgent referrals were seen within 2 weeks, but routine referrals had a 2-year wait. The RTT was being monitored manually on an ad hoc basis.

The district nursing service operated 8:30am to 5:00pm, 365 days per year. They provided a rapid response service where they liaised with the hospital and responded to patients such as those needing a nebuliser. This prevented patients from going to the hospital for this care.

District nursing team leads and senior registered nurses with specialist practitioner qualification were responsible for managing caseloads. The service aimed to provide approximately 1.0 WTE district nurse to 100 patients and this was monitored to ensure safe working. Records showed the caseloads were below 100.

Managers told us that staff were moved to support other teams where required across the district nursing community teams.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them. However, it was not easy for people to give feedback and raise concerns about care. The service did not always share lessons learned with all staff.

Patients, relatives and carers did not have access to information on how to complain or raise concerns. The service did not display information about how to raise a concern in patient areas.

Managers said that they shared feedback from complaints with staff and learning was used to improve the service. However, none of the staff could give any examples of learning from complaints.

Records showed that complaints were discussed at the care quality and safety committee. We

reviewed 3 sets of meeting minutes, and it was unclear how learning from complaints would be shared. There were examples of learning from other services such as being open and accountable and acting quickly and showing empathy. There was advice to communicate with all key parties involved in a complaint and ensure everyone named in the complaint response letter had sight of it before it was sent to the complainant.

Following our visit, we were provided with a complaints log which showed the service received 15 complaints in the previous 12 months. Of these the most common themes were delayed treatment (7), clinical treatment (4) and communication (3). We were not provided with any learning from these complaints.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

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

The leadership team for the care group consisted of a general manager, pharmaceutical advisor, clinical lead, associate director of nursing, therapy services lead supported by a business manager. Each manager had clearly defined roles and responsibilities. The leadership team was responsible for service provision, budgets and allocation, staffing and governance. Each service within the care group had a lead and they were supported by team leaders. Staff told us there were vacancies for a physiotherapy services manager and a therapy services manager.

We were told the leadership structure had improved. Service leads said the relationship with executive team improved since Manx Care was established and the chief executive was more approachable and inclusive. Staff said managers were more openminded and the general manager had requested to meet the teams.

We found that there was some inconsistency in the level of knowledge and awareness of individual service leads as to systems in place for monitoring or improving care. Not all service leads could clearly identify, or access, information that would support the delivery of improved care. Whilst they were supported by experienced and knowledgeable senior staff, there was evidence that individual development and support at service lead level was not consistently embedded.

Most of the staff said leadership had improved since Manx Care was established. Managers demonstrated leadership and professionalism. Staff said managers were accessible, visible and approachable.

Staff were encouraged to develop and progress within the organisation. Staff described development opportunities such as progressing to team and service leads.

Vision and strategy

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Staff did not understand the vision or know how to apply it and monitor progress.

Manx Care had a vision for what it wanted to achieve and a strategy to turn it into action at executive level. Manx Care set out is mission, vision and values in the required outcome framework. The stated mission was to become the best small island health and social care system in the world and the vision was to meet the health and social care needs of the island's population efficiently and effectively, and in line with accepted professional standards.

The CARE values were refreshed, and these were:

- Committed and passionate
- Accountable and reflective
- Respectful and inclusive
- Excellent and innovative

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The strategy set out the overall aim for achieving the vision and acknowledged the availability of complete, comprehensive, accurate and timely data was an essential component in the provision of high-quality services.

Staff could not tell us how the strategy would be implemented at service level, the quality measures and how it set out to achieve them. Some staff we spoke with did not know the vision and KPIs of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development.

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Some of the staff said they felt proud and positive to work for the service and were passionate about the work they do. Staff were supportive of each other. Staff said they enjoyed working at the service, and they were enthusiastic about the care and services they provided for patients.

Staff said there were challenges in the past, including bullying, and morale was low, but this has been steadily improving since Manx Care was established. Staff described the service as a good place to work, adding "I am allowed to be an autonomous practitioner", "really nice working here, good facilities, good resources, everything I need" and "fantastic team leader, very approachable".

Staff were supported in career development such as specialised practice qualification (SPQ) for district nursing, leadership courses and 2 staff were enrolled on a master's in professional practice.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff told us they felt confident they could raise concerns though they did not feel concerns were always addressed. Staff told us they were frustrated with not being able to access patient care records easily. Staff said they had raised concerns about the different IT systems for patient care records and they were told it would be addressed. Staff were unclear why no changes had been made for a concern they raised for several years.

The island did not have a 'freedom to speak up' process but did follow the government policy on standards for whistleblowing.

Staff said that due to staff shortages, they did not have the time needed to complete supervision,

appraisals, training and audits to measure patient outcomes.

Some staff told us there was some silo working and not enough integration and communication across community services. Additionally, some staff reported being left out of significant decisions made about their service and they did not understand why they were not consulted. Some staff said there is a lack of understanding about their role at an executive level.

Governance

Quality governance was not incorporated into every level of the organisation. Quality outcomes were not consistently monitored. There were limited opportunities to meet, discuss and learn from the performance of the service.

Staff told us information was not always filtered up and down, although this had improved since Manx Care was established. Service leads were positive about how the high levels of change over the last 12 months had been managed. They acknowledged that it would take more time for processes to be fully embedded.

During our visit, we were told the governance meeting structure included the care quality and safety committee, quality and safety group and district nursing team leaders meeting. We reviewed a sample of meeting minutes which evidenced staff discussion on significant incidents, audits, risk register, complaints and service reports. The minutes of the meetings we reviewed showed the number of incidents and complaints were discussed, although these did not state if there was any learning and how this was shared with staff. Not all service leads within the care group had the opportunity to attend senior leadership meetings.

We observed some of the risks and issues we found during our visit were documented in the care quality and safety group report and committee. For example, mandatory training, staffing and policies which were described as a work in progress. The meeting minutes did not provide sufficient information on how these risks would be addressed.

We asked for a sample of the minutes of staff meetings form other services. We were not provided with these records although some staff said these meetings took place. We were not assured that staff had had regular opportunities to meet, discuss and learn from the performance of the service.

Some staff told us there was no governance of their service and their work and performance was not reviewed.

The service did not collate enough data to provide assurances about the quality of the service or to identify where improvements were needed. The service did not have an audit schedule, so it was unclear what audits the service groups were required to complete and when they were to complete them. Following our visit, we asked the service to provide clinical audits completed in the previous 12 months. We were provided with data for infection prevention and control, hand hygiene audits and record keeping. The care quality and safety committee meeting minutes dated October 2022 states bag audits were undertaken. The improvements required were documented but it was unclear if audit results were shared with staff and when re-audits would be completed. Some staff were not aware of the Manx Care required outcome framework.

Risk assessments such as lone working and manual handling had been undertaken.

We were provided with an example of a staff newsletter, the therapies and podiatry staff bulletin dated September 2022. The newsletter described the assimilation of therapies and podiatry into the integrated primary and community care group as well as service and staff updates.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. It was unclear how risks and issues were identified, and actions agreed to reduce their impact.

Staff raised risks to their service leads who understood the risk escalation process and the risk register. Service leads had access to systems and data to allow them to manage and identify risks. Junior staff did not record risks on the risk register which mean they did not have the confidence to report and monitor risks and usually escalated them to service leads.

The reporting system allowed for data to be extracted for review and analysis. A risk manager post was not included as part of Manx Care changes, but an interim manager had been in post since August 2022, undertaking staff training and putting controls in place to improve risk management. Manx Care created a permanent risk manager post and recruitment is at an advanced stage.

Risks were discussed at the care quality and safety committee meetings.

At our visit, we reviewed service-specific risk registers. We were shown 3 examples of risk registers which identified risks such as a failure to access patient care records, staffing, reliance on bank staff, succession planning and policies and procedures not being updated, indexed and readily available to staff. The risk registers recorded risks, potential consequence to the service and the likelihood of the risk recurring. Following our visit, we were provided with a risk register for the care group, with a total of 17 risks, which did not contain all the risks identified in the service-specific registers. We were not assured there was adequate oversight of all risks related to each service within the care group.

The care group risk register identified risks such as the deterioration in patient condition, potential harm and delayed treatment due to staffing, patients requiring surgery due to cessation of the voice clinic and IT systems. Five of the risk levels were rated as extreme. Staff said that IT was the most significant risk to the service. The information provided did not show any updates or explain how risks had been mitigated.

Information management

The service did not collect reliable data. Staff could not always find the data they needed, in easily accessible formats. The information systems were not integrated.

It was difficult to measure how the services are performing. Data collected in various systems across the services was inconsistent. Staff accessed information using electronic systems. As noted above, the main record systems were not designed with data analysis in mind. Staff said the system was not set up to extract quality monitoring data and any attempt to do this was very labour intensive.

District nurses had access to an electronic device to complete their patient care records whilst out on home visits and a mobile phone. Staff told us they were in the process of piloting new devices which would be more reliable for recording on patient care records.

A quality dashboard had been implemented for the district nursing service. Service leads told us the dashboard was a work in progress and it was likely to change where improvements could be made. The other community services did not have quality dashboards.

Staff in all the services spoke of the difficulties they experienced due to different systems for patient care records.

Engagement

Leaders and staff actively and openly engaged with patients and staff. However, this was not consistent across community services. They collaborated with partner organisations to help improve services for patients.

We found good communication between managers and staff. Most of the staff felt they had good access to senior staff.

Most staff felt actively engaged and listened to. Not all staff across the care group attended regular staff meetings.

District nursing and community adult therapy staff actively sought patient feedback through patient satisfaction surveys. Patients feedback was consistently positive.

District nursing services had a care and quality visit where senior staff from other areas and lay-representatives undertake safety walk at each health centre twice per year. The safety walks reviewed the environment, staff and patient interaction, staff and patient feedback.

The Isle of Man Government completed a 'have your say' survey in 2021. Throughout the year, there were series of short 'pulse' surveys covering cultural assessment, people qualities, shared purpose, equality and wellbeing, leadership and development. Records showed that only 15-26 staff completed cultural assessment, equality and wellbeing survey. The lowest overall scoring on the survey was integrated community services.

Manx Care survey results were collectively analysed from 417 staff which was 15% of the workforce. Manx Care acknowledged the low response rate which means the findings did not represent a majority of our workforce. It was unclear what the actions would be taken based on staff feedback. There were no suggestions on how staff engagement could be improved.

Results showed that 60% of community staff felt their opinions were listened to and 62% were happy at work. Staff said they were committed to helping the organisation succeed (88%).

Learning, continuous improvement and innovation

Staff were able to describe many quality improvement initiatives although these were inconsistent across the services.

Staff told us they were supported to undertake further specialist training that resulted in improved services. For example, 2 podiatrists had completed fracture walking boot training in order to treat Charcot foot on the Isle of Man. A fracture walking boot is used in managing foot and ankle fractures. Previously patients would need to leave the island for this treatment so travel costs and time were reduced and patients could access the service quickly.

A fragility service was being developed by Manx Care as a part of the transformation project. Staff said a fragility practitioner had been appointed and would be a part of the acute service. Community services would work with the fragility service through the wellbeing partnership.

The diabetes and endocrinology service were a participating centre in the UK collaborative study of non-operated, non-functioning pituitary adenomas and the findings would be presented at the Society for Endocrinology conference in November 2022.

Staff said the diabetes service had a 5-year plan to develop GPs with special interest in diabetes and upskill community nurse and practice nurses. The plan is to roll out the Bradford diploma to GPs, practice nurses and community nurses to reduce referrals of routine type-2 diabetes patients to the service. The model that is planned would propose GPs managing type-2 patients and the specialist service managing the type-1 patients and the complex type-2 patients (metabolic

disease).

Leaders told us a short-term working group had been set up with partners in the UK and charities to look at service development for an assisted technology service for degenerative and neurological problems.

District nurses gave examples of research they had undertaken as a part of a master's programme such as community nurses' views on the implementation of a local weight management pathway and evaluating the quality of a dependency tool in community nursing practice.

The diabetic service implemented an education programme to train staff in care homes to administer insulin. District nurses would administer insulin until the care home staff had achieved their competencies. We were told this reduced the number of cases of hypoglycaemia in care homes.

District nursing staff said that extending the hours of the service would be beneficial to patients in allowing twice daily visits for insulins, twice daily dressing changes and intravenous (IV) antibiotics.

There were plans to develop quality dashboards for services across community health.

Some staff gave examples of how their service could develop. They told us they had made these suggestions in the past, but the ideas had not been explored and they did not receive feedback on the suggestions.

There was insufficient evidence to show the service had a learning culture such as sharing the learning from incidents and complaints across all service groups. Learning was not consistently shared with staff to improve patients' experience.

Community Health Services for Children, Young People and Families

Overall summary

Community health services for children, young people and families are provided by the integrated primary and community care services care group (IPCC). These services include community nursing, physiotherapy, speech and language and occupational therapy, diabetes, continence and wheelchair services. Services, such as long-term conditions, provide care to children aged 16 years and older.

As part of our assessment, we visited community health services at the diabetes centre, Noble's Hospital and RDCH, Thie Rosien and Central Community Health Centre (CCHC).

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

See the 'mandatory training' section under Medical Services on page 8 for issues common to many services.

We were told staff were not required to complete paediatric basic life support (BLS) because it was no longer a part of mandatory training. The Resuscitation Council UK recommends regular training in paediatric BLS for staff treating children and young people up to 18 years old.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse.

Manx Care had updated the safeguarding children guidance and procedures in 2022, which included child protection supervision. The strategy included implementing a multi-agency safeguarding hub (MASH), ensuring staff had the appropriate level of training and ensuring suitably qualified staff would be available to provide support.

We found staff did not have the appropriate level of training for their role. Service leads told us the appropriate level of training for clinical staff providing care for children and young people was safeguarding children and adults level 3. Records showed that children safeguarding level 3 compliance was 10% and adults' level 3 was 2%. Staff told us the training compliance rates were higher, but this was not supported by the data provided. This was not in line with the 'Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' or the 'Adult Safeguarding: Roles and Competencies for Health Care Staff' guidance which sets out the level of training required for different roles.

The children's therapy service which included physiotherapy, occupational and speech and language therapy had a service improvement plan which was effective from August 2022 to September 2023. The plan showed staff had at least 1 hour of safeguarding supervision with the

safeguarding lead in August 2022 and 8 hours level 3 training in September 2022.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to raise safeguarding concerns. Staff told us a flagging system for vulnerability has been introduced and it was working effectively. However, there were different IT systems that did not which did not “talk to each other” and this posed a challenge for all staff accessing information easily. This may impact on care and management of vulnerable children and families.

Manx Care produced a monthly assurance report for the operational clinical and quality group. The report dated June 2022 stated safeguarding needed better visibility within community services.

Cleanliness, infection control and hygiene

The service controlled infection risk well. They kept equipment and the premises visibly clean. However, not all the services for children, young people completed infection control audits and training completion rates were low.

Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. All clinical staff wore uniforms with short sleeves to ensure they were bare below the elbow, to perform effective hand hygiene and reduce the spread of healthcare associated infections.

Staff followed infection control principles including the use of PPE. The service provided staff with PPE, such as gloves, apron and masks. Staff decontaminated their hands and used personal protective equipment appropriately.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment between patients and completed daily cleaning checklists.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All the clinical areas we visited were visibly clean and free from clutter. Storage areas were tidy. Clinic rooms where patients attended for care and assessments were clean and staff decontaminated equipment between patients appropriately.

The service generally performed well for cleanliness. Following our visit, we requested data for infection control audits, and we were provided with audit results for physiotherapy. From December 2021 to September 2022, physiotherapy audits showed 95-100% compliance. We were not provided with audit results for any other service for children and young people.

Records provided by the service showed 36% of staff completed training in IPC.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The service did not always have suitable facilities to meet the needs of children and young people's families. Families could accompany patients on visits and were able to use communal areas or accompany patients to their consultation.

Staff told us they did not have equipment they needed. There was an effective process for checking the dates when equipment needed to be serviced and this was mainly carried out by the suppliers. For example, staff told us insulin pumps had a 4-year warranty and they were replaced by the supplier when expired. There was a good supply of spare equipment, and children and

young people had insulin pens they could use if the equipment malfunctioned.

There was a lack of appropriate facilities for children with special needs. We were told the service was exploring moving some community services to a new base. Staff told us GP practices were being considered because this would improve communication between both teams.

The service was not always able to supply wheelchairs, home aid and adaptations to the children and young people's home in a timely way. This equipment was necessary to help those with physical impairments to maximise their level of independence and wellbeing. The wheelchair services were provided by an occupational therapist, a part-time technician and supported by an external field engineer. We were told the service had been under significant strain until this team was established and service provision had improved. However, there were delays with the manufacturers and wheelchairs were not being provided within the agreed timescales.

The hydrotherapy pool, which was used to provide a rehabilitative environment that would help to restore health and heal injuries, had not been working. This service was suspended while the pool was being repaired. Once the pool was repaired, staff reported issues with the boiler and at the time of our visit, this service had not resumed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff knew about and dealt with any specific risk issues. This included the use of tools and assessments to consider home environments, physical health deterioration, domestic violence and safeguarding issues. Manx Care had a 'was not brought' policy. The policy explained what staff should do if children, young people or vulnerable adults were not brought to appointments, or if adults repeatedly did not attend appointments. The policy was reviewed in February 2022 and specifically refers to hospital appointments rather than those in community services for children and young people.

The safeguarding leads, in conjunction with CAMHS, developed a set of guidelines to support staff to focus on the emotional and physical wellbeing of children and young people in situations of intoxication and self-harm. The service liaised with community mental health teams to discuss children and young people under care or needing access to mental health services.

There were tools available to assist staff in considering risks such as the child exploitation risk indicator checklist.

Control of Substances Hazardous to Health (COSHH) materials had been stored securely and risk assessments had been completed. The COSHH assessment outlined the risk involved and measures to mitigate the risks and actions to take in the event of an accidental spillage.

Staffing

The service did not have enough nursing, allied health professionals (AHP) and support staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed staffing levels and skill mix. There was a reliance on bank and agency staff to fill gaps in the rosters.

The service had a high vacancy rate. We were told there were vacancies across all the services

for children, young people and families including 3 vacancies within the community nursing team. This caused an increase in workload that significantly impacted on the remaining staff. Staff told us the service was further affected when staff were sick.

There were 5 paediatric consultants who provided services in the outpatient clinics, and this included visiting consultants from a dedicated children's hospital off the island. Staff told us they felt unsupported during these clinics. There were occasions when the outpatient clinics operated without a trained nurse and other staff were expected to perform tasks which was outside of their scope of practice. Staff told us more qualified nursing support was needed.

Staff explained the challenges of providing physiotherapy services for children and young people. There was not enough staff, and this made the logistics challenging. For example, staff provided care for all children and young people with special needs, some inpatient care in hospitals, as well as clinic requirements. Children and young people with special needs were at 16 different schools across the island which was a logistic challenge.

We were told most of the physiotherapy service provided was urgent care and there were delays for patients who needed routine care.

Service leads could adjust staffing levels according to the needs of children and young people. Staff were allocated to meet the needs of the service. However, staff turnover was high and some services such as the therapies relied heavily on the use of bank staff. The service did not have a speech and language therapy on the island and services were being provided remotely from the UK.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely. However, records were not easily available to all staff providing care.

Patient notes were comprehensive. Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely. Community services for children and young people used an electronic patient care records system and records we reviewed were comprehensive.

Staff could not always access patient care records easily. Staff explained there were several different IT systems for patient care records and there was no interface between them. All staff told us about the problems they encountered due to there being 3 or more electronic IT systems which did not "talk to each other". This mean staff from different teams did not have access to 1 patient care record allowing continuity and information could not be shared effectively and quickly to provide patient care. Staff spent a long period of time looking for information on the different systems and this was cumbersome. Staff told us it was difficult to find all the relevant communication in the patients care records.

Incidents

Staff recognised and report incidents and near misses. Managers investigated incidents but did not share lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the services policy. Staff told us they knew what incidents were and how to report them.

Incidents that were reported were recorded on an electronic incident form and these were sent to senior managers for further investigation. Incidents were graded in seriousness, and most were low or no harm. Children, young people and their families were involved in these investigations.

The children's therapy improvement plan had an objective to complete team in-service training centred on incident reporting and patient safety. Staff understood further training was required to improve incident reporting. At the time of our visit, this training had not been implemented and the target date for completion of the improvement plan was September 2023.

Learning from incidents was not embedded. Staff told us learning from incidents was not widely shared and they did not receive feedback on incidents they reported once an investigation was completed. Therefore, staff did not feel encouraged to report incidents.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong.

Is the service effective?

We found that this service was not always effective in accordance with CQC's assessment framework.

Evidence-based care and treatment

The service was not able to show that care and treatment was always provided based on the most up to date guidance or evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice. There was a child protection medical assessment, a referral for medical assessment and a sexual abuse pathway. The service had a 'was not brought' policy for ensuring that staff attended to the welfare of children repeatedly not brought to appointments. These procedures were new and had not been embedded in community services for children and young people.

Following our visit, we asked for examples of treatment pathways from different community services for children and young people. We were provided with pathways for musculoskeletal physiotherapy (MSK) and a rheumatology physiotherapy for young people 16 years and older. There was a chronic pain pathway which was written in 2016 and due to be reviewed in 2018 but it had not been reviewed. This meant staff could not be assured they were providing care in line with the most up-to-date evidence-based guidance. Both the chronic pain and neck pain pathway did not mention any specific provisions for children and young people.

The treatment pathways we reviewed were for the community therapy service. We were not provided with pathways for the other community services for children and young people.

Nutrition and hydration

Staff regularly checked if children and young people were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Staff regularly checked if children and young people were eating and drinking enough to stay healthy and help with their recovery. Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Advice was given where necessary and alternate options were discussed to ensure adequate nutrition intake was

met.

Specialist support from staff, such as dietitians and speech and language therapists, were available for children and young people who needed it.

Patient outcomes

The service did not monitor the effectiveness of care and treatment in many areas. Therefore, they had limited opportunities to identify where improvements were needed or when they had achieved good outcomes for children and young people.

Staff did not routinely monitor the effectiveness of care and treatment. This hindered staff's ability to make improvements and achieve good outcomes for patients' children and young people. There was no system of regular audit throughout the service and no routine audit of quality measures or family's outcome.

Staff told us that they monitored the effectiveness of their interventions through the regular review of individual care plans. However, there was no collation of overall caseload outcomes to evidence that the service was meeting the needs of children and young people. This meant that staff did not use the findings to make improvements and achieve good outcomes for patients.

Staff were unclear about what treatment and performance outcomes should be measured. We were told the diabetic service participated in a UK audit in the previous 12 months. Following our visit, we requested audit data, but this was not provided.

One of the priorities from the children's therapy service improvement plan was improving the effectiveness of the service and an objective was to initiate introductory in-service training on therapy outcome measures. At the time of our visit, this had not been implemented and the overall priority was at 18% completion.

Competent staff

Staff did not always complete induction and competency checks. Managers did not always appraise staff's work performance. Supervision meetings were not held to provide support and staff development.

Managers did not give all new staff a full induction tailored to their role before they started work. All new substantive and bank staff were required to complete an induction within their designated team. Team leads were responsible for ensuring all new staff had a local induction. Staff were required to complete a corporate induction and data provided by the service showed 54% of staff completed it. The service could not be assured that all staff were provided with the required knowledge from the induction process.

Managers did not support all staff to develop through yearly, constructive appraisals of their work. Appraisal data was not held centrally therefore, there was no oversight to ensure staff received timely, effective appraisals of their work or clinical supervision. We were told staff completed appraisals although this was not supported by the data the service provided.

Records showed 85% of dietetics staff completed an appraisal in the previous 12 months. We were not provided with appraisal data for any other community service for children, young people and families.

Regular supervision meetings were not held with staff to provide support and development. Data was not collected on supervision compliance except for safeguarding in the children's therapy service.

Newly qualified staff were provided with a period of preceptorship for support.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care and communicated effectively with other agencies. However, there little evidence of integrated care planning when children and young people transitioned to adult services.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. All staff within the service who were responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked effectively with services in the women, children and young people care group such as health visitors and school nurses. Staff worked well with other specialists when required. There were good working relationships between physiotherapy, occupational therapy and speech and language therapy specialists.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. Staff referred into and liaised with CAMHS teams where there were concerns around mental ill health.

We were told most children and young people were transitioned to adult services at 16 years of age, except for those with special needs who were transitioned at 18 years. There was no training and advice sessions to help prepare children and families for the transition to adult care. We saw little evidence of integrated care planning and staff were not clear on their roles and responsibilities regarding transition. Children's and young people's services did not liaise with adult services to support the transition process.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. Health promotion within community health services for children included nutrition advice, general health advice and information and support with goal setting and communication skills. We saw staff support children and families to manage their own health, care and wellbeing and they were encouraged to be independent.

Staff also worked with and signposted children and families to other specialist agencies for help and support.

The diabetes service provided education within schools for children and young people. There was also an education programme with 12 learning outcomes for children, young people and families to support them in managing diabetes.

Consent

Staff supported children, young people and their families to make informed decisions about their care and treatment. However, they did not receive training and could not demonstrate they knew how to support children, young people and their families who lacked capacity to make their own decisions or who were experiencing mental ill health.

See the Consent section under Medical Services on page 18 for issues common to many services.

Staff did not understand how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff had not received mental capacity training. Staff did not understand how to apply best interest decisions if necessary. Staff did not understand how to determine a child's capacity to consent. This meant that some patients may have consented to care without understanding what they were consenting to and there were no 'best interest' decisions documented.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact in a respectful and considerate way. We observed staff delivering care in the clinics and in children's home. We saw staff were caring, respectful and had supportive relationships with their children, young people and their families. Their interactions were professional, friendly, and kind. Staff demonstrated an understanding of the importance of treating children, young people and their families in a caring and sensitive manner.

Staff provided family centred care. We spoke with children, young people and their families who visited the clinic who said the referral process was straightforward and they received "excellent" family centred care.

Children, young people and their families said staff treated them well and with kindness. One parent told us when treatment was required at a dedicated children's hospital off the island travel and flights were fully funded and arranged for the family.

Staff followed policy to keep patient care and treatment confidential. The staff respected the confidentiality of patients and did not discuss or display confidential information in the hearing of others. Staff shared information appropriately with each other either during handover or within the secure electronic patient care records systems.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff were knowledgeable about family circumstances that impacted on a child's wellbeing. Staff asked children and young people about their general wellbeing and acted appropriately if any other concerns were noted.

We observed that staff communicated well with children, young people and families. Staff took time to listen to their concerns and they offered support, reassurance and advice. Appointments for children, young were not rushed.

Staff understood the importance of caring for families holistically. Staff provided interventions that recognised the significance of maintaining patient's dignity. We observed staff taking the time to check patient's emotional wellbeing and spend time with children and young people who needed a little extra support.

Families with children and young people with multiple special needs that received care at home needed additional support. Families were concerned about respite care as they no longer had an open access facility following the COVID-19 pandemic. Families told us they needed more support with particular emphasis on a carer to look after the child 1 to 2 nights each week. However, there was only the limited option to use a hospice for 2 nights per month. Families said they were exhausted from providing care to the child during the night. Staff told us there was no capacity within the team to provide this service. The service could provide 2 hours of respite within the daytime on a limited basis. The service did not have a plan in place to support these families.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Staff listened and respected the opinions of children, young people and their families to help them make informed decisions. We saw staff actively encourage children and families to participate and be involved in the decision making about their care. This approach was consistent across all the services we looked at in community services for children, young people and families.

Children, young people and their families did not give feedback on the service and their treatment because staff did not support them to do this. The service did not use a range of methods to gain feedback and input from children, young people and their families.

Is the service responsive?

We found that this service was not always responsive in accordance with CQC's assessment framework.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the changing needs of the local population. The service had a community nursing team which included paediatric, continence and diabetic nurses. There were 5 nursery nurses who provided short term respite care for families with complex needs. There was no oversight of this care.

We were told there were challenges for oncology patients because of the limited number of staff who were able to administer chemotherapy. Children travelled to a dedicated children’s hospital off the island for this treatment.

There was a lack of respite care for children, young people, families with complex needs and no ready access for overnight care. The service had a complex care needs advisor for children with complex needs, who started in the post a year ago, but there was limited availability to provide the resources needed for the care required.

There were no consultants in the team for patients with cystic fibrosis or endocrine issues. However, staff told us the service had a small case load of 4 patients at the time of our visit. All cystic fibrosis patients moved to the adult service at 16 years of age. Other challenges included

the unavailability of respite care for children under 5 years of age and the heavy workload of the continence nurse. Staff told us children and young people were well managed despite the challenges they faced.

We were not assured there was a robust system to ensure that children, young people and their families who did not attend appointments were reviewed. We went to observe a clinic one afternoon and the children, young people and their families did not attend. We were told this was a common occurrence. A text reminder was sent 2 days before the appointment. Staff did not know how the failed appointments were dealt with. There was no evidence to show staff reviewed missed appointments to ensure there were no safeguarding concerns or serious clinical implications and recorded the outcome. The 'was not brought' procedure was not embedded across the service.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff identified a family's needs early on to ensure they received the support they needed in vulnerable circumstances.

Across the services we saw staff met the needs of children and young people with a disability or sensory loss. Staff had good local knowledge and understood the impact of deprivation on children, young people and families. They were responsive to clinical and safeguarding issues raised and provided quality care to patients with complex needs.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed.

Access and flow

People could access the service and received the right care. However, patients did not always receive care in a timely way.

The service could not demonstrate they responded quickly to children's, young people and family needs as waiting times were not routinely monitored.

Wellbeing partnerships had been created to promote the delivery of health and social care services closer to home for the people who needed it. It consisted of locally based healthcare professionals who provided coordinated support for people to help them stay well in their own community, through a single point of contact. There was no evidence to show patient treatment pathways and joint working protocols were completed and fully operational. We found that significant challenges remained in involving staff successfully in the new partnership arrangements, and in ensuring the service was wholly responsive to patient's needs.

There was an on-call service from 4pm on Friday to 9am on Monday. We were told this had an impact on core service provision because the team did not have the ability to provide this cover. Staff received training to provide on call care, such as respiratory and orthopaedic care.

Children from age 12 had treatment in the adult clinic for musculoskeletal physiotherapy. The service did not have processes for engaging children, young people and families in design and

running of the services.

Staff identified a need for the diabetic service to be available 24 hours per day, 7 days per week, to provide advice for children, young people and families if they needed it. At the time of our visit, the service did not have the capacity to provide this.

Staff supported children, young people and their families when they were referred between services. Families told us they were supported by staff. Families were given relevant information when introducing other services that would provide additional care and treatment to children and young people.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them. However, it was not easy for people to give feedback and raise concerns about care. The service did not always share lessons learned with all staff.

The service did not clearly display information about how to raise a concern in patient areas. The children's' therapy service improvement plan included the priority to enhance patient, service user and carers' experience and an objective was to update the notice boards in waiting areas to inform patients how they could provide feedback on the service. We observed at the time of our visit this had not yet been implemented.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. Staff gave examples of complaints affecting children, young people and their families such as a lack of wheelchair provision, the cancellation of hydrotherapy appointments because the pool was not working and access to speech and language therapy services. Records showed the complaints were investigated and responded to.

Managers did not share feedback from complaints with staff and so that learning could be used to improve the service.

Is the service well-led?

We found that this service was not always well led in accordance with CQC's assessment framework.

Leadership

Leaders were not always visible and approachable in the service for patients and staff.

Leaders within the service were not always visible and approachable for patients and staff. Staff told us there were challenges with the role of service lead which included providing clinical services within the same role. Some service leads were in the role on an interim basis, and this had been ongoing with the interim role extended for long periods of time. The interim role should be a temporary measure until more permanent staff were found.

We were told the leadership structure had improved. Service leads said the relationship with executive team improved since Manx Care was established and the chief executive was more approachable and inclusive.

Manx Care understood the service's recruitment challenges and had started to incorporate succession planning.

Vision and strategy

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Staff did not understand the vision or know how to apply it and monitor progress.

Manx Care had a vision for what they wanted to achieve and a strategy to turn it into action at executive level. Staff could not tell us how the strategy would be implemented at service level, the quality measures and how it set out to achieve them. Some staff did not know the vision and key performance indicators of the service.

The cascading of this information upwards to the senior management team and downwards to the clinicians and other staff was incomplete. Senior managers had not provided enough information about the implementation of the vision and strategy. Staff did not have a common understanding of its benefits for patients and of the implications for staff delivering the services.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care.

Staff told us they needed more openness from the service leads, and they had no meaningful contact with senior management. Managers were not always visible, and staff felt they were not always supported. Staff felt that senior managers underestimated the pressures of understaffing and high caseloads. Staff told us they continued to find delivering services to meet the high level of demand challenging. Managers had not ensured staff were supported to cope effectively and maintain their morale.

Governance

Leaders understood the need for improved governance arrangements and the extent of changes required. The implementation of these changes was at an early stage.

Staff told us information was not always filtered up and down, although this had improved since Manx Care was established. Service leads were positive about how the high levels of change over the last 12 months had been managed. They acknowledged that it would take more time for processes to be fully embedded.

Not all service leads within the care group had the opportunity to attend senior leadership meetings. This meant that all the service leads were not involved in the quality governance process.

We were not assured that staff had had regular opportunities to meet, discuss and learn from the performance of the service. We asked for records of staff meetings, and these were not provided.

Some staff told us there was no governance of their service and their work and performance was not reviewed.

The service did not collate enough data to provide assurances about the quality of the service or to identify where improvements were needed. The service did not have an audit schedule, so it was unclear what audits the service groups were required to complete and when they were to complete them.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. It was unclear how risks and issues were identified, and actions agreed to reduce their impact.

Staff raised risks to their service leads who understood the risk escalation process and the risk register. Service leads had access to systems and data to allow them to manage and identify risks. Junior staff had access to the risk register, but they did not record risks which meant they did not have the confidence to report and monitor risks and usually escalated them to service leads.

The children's therapy service which included physiotherapy, occupational and speech and language therapy had a service improvement plan which was effective from August 2022 to September 2023. One of the objectives was to complete team in-service training centred on incident reporting, patient safety and the risk register for improved accountability. The plan was implemented in August 2022 and this objective had not been achieved at the time of our visit.

Information management

The service did not collect reliable data. Staff could not always find the data they needed, in easily accessible formats. The information systems were not integrated.

It was difficult to measure how the services are performing. Data collected in various systems across the services was inconsistent. Staff accessed information using electronic systems. As noted above, the main record systems were not designed with data analysis in mind. Staff said the system was not set up to extract quality monitoring data and any attempt to do this was very labour intensive.

Staff in all the services spoke of the difficulties they experienced due to different systems for patient care records.

Engagement

Leaders and staff actively and openly engaged with staff. However, this was not consistent across community services.

We found good communication between managers and staff. Not all staff across the care group attended regular staff meetings.

The Isle of Man Government completed a 'have your say' survey in 2021. Throughout the year, there were series of short 'pulse' surveys covering cultural assessment, people qualities, shared purpose, equality and wellbeing, leadership and development. Records showed that only 15-26 staff completed cultural assessment, equality and wellbeing survey. The lowest overall scoring on the survey was integrated community services.

Manx Care survey results were collectively analysed from 417 staff which was 15% of the workforce. Manx Care acknowledged the low response rate which means the findings did not represent a majority of our workforce. It was unclear what the actions would be taken based on staff feedback. There were no suggestions on how staff engagement could be improved.

Results showed that 60% of community staff felt their opinions were listened to and 62% were happy at work. Staff said they were committed to helping the organisation succeed (88%).

Children, young people and families did not have opportunities to engage with staff to plan and improve service provision or look at ways to innovate and improve practice.

Learning, continuous improvement and innovation

Staff were able to describe a quality improvement initiative.

The children's therapy improvement plans had specific goals and objectives along with specific quality measures. Records showed staff monitored each of the priorities.

The following quality improvement priorities were listed in the therapy improvement plan:

- Preventing harm
- Safeguarding adults, children and young people
- Enhancing patient, service user and carer experience
- Creating a continuous learning culture
- Improving access to the service
- Improving the effectiveness of the service

Staff developed objectives for each of the priorities and were in the process of completing them. For example, under preventing harm and safeguarding patients, which was at 64% completion, a link worker was identified to attend Manx Care meetings.

The other services for children, young people and families did not have service improvement plans.

There was insufficient evidence to show the service had a learning culture such as sharing the learning from incidents and complaints across all service groups. Learning was not consistently shared with staff to improve patients' experience.