

**Requires Improvement**

# Liverpool Community Health NHS Trust

## Quality Report

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Core services inspected	CQC registered location	CQC location ID
Long term conditions – adults services	Liverpool Community Health NHS Trust	RY1X8
Children's and family services	Liverpool Community Health NHS Trust Smithdown Children's Walk in Centre	RY1X8 RY106
End of Life Services	Liverpool Community Health NHS Trust	RY1X8
Walk In Centres	Old Swan Walk in Centre Garston Walk in Centre The Beat	RY104 RY1X6
In-patient services	Alexandra Wing Broadgreen Hospital ward 11 Alexandra Wing Broadgreen Hospital ward 9 Ward 35 Aintree Hospital	RY1X7 RY1X7 RY1X4

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

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for community health services at this provider

Requires Improvement



Are services safe?

Requires Improvement



Are services caring?

Good



Are services effective?

Requires Improvement



Are services responsive?

Requires Improvement



Are services well-led?

Requires Improvement



# Summary of findings

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# Summary of findings

## Overall summary

We found that the provider was performing at a level which led to a judgement of requires improvement.

We judged the majority of services to be safe; however there was a risk to patient safety from reduced community staffing levels, most notably in children's and family services, and from the acuity of patients being admitted to the intermediate care wards. Staff reported incidents and the majority felt confident to do so; however learning tended to take place within local teams. Staff levels and caseloads varied in risk across the organisation; community services carried the greatest risk, though action had been taken to improve staffing levels in district nursing services. The acuity of patients on inpatient wards had resulted in a lack of rehabilitation.

Staff were able to describe how to use pathways of care and treatment that are based on nationally agreed best practice. There was multidisciplinary team work taking place. Training had improved recently and staff welcomed the block training approach that offered them better opportunities to attend. The trust took part in national audits; local audits were also carried out. Learning tended to remain local within teams.

Most patients commented on the caring and compassionate approach of staff across the organisation. We saw staff treating patients with respect. Patient surveys carried out by the trust showed good levels of patient satisfaction. Patients were involved in care decisions in the majority of services. However some patients were concerned about shared waiting areas in the walk in centres. There were some concerns regarding care within intermediate care wards which didn't demonstrate patient involvement in their care and assessment.

The majority of services we reviewed were responsive to the needs of the patients. There was good triage in the walk-in centres. Multidisciplinary teams were working to make sure patients were discharged smoothly and the children's care services were centred on the needs of families. Concerns were identified with access to some services; although staff had taken a range of action to improve the service, there remained long waiting times for access to wheel chair assessments for adults. Some elements of the healthy child programme were not being

met due to staffing arrangements and a prioritisation of vaccination and immunisation clinics. Response times at the single point of contact were adversely impacting on access to some services.

The trust had a vision and values in place, but these were not well known by all staff, and staff had not been engaged with effectively in some service reconfigurations. Governance structures had developed since a warning notice was issued in January 2014 but trend analysis required further development and systems to share and develop learning needed to be embedded across the trust. There had been recent changes amongst executive staff at the trust and staff we interviewed welcomed the changes. Staff told us they felt there had been improvements in the culture of the organisation and some more punitive processes had been changed. Patient engagement was good with evidence of service development as a result of patient stories shared with the trusts board.

The trust had been served with two warning notices in January 2014. The provider was served with a warning notice for outcome 16 (regulation 10, assessing and monitoring the quality of service provision) and ward 35 intermediate care unit was served with a warning notice for outcome 14 (regulation 23 supporting workers). The trust was told to ensure they were compliant with these regulations by 1 April 2014.

During our inspection in May 2014 we judged that the provider had met the requirements of regulation 10 and had demonstrated suitable improvements to its systems for assessing and monitoring the quality of service provision. With regard to the warning notice served on ward 35 intermediate care unit, we judged that the provider had met the requirements of regulation 23 supporting workers.

In addition to this compliance actions were served on both the provider, ward 35 intermediate care unit and Alexandra Wing, Broadgreen Hospital. At the provider level, these were outcome 4 (regulation 9 care and welfare of service users), outcome 11 (regulation 16 safety, availability and suitability of equipment), outcome 13 (regulation 22 staffing) and outcome 14 (regulation 23 supporting workers).

# Summary of findings

At ward 35 intermediate care unit these were outcome 4 (regulation 9 care and welfare of service users), outcome 9 (regulation 13 management of medicines), outcome 13 (regulation 22 staffing), and outcome 14 (regulation 23 supporting workers).

At Alexandra Wing, Broadgreen Hospital these were outcome 9 (regulation 13 management of medicines) and outcome 14 (regulation 23 supporting workers).

Whilst trusts are told the date by which they are to be compliant when served with a warning notice; trusts inform CQC when they expect to be compliant when served with a compliance action. At the time of this inspection (12 May 2014), the dates for compliance (against the compliance actions served above) were;

- Outcome 4 (regulation 9) – June 2014
- Outcome 9 (regulation 13) – March 2014
- Outcome 11 (regulation 16) – July 2014
- Outcome 13 (regulation 22) – June 2014
- Outcome 14 (regulation 23) – June 2014

As a result of this, whilst we reviewed evidence against these outcomes, with the exception of outcome 9 (regulation 13) further inspection will be required to judge compliance against these outcomes during the coming months. During the inspection in May 2014 we assessed and judged the trust compliant with outcome 9 (regulation 13).

# Summary of findings

## The five questions we ask about the services and what we found

We always ask the following five questions of services.

### Are services safe?

Whilst we judged the majority of services to be safe there was a risk that a lack of staff in children and family services was impacting on the delivery of services. Staff were aware of how to report incidents and systems were in place for them to do so. Learning took place but this tended to be within the local teams. The trust had made a number of improvements to its systems and processes which had resulted in improved corporate surveillance, and is developing systems to improve wide learning and sharing, however momentum is required to ensure these systems are embedded.

Staff believed that the culture had improved and that the 'scoping' meetings which had felt punitive in nature had been changed, were held locally and considered learning events rather than blame events.

Premises were well maintained, infection prevention was good, and staff received training. Medicines management was also appropriate across the clinical areas we inspected.

Records were generally of good quality and stored correctly though there were concerns regarding the quality of some records on inpatient wards, though recent changes in children's and families services, whilst done to ensure good practice had created concern for staff that they could no longer link all members of the family together.

Staff were aware of their safeguarding responsibilities and had received training; lone working policies were in place, and the majority of staff had mobile phones, though local procedures in places were not as effective as they could be.

Staff levels were acceptable in the majority of services, and concerns raised earlier in adult community services had been mainly rectified; however concerns regarding health visiting staff numbers and recent changes with school nurses meant that there were not enough staff to deliver a full service. Emergency plans were in place.

We had concerns regarding the levels of patient risk on inpatient wards as patients often did not meet the admission criteria and were too ill to benefit from rehabilitation.

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### Are services effective?

The effectiveness of inpatient services was variable. In terms of rehabilitating patients and preparing patients for discharge home or to a less acute healthcare setting, the service struggled to meet

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# Summary of findings

these objectives with many patients because of increased levels of acuity. Rehabilitation and related activities, such as encouraging patients to eat at a table or walking independently was less than expected. In addition, activities to support patients to remain engaged and relieve boredom were limited.

Staff used evidence based guidance to deliver care, and the trust had made good progress in developing how it manages NICE guidance across the organisation. Pain relief and nutrition and hydration were effectively delivered where applicable, and whilst staff took part in clinical audits and there had been reductions in the number of grade 3 and 4 pressure sores, there was variation in outcomes in some children's and families services.

Performance information was available and discussed through the divisions, but the divisions tend to work in silos, and there was limited trend analysis taking place.

The majority of staff had received a performance development review and mandatory training levels had improved and staff were positive about the new approach to delivering mandatory training. However clinical supervision was still not accessed by all staff and further development was required. Staff indicated they could access professional training.

Facilities were appropriate and staff did not indicate any concerns with access to equipment with the exception of one team in children's and family services.

## Are services caring?

Patients were overwhelmingly positive about the quality of service that they received. We saw care being delivered across a wide range of services, and staff treated patients with dignity and respect.

The majority of patients told us that they were involved in planning their care and provided with enough information to make informed decisions. Staff were passionate about the care they delivered. This was reflected in the comments made by patients and their relatives.

We identified some staff on inpatient wards who were less approachable with patients, and whilst we observed staff providing emotional care to patients, evidence in care records did not document how best to meet the emotional needs of patients.

Good



## Are services responsive to people's needs?

Some targets of the Healthy Child Programme were not being achieved, and there were long waits to access wheel chair services and non-obstetric ultrasound services. Though action plans were in place to deliver improvements in wheel chair services this was not expected to be achieved in the short term.

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# Summary of findings

Staff were aware of the different needs of their local populations and endeavoured to provide flexible services as close to the home of people as possible. Performance at walk in centres was good.

Staff assessed the individual needs of people and ensured that services met needs though there was some risk when children moved from health visiting to school nursing services.

Staff worked hard to meet the needs of people on inpatient wards but, at times, it was challenging because of the acuity levels of some patients. Many patients had multiple healthcare needs that did not enable them to engage actively in rehabilitation activities. Falls prevention was judged to override the rehabilitation needs of some inpatients resulting in reduced rehabilitation activities.

Complaints information was available and there were systems in place to investigate and feedback to staff. Some learning took place at the board and there were examples of patient's stories at board level with associated learning.

## Are services well-led?

There had been recent changes to the senior leadership at the trust which had been positively welcomed by staff. Staff reported that they had already noted improvements in the culture of the organisation, and some of the punitive policies had been reviewed and changed.

During our last inspection in December 2013 we identified a range of weaknesses in the governance arrangements across the organisation. During this inspection we noted a wide range of improvements to systems and processes, but note that the trust still has further work to embed and develop these. In particular the trust needed to engage fully with staff, and improve the quality impact element of its cost improvement plans. The board needed to refocus from an organisation whose focus was predominantly one of finance to rebalance this to one of finance and quality. The trust needed to ensure it continued to develop its systems to share learning and reduce the silo working that took place within its divisional structures.

Having noted these concerns and challenges there were still positive developments at the organisation. The quality of care was good, and innovation took place across pockets of the organisation. Health promotion was particularly strong.

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# Summary of findings

## Our inspection team

Our inspection team was led by:

**Chair:** Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

**Head of Inspection:** Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Nurse, Therapists, Senior Managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

## Why we carried out this inspection

Liverpool Community Health NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health

services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

## How we carried out this inspection

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

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

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.

3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Liverpool Community Health NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 13 and 15 May 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 23 locations including three community inpatient facilities ward 35 Aintree Hospital, and wards 9 and 11 in the Alexandra Wing, Broadgreen Hospital. The remaining locations included three walk-in centres and various community facilities. We carried out an unannounced visit on 13 May to the evening district nursing services.

# Summary of findings

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

We spoke with a range of children, young people, their families, patients and their relatives during the inspection and with patient representative groups before the inspection. We also gathered comment cards from patients and relatives during the week of the inspection.

Overwhelmingly feedback on services was positive, with patients saying they were listened to by their health professional and involved in decisions about their care. Patient survey data that we reviewed was positive with the majority of patients indicating they were satisfied with their care.

## Good practice

- The North Sefton Complex Care Team had good systems in place for ensuring staff were competent to carry out their roles, for example the development of evidence based competency training and assessment for non-professionals to enable them to carry out interventions, such as gastrostomy feeds, in either school or home settings.
- Speech and language therapists used Skype to carry out therapy sessions in schools. Teams across the division used iPads to access public health education information via a range of apps and the internet
- The continence team had been involved in the development and pilot of a catheter care passport to promote patient understanding and self-care. The continence team also used self-help packs where relevant to support children and their families to manage their own treatment and care needs.
- The trust was developing telehealth which used electronic information and communication to provide long-distance healthcare and health related education to patients in their home rather than having to go to hospital unnecessarily.
- Community nurses were able to connect using a tablet device to mobile technology which enabled them to access and add to the patient's electronic health record whilst working in the community.
- The trust had a virtual ward led by clinicians and was able to manage each patient's condition to keep them well and prevent them from being admitted to hospital unnecessarily. The team were able to access extra advice and help from a range of services that were appropriate for a patient's care such as heart failure nurses, respiratory team, diabetes team and dieticians.

## Areas for improvement

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

- The trust must ensure there are sufficient numbers of staff to provide safe, effective and responsive services. (Note – action a provider must take is associated with the issuing of a compliance action. In this case a compliance action against regulation 22 was still in force at the time of the inspection and further inspection activity will take place to assess compliance).
- The trust must take action to ensure all clinical staff have access to regular protected time for facilitated, in-depth reflection on clinical practice. (Note – action a provider must take is associated with the issuing of a compliance action. In this case a compliance action against regulation 23 was still in force at the time of the inspection and further inspection activity will take place to assess compliance).
- The trust should engage with staff to redevelop the organisations' visions and values and develop and embed an open, transparent and learning culture across the trust. Ensure that staff at all levels have opportunities to undertake leadership training.
- The trust should take steps to ensure appropriate patients are admitted to the intermediate care rehabilitation beds that fulfil the admission criteria and therefore benefit from rehabilitation.

# Summary of findings

- The trust should take steps to address the issue that it is not currently meeting key areas of the Healthy Child Programme and waiting times for therapy services.
- The trust should continue to evolve and embed the improvements to the trusts clinical and corporate governance structures, improving the quality of oversight and level of analysis that places quality at the heart of the organisation.
- The trust should ensure that health visitors have full oversight of their caseloads and ensure the relevant appropriate systems are in place to support this.
- The trust should take steps to improve the quality of assessment and record keeping on inpatient wards.
- The trust should ensure staff and people who use services are meaningfully engaged with cost improvement plans/service redesign plans to allow clear trust oversight of potential issues and impact of changes.
- The trust should ensure there is clear, effective leadership so that teams don't work in isolation of each other and there is shared learning to drive improvement and sharing of staff and resources.
- The trust should in conjunction with commissioners ensure there are clear commissioning intentions and agreements for all services.
- The trust should continue to develop integrated information technology systems to enable full integration and connectivity across the trust ensuring clear communication with and involvement of staff.
- The trust should ensure that all staff, including managers are aware of the organisations risk management policies and guidance including knowledge of incident reporting and management.
- The trust should take measures to protect the safety of all staff, and in particular lone working staff, in a consistent way.
- The trust should ensure newly qualified staff receive the time and support they require to be confident and competent to undertake relevant tasks such as immunisation and vaccination clinics.
- The trust should monitor and implement the recovery plan to ensure waiting times for wheelchair assessments are reduced to meet the 4 week target.
- The trust should take remedial action should be taken to ensure people's privacy and confidentiality when attending the co-located services to ensure that people were seen in a timely manner according to different service needs.
- The trust should continue to review the appropriate transfer of information to primary care through robust information systems.
- The trust should develop with staff effective hub locality working opportunities.
- The trust should improve general oversight for managers with regard to the End of Life team's prescribing to highlight any causes for concern.
- The trust should ensure staff record the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status of patients.
- The trust should develop regular one to one meetings and mechanisms within the end of life team to address poor performance.
- The trust should provide leaflets or booklets to patients or their relatives regarding information on end of life care, complaints or bereavement support.
- The trust should develop major incident plans for all services.

## Action the provider COULD take to improve

- The trust could improve communication with staff regarding concerns raised, identified risks, management of staffing vacancies and management of change to ensure staff anxiety is reduced.
- The trust could continue to implement the action plan to ensure the call centre of single point of contact (SPC) enables patients to access the service out of hours and at weekends, receive the correct information and avoid delays in patients being seen.
- The trust could continue to roll out training on dementia to all clinical areas.

# Liverpool Community Health NHS Trust

## Detailed findings

**Requires Improvement**



### Are services safe?

By safe, we mean that people are protected from abuse \* and avoidable harm

### Summary of findings

Whilst we judged the majority of services to be safe there was a risk that a lack of staff in children and family services was impacting on the delivery of services. Staff were aware of how to report incidents and systems were in place for them to do so. Learning took place but this tended to be within the local teams. The trust had made a number of improvements to its systems and processes which had resulted in improved corporate surveillance, and is developing systems to improve wide learning and sharing, however momentum is required to ensure these systems are embedded.

Staff believed that the culture had improved and that the 'scoping' meetings which had felt punitive in nature had been changed, were held locally and considered learning events rather than blame events.

Premises were well maintained, infection prevention was good, and staff received training. Medicines management was also appropriate across the clinical areas we inspected.

Records were generally of good quality and stored correctly though there were concerns regarding the quality of some records on inpatient wards. Recent changes in children's and families services, had been made to ensure good practice, had created concern for staff that they could no longer link all members of the family together.

Staff were aware of their safeguarding responsibilities and had received training; lone working policies were in place, and the majority of staff had mobile phones, though local procedures in places were not as effective as they could be.

Staff levels were acceptable in the majority of services, and concerns raised earlier in adult community services had been mainly rectified; however concerns regarding health visiting staff numbers and recent changes with school nurses meant that there were not enough staff to deliver a full service. Emergency plans were in place.

We had concerns regarding the levels of patient risk on inpatient wards as patients often did not meet the admission criteria and were too ill to benefit from rehabilitation.

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## Our findings

### Incidents, reporting and learning

Staff reported that they were aware of and utilised the trust incident reporting system Datix. Staff indicated that the culture for reporting incidents had improved, and changes had been made to scoping meetings which were held locally and acted as learning opportunities and felt less punitive. For example on a weekly basis, harm meetings were held and attended by ward managers and the interim manager for inpatient services. The harm meetings reviewed all incidents recorded during the relevant weeks and provided opportunity to pick up on any developing trends. The harm meetings were seen as a positive forum for reviewing incidents and from a general perspective, the interim bed base manager had no evidence to suggest staff were not reporting incidents when they should.

Staff indicated that they received feedback, this occurred through Datix if they had raised the concern. The majority of staff indicated that they discussed incidents and learning in their local teams, but this tended to remain local and requires further development. The trust was developing systems to improve incident reporting and learning across the organisation. The trust was introducing 'captivate' training, an online training package available to all staff that acted as a visual aid to report incidents, and a Staff Information Resource Site (SIRS), scheduled to go live in June 2014, which provided lessons learned from incident and complaint investigations along with policy information and key patient safety messages for staff.

All three divisions held governance meetings to review key themes and incidents to improve practice. The divisions produced a quarterly report to the Healthcare Governance Subcommittee. The report compared incident, complaint and compliment data by quarter and in comparison to 2012-2013. The report provided some outcomes and actions in response to individual complaints but it did not provide a narrative around actions taken in response to incidents and/or themes. We were told that actions were to be agreed at the next integrated governance and quality meeting.

One of the areas for improvement at our December inspection was the wider sharing of learning from individual serious incidents. For example, pressure ulcer incident investigations would often have the action to provide the team involved with training rather than

providing all teams with training to prevent incidents in all areas. Since this time, the trust had undertaken an aggregated root cause analysis of 10 pressure ulcer incidents to identify areas for improvement in practice overall. This has been done in conjunction with the CCG.

The trust has significantly increased patient safety incident reporting. From the trust's record of uploads to the NRLS there had been 1143 incidents successfully uploaded from the 29th October 2013 to the 4th April 2014, with 970 of these uploaded since January 2014.

Pressure ulcers accounted for the largest proportion of incidents (85%). Outcomes for community acquired pressure ulcers had seen a 10% reduction in grade 3 pressure ulcers and a 64% reduction in grade 4 pressure ulcers in 2012-2013.

Whilst there had been improvements in incident reporting further development was required. The process for reporting grade 3 and 4 pressure ulcers changed from the 1 December 2013 with the requirement for all of this type of incident to be reported on STEIS within 48 working hours. A paper was presented to the Trust Board on the 25th March 2014, Management of Reportable Issues including Serious Untoward Incidents. Appendix 3 of this report lists the 24 'unconfirmed' serious incidents in relation to pressure ulcers from December 2013 to February 2014. Of this 24, only 4 were reported as a serious incident within the 48 working hour's timeframe.

### Cleanliness, infection control and hygiene

All of the premises that we visited were noted to be visibly clean and well maintained. Staff were observed to adhere to the bare below the elbows policy, and regularly washed their hands and used disinfectant hand gel.

Staff reported receiving infection control and prevention training and cleaning schedules were in place in the clinics and walk in centres.

There were two cases of community acquired methicillin-resistant staphylococcus aureus (MRSA) bacterial infections or clostridium Difficile infections detected in the bed based services between April 2013 – March 2014. The infection control lead told us root cause analysis had been undertaken and actions put in place to minimise the risk of infection.

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A number of infection control audits had taken place across various clinics and units with compliance ranging from 87% to 99%.

## Maintenance of environment and equipment

Environments at the units we visited were well maintained, and had procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Procedures were in place to ensure equipment was regularly maintained and fit for purpose. Patients were provided with information detailing the procedure for equipment repairs and reporting of faults out of hours.

## Medicines

There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. There was a medicine management team (MMT) who provided a range of services to community teams which included referral for medication reviews of patients at risk or with complex medication needs from secondary care, falls service, GPs and community matrons. Clear procedures were followed in practice, monitored and reviewed for medicine handling that included prescribing, safe storage and monitoring.

Staff told us that they were able to prescribe medicines through use of patient group directions (PGDs). Patient group directions refer to a group of medicines that can be given by a practitioner who has had training and knowledge which meets PGD guidelines provided by the trust.

There had been a number of incidents related to the refrigerated storage of immunisation and vaccination medications, we noted that these had been unrelated and that the trust had learnt and taken appropriate action.

In December 2013 we had identified concerns with medicines management on ward 35. We closely reviewed medicines during the inspection across all in patient wards. We observed nurses across all three wards (9, 11 and 35) administering medicines and they were kept safely during medicine rounds. Prescriptions were written clearly and signed. Morning medicines are prescribed at 8am. In practice, the morning 'round' starts between 09:00 and 09:30. There were no 'gaps' in administration records and a 'missed dose' audit is completed each night; this was done

by the night nurses. In addition, medicines in the medicines storage rooms (keypad access) were all in locked cupboards or the locked medicine refrigerator. The trust's bed based medication storage audit in February 2014 found that all wards achieved 100% compliance with fridge temperature recordings. We checked a sample of controlled drugs and looked at the CD registers on the wards; stocks were correct.

## Safeguarding

Staff we spoke with were trained in safeguarding and able to describe signs of abuse and the appropriate actions and systems for reporting allegations of abuse. We saw clear examples of safeguarding policies and procedures including flow chart algorithms.

Staff told us that they had access to advice and support from the trust safeguarding team. We saw that alerts were place on the electronic records system which we witnessed in use.

On one of the inpatient wards a safeguarding issue occurred during the inspection and we observed correct procedures being followed in order to report the concerns and protect the people involved. The ward managers we spoke with said there had been increased awareness by staff in relation to safeguarding and training was provided to all relevant staff. The percentage of staff trained in both adult and children's safeguarding was acceptable.

## Records

We reviewed a range of records across all the services that were inspected. Overall records were completed accurately and in sufficient detail to allow care to be delivered effectively, though there were some gaps in records on inpatient wards. We reviewed audits that had taken place to assess the quality of record keeping and overall these demonstrated a high level of compliance.

We reviewed care plans across the bed base and the detail in them was variable. We spoke with patients about their care needs and their notes did not always fully reflect the care being provided. Two patients we spoke with on ward 9 were concerned about the lack of information in their records about their care. One patient was confused and lacked insight into what their care needs; their notes did not provide any information on how to manage / support the patient with their confused state. Some nursing notes

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we read also lacked a sense of empathy. For example, one patient had times when they would cry and there was very little information in the nursing records about the emotional support needed and how to support the person.

There were some concerns regarding discharge information for patients who had attended one of the walk in centres, as this was not electronic and had led to delays on occasions. In end of life services, do not attempt cardiopulmonary resuscitation (DNACPR) was not noted to be recorded, and some of the records were designed for patients requiring palliative care and were therefore not suitable for people requiring end of life care.

In children's and families services, recent changes to the storage of records by date of birth rather than GP, whilst changed to be in line with best practice, had led to reduced oversight of staff. Changes had taken place to aid clerical and administration staff who would be supporting the teams but this meant that staff did not have clear oversight of their portfolios and this had led to some children being 'lost' in the system. For example, one member of staff told us they had gone to perform a home visit for one child only to discover there was a second child also living at the home. We were told that data analysts had been recruited to rectify the situation so that EMIS (an electronic medical records system) would allow staff to view their caseloads. In the meantime, the manager told us that staff should be able to identify their caseloads by using their 'birth book'.

The changes had also led to a delay in the transfer of records from health visitors to school nurses. In turn school nurses reported they were faced with a backlog of records to review which meant delays in reviews of potentially 'at risk' children. Staff reported that records were not arriving on time for children going into special schools and due to the changes in caseloads they could not track down the health visitor who had been previously responsible. However we found that any children going into special schools who were potential safeguarding risks were identified beforehand and their records were sent separately to ensure they weren't missed.

## Lone and remote working

There were systems and policies in place with regard to lone working and staff we spoke with were all aware. In the walk in centres there were panic buttons and security staff

available. The majority of community staff told us they had mobile phones; however some staff indicated that they were not always aware of where high risk areas may be particularly following changes to caseloads.

## Adaptation of safety systems for care in different settings

Staff took account of and adapted services to meet patient's needs. We saw examples of staff working proactively with other clinicians across the trust following identification of clinical risks. For example, the re-design of wheelchair services had led to improvements in triage processes to ensure patients were prioritised for equipment based on their clinical need.

Equipment reviews were undertaken to identify equipment that was unsafe. Assistant practitioners in the community equipment nurse specialist team (CENS) carried out these reviews and an audit between July and October 2013 showed patients who had their pressure care equipment downgraded or removed had no reoccurrence of pressure ulcers.

## Assessing and responding to patient risk

In children's and family services, teams demonstrated ways they assessed and responded to patient risk in order to provide a safe service. For example, staff at the children's walk in centre used the Manchester triage system to assess and prioritise patients' needs.

In adult's services, we saw that risk assessments were completed and staff responded to findings by referring people for additional assessments or for relevant equipment. We observed safe patient handovers. The senior nurse provided a clear clinical overview and identified relevant information to ensure patient safety.

We had concerns across inpatient wards in relation to the admission of patients and the acuity of existing patients. Senior nursing staff frequently described situations where staff from nearby acute trusts would request patients to be admitted to inpatient wards who did not meet the admission criteria. Examples were provided where band 6 nurses from the wards had reviewed patients at a nearby trust and determined that certain patients were not suitable for transfer. The nurses would then arrive on shift the following day to find the patient/s had been transferred regardless. In some instances, this meant the patient/s needed to be re-admitted back to the nearby acute trust.

# Are services safe?

By safe, we mean that people are protected from abuse \* and avoidable harm

There were a disproportionately high number of patients across inpatient wards who were not receiving any form of rehabilitation therapy because they were too unwell. We observed limited therapy activity for what should have been very active wards in terms of people being supported to walk and spending time with physiotherapists and occupational therapists. For example, one patient we observed was at risk of falls and was not having any rehabilitation. The patient had been on the ward for two months and was confused, had recently had a surgery and further medical problems. They also had a urinary tract infection, were diabetic and on intravenous antibiotics.

The trust continued to hold its weekly 'meeting of harm'. The medical director chaired this meeting where a review was undertaken of all incidents reported that week to identify any emerging themes. The medical director described this as a temperature gauge for the organisation where he can get a feel for what was happening and where any risks may be emerging. An action log was kept and monitored as a record of the weekly meeting. The outcomes from this meeting were reported to the executive team, integrated governance and quality committee and the trust board. One of the non-executive directors told us that the feedback from this meeting is valued by the integrated governance and quality committee.

## Staffing levels and caseload

There was variation across the trust with regard to staffing levels. Within end of life services, whilst workload fluctuated, staff considered there to be adequate staff. Increasing volumes of patients attending walk in centres had impacted on workload in the centres. This had been recorded in the service risk register, and staff reported that they were working additional hours whilst vacancies were recruited to. Managers were aware and were taking action to fill vacancies, and whilst staff indicated that local managers were supportive, they were less convinced that senior managers would take action.

In community services, where CQC had identified staffing concerns in adult's services in December 2013, we now found many vacancies had been filled and teams were usually able to meet the demand for patient referrals. Where this was not the case staffing issues had been escalated to the trust risk register and the trust had responded to information about incidents occurring and staff views by recruiting additional staff.

In children's and family services, there remained a number of vacancies, and staff told us that there had been a high turnover of newly qualified health visitors. There was a difference in view as to why turnover was high; managers we spoke with told us this was due to staff getting jobs closer to home but some staff told us it was because new staff felt overwhelmed and unsupported.

We reviewed staffing levels across inpatient services during the inspection and there was a suitable complement of staff and skill mix. In some instances, staffing was above the required number and this was because a ward had recently been closed so extra staff were available. We spoke with the interim bed base manager and it was the intention to ensure that nurse staffing levels were appropriately maintained. The trust used the Royal College of Nursing safer staffing tool and this was used as the benchmark.

The trust benchmarked its performance for sickness and absence levels externally, and was above England and comparative organisations. Staff told us the sickness absence policy was punitive and could result in a first warning for an episode of sick leave. This practice had been stopped since the recent changes to the executive team. Senior managers were aware of the vacancy issues across the trust, and had taken steps to improve recruitment. We were told of extremely slow recruitment processes that had been handled by an external recruitment company who dealt with recruitment for the trust. The trust had taken action to bring in temporary internal HR staff to speed up the process whilst they reviewed their contract with the external company.

## Deprivation of Liberty safeguards

Staff we spoke with generally understood their responsibilities with regard to the Deprivation of Liberty Safeguards. Staff were aware of procedures and there were a number of trained DoL's assessors.

We reviewed how staff on inpatient wards took into consideration Deprivation of Liberty safeguards (DOLs). There was some positive work in this area, for example, an action plan had been developed assessing the impact of the changes in guidance, in relation to DOLs following the Cheshire West judgement.



# Are services safe?

By safe, we mean that people are protected from abuse \* and avoidable harm

We reviewed DOLs training schedules for May 2014 and it was clear that key staff were supported and trained in DOLs. Staff we spoke with on the wards had a reasonable understanding of DOLs but all were able to describe who they would contact for support.

## Managing anticipated risks

Clinically staff anticipated risks and took action to mitigate. For example there were business continuity plans in the walk in centres; in the children's walk in centre, staff had access to bank staff that were familiar with the service to cover sickness to ensure continuity of care. In end of life services, there was routine engagement with the district nurses, GP's, hospice staff and social workers so the staff were kept informed of patients' conditions and could make arrangements for patients that were awaiting referral for end of life care services.

The trust had a process for quality impact assessments (QIAs) to be undertaken for all cost improvement programmes with clinical sign off. However, this was not working effectively and did not provide an overview of how

any problems with quality and safety were identified pre, during and post implementation of the cost improvement programme. The medical director sometimes received 20-30 QIAs to sign off at a time; however there was no clear process to ensure that any concerns identified by the medical director would then be acted upon and resubmitted to the medical director for final sign off. Other board members were also concerned about how robust the process was, and the trust had included QIAs as a gap in controls in its board assurance framework. This was to be presented to the trust board in June 2014.

## Major incident awareness and training

The majority of staff we spoke to were aware of major incident plans and training was available to them. There were business continuity plan in place in the walk in centres including following major incidents, sporting events or bad weather.

Within end of life services we did not identify a major incident plan and staff had not received training.

# Are services effective?

Requires Improvement 

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

## Summary of findings

Staff used evidence based guidance to deliver care, and the trust had made good progress in developing how it manages NICE guidance across the organisation. Pain relief and nutrition and hydration were effectively delivered where applicable, and whilst staff took part in clinical audits and there had been reductions in the number of grade 3 and 4 pressure sores, there was variation in outcomes in some children's and families services.

Performance information was available and discussed through the divisions, but the divisions tended to work in silos, and there was limited trend analysis taking place.

The effectiveness of inpatient services was variable. In terms of rehabilitating patients and preparing patients for discharge home or to a less acute healthcare setting, the service struggled to meet these objectives with many patients because of increased levels of acuity. Rehabilitation and related activities, such as encouraging patients to eat at a table or walking independently was less than expected. In addition, activities to support patients to remain engaged and relieve boredom were very limited.

The majority of staff had received a performance development review and mandatory training levels had improved and staff were positive about the new approach to delivering mandatory training. However clinical supervision was still not accessed by all staff and further development was required. Staff indicated they could access professional training.

Facilities were appropriate and staff did not indicate any concerns with access to equipment with the exception of one team in children's and family services.

evidence based guidelines. The children's speech and language team (SALT) used a risk assessment tool based on the Malcolmess Care Aims philosophy in order to triage children and identify their needs.

End of life services had procedures based on other national and regional guidelines, including the Preferred Priorities for Care (PPC), the Gold Standards Framework (GSF) and the Merseyside and Cheshire Palliative Care Network Audit Group Standards and Guidelines. The palliative care nurses also followed guidelines from other organisations, such as the Macmillan Cancer Support and Marie Curie Cancer Care. The staff within the team were highly trained and had a good understanding of existing end of life care guidelines and implemented these effectively.

Further to our last inspection the trust had introduced quarterly NICE updates from the divisions to the healthcare governance sub-committee. New NICE guidance was received monthly and disseminated to the appropriate lead clinicians within the divisions. The leads were given 2-3 weeks to review the guidance for applicability and were required to report back to the NICE Implementation Group, which met monthly. The group then confirmed the applicability and monitored action plans for implementation. Any risks, concerns and progress were reported to the clinical effectiveness group. This was in addition to the quarterly divisional reports to the healthcare governance sub-committee. A register of all NICE guidance to record the status was maintained. Whilst not all actions reviewed had completion dates confirmed, it was clear the trust had progressed in this area significantly since December 2013.

### Pain relief

Records reviewed indicated that patients were provided with appropriate pain relief. Staff working in end of life services and walk in centres, were able to prescribe medicines through the use of patient group directions.

### Nutrition and hydration

Nutrition and hydration assessments were completed for appropriate patients. We observed the majority of staff supporting patients with meals on inpatient wards, though some were a little abrupt and positioned themselves that meant there was no eye contact with the patient. Assessments were detailed and used nationally recognised nutritional screening tools. In adult services where patients were at risk of malnutrition referrals had been made to the

## Our findings

### Evidence based care and treatment

Staff used evidence based guidance to ensure they delivered effective care. For example, the trust had a family nurse partnership (FNP) team in Liverpool. The FNP was a voluntary health visiting programme for first time mothers that was underpinned by internationally recognised

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dietitians for advice and support. The community nutrition support dietetic team worked across Liverpool as well as having good links with the city's hospitals which enabled collaborative working.

## Patient outcomes

Staff from all the clinical services were able to describe audit that had taken place within their clinical area. In end of life services, 4 local audits had been undertaken including use of NICE guidelines. In community adult services, 52 audits of had been completed between September 2013 and February 2014. We looked at the chronic respiratory palliative care outcomes audit 2013/2014 which showed actions had been identified for completion by July 2014 and included increased awareness of trigger factors for patients accessing supportive palliative care and improved documentation and training for staff.

Outcomes for children, families and young adults using the service varied when compared with other services and national targets. For example, the Family Nurse Partnership annual audit report 2013 found the Liverpool Family Nurse Partnership team had met three out of five targets in the pregnancy stage, four out of five targets in the infancy stage (improvement on 2012) and one out of five targets in toddlerhood stage. The report demonstrated that performance had been reviewed and actions were in place to improve outcomes.

The trust had up to date procedures for registering and completing a clinical audit. All divisions participated in the audit programme with a combination of undertaking at least 2 trust priority audits and additional audits of the division's choice. The central governance team monitored the implementation of the clinical audit forward plan and completion of actions. This monitoring was compiled into a report for the integrated governance and quality committee.

We were provided with a selection of audits completed in 2014. These all had appropriate actions plans to address the recommendations within the audits. All actions had a lead and timescale for completion.

## Performance information

The trust used the NHS Safety Thermometer which is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. We looked at the figures for the last 12 months which showed the trust

was the same as the national average for falls with harm but was below the national average for venous thromboembolism (VTE) and new urinary tract infections (UTIs) for patients with a catheter. The results for district nursing services showed between 90%-100% harm free care was achieved in most localities.

On inpatient wards, the trust recognised that performance information relating to falls was a particular concern and the Falls Safe Measures Audit 2013 supported this. The trust introduced a Fall Safe Care Bundle across the three bed-base wards to address safety concerns.

Performance information was available down to team leader level, and there were regular meetings held through the divisions to discuss both clinical and staffing performance including complaints and complements received. However staff told us that there was limited trend analysis taking place, and each division tended to work in its own silo.

## Competent staff

Staff told us that access to mandatory training had improved recently. The trust had implemented a 3 day mandatory training programme held in a single block which staff were able to attend. Performance review rates were good for all teams at around 90% for the different divisions. Staff that had recently gone through the induction programme were positive about it, and staff were able to access professional training in line with their specialism. A range of leadership and management training had also been developed.

Supervision whist received by some staff, for example end of life staff received supervision from a consultant from Marie Curie, but was not universally available to all staff. The trust had taken action to improve access to supervision but this still requires further development.

During our inspection of Ward 35 in December 2013 we identified major concerns regarding how staff were supported. During this inspection we reviewed information in relation to staff training and professional development including induction, mandatory training, appraisal and clinical supervision. Training needs analysis had been completed for all staff and it was known what training each staff group was required to complete.

We reviewed mandatory training data for all three wards and overall compliance at the time of inspection was around 71%. This had increased from the previous year

# Are services effective?

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which was around 60%. We could clearly see the efforts being taken to improve delivery of and attendance at mandatory training and compliance figures were continually improving. Induction compliance figures for inpatient wards were acceptable.

There had also been significant increases in attendance at non-mandatory training and focus on essential skills training for staff including catheter care, dementia awareness and wound assessment. There had been a recent focus on developing the appraisal process and the trust had introduced a new performance appraisal process towards the end of 2013. We spoke with the ward manager for ward 35 and it had been recognised that during the previous year appraisals, mandatory training and essential skills training had fallen behind. However, there had been a focus on improving compliance and this had been achieved.

Plans were in place to improve supervision for staff and it was recognised that work still needed to be done to fully embed the process. A clinical supervision policy had been developed in 2013 but the priorities had been on mandatory training. Clinical supervision was happening with some nursing groups and there were plans to continue to develop compliance with clinical supervision; particularly for nursing staff.

## **Use of equipment and facilities**

Facilities that we visited were well maintained and fit for purpose. The trust was in the middle of a programme to move clinical staff to hub locations from locality based premises, many of which had not benefited for purpose. Some staff felt that the potential problems of moving to a hub location had not been fully considered, for example loss of local ownership and knowledge of patients and increased travel times. Some action had already been taken including changes to mileage allowances to take into account the increased travel distances, but further engagement was required.

Staff did not raise any concerns regarding access to equipment, though the ordering process for one team in children and family services was carried out by administration staff that had to wait for clinical staff to check and approve the order. This had resulted in delays in obtaining the correct equipment.

We visited two equipment loan sites and found the service was working proactively with staff to implement a major

restructure of the service. New practices were in place to improve the efficiency of equipment delivery within a seven day target. Equipment was prioritised using a critical risk matrix. For example critical equipment referrals were processed within 24-48 hours and procedures were in place for issuing equipment out of hours and for the end of life services. The operations manager told us they were meeting with clinical leads each month to discuss key priorities relating to equipment risks and we saw action plans were in place and concerns had been escalated to the trust risk register.

## **Telemedicine**

The trust was developing telehealth which used electronic information and communication to provide long-distance healthcare and health related education to patients in their home rather than having to go to hospital unnecessarily. The trust had carried out a telehealth patient experience survey in May 2014 which showed improvements in patient health and wellbeing, management of blood pressure and weight and greater control of their long term conditions. Patients we spoke with were very positive about the system and confirmed they felt in control of their condition and could access clinical advice quickly.

## **Multi-disciplinary working and working with others**

Multi-disciplinary working was generally good in most teams. In end of life services, we visited a Gold Standards Framework (GSF) meeting with a member of the team and saw multi-disciplinary working in practice during a home visit with both community nursing and Marie Curie staff. Each team routinely conducted staff meetings and we saw evidence of shared learning.

Clinical staff at walk in centres worked effectively with staff from local hospitals but did not have regular contact with primary care colleagues. Community services for adults worked effectively with primary care colleagues, though this was more variable in children and family services. For example the North Sefton complex care team had clear processes in place for transition from child to adult services; however this was not the case with all teams.

Across inpatient ward we observed patient care and multi-disciplinary team working between nurses, GPs and allied healthcare professionals such as occupational therapists and physiotherapists. Staff commented that working relationships had improved with the new management structure. We spoke with a therapies manager and they felt

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that structures and governance were much improved and the introduction of a therapies lead had enhanced working arrangements across bed base, especially between nursing and allied healthcare staff.

## Co-ordinated integrated care pathways

Care pathways were in use with clinical teams and links were in place with a range of key professionals, for example in adult services, the respiratory team worked closely with national and regional networks such as the British Lung Foundation. In children and family services Health visitors used a perinatal mental health pathway to identify mothers at risk of developing post natal depression. The pathway was based on NICE guidance and was followed from the initial birth visit through to the 12 month visit. A clear flowchart and guidance document were in place to support staff in how to complete the pathway and identify appropriate interventions that may be required.

We spoke with inpatient staff about integrated care pathways and it was felt that, in general, discussions

between multi-disciplinary teams were structured and the handover of patients was well co-ordinated. We observed positive and constructive working relationships between bed base and social services in the planning of and integration of care. The main area of concern was the relationship between bed base and local acute trusts. There were examples where patient care was affected because co-ordination of care was not managed well. For example, some patients were admitted to bed base from the nearby acute trust and promptly re-admitted; this was often due to poor communication and sharing of inaccurate information.

There were also some weaknesses in terms of discharge planning. Several patients on bed base no longer required the levels of care and support they initially required and were suitable for transfer to other healthcare facilities or social care. In some instances, with some patients, there was limited discharge information and / or discharge planning.



# Are services caring?

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

## Summary of findings

Patients were overwhelmingly positive about the quality of service that they received. We saw care being delivered across a wide range of services, and staff treated patients with dignity and respect.

Patients told us that they were involved in planning their care and provided with enough information to make informed decisions. Staff were passionate about the care they delivered. This was reflected in the comments made by patients and their relatives.

We identified some staff on inpatient wards who were less approachable with patients, and whilst we observed staff providing emotional care to patients, evidence in care records did not document how best to meet the emotional needs of patients.

## Our findings

### Compassionate care

We spoke with and received comments from around 200 patients and / or their carers during the inspection and they were overwhelmingly positive about the quality of care that they received. We observed staff caring for people with empathy and compassion. Patient survey results were also positive with high levels of patient satisfaction. For example, we looked at the patient experience survey results for health visiting (February 2014), community matrons (April 2013), Sefton occupational therapy (February 2014) and Sefton physiotherapy (February 2014). All the surveys showed high levels of patient satisfaction with the services provided. 99% of respondents to the health visiting survey and 100% of respondents to the community matrons, physiotherapy and occupational therapy surveys said they had confidence and trust in the staff supporting them.

We noted some staff that were unnecessarily abrupt with patients on the inpatient wards. We discussed our concerns with the interim manager who was already aware and had begun to address the situation.

### Dignity and respect

We observed patients, children, young adults and their families being treated with dignity and respect. Staff were polite and respectful in their approach to individuals, and in discussions about treatment options. Patient experience results supported these positive observations.

### Patient understanding and involvement

Patients or their relatives we spoke with indicated that they were involved in the planning and involvement of their care, though there were exceptions to this on some of the inpatient wards. The majority of services provided a range of information for patients. We did not identify information in end of life services; however patients we spoke with did not raise this as a concern.

The majority of respondents to the health visiting survey indicated they were involved in decisions about their treatment, and staff in children and family services used a variety of methods to engage with and involve children and young adults, including the use of Skype to carry out some therapy sessions.

Staff we spoke with were clear with regard to their role in gaining consent to treatment both verbal and written, and records demonstrated consent had been sought prior to treatment.

### Emotional support

Patients and relatives told us that they received appropriate emotional support. In adult community services we observed staff using a holistic approach to care including assessing patients for physical, social and spiritual needs.

In children and family services, we saw one example of extensive support provided to a mother who had suffered from post-natal depression. The family told us they appreciated the support and guidance the health visitor had offered to enable the family to cope during such a difficult time.

We observed staff on inpatient wards providing emotional support but care records were less clear what support patient required when this was on an on going basis.

### Promotion of self-care

Staff supported the concept of self-care with their patient groups. In the walk in centres an initiative called Every Contact Counts promoted the use of health promotion interventions in such areas as smoking cessation, oral

## Are services caring?

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health and dietary advice, in adult community services, staff supported patients to learn and recognise early signs and symptoms of heart failure and chronic respiratory disease. In children and family services, the continence team used self-help packs and staff reported this had resulted in patients not requiring their service any further.

Whilst the central premise of the inpatient wards was to assist patient rehabilitate, due to the health status of many patients this did not occur.

# Are services responsive to people's needs?

Requires Improvement



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

## Summary of findings

Some targets of the Healthy Child programme were not being achieved, and there were long waits to access wheel chair services and non-obstetric ultrasound services. Though action plans were in place to deliver improvements in wheel chair services this was not expected to be achieved in the short term.

Staff were aware of the different needs of their local populations and endeavoured to provide flexible services as close to the home of people as possible. Performance at walk in centres was good.

Staff assessed the individual needs of people and ensured that services met needs though there was some risk when children moved from health visiting to school nursing services.

Staff worked hard to meet the needs of people on inpatient wards but, at times, it was challenging because of the acuity levels of some patients. Many patients had multiple healthcare needs that did not enable them to engage actively in rehabilitation activities. Falls prevention was judged to override the rehabilitation needs of some inpatients resulting in reduced rehabilitation activities.

Complaints information was available and there were systems in place to investigate and feedback to staff. Learning took place at the board and there were examples of patient's stories at board level with associated learning.

One concern was raised with us during the inspection, and that was with regard to the co- location of the walk in centre with the sexual health clinic. Some people told us that they felt embarrassed attending the shared waiting area and reception for sexual health services when attending the walk in centre. Other people were less concerned and felt that it may break down barriers to people attending for sexual health. We did not find evidence of any plans to address the issue to ensure people's privacy and confidentiality were maintained.

Admission criteria had been reviewed on the inpatient wards, and the trust is engaged in the pan Liverpool Healthy Liverpool Programme to agree the future needs of patients across all services.

Overall the walks in centres performed well when compared against the England average key indicators. Data showed that the centres consistently met or exceeded the threshold of 5% set by the department of Health, for re-attendance. The re-attendance rates were important as they may indicate an initial incorrect diagnosis or poor initial treatment.

The trust set its priorities around its dementia strategy for 2013/2014. This included the roll out of dementia screening to a number of different services, continued training and development for staff and ensuring the right support was in place. Staff told us that access to training was variable.

The divisional manager for primary care and public health was able to discuss the wide range of services the trust provides for meeting people's needs. For example the sexual health service had responded to feedback from patients. We were also told how hard to reach groups, such as gay and lesbians, were engaged with through members of staff going to nightclubs to promote health services.

In children and family services, staff understood the needs of the local population, and provided a range of services to meet people's needs. The recent service redesign and a change to commissioning to continue to deliver the 0-5 years immunisations for a further 2 years had impacted on the ability of the health visitor service to deliver against key areas of the Healthy Child Programme. For example, one of the health visiting teams told us they had to cancel new birth visits in order to undertake immunisation and vaccination clinics.

## Our findings

### Service planning and delivery to meet the needs of different people

Staff understood the needs of the local populations, and there were a range of examples where services had been developed to meet local need, including the development of evening, weekend and early morning clinics to improve access for patients.

In end of life services, regular gold standards framework meetings took place involving health and social care professionals, and staff had developed services to support homeless people who required end of life services.



# Are services responsive to people's needs?

Requires Improvement



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

## Access to care as close to home as possible

There were a range of services that were available across the city to ensure that patients, children, young people and their families could access care as close to their homes as possible.

There were four adult and one children's walk in centres across Liverpool and South Sefton which provided ease of access for people. Children's and family services provided a range of services in family homes, schools and the community; drops in sessions were held in GP practices.

End of life services were delivered in people's own homes or at local hospices and patients reported a flexible service.

We found that the community virtual ward was well led by clinicians and there was an effective system of review of patient's needs in weekly multidisciplinary meetings. By working together more closely through the virtual ward, the team was able to manage each patient's condition to keep them well and prevent them from being admitted to hospital unnecessarily. The team was able to access extra advice and help from a range of services that were appropriate for a patient's care. This included heart failure nurses, respiratory team, diabetes team and dieticians.

## Access to the right care at the right time

In adult services we found generally good access to services across the trust, with some services providing flexible clinic opening times including weekends and out of hours. For example, the anticoagulation and blood testing services operated several clinics across Liverpool providing flexible appointment times and domiciliary visits for housebound patients. Advice lines were also available for patients to contact and discuss medication or clinical changes. Patients confirmed they were able to choose appointment times which best suited their needs. Figures showed waiting times in most services were meeting national targets.

The integrated performance and quality report, presented to the trust board on the 25th March 2014 showed that 2 improvement priorities for 2013/2014 involving access were not met. These were wheelchair service assessment waiting times, where the aim was for a 4 week maximum waiting time but the February data and the forecast outturn was 20 weeks; and non-obstetric ultrasound waiting times where the target was for a 6 week maximum

wait but as at February 2014 was 13 weeks. There were action plans in place to rectify these, though the waiting times for the wheelchair service were not expected to improve in the short term.

On inpatient wards, we found that staff, with some patients, were not clear about the reasons patients were still on the ward's. Many patients were suitable for discharge and in some cases delays in arranging social care support were delaying discharge. There was a lack of ownership of the problem of delayed discharges and staff felt there was some leadership lacking in terms of ensuring patients were discharged at the right time and in a timely way. However, the average length of stay for patients on bed base was within average limits compared to other community trusts.

Walk in centres operated 365 days of the year with extended opening hours, staff skill mix was reviewed to ensure that the correct staff were available to provide care, and staff levels varied to ensure that care could be provided effectively at times of peak demand. Data indicated that the walk in centres met access targets with treatment times averaging one to two hours.

In children and family services we found the speech and language therapy team had set up drop in sessions to try and support parents and children who were on the waiting list. The aim was to reduce parental anxiety and provide faster access to advice possibly reducing the need for a referral or to reduce the length of clinical input required. A review of the impact of the drop in centres after the first three months was undertaken and parents' feedback was positive.

## Flexible community services

The majority of services aimed to be as flexible as possible to the needs of the local communities. We identified one or two concerns, evening district nursing services were being stretched when attending visits in North Sefton due to the travel distances, though managers were reviewing this with local commissioners.

Community nursing teams identified the call centre or single point of contact (SPC) as a continuing risk which affected the flexibility of community services. The teams remained concerned about possible delays of patients being seen, confusion for patients trying to contact them at

# Are services responsive to people's needs?

Requires Improvement 

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

weekends and out of hours and ensuring that the SPC gave patients the correct information. The trust had identified the telephony infrastructure on its strategic register and an action plan was in place to mitigate the risks.

## Meeting the needs of individuals

Records we reviewed, staff we spoke to and patients, children, young people and families we spoke with all told us that staff endeavoured to meet their individual's needs. Assessments indicated that individual needs including emotional, spiritual and physical aspects were assessed. Staff told us how they could access interpretation services should they be required.

The needs of patient within inpatient settings was not always being met, partly due to the acuity of the patients, but also due to the need to balance the risk of falls assessment with rehabilitation input.. For example, the key aim for one patient who had recently had surgery that affected their mobility was to support them to walk using walking aids. However, the person's assessment in terms of risk of falling meant that physiotherapy staff were limited with the amount of therapy they could provide. The balance of risk versus the need to rehabilitate was not ideal in this case.

This was true with other patients, in that the risk of falls assessments meant that rehabilitation input was limited. Many patients with a high risk of falls had a buzzer that alarmed if they stood up unaided; physiotherapy staff said that rehabilitation was slow because nursing staff were sometimes reluctant to detach the falls buzzer.

## Moving between services

People moved between services effectively in the majority of circumstances. In children and family services there were systems in place when a child moved from health visiting to

school nursing or into adult services, and as has been described earlier recent changes had led a backlog of assessment for children moving to the care of school nursing.

Staff at the adult walk in centres had developed links with the local ambulance service to ensure when patients required transfer to an acute hospital this took place effectively.

In adult services a single assessment process took place in conjunction with GP's and nurse prescribers to ensure patients received care continuity of care when discharged from hospital.

## Complaints handling (for this service) and learning from feedback

We saw posters and leaflets at various clinics providing information as to the trusts complaints procedures. Staff indicated that they received feedback following complaints, and there were examples of learning from complaints.

Examples of actions taken in response to individual complaints were seen for all divisions in the Aggregated Data Annual Report 2013/2014. During 2013/2014, the trust received 140 complaints and took an average of 17.2 days to close a complaint, against a target of 25 days. The Trust offered meetings with complainants at the beginning and end of the complaints process. To support staff with learning from complaints, the Customer Services Department would write to individual members of staff following a complaints investigation. This provided the member of staff with a copy of the complaint and final response, and an opportunity to meet with the Customer Services Department if they are unhappy with the investigation process or would like any further support or information.

# Are services well-led?

**Requires Improvement** 

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

## Summary of findings

### Instructions

There had been recent changes to the senior leadership at the trust which had been positively welcomed by staff. Staff reported that they had already noted improvements in the culture of the organisation, and some of the punitive policies had been reviewed and changed.

During our last inspection in December 2013 we identified a range of weaknesses in the governance arrangements across the organisation. During this inspection we noted a wide range of improvements to systems and processes, but noted that the trust still had further work to embed and develop these. In particular the trust needed to engage fully with staff, and improve the quality impact element of its cost improvement plans. The board needed to refocus from an organisation whose focus was predominantly one of finance to rebalance this to one of finance and quality. The trust needed to ensure it continued to develop its systems to share learning and reduce the silo working that took place within its divisional structures.

Having noted these concerns and challenges there were still positive developments at the organisation. The quality of care was good, and innovation took place across pockets of the organisation. Health promotion was particularly strong.

frustration when counter proposals were ignored. Staff told us this resulted in an internal divisional focus and silo working. Staff delivering patient care, felt that their contributions to quality impact assessments had been ignored.

The trust board was aware that this was the view of staff and had plans to support staff to more effectively contribute to quality impact assessments, and put quality and patient safety first. The medical director was currently reviewing the integrated clinical and quality strategy and had involved a clinical reference group for clinical engagement with this review. The medical director understood that clinicians needed to be able to make service improvements for patients for quality purposes and not as part of cost improvements alone. Future plans included working with localities to empower clinicians to lead in their service areas. The revised strategy was anticipated to be complete in June 2014.

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

The trust board had a committee structure to support it in managing risks and the business of the organisation. However, it had been acknowledged by the trust that this structure could be improved further. The integrated governance and quality committee, a subcommittee of the board, had responsibility for quality, risk, patient safety and all workforce issues. The non-executive director chair for this committee explained that the agenda was too large and that key pieces of information that should have been escalated to the board had been missed in the past. To minimise the risk of this happening again, an action tracker had been introduced to the committee and actions were not taken off the tracker until evidence of completion had been seen.

The committee structure was currently undergoing a further review. Discussions were held around poor attendance at the clinical effectiveness group and patient experience group, which were to be taken into consideration as part of the review. One of the main concerns discussed was the size and scope of the agenda for the integrated governance and quality committee and whether a separate committee for workforce issues would better serve the trust board in managing these risks. The medical director confirmed that these issues were picked up as part of the review with the head of governance.

## Our findings

### **Vision and strategy for this service**

The trust had a vision, and some services had a clear local strategy in place, for example end of life services. The trust had three strategic objectives; integration, prevention and growth, but staff were not clear as to the vision and values of the trust.

Staff at all levels of the organisation stated that the main drive for the organisation had been financial targets through the development of cost improvement plans. Quality impact assessment had formed part of this process, but was often limited in scope and staff involvement. We were given a number of examples where senior staff had been given unrealistic cost savings to make, and heard of

# Are services well-led?

**Requires Improvement** 

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

As an aspirant foundation trust, the trust had been assessed against Monitor's quality governance framework. The initial assessment was undertaken by Deloitte and gave a score of 4.5; the trust's own self-assessment was then reduced to 3.5 prior to participating in a pilot with Monitor undertaking the review. Monitor assessed the trust to be 7, which meant the trust did not meet the requirements to progress with its foundation trust application.

Further to the December 2013 inspection, progress had been made with the risk register. The head of governance had met with divisional managers to review all risks with a score greater than 15. This review had included the risk description, controls, adequacy of controls, consistency of risk rating and planned actions. The template for the risk register had been amended to include the adequacy of controls and a progress update. The divisional managers had been tasked with reviewing all other risks on their risk registers with the risk owners.

Amendments had also been made to the board assurance framework to provide an overview of the risk journey. An 'at a glance' table had been included at the front of the framework to enable the trust board to see the initial, current and target risk scores. The board assurance framework was last reviewed in January 2014 and was currently undergoing a review for May 2014. This meant that some of the gaps in assurance, such as the CQC inspection findings from December, were not fully captured in the approved document. However, we did see evidence of this in the working draft that will be presented to the trust board in June 2014. Part of the recent review had included the divisional risk registers and including any clinical risks as gaps in controls against the relevant strategic risk.

## Leadership of this service

Staff across delivery areas indicated that they felt well led by their local managers. Staff locally felt well supported, but were critical of the recent leadership of the organisation. We were told of a variety of punitive policies that had been in place. Senior managers told us of a culture of bullying that they had been subject to, a focus on financial cost savings, and a lack of engagement and involvement.

Recent changes on ward 35 had resulted in a high number of nurse leaders on the ward at present. Staff felt this had led to a reduction in clear leadership and decision making.

Morale amongst staff had been low. There have been recent changes to the leadership of the organisation and the trust currently has an interim chief executive, interim director of nursing, interim director of operations, interim director of performance and an acting director of human resources and organisational development. Staff we spoke with were positive about the recent changes. Staff felt there had been an immediate change in culture, and whilst they recognised that there were challenges to develop and improve services, had greater confidence in the leadership of the organisation than they had in recent years.

Further development was required with regard to engagement with commissioners. Senior managers expressed frustration that they had often not been included in contract negotiations, or the ability to move resources around as the contracts would not allow that flexibility. For example one senior manager was successful in obtaining additional funds from the commissioner for community equipment on a non-recurrent basis even though activity was increasing rather than decreasing; while another senior manager was unsuccessful but the trust had taken the decision to invest in this service. Discussions around reducing some contracts to invest in others services appeared not to be encouraged with no overview or understanding of the whole contract.

## Culture within this service

Staff were generally positive about the culture within their service, and believed that they received effective support from their line managers. As noted staff described a shift in culture recently, had noted an increase in engagement and felt their voice was beginning to be heard.

Many staff identified that they had had real concern about the organisation but as noted had been positive about recent changes. CQC had received a high number of whistle blowing concerns before, during and after our inspection in December 2013 linked to these concerns. We were told during the inspection by a number of staff about the bullying culture that they perceived had been in place at the trust, which had had an impact on people individually as well as driving a 'heads down' mentality which had further encouraged silo working. Senior staff told us of a culture that relied on the use of numerous meetings and an email culture that perpetuated a long working hour's culture.

Staff focus had remained on delivering a high quality service, and this was reflected in patient surveys and our

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finding during this inspection. Senior and board staff interviewed also reported that whilst there had been considerable problems with the governance of the organisation, the quality of care had always remained a priority for staff.

## **Public and staff engagement**

A range of patient surveys have been undertaken across all clinical services. The results of these all suggest a high level of satisfaction with the quality of care. In adults services, the community equipment and disability advisory service had held a user event to encourage users of community services to feedback on their experience and to sustain the engagement of individuals who could be lifelong users of the service. Minutes of the June 2014 meeting showed a number of improvements had been made in communication, delivery times and replacement equipment.

Staff told us that engagement with them had improved recently. The trust had started the Listening into Action programme and had held the 8 'big conversations'. Over 300 members of staff attended the programme in total and came up with over 100 ideas. The top 10 ideas had yet to be decided, although this was being done with the support of the Staff Side Steering Group. Some staff whilst aware of the Listening into Action events were frustrated that they had not been able to attend due to work pressures. Other examples of engagement with staff include staff and matron surgeries.

Following our inspection in December 2013, the trust engaged the services of ACAS the conciliation service to review and capture the concerns of staff that were being raised through whistle blowing concerns to both CQC and a local MP.

There was some learning at board level from patients; examples were provided to us of learning from patient stories. Patients were invited to present their story to the trust board to share their experience and facilitate learning.

The stories were largely identified through complaints although examples were also available through other routes, for example one patient had helped the trust deliver domestic violence training in response to her experiences.

## **Innovation, improvement and sustainability**

We identified a range of innovation and improvements to services, the respiratory team had developed point of care testing for blood gas analysis which enabled trained nurses to carry out tests in patient homes avoiding unnecessary admissions to hospital.

The trust was one of three in the country participating in a pilot run by the Royal College of Paediatrics and Child Health for the e-Redbook. The e-Redbook is an online personal child health record based on the existing, paper-based, Redbook. It is designed to allow parents/carers to maintain records of their child's health online. Although not fully rolled out across the division, staff were being provided with iPads that enabled remote access to information such as NICE guidelines and the British National Formulary. We saw how staff were using iPads to engage patients and improve learning and health promotion during home visits.

Clinical staff all had iPads that allow them to access a variety of clinical systems and had a number of bespoke applications on them. This had been internally developed by a member of staff and was called the 'OPERA' system. Managers had the ability to view mandatory training data, appraisal data, complaints and incidents in their areas.

Most staff we spoke to were positive about being able to connect using a tablet device to mobile technology which enabled them to access and add to the patient's electronic health record whilst working in the community. There were some challenges regarding access to other electronic systems and the trust was addressing connectivity issues for these staff members.