Bridgewater Community Healthcare NHS Foundation Trust

Quality Report

Bevan House,
17 Beecham Court,
Smithy Brook Road,
Wigan,
WN3 6PR
Tel: 01942 482630
Website: http://www.bridgewater.nhs.uk/

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Core services inspected	CQC registered location	CQC location ID
Urgent Care Services	Bevan House	
Community Inpatient Services	Bevan House	
Community Dental Services	Bevan House	
Community Health Services for Adults	Bevan House	
Community Health Services for Children, Young People and Families	Bevan House	
Community Sexual Health Services	Bevan House	
Community End of Life Care	Bevan House	

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 effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Letter from the Chief Inspector of Hospitals

We last inspected this trust in April 2014 as part of the pilot project of our new comprehensive inspection methodology. We did not rate the Trust at that time.

However we told the trust that they must make improvements to:

- Incident reporting and learning from incidents.
- Ensuring all staff had appropriate safeguarding training.
- Improving the standard of record keeping and IT systems.

We carried out an announced comprehensive inspection of this trust between 31 May –3 June 2016 and an unannounced inspection on 16 June 2016 to make sure improvements had been made and to rate the service. As part of the inspection, we assessed the leadership and governance arrangements at the trust and inspected the all core services provided by the trust:

- Community Health Services for Adults.
- Community Services for Children, Young People and Families.
- Community Inpatient Services.
- Community Dentistry Services.
- Community Sexual Health Services.
- Urgent Care Services.
- Community Midwifery Services.
- Community End of Life Services.

Before carrying out the inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust and its services. These included local clinical commissioning groups (CCGs), NHS Trust Development Authority (TDA), NHS England, Health Education England (HEE), and the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Royal colleges. Patients also shared information about their experiences of community services via comment cards that we left in various community locations across the Halton, Oldham, Southport, St. Helens, Warrington, Wigan Borough and Trafford areas.

Since the last inspection, there had been a number of changes to senior staff at the organisation and there had been a concerted effort to improve the culture and support for staff, which was evident in the majority of services at the time of the inspection.

The trust had developed a transformation programme that had led to services being delivered within a framework of localities across the trust's geographical footprint.

It was evident that the trust had sought to address the findings of our last inspection and improvements had been made in some areas. However in some cases progress in making the necessary changes was slow with a lack of consistency across the trust and services. Some services required further improvement and were still not meeting important targets, such as those for the healthy child programme, the development of the end of life strategy and the implementation of consistent IT systems across the trust.

Our key findings were as follows:

- At this inspection we saw significant improvements in culture especially in inpatient services.
- Staffing had improved in the community since the last inspection but there were some concerns about the number of staff in children's and young persons services particularly consultant paediatricians.
- Performance against key metrics in the Healthy Child Programme had improved but progress had been very slow and performance was still below key national targets.
- Waiting times in the community adults and the children, young people and families' service had improved in some areas but not in all.
- An example of this was the trust reported that 200 children, in St Helens that had been transferred care from another trust, in November 2015, had not been reviewed by a community paediatrician. The trust developed an action plan that stated that all children needing review would be seen by the 31 July 2016.

Summary of findings

- In Urgent Care and Walk-in Centres there was a lack of uniform triage processes that met with national guidance.
- The trust medicines strategy expired in 2013. We were told that the strategy, standard operating policy and terms of reference would be reviewed when the new head of medicines management started in June 2016.
- We found unsafe practise regarding the prescribing of end of life medication because it was open to mistake or abuse.
- The trust's visions and values were widely understood and visible across services however end of life, dental, midwifery and children's and young people's services did not have clear embedded service specific strategy, vision and values.
- The governance systems needed to be improved in some key areas to ensure that the trust are using all available information to measure quality and drive improvement in services.

We saw several areas of **outstanding** practice including:

Community Services for Adults

The matrons at Wigan worked with the North West Ambulance Service (NWAS) utilising the community care pathways (CCPs). The community care pathway consisted of a yellow folder containing the patients care plan; their medication and medical history. The community care plan was left at the patients address next to their telephone. When the patient rang for an ambulance the address would trigger an alert to identify that the patient was on the community care pathway and a matron was involved. This would enable ambulance paramedic staff to determine the most effective referral and treatment options for known patients. One option for the paramedic would be to contact the community matron to attend the address allowing the paramedics to continue onto another patient.

Patients who have known healthcare needs and long term health conditions can have individual care plans produced; this reduced unnecessary hospital admissions and alleviates pressure on A&E departments.

Inpatient Services

We observed staff treating patients and their relatives with the upmost dignity and respect. Patients told us staff were exceptionally kind, caring and compassionate. Staff were exceptionally attentive and responded quickly and compassionately to patients who needed help or assistance, they anticipated the needs of their patients and offered assistance proactively.

Children and Young Peoples Services

The Parallel service, in Bolton, was a new service within Bridgewater that offered a 0 – 19 years' service for young people as a single point of contact for a range of services. We found the staff to be passionate and committed to young people with a range of specialist skills.

Urgent Care and Walk in Services

The joint initiative for hospital avoidance between Bridgewater and North West Ambulance Service was the highest performing admission avoidance pathfinder initiative within the North West.

End of Life Care

The development of an AHP specialist palliative care team was an example of outstanding practice in this service.

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

Importantly, the provider **must**:

Trust Level

- Ensure the trust medicines strategy and standard operating policy is up to date.
- Ensure that robust systems are embedded in all services to assess, monitor and improve the quality of the services provided.

Community Services for Children, Young People and Families

- Ensure that children / young people are reviewed in a timely manner and provide assurance of safe care and treatment in the delivery of the service.
- Ensure staffing levels for all clinicians are consistently sufficient to meet the demands of the service.
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Urgent Care and Walk in Services

- Ensure that patients are triaged appropriately in line with national guidance.

End of Life Care

Summary of findings

- Ensure that there is a trust wide vision for end of life services, which is in line with national guidelines and recommendations.
- Ensure that there is a trust wide strategy for end of life services.
- Ensure that there are trust wide governance systems to monitor progression towards national targets.
- Ensure that an individual plan of care is embedded into all documentation for patients at the end of their life.
- Ensure that there is a safe and consistent system of documentation for end of life medication across all services.

Midwifery Services

- The provider must ensure that staff have the necessary competencies, knowledge, skills and experience in order to deliver care and treatment safely during a homebirth.
- The provider must ensure routine or mandatory trust rotation into the local acute trusts, to keep staff updated with skill aptitude and proficiency.
- The provider must ensure regular training for pool deliveries to ensure staff competencies and trust policies are followed correctly.
- The provider must ensure that basic emergency and resuscitation equipment are immediately available for their homebirth service.
- The provider must ensure staff training for any new emergency equipment purchased.
- The provider must ensure a more robust audit system to assess trends, implement lessons learnt and improve practice and services.
- The provider must ensure the development of robust action plans and methods of implementing audit findings.
- The provider must ensure how risks and incidents are assessed and managed and provide a robust feedback system to staff.
- The provider must ensure easy accessibility and storage location of resuscitation trolleys at the HCRC and the Runcorn clinics and that all midwives take responsibility for daily checks to ensure staff competency in using the resuscitation equipment.
- The provider must ensure the safe and effective use of patient data collection using digital pens.
- The provider must ensure improving the emergency nurse call bell system at the HCRC.
- The provider must ensure establishing a Maternity Services Liaison Committee (MSLC), to enable for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families.

Dentistry Services

- Ensure the safe management of medicines and stock control of medicines.
- Ensure the safe stock control of dental instruments.
- Ensure the safe infection control management of used dental instruments on localities where cleaning and sterilisation of dental instruments is provided by a third party company.
- Ensure internal and external assurance systems are in place and managed that ensure clinical services are delivered in a safe, effective, responsive and well-led manner.
- Ensure learning from incidents and complaints is shared and embedded with all staff.

For shoulds please see individual core service reports

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our inspection team

The Inspection team included 12 CQC inspectors, two inspection managers, an assistant inspector and a variety of specialists: an urgent care matron, an occupational therapist, a physiotherapist, a consultant paediatrician, a health visitor, a midwife, a school nurse, a dentist and a governance specialist.

Why we carried out this inspection

We previously inspected Bridgewater Community Health NHS Trust in April 2014 as part of the pilot project of our new comprehensive inspection methodology. We did not rate the trust at that time.

Our main concerns in April 2014 were, incident reporting and learning from incidents, ensuring all staff had appropriate safeguarding training, improving the standard of record keeping and the IT systems used in the trust.

This inspection was a planned comprehensive inspection. The inspection was announced and was to enable the trust to be rated and follow up on concerns at our previous inspection.

How we carried out this inspection

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

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

We carried out an announced comprehensive inspection of this trust between 31 May– 3 June 2016 and an unannounced inspection on 16 June 2016. At this inspection, we assessed the leadership and governance arrangements at the trust and inspected the all core services provided:

- Community Health Services for Adults.
- Community Services for Children, Young People and Families.
- Community Inpatient Services.
- Community Dentistry Services.
- Community Sexual Health Services.
- Urgent Care Services.
- Community Midwifery Services.
- Community End of Life Services.

Before visiting, we reviewed a range of information we requested from the trust and asked other organisations to share what they knew about the trust and its services. These included local clinical commissioning groups (CCGs), NHS Improvement, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Royal colleges.

We held focus groups and drop-in sessions with a range of staff, including district nurses, health visitors, school nurses and allied health professionals (AHPs). We also spoke with staff individually as requested.

We talked with patients and staff in ward areas and community clinics. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Summary of findings

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Bridgewater Community Health NHS Trust.

Information about the provider

Bridgewater Community Healthcare NHS Foundation Trust is a provider of community health services in the north west of England. The trust provide community and specialist services to 831,270 people living in Halton, Oldham, Southport, St. Helens, Warrington, Wigan Borough and Trafford.

The trust's major funders/commissioners are NHS Warrington CCG, NHS Halton CCG, NHS St Helens CCG and NHS Wigan CCG and in 2014/15 the total trust income was approximately £140 million.

The trust employs over 3,240 staff and approximately 80 percent of those are practising health professionals including nurses, community matrons, health visitors, GPs, dentists, dieticians, podiatrists, physiotherapists, occupational therapists and speech and language therapists.

The trust provides community health services to adults, children, young people and their families. Services are provided for patients in their own homes and in over 60 locations including, 3 walk-in centres. Bed based care provided by Bridgewater community inpatient services comprised of a total of 117 beds across four sites. There is one 30 bedded community inpatient ward based at Newton-le-Willows community Hospital, this is the only inpatient facility that is registered to Bridgewater community NHS foundation trust. However there are also inpatient facilities at Padgate House with 35 beds, Maple Court with 12 beds and Alexandra Court with 40 beds. These facilities were registered to other providers but Bridgewater did have staff working in these facilities and the trust did have some input into the commissioning and management of these inpatient services to varying degrees.

Following a transformation programme undertaken by the trust, services are now delivered within a framework of localities across the trust's geographical footprint. These localities are, with each locality led by an associate director and clinical lead.

Bridgewater Community Health NHS Trust became an NHS Trust on 1 November 2010 and obtained Foundation Trust status in 2014.

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Areas for improvement

Bridgewater Community Healthcare NHS Foundation Trust

Detailed findings

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Overall the safe domain was judged as requires improvement. Improvements are needed in the end of life, midwifery, urgent care services and the dentistry service provided by the trust, the remaining services were judged as good.

- There were significant gaps in the management of medication at the trust. The trust medicines strategy expired in 2013, we were not provided with an updated copy of this.We were told that the strategy, standard operating policy and terms of reference would be reviewed when the new head of medicines management started in June 2016.
- In EOLC services the systems and processes for medicines management across the trust were not standardised and subject to an unacceptable level of variation with regards to risk. Some boroughs were using confusing documentation to authorise prescriptions for end of life patients and not complying with trust policy for this documentation.
- We found that, there was a practice in operation of GPs prescribing an unacceptably wide range of doses for end of life medications and district nurses titrating the medication dose upwards without medical review. District nurses reported they had not had training in EOL medications.
- This issue had not been picked up by the medicines management team. This practice was unsafe because it was open to mistake or abuse and consequently was escalated immediately to trust management and additional safety measures put in place.

Requires improvement

Are services safe?

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

- The assessment and response to risk was not consistently managed across all services. For example an Early Warning Screening Tool to manage the deteriorating patient was used in inpatient services however not at the urgent care centres.
- Also different Urgent care centres used different triage systems and did not always follow national guidance.
- Data from the national reporting and learning system (NRLS) (published September 2015, covering incidents reported to the NRLS between 1 October 2014 and 31 March 2015) showed that the trust could not be considered a consistent reporter as 50% of incidents were submitted more than 48 days after an incident occurred. The trust was a high reporter of incidents where no harm was caused, which indicates a positive reporting culture. However, the proportion of those categorised as severe harm was 2% higher than the community trust average. During the inspection in the majority of services there was evidence of a good culture of openness, reporting and investigation of incidents. There was evidence of positive improvements and changes made as a result of incidents.

However

- During the inspection in the majority of services there was evidence of a good culture of openness, reporting and investigation of incidents. There was evidence of positive improvements and changes made as a result of incidents.
- Staff were aware of the trust infection control policy and we saw good examples of practise in the majority of services.
- Following the last inspection we told the trust they must ensure there were sufficient numbers of staff to provide care and treatment. At this inspection we found that there had been a significant improvement in the number of staff across the majority of community services. For example, there had been a net increase of 57 district nurses since our last inspection and a further 20 were to be recruited.
- At the last inspection, staff told us they did not always feel safe when performing home visits. As a result, we told the trust they should take measures to protect the safety of all staff, and in particular staff working alone, in a consistent way. At this inspection, we found that there had been a significant improvement in the number of people accessing and using lone worker safety devices. The trust was monitoring and encouraging staff to maintain usage of the devices.

Our findings

Incident Reporting

- Data from the national reporting and learning system (NRLS) (published September 2015, covering incidents reported to the NRLS between 1 October 2014 and 31 March 2015) showed that the trust could not be considered a consistent reporter as 50% of incidents were submitted more than 48 days after an incident occurred.
- The trust reported a total of 1,263 incidents to the NRLS between February 2015 and January 2016, when compared to other similar trusts Bridgewater were in the middle 50%.40.7% (514) of incidents reported to NRLS resulted in no harm, 52% (666) of incidents were reported as resulting in low harm, 6.3% (80) in moderate, no incidents resulted in severe harm and 0.2% (3) resulted in death.
- The trust reported 116 pressure sores between February 2015 and February 2016 with the highest monthly number reported in July 2015.
- The trust reported 73 falls during the same period with the highest number 11 being reported in May 2015.
- However the trust had begun work to improve the incident reporting culture to improve consistency across services.
- During the inspection in the majority of services there was evidence of a good culture being developed of openness in reporting and investigation of incidents. There was evidence of positive improvements and changes made as a result of incidents. Learning was taken from the investigations and this was disseminated and shared with staff to prevent future occurrences in the majority of services.

Requires improvement

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- The trust reported a score of 3.78 in reporting staff confidence and security in reporting unsafe clinical practice.This figure is 0.17 higher than the 2014 survey. This figure is 0.02 higher than the national average for community trusts.
- The results from recent pressure ulcer audit, March 2016, evidenced that staff are now managing pressure ulcers and the prevention of pressure ulcers within trust and national guidelines, a consistent 10 steps approach had been followed in all investigations and documentation was of a high standard. However within dental, midwifery and end of life services more work needed to be done to ensure the culture of learning from incidents and complaints was embedded and cascaded to staff for example in January 2016, there were two separate incidents relating to out of date local anaesthetic medicines being administered to patients in dental services. Considering that during the inspection we found that at one dentistry service location five vials of a local anaesthetic had expired in May 2016, it became evident that learning had not taken place.

Staffing and caseloads

- The trust senior managers acknowledged that staffing had been problematic across some services especially at times of change and uncertainty, but they were working with staff to ensure safe staffing levels were safe until procurement processes had been finalised. This meant that some services were more affected by staff shortages than others.
- A 'weighting tool' was used across all the locations on the trust. The weighting tool assessed the acuity of the patients and enabled the district nurses to have a shared caseload and ensure that patients received safe care and treatment at all times.
- A recent external review (prior to April 2016) of Bridgewater community nursing workload and staffing study identified that that the community adult teams had a 52.9 whole time equivalent (WTE) staffing shortfall, based on current workloads.
- The trust was in the process of recruiting 20 district nurses to be spread across the trust.
- The same external audit showed temporary staffing (bank, agency and overtime) figures were close to the England average.
- Overall we saw a positive staffing group who felt their team's workload was safe. For example within inpatient services safer staffing records showed a minimum of 95% shift fill rates were maintained and the number of midwives employed met best practice Birthrate Plus recommendations 2007.

However:

- We found particular concern regarding staffing shortages for paediatricians, school nurses and therapists highlighted that had coincided with an increase in caseloads. There were shortages of paediatricians highlighted, in St Helens, that were needed to review children and young people that were transferred from a neighbouring trust in November 2015. This had not been resolved at the time of inspection.
- Also there were staffing shortages for paediatricians highlighted that had coincided with an increase in caseloads in Warrington.
- Long-term sickness and maternity leave "children's needs not being met, performance expectations not being met" was highlighted in the risk register report for children and young people was long term sickness and maternity leave cited as impacting on the service.

Medicines

- The management of medicines across services was not consistent and shortfalls in some services had not been identified through the trust internal audit processes, particularly in end of life services.
- The trust's medicine policies were available through the trusts intranet page and had review dates. Two accompanying Standard operating procedures (SOPs) set out time frames for medicines audits at intervals of monthly, 4 monthly and 6 monthly. When asked what oversight the medicines management team had to ensure compliance with the audits we were told that the team did not know if audits were being completed.
- The trust medicines strategy expired in 2013, we were not provided with an updated copy of this. We were told that the strategy, standard operating policy and terms of reference would be reviewed when the new head of medicines management started in June 2016.

Requires improvement

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- An independent medicines management review was completed for 2015-16 and found eight risks, four of which were deemed high. A response to the recommendations was delivered to the Quality and Safety Committee in May 2016. Although the risks were acknowledged, the actions relied on the appointment of new staff that at the time of our inspection were not in post.
- Until then responsibility fell to one locum pharmacist, a pharmacy technician and the nurse prescribing lead.
- Medicines management for Newton-le-Willows Community Hospital was provided under a service level agreement (SLA). The trust could not demonstrate compliance with this agreement. The medicines management team did not have information regarding medicines reconciliation or oversight of the services provided at the Community hospital. The service level agreement for medicines management services provided to us for the Newton Community Hospital expired in March 2016. This had not been picked up as part of the medicines review.
- The trust used Patient Group Directions (PGDs). PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. Of the 65 PGDs that we viewed we found that 9 had had the expiry date extended and 1 of the 9 was outside its extended expiry. We were told that the medicines management team did not have the capacity to review the PGDs. The policy stated that the medicines management team held a database of staff signed up to PGDs. This information was submitted by the service managers along with any amendments, we were told that the medicine management team did not have a database and so they could not be confident who was using the PGDs or that staff were using the most up to date PGD. Therefore we could not assure ourselves that the PGDs were fit for purpose or that systems were in place to keep people safe.
- We reviewed a patient's district nursing notes and found that GPs had prescribed EOL medications as and when required (PRN) using an inappropriately broad range. It was then left to the district nurse caring for the patient to tritrate the doses using her own professional judgement. This represented a patient safety risk which we escalated to the trust management at the time of the inspection. However from the patient's medical record we were able to identify that the district nurse administered all medications at an appropriate dose.
- At the time of our inspection there was no medicines management interface group any Medicines Safety Committee; this is a requirement of the NHS England MHRA alert: Improving Medication Error Incident reporting and learning 20 March 2014.

Infection control

- We saw good infection control practises across the trust apart from some areas of dental services.
- The trust infection control policy was available to staff on the trust intranet and staff were aware of its contents.
- Infection control was part the staff mandatory training program and the trust 89% compliant with mandatory training.
- Walk In Centres and clinic areas were visibly clean.
- The inpatient environment was clean and hygienic with low levels of healthcare associated infection and high levels of harm free care. Statistics showed that Newton-le-Willows inpatient facility performed better than similar providers in terms of the safety thermometer data.
- Leaflets and notice boards with information about infection control were accessible and visible to patients.
- An external agent collected clinical waste collection following a homebirth directly from the patient's home. This avoided midwives from carrying dirty clinical waste in their cars.
- Overall, dental staff adhered to infection prevention and control procedures, such as safe disposal of sharps and handwashing practices.
- However on two sites, we found that cleaning and sterilising of dental instruments was carried out by a third party company and at the time of inspection, dental staff and the senior dental management team did not provide documented evidence that infection prevention and control procedures were adhered to in line with trust policy. At the time of inspection, dental staff and the senior dental management team did also not provide documented evidence that cleaning and

Requires improvement

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sterilising of dental instruments was carried out in accordance to recommended guidelines (HTM0105) from the Department of Health. This was discussed with the trust management and we were informed that the current contract was about to be renewed and a new provider found.

Assessing and responding to Risk

- The assessment and response to risk was not consistently managed across all services.
- National guidance requires that Urgent Care centres (UCC) and Walk In Centres (WIC) triage patients within 15 minutes if they are children or 20 minutes if they are adults. At Leigh WIC a decision had been taken for triage to be stopped and for patients to be treated on their first contact with a clinician, unless they had been waiting for an hour or more. When patients had been waiting an hour or more, band 5 nurses reviewed them and completed initial observations and a triage assessment. This represented a patient safety risk and was escalated to the service manager at the time of our inspection. On our unannounced visit this practice was still continuing. We reviewed the computer system, which showed that three patients had not been seen within one hour including one two year old, an 18 year old and a 25 year old. There was also one patient who had been waiting for 18 minutes with shortness of breath.
- The UCC service did not have a standardised early warning score system in place, which is not in accordance with best practice in managing the deteriorating patient.
- Staff followed best practice guidance when assessing and responding to patients' needs and used a EWS in inpatient services.
- In midwifery services the assessing, mitigating and management of risk was poor by staff. Anticipation and processes of events going wrong or the event of an emergency was poor. At the time of inspection, staff told us they only booked low risk patients so did not envisage poor outcomes or high-risk emergencies. If something did go wrong, they told us they were happy to call for an ambulance or an emergency crash team and wait for help to come. This did not provide reassurance that staff assessed, prevented, detected or anticipated risk to ensure the health and safety of their service users.

Safeguarding

- The trust achieved an 89% compliance with mandatory training which included safeguarding training (up to level 2).
- We found good processes in place to reduce the risk of abuse and avoidable harm in the local teams.
- Staff were aware of their responsibilities regarding safeguarding and the correct procedures to follow; training rates were generally satisfactory and staff could describe the safeguarding processes. There was evidence of that safeguarding referrals had been made appropriately.
- There were robust systems in place for safeguarding children and young people with an average compliance of 94.88% staff had received level three training.
- Dental staff also had a good understanding of safeguarding adults and children principles and training was provided; staff told us they were encouraged by the senior dental management team to initiate safeguarding procedures if they had any concerns.
- Data received prior to inspection confirmed that all midwives had completed safeguarding level 3 training. However all nursing staff had not completed level three safeguarding training, which is recommended by the intercollegiate guidance document for staff working in urgent care services.

Duty of Candour

- There was good knowledge and application of the duty of candour procedures and patients were kept informed during the process.
- Staff were aware of the principles of the duty of candour. However, they were not aware of the terminology and some cases this needed to be explained.
- Staff understood their responsibilities regarding duty of candour.

Managing anticipated risk

- The trust responded promptly to actions identified during the inspection. An action plan was under way at the time of our unannounced visit to review emergency equipment, supervisor of midwives role in the future, up to date skills of midwives and robust auditing processes.

Requires improvement

Are services safe?

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- Processes including methods for alerting staff to ongoing concerns and multi-agency working were good.
- A 'weighting tool' was used across all the locations on the trust. The weighting tool assessed the acuity of the patients and enabled the district nurses to have a shared caseload and ensure that patients received safe care and treatment at all times.
- There were no details of reviews by paediatricians, of up to three years, recorded in care records for children, in St Helens that had transferred from a neighbouring trust. This was raised.
- Community midwives did not have access to oxygen or suction for maternal collapse at homebirths. There was no evidence of completed risk assessments for homebirth equipment. Therefore, this did not reassure us that the safety and welfare of patients and their needs was provided.
- In the maternity clinical area at Halton Hospital, there were no emergency call bells, no oxygen or suction equipment. Emergency equipment for general use was stored in a locked cupboard by the hospital main entrance, which was a distance from the maternity area. This did not reassure us that patient safety in an emergency situation was assessed for risk or timely treatment was provided to service users.
- At the HCRC, there was only one emergency resuscitation trolley within the whole building. This was not situated or located near the maternity area. Staff were not aware where it was stored or what equipment the trolley contained. Again, this did not reassure us that patient safety and timely treatment in an emergency situation was assessed for risk or provided to service users.
- At Leigh WIC the triage system in place did not reflect national guidance and meant that patients were not assessed in a timely manner.

Safety of equipment

- At trust level equipment was readily available for patients at home. For large items of equipment, such as beds and commodes, the community equipment service aim to dispatch the equipment on the day of request.
- Midwifery staff informed us that the Entonox (gas and air) cylinders for home deliveries were delivered directly to patient's home by the trust transport service. Therefore, the staff did not have to carry these cylinders in their cars.
- At the time of inspection, dental staff and the senior dental management team did not provide documented evidence that legionella assessments and water services maintenance were in date for all dental sites.
- We did not get assurance that water lines and bottles in both frequently and infrequently used clinic rooms were flushed in accordance with the recommended guidelines from HTM0105.
- Digital pens used to collect and store patient data was troublesome and at times ineffective. However, the trust was exploring new data collection systems. Staff reported that data was often not stored on the system when they entered patient information and a lot of time was spent ringing the production company helpline for advice and support. This did not reassure us that care and treatment was recorded and stored accurately and contemporaneously.
- District nursing teams in Halton were based in GP clinics and some had poor facilities and limited office and meeting room space.

Mandatory Training

- The trust achieved an 89% compliance with mandatory training this included infection control, medicines management, dementia awareness, safeguarding and information management.
- Mandatory training was a mixture of face to face training courses or could be completed by being done remotely on a computer.
- Training was adapted to meet the needs of staff working in particular circumstances for example reception staff at urgent care centres were trained in red flag symptoms and knew in what circumstances to prioritise these patients for medical support.
- .Mandatory training levels were below the trust's target at Halton UCC and Leigh WIC, as was level 3 safeguarding training.

Records

Requires improvement

Are services safe?

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

- At the time of the inspection, the dental staff and the senior dental management team did not provide documented evidence that comprehensive dental records audits carried had been carried out in 2015 and 2016 [PP1], in line with recommended guidelines from the BDA. In turn, at the time of inspection, we could not be assured that clinical records were thus reflecting safe and effective practice.
- Allergies information was not recorded in 33.3% of the records we reviewed.
- At Leigh WIC the second signatory did not individually sign the PGD documentation. This breached the trust's policy and was escalated at the time of our inspection.
- We identified that the records of the district nurse team in Widnes were of a poor standard in that they were not complete, in one instance a set of records contained details of a documentation audit which included confidential details from other patients and in another contained post-it notes containing important information which was undated, unsigned with no patient identifiers.

Major Incidents

- We reviewed the trust's intranet and found a major incident policy that was over one hundred pages long, generic and did not specify specific actions for the centres/services. We escalated our concerns to the trust at the time of our inspection.
- A number staff were unaware of the major incident plan including at the inpatient services WICs and UCC.

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

Overall the effectiveness of services requires improvement. Improvements are needed in End of Life Services and Midwifery services provided by the trust, the remaining services were judged as good.

- In midwifery services there was no evidence provided around auditing, monitoring and updating midwifery skills, experience and competencies within the homebirth environment and potential emergency situations. There was no plan for staff to rotate into any of the local trusts to keep updated with skills aptitude and proficiency this as particularly relevant due to the low home birth rate.
- There was no evidence to show that information collated on the maternity dashboard was used to inform or improve practice. The Trust annual performance targets were not always sets on the dashboard. The trust did not routinely benchmark their service; therefore, there was no oversight of themes and trends.
- We found no evidence to confirm that there was a robust, continuous auditing process in place. Therefore, there was no oversight of themes and trends or practice improvement.
- In EOL services individual care records for patients were not being consistently used across the trust.
- There was no formal pain assessment tool being used consistently, across the trust, to assess the pain levels of patients at the end of their life. In addition there was no formal pain tool being consistently used across the trust to assess the pain of non-verbal patients.
- In dentistry services at the time of inspection, dental staff and the senior dental management team could not provide documented evidence that comprehensive dental records audits had been carried out in 2015 and 2016; therefore we could not be assured that clinical records were thus reflecting safe and effective practice with regards to documenting consent and documenting patient's clinical outcomes.
- At the time of inspection, the senior dental management team did not provide us with documented evidence that all dental staff had undergone a DBS check this was provided following the inspection.

However

- We saw good evidence that consent, across services, was sought and documented in patients notes including initial nursing assessments.
- Training in consent was part of mandatory training for staff and the trust achieved 85.9% in 2015/16
- Gillick and Fraser guidelines were fully explained where appropriate
- The majority of patients were treated in accordance with best practice and recognised national guidelines,
- Within most services, such as community adults, children's and young peoples and sexual health, staff were engaged in monitoring and improving outcomes for patients. We saw how outcome monitoring, national, and local audit data was influencing practice particularly within the sexual health service and community hospitals. Teams worked together and there was good evidence of multidisciplinary working.

Our findings

Evidence based care and treatment

- The majority of services provided care and treatment that was evidence based
- Care was given in line with policies which were based on evidence and in line with national guidance.
- We saw evidence of holistic assessment and treatment in inpatient services which followed best practice guidelines issued by the National Institute of Health and Care Excellence (NICE).
- In Urgent care services we saw examples where staff followed NICE (such as head or neck injury guidelines). Guidelines were accessible on the trust intranet with paper copies in folders.

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.

- Local audits were completed to ensure pathways were followed correctly. For example the Urgent Care service undertook a quarterly antibiotic audit to ensure were being used and issued appropriately in accordance with Pan Mersey Area Prescribing Committee formulary and National Institute of Health and Care Excellence.
- Care and treatment was evidence based in sexual health services. The team were actively engaged with regional and national networks. Trafford sexual health services had membership of Greater Manchester Sexual Health Network which in turn provided best practice information, events and a research library. Clinicians from Trafford .also contributed to the network as speakers.
- The service follows BASHH Guidance.
- In midwifery services though some staff said they did benchmark practise against other local units we saw no evidence of this .Also there was no evidence to show that the trust routinely benchmarked their service on a national basis. We were informed that it was a "unique" service and there was nothing similar to benchmark with. NICE (2014) recommend that maternity services should provide a model of care that supports one to one care in labour for all patients and benchmark services to identify issues.
- There was a lack of consistency regarding the implementation of an evidence based pathways for all patients who were in the last year of their life. The Liverpool Care Pathway had been phased out in 2013but there was no trust wide individual plan of care to replace
- Three different care plans were in operation, which had each been developed within geographical locations using the borough based clinical networks that existed. All the care plans that we saw were based on national guidelines.

Patient outcomes

- Patient outcomes were monitored across the majority of services via a dashboard system. These outcomes were reported against a range of trust and national targets including the Friends and Family test, readmission rates, infection control, length of stay, delayed transfer, safety thermometerprescribing patients booking before or after 13 weeks of pregnancy, percentage of planned and unplanned homebirths, breastfeeding and smoking rates and workforce data.
- At Newton Le Willows the main inpatient service of the Trust data showed that year to December 2015, the large majority 76% of patients were successfully discharged to their own homes. Ward performance and key performance indicators were displayed which showed how they had achieved zero cases of MRSA, zero cases of Clostridium difficile, zero case of acquired pressure ulcers, 100% MRSA screening and 100% VTE assessments.
- It was difficult to determine from the dental service audits inspected if effective patient outcomes had been achieved because they did not clarify this element in the actual audit.
- The maternity dashboard recorded monthly data (in percentages) from April 2015 to December 2015.
- It was unclear if the target column on the maternity dashboard was set against trust targets or national targets, as this was not clearly stated.
- Of the 24 items listed on the maternity dashboard, only 11 had target figures set for them. Thirteen items listed had no data for the period or no target set or agreed.
- The sexual health service took part in part in relevant audits and outcomes from these were shared with staff.
- In community services for children and young people clinical pathways were in place and gave clear and consistent guidance across the therapy services.There was a high number of children that had received immunisations, as per the trust schedule for reaching their second birthday, for the year 2015/16. For diphtheria, tetanus and pertussis (DPT) and polio the percentage was 97.3%, for haemophilus influenza B it was 97.5%, for pneumococcal booster it was 94.3% and measles, mumps and rubella (MMR) it was 94.7%.
- From the last inspection, in February 2014, it was identified the there was a backlog of health assessments, in one borough, for looked after children on the risk register: continued to be a risk in the trust and had not been resolved since the previous inspection.

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.

Pain relief

- Overall services managed patient's pain well; the trust had prescribing guidelines and algorithms in place for medications to address the five key ends of life symptoms of pain, breathlessness, nausea, respiratory secretions and restlessness. These guidelines were based on the Merseyside and Cheshire palliative care network audit group guidelines, which are based on nationally recommended best practice.
- We found evidence of prescribing for anticipatory medications for patients at the end of their life in case notes and all patients had an adequate stock of anticipatory medication.
- However in In Warrington and Halton EOL services we were told that staff did not use a formal pain tool to assess patients' pain levels and there was no pain tool used to assess the pain of those patients who were not able to respond to verbal questions about pain.
- In the inpatient areas, pain was assessed as part of the early warning system (EWS). The measuring of pain levels was integral to the EWS scoring system. Whereby each time observations were taken, the patient was asked about their pain levels and a 'score' was recorded.
- Patients were prescribed pain relief in keeping with the World Health Organisation 'analgesia ladder', which advocates an incremental approach to the administration of pain relief. Patients were asked for a score of their pain levels and they were given pain relief commensurate with these scores.

Competent staff

- The trust had an induction program for all staff to attend before working directly with patients and was service specific In Urgent care services new staff followed an induction programme which included enrolment on the service's minor illness and ailments course which is accredited by Chester University.
- Trust wide appraisal rates for 2015-16 were 85.3%. Inpatient services achieved 100% and Children and Young people services 95.5%. Staff said they received good support and supervision from their line managers, in addition to their annual appraisal, they could request meetings with managers and there were always someone to go to for advice
- There were good opportunities for development and training for nursing and allied professional staff. They were encouraged and supported to develop their expertise and competencies and extend their skills.
- In EOL care services all staff were trained to postgraduate level education, specialising in the care of the dying patient. SPCT in Halton were all independent prescribers and able to prescribe anticipatory end of life medications.
- Staff within the urgent care service who were above band fives were IRMER trained to read x-rays.
- However in midwifery services there was a low rate of homebirths and pool deliveries. There was no routine or mandatory trust rotation system in place to keep staff updated with skill aptitude and proficiency. If staff requested to rotate into a trust at their annual appraisal, then it would be arranged but there was no evidence if this had occurred. Some staff did not see this as an issue as they felt confident about their own skills and the support from the SOM's.
- We found no evidence that the service was aware of number of staff trained in suturing and the number of staff that had used their suturing skills in the past 12 months. Managers we spoke with confirmed that they had no overview of staff training or competency in relation to suturing. These issues were raised at the time of the inspection and action taken by the trust to suspend home deliveries while the issue was addressed.

Multidisciplinary working

- The trust had good multidisciplinary working practises in services across the trust this was not always straightforward due to certain services being provided by other trusts and the local authority an added complexity was the large geographical spread of the trust, however staff and managers had worked together to lessen the impact of these issues on patients.
- The inspection team observed effective multi-disciplinary working between trust staff and social workers employed by the local authority.
- Multidisciplinary working was clearly evident in the community teams. Nursing, medical, therapy, ambulance services and social care staff were

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committed to working together to meet the individual needs of their patients. For example, staff within the urgent care services worked closely with GPs and could request chest x-rays from them.

- There was a fully integrated multi-disciplinary approach to the management of care records. Patients were asked to sign a consent form to enable records to be shared.
- In Wigan and St Helens, where specialist palliative care staff were employed by a different provider, there was evidence of good communication between teams. Regular meetings took place, including End of life care committee meetings that included representation from the trust, GP's, hospital, hospice, local authority and ambulance service and took place every two months.
- In community services for children and young people we saw evidence that staff worked professionally and cooperatively across different disciplines and organisations. For example, in Wigan, the community nurses received referrals from a number of sources that included the local trust children's ward and accident and emergency department, the walk –in centres, GPs and self-referrals or for children with learning disabilities, joint visits could be arranged with the social worker.
- However communication with vascular and orthopaedic clinics in adult services was not as effective as it could be. We were told that the nurses could only contact these services via the GP. This was time consuming and delayed patient care.

Access to information/ Technology and telemedicine

- From the last inspection, in February 2014, a recommendation was that the trust should continue to develop information technology systems to enable full integration and connectivity across the trust. From the action plan, post inspection, the trust target date was June 2015. In all services this was not completed
- The trust was in the process of transferring from paper records to electronic in a phased approach. There were variations throughout the trust including two electronic systems.
- A numbers of problems were apparent during the inspection for example staff reported difficulties accessing the electronic system as new starters, taking up to a month to have a personal login.
- Also trust specialist palliative care consultants that were based in local hospices were unable to access trust IT systems, which created difficulties communicating about patients.
- In midwifery services an electronic digital pen system had been introduced, staff reported many problems with the system including experiencing missing data, which they had to find and re-enter onto the system. Staff said this affected the length of time allocated to each woman. This was on the risk register and management were investigating a new system to improve data collection and data storage.
- The digital pen system did not interface with the trust 'systemOne' computer system therefore staff told us it was time consuming having to access two computer systems.
- Consultants did not have access to their own digital pens when working in the community clinics. We observed that one consultant had to borrow the midwives pens to complete their documentation.
- However in Wigan, the electronic patient record system allowed all staff to have instant access to the most recent patient information so that treatment and care could be optimised.
- District nursing staff in Wigan could access the trust intranet via their laptops. This allowed access to all policies and procedures, and the most current guidance and best practice whilst in the community
- Staff could access the trust wide intranet system for policies and standard operating procedures as well as hard copies in local areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a written policy in place governing uDNACPR Universal Do Not Attempt Cardio Pulmonary Resuscitation). This policy included advanced decisions, lasting power of attorney, mental capacity guidance and the use of independent mental capacity advocates.
- All staff received mandatory training regarding mental capacity and deprivation of liberty safeguards as part of safeguarding 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.

- We saw evidence of uDNACPR in case notes and these were completed either by a GP or when patients where in hospital, by a consultant.
- We saw examples of completed capacity and DoL assessments in the healthcare records we inspected. They were completed appropriately and in full.
- Staff undertook and documented inpatients' informal consent to undertake personal care and therapy treatment in the patient's notes. We observed staff seeking consent to interventions during or inspection.
- In Children's and Sexual health services there was a 'consent to assessment examination and / or treatment policy that included a section for Fraser guidelines (A child under 16 years may consent to medical treatment if he/she is judged to be competent to give that consent) with Gillick competency guidelines incorporated.
- Staff understood and were able to explain the use of Gillick competency guidelines in relation to consent. Gillick competency guidelines refer to a legal case which looked at whether doctors should be able to give advice and treatment to under 16 year olds without parental consent. They are now used more widely to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions

Good

Are services caring?

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

Summary of findings

We judged caring to be good in all services with the exception of the community inpatient service where we judged it to be outstanding.

- Overwhelmingly all service users reported care that was delivered with kindness and compassion and there was a strong, visible patient-centred culture.
- Within community inpatient services patients said staff went the extra mile and the care they received went beyond their expectations. It was clear that the anxieties of patients and their relatives were alleviated with the caring nature of all of the staff.
- Within community inpatient services patients, carers and relatives were active partners in care and worked in partnership with staff to deliver the best outcomes for patients.
- The NHS Friend and Family Test results could not be disaggregated for across all services. However trust wide figures showed that 97% of patients would recommend services provided to their friends and family; the England average rate was 95%.
- Care offered by staff promoted people's privacy and dignity and a range of evidence supported this.
- Comments from patients included:

"I can ask anything and really appreciate her coming, she understands what is happening and I can ask her anything."

"I have no fear; I have confidence in her that she's not hiding anything from me."

Our findings

Dignity, respect and compassionate care

- People were treated with kindness, dignity and respect when receiving care and treatment. This information came from the comment cards completed in advance of the inspection by patients and carers, from the observations of the team and conversations that took place during the inspection.
- The NHS Friends and Family Test results in March 2016 showed that 100% of women receiving care and treatment from the maternity service and 95.8% of users of the children's and young people's service were likely or extremely likely to recommend the trust as a place to receive care.
- Feedback about the care in the four community inpatient care facilities was that staff were very person-centred in caring for their patients and was overwhelmingly positive.
- In the four community inpatient care facilities we observed staff speaking with patients in a professional and respectful manner and offering them choices.
- Staff addressed patients by their chosen name when carrying out treatment or personal care.
- We observed that cubicle curtains were drawn and single room doors were closed during consultations, interventions and patient care which protected the privacy and dignity of patients, all staff knocked and sought permission before entering patient areas.
- PLACE assessments awarded Newton-le-Willows; the largest inpatient service attained a score of 90.5% which was better than the England average of 86% for meeting the privacy and dignity needs of patients.
- During our inspection we gathered many examples of instances of staff going the extra mile for their patients which demonstrated their commitment and desire to give the very best care to their patients.
- In community services for adults we observed, staff showed respect for patients and their families and a commitment to promoting the dignity of patients. The needs of patients with complex needs were considered with compassion. During our inspection we attended patients homes with the district nurses, all the feedback from patients was positive. On one home visit a carer told us that they had recently rang a district nurse with concerns about their family members wound, they said the nurses listened to them and responded promptly with a visit.
- We spoke to one patient who had attended for their appointment at clinic on the wrong day, they were not automatically sent away, but an appointment was fitted in for them.

Good

Are services caring?

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

- In the community services for young people we observed staff treat children with kindness, dignity and respect in an age appropriate way.
- The team found that patients who were at the end of their lives were treated with compassion. We spoke with patients and relatives from St Helens and Wigan boroughs and all were positive about the compassionate care they had received. We were told that nurses were always polite and pleasant, asked about nutrition and pain levels and always respectful when providing care. Plans and wishes for the future had been discussed.
- We were told all the nursing staff visiting patients homes were "brilliant, wonderful" and "superb".

Understanding and involvement of patients and those close to them

- People who use services and those close to them are involved as partners in their care.
- In all services we were told staff involved patients and carers in planning and here possible delivering their care and treatment.

Examples of this were:

- In the community inpatient services the patients and relatives we spoke with told us they found all members of staff respectful, responsive and approachable. Patients said they felt they had sufficient time to ask their questions and had all their questions answered.
- Patients and their carers also said were involved in decisions about their care at each stage of their rehabilitation. They participated in discussions upon admission and were involved in review and progress measurement throughout their stay.
- At Newton-le-Willows, the largest inpatient service, the corridors were marked with 'landmarks' to measure distance and as such patients progress against their mobility targets. For example "we reached Paris today, we are aiming to reach New York by the end of next week". This enabled patients to see tangible results and could take ownership of their own rehabilitation.
- In the community service for adults we observed staff communicating with the patients in a caring manner, the SALT team had various methods to communicate with patients with speech problems and patient leaflets were available in easy read format, for Learning disability patients to go through with staff when needed.
- In the community services for young people in all areas we visited, staff involved the whole family but with a patient-centred approach.
- Parents told us that they were involved in the care and listened to involved in decision making.
- We observed staff interacting with children and their families in a caring and respectful manner.
- In the sexual health service staff gave us examples of cases where they had demonstrated that they had taken extra time to interact with patients and ensure their involvement. An example of this was the Parreles position which allowed peers to support patients whilst they were in clinic areas. Staff felt this enabled young people to feel supported and increased the likely hood of engagement in the treatment process.
- Patients who were at the end of their lives and those close to them were involved with their care.
- An end of life champion nurse told us that when she delivers training regarding involving patients and those close to them and she always reminds staff that they are a guest in that person's home and an intimate part of their life.
- In the urgent care services all the patients and carers we spoke with felt that staff communicated well with them, ensuring they were fully informed about their medical condition and what care or treatment was required.
- Patients told us that staff had responded in good time to their needs.

Emotional support

- People using services and those close to them received the support they needed to cope emotionally with their care, treatment and the condition that they are dealing with across all the services inspected. People were supported to maintain their contact and relationships with their families, carers and friends.

Some examples of this were:

Good

Are services caring?

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

- In the community inpatient services counselling services were available to patients who experienced emotional and mental health problems. Newton-le-Willows had a mental health nurse on staff who was able to give counselling to patients as necessary.
- Condition specific advice and support was also available from specialist nurses such as stoma nurses, cardiac and heart failure nurses and diabetes nurses.
- In the community maternity service we observed all staff discussing emotional wellbeing directly with patients in a sensitive and dignified manner.
- Patients were allocated enough time during their clinic appointments to discuss issues with midwives.
- In the community dentistry service dental staff regularly assessed and treated adults and children with learning disabilities and adults with dementia related conditions; the staff we spoke with conveyed a clear understanding of the importance of emotional support for these patients and those close to them.
- In the community services for adults patients told us they felt listened to, staff demonstrated that they understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives.
- Emotional support was also provided by Macmillan nurses, who provided counselling for bereavement and offered support for patients and families.
- In the community services for children and young people parents told us they felt supported emotionally by staff. We observed staff providing emotional support to parents / carers during consultations with paediatricians.
- In the community EOL services we spoke to a patient who told us how much they was supported by the service. They said the staff spoke to them “like they were normal” and “she is here for me, I can ask anything and really appreciate her coming, she understands what is happening and I can ask her anything, I have no fear, I have confidence in her that she’s not hiding anything from me.”
- Two further patients told us they had received calls since their loved one had passed away. One said she felt they genuinely cared and the other relative said she had personally thanked the staff in the newspaper.

Good

Are services responsive to people's needs?

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

Summary of findings

Overall the responsive domain was judged as good. Improvement was needed in the children's and young peoples services provided by the trust, the remaining services were judged as good.

- We saw that the majority of services were responsive to peoples needs and services were planned and delivered with the needs of local users in mind for example.
- Midwifery and sexual health services held clinics across a wide geographical area, close to patient's homes and there were weekend drop in clinics for patients.
- Premises were mostly fit for purpose and were appropriately accessible and laid out; waiting areas at the urgent care facilities had plenty of seating and toys available for children.
- End of life services had rapid discharge procedures in place to assist the facilitation of a patient's discharge to their preferred place of care in all boroughs.
- Inpatient services identified vulnerable patients on admission and staff provided individualised care to meet their needs.
- The trust had a comprehensive complaints policy that was clearly articulated by staff involved in the management of complaints at trust level. The policy made specific reference to 'being open' and gave details as to how compliance policy would be monitored at trust board level.
- At service level overall complaints were well managed with information and signposting available to patients and staff were aware of and working to the trust policy.

However

- In some services, children and young people were waiting long periods of time for review appointments which included a medication review in some cases. For example, in St Helens, there were children, whose care had been transferred from a neighbouring trust, in November 2015, who were awaiting review of care and treatment for up to three years. Following the inspection an action plan was drawn up to address this matter by the end of July 2016 which has now been completed. In addition audiology services, in Southport, up to 41% of children had waited longer than the 18 week target for an appointment.
- Some dental facilities were underused thus local patients may have been required to travel some distance to access dental services; potentially contravening the 'care closer to home' principle.

In the majority of services inspected advice leaflets were only available in English, in inpatient areas, which did not reflect the diversity of local service users.

Our findings

Service planning and delivery to meet the needs of local people

- The majority of services provided by the trust used information about the needs of the local population to inform how they planned and delivered services. Drop in clinics were arranged by midwifery and sexual health services following feedback from patients. We found that community sexual health services had a flexible wide range of choice of services in place to meet the needs of its population. Services like the Parallel which also focussed on well-being, showed considerable scope in catering for the needs of a younger population.
- The services worked well with local commissioners, community organisations, acute, and other healthcare organisations to meet the holistic needs of patients and overcame potential barriers to implement effective individualised care. For example commissioners worked closely with the three urgent Care centresto help develop the services at Leigh WIC the CCG worked with North West Ambulance Service and the trust to develop the 'pathfinder service', an admission avoidance service.
- Premises were mostly fit for purpose and were appropriately accessible and the lay out suitable; for example waiting areas at the urgent care facilities had plenty of seating and toys available for children.
- However in Oldham children and young peoples services where the model for the future provision had not been confirmed, although staff were taking a

Good

Are services responsive to people's needs?

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'business as usual' approach, the lack of school nurses led to a risk based approach in the delivery of the service. They currently did not have the capacity to carry out all their public health plans such as sessions in schools.

- Also the trust did not strategically plan end of life care across all geographical areas. Although there was excellent local planning, based around local authority boroughs and local CCGs, there was no consideration of patients needs on a trust wide basis, which allowed gaps in service provision and quality to go unidentified.

Equality and diversity

- Staff received equality and diversity training on an annual basis through the mandatory training programme.
- In the Warrington area a carers support group was held for those caring for patients with **Multiple sclerosis MS** or had suffered a stroke. The support group belonged to a regional network.
- A disability awareness centre was also based in the Warrington locality and provided training for carers in moving and handling, back care and financial management.
- However in the majority of services inspected advice leaflets were only available in English, in inpatient areas, which did not reflect the diversity of local service users.

Meeting needs of people in vulnerable circumstances

- The trust worked well with people in vulnerable circumstances. The trust-wide safeguarding team provided support for patients with dementia and learning disabilities this provided a source of expertise and knowledge that was shared to accommodate the needs of those with mental health needs. The services were able to make reasonable adjustments to accommodate their needs and were flexible in their approach including a double room with an adjoining room which had been used recently for a couple one of whom was living with dementia and become very unsettled being apart from their partner.
- There were dedicated children in care nursing teams available in Warrington, Wigan as well as looked after children specialist nurses in Halton and St Helens. For children with learning disabilities, visual schedules could be given to families, for example use of symbols for improving sleep patterns. The paediatric continence service in Halton and St Helens was available for children and young people aged 0-19 years, although; young people with learning disabilities could continue to be supported and treated in the service until aged 25 years if the young person/parent/carer and practitioner agree that this is most appropriate service.
- Clinical outreach teams took referrals for vulnerable individuals who could not access mainstream sexual health services. A sexual health promotion team provided education training and outreach to those individuals. The clinical outreach team also supported looked after children where needed and supported them to make decisions about relationship choices, skills and knowledge.
- Dental services provided patients with additional mobility sites which are more appropriate for those patients' needs, for example, Pemberton Health Centre had a wheelchair accessible dental chair (Diaco Dental Chair).
- In end of life services it was identified by a team member that the emotional needs of bereaved men were not being addressed. Funding was sought for a men's shed scheme, specifically for those men who have been bereaved. A programme of activities and support been developed, targeted for this client group. The men we saw were very appreciative of the service. This service had received a number of awards.

Access to right care at the right time

- There were several delays in children's and young peoples services with regard to children being assessed and treated in a timely way.
- Whilst on-site, we were told that 1760 children and young people in St Helens were transferred care from another trust in November 2015. It became clear that a number had not been reviewed as yet which in some cases this involved a medication review. The trust was aware of this and had highlighted it on their risk register but no suitable action plan was in place. Information from the trust reported that 200 children in St Helens that had been transferred care from another trust in November 2015 had not been reviewed by a community paediatrician. This delay was seen as unacceptable by the inspection team. An action plan was then

Good

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established by the trust with weekly updates provided following the inspection . As part of the action plan, all families were phoned to arrange appointments (GPs were contacted if unable to contact parents / carers) as well as the 0-19 nursing services, walk-in centres and out of hours GPs. As of week ending 17 June 2016, 154 children were waiting to be seen. The trust developed an action plan that stated all children needing review would be seen by 31 July 2016. This was achieved.

- In the governance meeting on 31 March 2016, it was minuted that there had been breaches in the six week audiology target of 99%, for audiology in Southport. In January there were 38 children (41%) that had not been seen and in February there were 13 children not seen. From the report regarding Southport audiology, on 26 April 2016, to the clinical governance committee, it was identified that there were 307 children who should have been reviewed between November 2011 and 2016 that had not been reviewed. It was found that a lack of consistent administrative processes was adversely affecting the allocation of appointments and reporting of data. Processes were put into place with a new referral and follow up management system.
- Therapy staff at the child development centre, Sandy Lane in Warrington told us that there was a recent breach in waiting times beyond 18 weeks due to a lack of suitably qualified staff.
- Other high risks included: children did not receive a high standard of care within appropriate timeframe from the children's complex needs team in Wigan and the commissioned immunisation programme was potentially unable to be delivered by St Helens school nursing.
- The delays seen in accessing children's and young people's services were not seen in other services. We were told that patients at the end of their life were identified as a priority by all district nursing teams. We found evidence to support this prioritisation in patient case notes.
- The District Nurse Care of the Dying Quality Indicator Audit Results indicated that the percentage of patients who had discussions about their preferred place of care/death recorded in their notes was high, between 95-100%. The percentage of patients who died in their preferred place of care/death was also high, between 89-97%.
- Adult services were seeing patients referred to the speech and language team (SALT), the continence service and podiatry services with 18 weeks and some services were improving on this. The waiting time for podiatry in the Halton area was 11 weeks in most cases.
- Midwifery clinics were observed to run on time and patients did not wait excessive amounts of times to be seen. The Department of Health target for urgent and emergency services is to admit, transfer or discharge 95% of patients within four hours of arrival. The average time from arrival to departure across the services was 192 minutes meeting the Department of Health target.
- There were drop in clinics for patients using sexual health and phlebotomy services across the trust.
- Dental services were delivered over a large geographical area and a number of different locations, indicating that dental services generally delivered 'care closer to home'. However, it appeared that some facilities (for example the dental clinic at Partington Health Centre) may have been underused and thus local patients may have been required to travel some distance to have accessed dental services; this may have posed challenges for patients from a poor socio-economic background and may potentially have contravened the 'care closer to home' principle.

Learning from complaints and concerns

- The trust had a comprehensive complaints policy that was clearly articulated by staff involved in the management of complaints at trust level. The policy made specific reference to 'being open' and gave details as to how compliance policy would be monitored at trust board level. We reviewed six complaint files overall these reflected the requirements of the policy.
- Managers ensured that lessons from complaints were disseminated via email/newsletters and team meetings. We noted that information on how to make a complaint was visible in the corridors at the inpatient facilities and leaflets available at urgent care and sexual health centres.

Good

Are services responsive to people's needs?

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

- The director of governance and head of risk management were also notified so that any organisational or clinical risks arising from complaints could be added to the corporate risk register.
- A patient questionnaire relating to the complaints management was sent to the complainant on completion of local resolution of the procedure.
- Complaints and customer care training was part of the trust mandatory training to all staff and complaints investigation training to all managers.

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

Overall we judged that improvements were required in the leadership of services. Individually we judged that improvements were required in end of life care, children's and young peoples services dentistry services, and midwifery services and at trust level. We judged the leadership in sexual health services, urgent care services, , community inpatients and community adult services to be good.

- The trust's visions and values were widely understood and visible across services. However EOL, dental, midwifery and children's and young people's services did not have a clear embedded trust wide service specific strategy or vision and values.
- With regard to the management of risk the board assurance framework was not detailed enough to provide assurance to the board that risks were being sufficiently monitored and mitigated .
- Because of the newness of some of the appointments in the executive team EOL, midwifery, children's and young peoples services and dental services reported difficulties with lines of leadership and accountability for staff. For example, leaders in the midwifery service stated there were no formal arrangements in place between the maternity management and trust senior executive team for regular one to one meetings.
- However executive and non-executive directors took part in a programme of quality visits to a range of locations and there was a predetermined schedule. Feedback from these visits was recorded and included non-executives raising questions.
- There were clear programmes for internal and external audit.
- Staff talked about an open and patient focused organisation in the majority of services. Many staff felt that they were valued and that openness and honesty was encouraged in their service.
- There was a process in place to determine the trust's compliance with the regulation for fit and proper persons in relation to board members. The necessary checks were found to be in in place at the time of the inspection.
- The trust took part in a Patient Partners Scheme, encouraging service users to input their experience to help the trust make changes for the better.

Our findings

Vision and strategy

- The trust's strategic objectives were focussed around 'quality, innovation, sustainability and people'. Their mission was "to improve local health and promote wellbeing in the communities we serve. We will do this by working closely with local people and partners to promote good health and to be a leading provider of excellent community healthcare services in the North West".
- During our inspection we saw posters at various locations reminding staff of the values and objectives. Most staff was aware of the trust's vision, mission statement and core values.
- However at local level we found several services did not have a service level strategy and vision.
- It was not clear what the senior dental management team's short, medium and long term vision was for the dental service. The trust did not have a strategy for end of life services. We found that the trust did not have an end of life strategy group. The trust accepted our findings and commented that the first trust strategy group was set up for June 2016. There was no trust vision for end of life services.
- There was no single vision and strategy across the trust specific for children and young peoples services, although there were five year 'operational and strategic plans' for some individual boroughs. There was no strategy seen for Southport.

Are services well-led?

Requires improvement

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- There was no evidence of a specific vision or strategy for the community midwifery service within documentation reviewed and no evidence to maintain or improve the sustainability of the service.
- There was also some uncertainty at local level over the future strategy within some areas of the intermediate care facilities due to the uncertainty over the future ownership of some intermediate care services.

Governance, risk management and quality measurement

- The trust had set out their governance arrangements in the board assurance framework which was reviewed annually. The framework summarised the strategic risks faced by the trust governance and risk management was maturing but was not yet well embedded. The trust had recognised that improvements in clinical governance were needed and there had been changes in teams responsible for leading this. These changes had increased in pace in the six months before the inspection with new roles having been created however there remained a number of improvements that needed to be completed .
- The board assurance framework (BAF) did not contain sufficient detail to provide the board with assurance that risks are being effectively monitored and mitigated. Where gaps in both assurance and controls are identified there were no actions to address these gaps also there was no owner assigned to any of the corporate and strategic risks in the BAF. For example some medical staff shortages were identified in out of hours services causing delays in patients being seen and medication being administered. A plan had been put in place but no plan was available to the board to consider and challenge if needed.
- There were no robust governance systems in place for end of life services at trust level. By this we mean that there was no end of life steering group setting targets and measuring progress towards these targets, for end of life services.
- Risks to the end of life service were not fully identified. An example of this is that the up and coming change to a consultant's role meant a decrease in medical service provision, but this was not identified as a risk to the service.
- There was also no evidence of a clear governance structure within midwifery services. There was no evidence that risk was managed within a framework that included clinical audits, education and training, complaints, health and safety, service user involvement and service development. There was no robust evidence to show us that there were links within the Bridgewater trust wide strategies and initiatives and that risk management was integrated within the general trust management and business plan.
- Executive and non-executive directors took part in a programme of quality visits to a range of locations and there was a predetermined schedule. The programme included community hospitals and community services such as podiatry and the community nursing service. Feedback from these visits was recorded and included non-executives raising questions.
- There were clear programmes for internal and external audit. The lack of maturity in some governance areas was a challenge for the inspection team in obtaining trust wide data. There was readily available information for services and locations but looking across the organisation was more of a challenge.

Leadership of the provider

- The chief executive had been in their current role since April 2015 and a number of executive directors were in their first substantive posts and consequently were a relatively new team compared to other similar trusts. There had been some recent changes with the medical director recently appointed and the director of nursing in post for a relatively short time. There was a good functioning relationship between the chair and chief executive.
- Because of the newness of some of the appointments the trust leadership for services EOL, midwifery, children's and young peoples services and dental services reported difficulties with lines of leadership and accountability for staff. For example, midwifery staff stated there were no formal arrangements in place between the maternity management and trust senior executive team for regular one to one meetings. Staff informed us that there had been many executive team changes and "they needed time to settle before a formal plan was arranged".

Are services well-led?

Requires improvement

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- However staff stated they felt supported by senior trust management in some inpatient services. Staff at Newton-le-Willows said that the chief executive had visited the ward regularly and had participated in the listening in action programmes that had been undertaken there.

Culture within the provider

- Staff talked about an open and patient focused organisation in the majority of services. Many staff felt that they were valued and that openness and honesty was encouraged in their service.
- The trust leadership recognised that some community staff had been through a period of prolonged change and uncertainty with some community staff having a number of employers over a number of years. Children and young peoples services reported a lack of consultation during some of these changes.
- Bridgewater Trust had signed up to the national Speak out Safely (SOS) campaign. The SOS campaign encourages NHS organisations and independent healthcare providers to develop cultures that are honest and transparent, while actively encouraging and protecting staff who raise the alarm when they see and report poor practice. However staff in the midwifery service told us that midwifery service did not take part in this this did not assure us that midwifery staff were supported to raise concerns about wrongdoing or poor practice and that they felt confident that their concerns were addressed in a constructive way by the trust.
- Also a significant number of staff we spoke in end of life services indicated that they felt very isolated from the trust and considered themselves to be more part of the service from where they were based, than a trust employee. Staff could not identify the trust lead for end of life services.
- We noted that staff providing services to patients were very happy with the quality and openness of their line management arrangements. However, as seniority increased there was an increasingly frequent reporting of difficulty in management relationships.

Fit and proper persons

- There was a process in place to determine the trust's compliance with the regulation for fit and proper persons in relation to board members. The necessary checks were found to be in in place at the time of the inspection.
- We looked at the records for a sample of board members and saw that the relevant information had been obtained. For example, references, insolvency checks and Disclosure and Barring Services (DBS) checks.

Staff Engagement

- The listening into action programme was a key platform for engagement with staff. They held 'big conversations' with some teams and also 'director drop-ins'. There were also 'open space' events where the chief executive led sessions for any staff member to attend and participate in a variety of locations across the boroughs. Team brief sessions were also held and delivered by other members of the executive team. Staff told us these events have increased their feeling of inclusion and engagement with the trust and their working environment which in turn has increased their job satisfaction. They felt listened to and included in decision making.
- The trust scored above the England average for staff who would recommend the trust as a place to receive care with 85% compared to an England average of 79%, whilst also scoring lower than average for the percent who would not recommend. However the response rate was 6% lower than the England average.
- The trust scored 20% below the England average with 42% of staff recommending the trust as a place to work whilst 37% would not recommend, when compared to an England average of 19%.
- Staff engagement occurs through meetings and trust-wide blogs.
- We saw several examples for district nursing staff receiving a trust 'Star of the Month' award. A 'wall of praise' was displayed in nurse team bases so that all staff could see the compliments received.
- Staff surveys were undertaken yearly and results were analysed and published.

Public engagement

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.

- Bridgewater Community Healthcare trust took part in a Patient Partners Scheme, encouraging service users to input their experience to help the trust makes changes for the better.
- The latest NHS staff Friends and Family Test results for Bridgewater as a whole showed that 42% of staff would recommend the trust as a place to work, compared to England average of 62%; and 85% of staff would recommend it as a place to receive treatment, compared to an England average of 79%. These results were based on a 5.4% completion rate, the England average response rate was 11.4%.
- Children's and young persons services held a 'listen 4 change parent / carer information day', in St Helens in June 2015 that included representatives for the local authority and charities as well as health providers. Further public health events were planned in the Warrington borough, with themes including child safety and dental hygiene.
- Patient surveys were undertaken across a wide range of services and teams.
- At time of the inspection with regards dental services, we were not presented with evidence that indicated satisfactory engagement with the public, in particularly with regards to accessibility of services.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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