

Liverpool Heart and Chest Hospital NHS Foundation Trust

RBQ

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
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This report describes our judgement of the quality of care provided within this core service by Liverpool Heart and Chest Hospital NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Liverpool Heart and Chest Hospital NHS Foundation Trust and these are brought together to inform our overall judgement of Liverpool Heart and Chest Hospital NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Outstanding	☆
Are services safe?	Good	●
Are services effective?	Outstanding	☆
Are services caring?	Outstanding	☆
Are services responsive?	Outstanding	☆
Are services well-led?	Outstanding	☆

Summary of findings

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Summary of findings

Overall summary

We rated community services at Liverpool Heart and Chest Hospital as outstanding in caring, responsive and well led key questions. We rated safe and effective key questions as good.

- Feedback from patients and those close to them was consistently positive about the way staff treated them. Staff went the extra mile to provide care and support. There was a strong person-centred approach to providing care.
- Relationships between people who use services and staff were caring, respectful and promoted people's dignity.
- Services provided by the trust reflected people's individual needs and preferences and continuity of care for patients was central for staff. The hospital had implemented a number of schemes to help meet people's individual needs
- Incidents were reported by staff through effective systems. Lessons were learnt and staff were able to recognise and respond to changes in risk to people who used community services.
- Staff followed good hygiene practices.

- Staffing levels were reviewed to ensure that there were enough staff with the correct skills to keep people safe.
- Best practice guidance in relation to care and treatment was followed and community services participated in national and local audits. Action plans were in place to continuously monitor service quality and delivery and maintain standards. All staff were engaged with monitoring and evaluating their services. The service was meeting or exceeding the majority of their key performance targets and met or exceeded outcomes in line with national benchmarking and guidance such as
- Patients were supported to raise a concern or a complaint. Lessons were learnt and improvements made from complaint investigations. Community services captured views of people who used the services with changes made following feedback. The friends and family test showed that people would recommend the hospital to friends or a relative.
- All staff knew the trust and service vision and were committed to driving continuous improvement setting their own internal targets to seek out and trial new models of care in the community.

Summary of findings

Background to the service

The trust provides a Community Cardiovascular Service (CVD) and Community Respiratory Service in Knowsley. Both services have been commissioned by the Local Commissioning Group (CCG) from 2010. This contributed to the CCG overall strategy to reduce premature deaths and decrease unnecessary emergency demand within secondary care, improve diagnosis, treatment and rehabilitation. The services are provided in a variety of locations throughout the borough.

There were 43,301 attendances at the trust's community clinics between February 2015 and January 2016.

Spirometry, oxygen therapy and Pulmonary Rehabilitation was also delivered within the community of Liverpool.

The services provided are multidisciplinary comprising of: CVD and Respiratory, heart failure, Home Oxygen Assessment and Review Service (HOSAR), consultant led diagnostic, spirometry, community cardiac, pulmonary and stroke rehabilitation.

Spirometry, Oxygen and Pulmonary rehabilitation was also delivered within the Liverpool community area. The care provided is patient centred, with all aspects of health care integrated and seamless from the patient's perspective.

We visited Liverpool Heart and Chest Hospital as part of our announced inspection on 25 April to 29 April 2016.

How we carried out this inspection

We reviewed the environment and staffing levels and looked at 14 care records and prescription records. We

spoke with one family member, 20 patients and 25 staff of different grades including nurses, doctors, physiotherapists, and senior managers who were responsible for community services.

What people who use the provider say

People told us:

"Everybody has been very nice."

"I have been able to change to a different health centre that's nearer to where I live."

"They have never cancelled an appointment."

Outstanding practice

- Community COPD service had been awarded external network funding to undertake a study utilising a self-monitor system on patients with COPD. This worked by using web-connecting electronic tablets which are provided to patients, for self-monitoring.
- Knowsley CVD service had been awarded regional innovation funding (RIF) to pursue a 'cancer rehabilitation' project using the blueprint of cardiac rehabilitation to continue the favourable clinical and psychological outcomes demonstrated in a pilot

study. The service was using this opportunity to bring additional specialist resources and clinical expertise to support a more individualised rehabilitation programme for a group of patients who require specific clinical expertise to promote improvement outcomes in cancer management.

- The service had creatively used the cross over integration between the rehabilitation teams. The service had merged rehabilitation groups to engage with more patients and increase the

Summary of findings

- The service was involved in a pilot to reach hard to group patients such as those on methadone. Staff encouraged patients to have spirometer tests when attending for drug therapy to try and reach people early in the disease process.

Liverpool Heart and Chest Hospital NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated community services as 'Good' for Safe because:

- Incidents were reported by staff through effective systems and staff were aware of lessons learnt and that improvements had been made from investigations into incidents. There were systems and standard operating procedures in place to keep people safe and staff were aware of how to ensure patients were safeguarded from abuse.
- There were systems in place to manage the safe administration and prescribing of medication. We found that arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the trust governance arrangements. We found there was an open culture around the reporting of medicine errors.
- There was a system in place to learn from medication errors which was fed down from the Safe Medication Practice Committee and within daily safety huddles, in which staff from all departments gathered to discuss any concerns or lessons learned.
- There were effective systems in place to ensure patient safety was monitored and maintained which included signs of deteriorating health and medical emergencies.
- The environment was fit for purpose and was clean and staff followed good hygiene guidance. There was good monitoring of infections and we observed that cleaning schedules were completed as required.

However,

- The service had a mixture of processes for recording patient's records and accessing clinical information. The service was in the process of introducing an electronic patient record to improve the quality of records and to mitigate the risk of carrying patient records in the community.

Are services safe?

- The service was working with local providers to meet the staffing requirement for speech and language therapy in the community.

Safety performance

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- We had limited safety thermometer information for community services. However it showed that between January 2015 and January 2016 there had been no pressure ulcers or community acquired urinary tract infections (CAUTI's) which resulted in harm. Between January 2015 and December 2015 the service had reported only one fall in the service. The trust monitored incidents of pressure ulcers and falls through their performance dashboard each month.
- In the last twelve months LHCH had introduced a daily safety huddle meeting (led by the CEO) to encourage interdisciplinary working. The aim of the huddle was to enhance the delivery of high quality, safe care to patients and staff and to ensure learning from incidents and good practice. The community staff were very positive about this meeting and confirmed that staff could attend on a rota basis as a learning and development opportunity.

Incident reporting, learning and improvement

- There were systems and processes in place to report incidents using a hospital incident reporting system (HIRS). Staff were able to explain the process of using the trusts electronic reporting system and describe the types of incidents that would be reported.
- Between January 2015 and January 2016 community services reported 36 incidents. Of these, 24 were categorised as a near miss. The remainder of the incidents resulted in low or no harm to patients. We found that the main reasons for incidents reported were due to either communication or documentation issues. Between March 2015 and February 2016 there were no serious incidents reported throughout community services at the hospital.

- A root cause analysis tool was used to investigate any adverse events or serious incidents. We saw that an action plan was put in place, when required, to reduce the risk of the incident happening again. For example the service had plans in place for the introduction of an electronic patient record to assist in reducing any issues with documentation. Action plans included evidence of feedback and actions for learning which were shared with clinical teams and the wider trust. The staff were able to describe a change made following an incident. For example, reviewing the process for monitoring oxygen in the community. Information about incidents was discussed as part of the divisional governance committee meetings and team meetings. This included learning from incidents in other divisions.
- Mortality and morbidity meetings were held every month and themes and trends were discussed.
- Senior staff were aware of their responsibilities relating to Duty of Candour legislation and were able to give us examples of when it had been implemented. The trust had a Duty of Candour process in place to ensure people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Safeguarding

- There were trust wide safeguarding policies and procedures in place, and there was an internal safeguarding team who could provide guidance and support to staff in all areas during normal working hours. Staff had access to advice out of hours and at weekends from the hospital on-call manager
- Staff gave examples of the types of concerns they would report and were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse.
- Staff told us they received feedback from safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to frontline staff through their line managers.

Are services safe?

- We saw examples of incidents recorded by staff where abuse was suspected which also included details of actions taken to support the individual. This demonstrated that staff followed the trusts policy correctly and that the provider had appropriate systems in place for reporting.
- Training statistics provided by the trust showed that 100% of staff in community had completed level 1 safeguarding adult training and 92% had completed level 2 training. This was in line with the trust target of 95%
- The trust target for safeguarding children was 95% and compliance rates for safeguarding children level 1 was 100% and level 2 was 100%.
- Basic safeguarding training was included in induction training for all temporary staff before commencing work.
- Staff were able to administer regular use medicines through the use of patient group directions (PGDs). Patient group directions refer to a group of medicines that can be given 'as required' by a practitioner who has the training and knowledge which meets PGD guidelines. Examples may include paracetamol or certain dressings.
- Staff undertook annual training in medicines management. The compliance rate was 100%
- The service had clear medicines reducing regimes and patient group directives in place. Nursing staff were able to describe clear examples of the safe use of medicines particularly liaison with care agencies who were involved in supervising patients with their own medicines.
- There were clear protocols and regimes in place for Salbutamol and ipratropium nebuliser reducing regimes.
- There were also clearly documented regimes to manage the reduction of certain respiratory specific medicines such as when to stop ipratropium and Prednisolone reducing regimes.

Medicines

- Between January 2015 and December 2015 there were three medication errors reported in community services. One of which was incorrectly prescribed or administered medication.
- We looked at the prescription and medicine records for 13 patients. We saw arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- Medicines were stored, administered and recorded in line with best practice guidelines.
- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the trust governance arrangements. We found there was an open culture around the reporting of medicine errors. There was a system in place to learn from medication errors and this was fed down from the Safe Medication Practice Committee and within daily safety huddles, in which staff from all departments gathered to discuss any concerns or lessons learned.
- Nurses from the out of hour's team said that they had good relationships with primary care general practitioners (GPs) and had no problems when they needed medicines for patients. They would complete joint visits when required.

Environment and equipment

- All the locations we visited were visibly clean, tidy and fit for purpose.
- Each area had appropriate resuscitation equipment readily available. There were systems in place to ensure the equipment was checked and ready for use. Records indicated checks of the equipment took place prior to a clinic taking place. This meant there was emergency equipment available and in date when required.
- There were systems to maintain and service equipment. Records indicated that the pulse oximetry equipment and electric weighing scales had been checked and had been serviced regularly. Electrical equipment was tested at appropriate intervals and electrical safety certificates showed it had been tested within the last 12 months.

Cleanliness, infection control and hygiene

- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. In all the locations we visited

Are services safe?

staff had access to appropriate personal protective equipment. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow.

- Between April 2015 and December 2015 community services reported no cases of clostridium difficile, methicillin-resistant staphylococcus aureus (MRSA) or methicillin-susceptible staphylococcus aureus (MSSA).
- The service used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use. Staff we spoke with understood this labelling system.
- We observed that cleaning of the different locations we visited was thorough and we saw this being undertaken during our visit.
- Monthly infection control audits were undertaken across all wards, which looked at standards such as the cleanliness of patient equipment. However we did not have access to any specific audits for community services. The overall score for the medicine division was above 90. Monthly hand hygiene audits were undertaken by staff being observed. Results were all above the trust target of 95%.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Most sharps containers were dated and signed on assembly, and the temporary closure was used when sharps containers were not in use.

Quality of records

- We looked at 13 sets of paper records. All of these contained entries that were dated; there was evidence that care plans were completed for patients as appropriate and documentation that consent had been obtained when needed. The records were found to be clear, legible and up to date and contained no loose sheets of paper.
- We saw that recent entries were easy to follow and had detailed information for patients' care and treatment and all had a completed nursing assessment and a clinical management plan.
- Patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient's stay.

- Staff told us, and this was confirmed on the service risk register, that the use of an electronic patient record would improve the quality of record keeping and reduce the risk of transporting patient records around the community. The service had put plans in place to mitigate the risk of transporting records and plans were in place to move towards an electronic record system.

Mandatory training

- Staff received mandatory training on a rolling basis in areas such as infection control, manual handling and fire. The trust target was 95%.
- At the time of our inspection the majority of staff in community services had completed their mandatory training that they were required to do. The service was above the trust target for mandatory training in all areas including health and safety and manual handling.
- The trust kept detailed records of mandatory training. Staff told us that they were encouraged complete their mandatory training, which they were able to complete in work time.
- New staff were required to complete a full day corporate induction and a local induction before undertaking their role.
- Staff received an email alert within a month of when their mandatory training was due. This meant they could book on a course to ensure they were compliant with their training by the due date.

Assessing and responding to patient risk

- There were processes in place to maintain the safety of patients. There were close links with colleagues in primary care to ensure clear communication and management of individual patients.
- We reviewed patient assessments and documentation. Risks to patient safety were assessed on an initial visit and the required actions identified. Risk assessments were completed for things such as pressure ulcers, delivery of home oxygen, nutrition and hydration, moving and handling and falls. We found that teams in the community were aware of key risks, such as falls and deterioration of a patient's condition.
- A modified early warning score system (MEWS) was used to alert staff if a patient's condition was deteriorating.

Are services safe?

This is a basic set of observations such as respiratory rate, temperature, blood pressure and pain score and is used to alert staff to any changes in a patient's condition.

- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had appropriately escalated their concerns.
- Staff could articulate what to do if a patient deteriorated and were aware of the escalation processes for senior manager support and what they would do in an emergency.
- The service had developed the 'Single Point of Access' approach to rapid response and the team had developed clear triage flowcharts for the escalation of cases such as pain relief or immediate respiratory distress.
- Patients and their families were advised by staff to contact their GP or to attend the emergency department if they became unwell or their condition suddenly deteriorated.
- Multi-disciplinary team meeting with primary care were held regularly to discuss care of patients at the end of life and any other complex cases.
- We found there were systems in place to promote the safety of staff when working alone. Staff were provided with a lone worker device linked to the local police
- A 'lone working policy' was in place and staff showed us how they accessed it.
- We saw that staff communicated any risks highlighted during visits as part of the handover to ensure staff
- We saw evidence of advice given to patients on how to use equipment and what to do if it wasn't working with escalation numbers for support.

Staffing levels and caseload

- Staffing on a day to day basis was reviewed at the trust bed management meetings and the trust safety huddle meeting with the chief executive.
- Data provided for the contract review meeting in March 2016 showed the turnover rate for nursing staff services was 2.2% for Chronic Obstructive Pulmonary Disease (COPD) services and 1.39% for the cardiovascular

service. This was below the trust target of 9%. However the highest turnover rate was seen among other staff in COPD services with 4.7%. The registered nurses in the CVD service had a turnover rate of 10%.

- We reviewed the use of agency and bank nurses between April 2015 and March 2016 and found there were a number of areas which used temporary staff regularly although not excessively. The highest sickness rate was seen among health care assistants in the COPD service with a sickness rate of 6.2%.
- The service had an, 'escalation' process for when staffing levels fell below the required numbers for the service. Managers deployed staff so care was provided in the community at all times within the agreed timeframe. The respiratory team worked closely with other community colleagues to ensure shifts were covered to ensure both services were working effectively. Staff told us that there was a marked increase in demand for respiratory service over the winter/ Christmas period. There was a reported issue accessing sufficient bank staff so staff helped out each other working extra hours as necessary to meet the demands on the service.
- The COPD service had a vacancy rate of 14% for nursing staff as of February 2016 (1.9 WTE's out of 13.8 WTE's). The Cardiovascular disease service had no vacancies at the time of our inspection. CVD service staffing ratios for covering rehabilitation groups was planned and assessed weekly. Between the two elements of Cardiac Rehabilitation and Heart Failure services were job roles which allowed a Multi Disciplinary Team approach to support patients in each part of the service.
- Stroke elements of service (specifically Speech and Language Therapy) were under review with a service level agreement contract with a local provider. At the time of our inspection there was support for two days per week currently and this was highlighted on the service risk register). LHCH has identified staff who can assess patients for Speech and Language outside of the usual provider support. Therapy staff in the Knowsley respiratory service had an establishment of 5.93 actual posts with two additional posts in the recruitment phase.
- The CVD service had an establishment of 20 allied health professionals in post. For the Pulmonary

Are services safe?

Rehabilitation service the staffing ratio to service delivery was in line with the national recommendations by the British Thoracic Society for pulmonary rehabilitation. Patient exercise classes were staffed (1:8) and (1:16) for education sessions, with a minimum of two supervisors in attendance, 1 of whom must be a qualified respiratory specialist health care professional to supervise the exercise component. We were told that the ratio of staff would be increased if oxygen users were included.

- Cardiac Rehabilitation (CR) was staffed with: One appropriately qualified exercise professional at all supervised exercise sessions. In the early rehabilitation phase a minimum of two appropriately trained CR professionals who meet the nationally identified criteria for rehabilitation (identified by the BACPR-EPG) were present at all supervised group exercise sessions.

Staff-to-individual ratios for instruction/supervision depended on the phase of rehabilitation, and the extent of any specialist help or supervision for concomitant physical or psychological/cognitive disabilities. The Association of Chartered physiotherapists in Cardiac Rehabilitation (ACPICR) recommendation of staff-to-individual ratio was 1:5 (early rehabilitation). Data provided by the trust showed that this was being adhered to.

- Community services were staffed from Monday -Friday from 9.00-5.00pm
- There was no on call cover or out of hours working for medical staff in community services.
- The percentage of consultants working in medical services trust wide was 42% which was higher (better) than the England average of 34%. The percentage of registrars was 46% which was above (better) than the England average of 39%. The percentage of junior doctors was 12% which was lower (worse) than the England average of 22%. There were no middle grade levels compared with the England average of 6%.

Managing anticipated risks

- There were processes in place to maintain the safety of patients. There were close links with colleagues in primary care to ensure clear communication and management of individual patients.

- We reviewed patient assessments and documentation. Risks to patient safety were assessed on an initial visit and the required actions identified. Risk assessments were completed for things such as pressure ulcers, delivery of home oxygen, nutrition and hydration, moving and handling and falls. We found that teams in the community were aware of key risks, such as falls and deterioration of a patient's condition.
- A modified early warning score system (MEWS) was used to alert staff if a patient's condition was deteriorating. This is a basic set of observations such as respiratory rate, temperature, blood pressure and pain score and is used to alert staff to any changes in a patient's condition.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had appropriately escalated their concerns.
- Staff could articulate what to do if a patient deteriorated and were aware of the escalation processes for senior manager support and what they would do in an emergency.
- The service had developed the 'Single Point of Access' approach to rapid response and the team had developed clear triage flowcharts for the escalation of cases such as pain relief or immediate respiratory distress.
- Patients and their families were advised by staff to contact their GP or to attend the emergency department if they became unwell or their condition suddenly deteriorated.
- Multi-disciplinary team meeting with primary care were held regularly to discuss care of patients at the end of life and any other complex cases.
- We found there were systems in place to promote the safety of staff when working alone. Staff were provided with a lone worker device linked to the local police
- A 'lone working policy' was in place and staff showed us how they accessed it.
- We saw that staff communicated any risks highlighted during visits as part of the handover to ensure staff

Are services safe?

- We saw evidence of advice given to patients on how to use equipment and what to do if it wasn't working with escalation numbers for support.

Major incident awareness and training

- There were documented major incident plans within community services and these listed key risks that could affect the provision of care and treatment. Staff understood local plans for staff to follow in the event of a fire or other major incident in the community buildings they visited.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.
- All staff undertook emergency planning awareness training as part of their induction.
- Contingency plans were in place in the event major events, such as outbreaks of flu or winter weather affecting the staff's ability to travel.



Are services effective?

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

Summary

We rated community services as 'Outstanding' for Effective because:

- Care was provided in line with national best practice guidelines and community services participated in a wide range of clinical audits and benchmarking of the services which were applicable to their service. For example British Thoracic Society Guidelines.
- Nutrition and fluid assessments were regularly assessed and patients were well supported in meeting their nutritional and hydration needs.
- People had comprehensive assessments of their needs both before during and after rehabilitation programmes and one to one interventions with robust mechanisms for monitoring outcomes.
- Most staff said they were supported effectively and the majority of staff had received their annual appraisal which was above the trust target.
- Patients pain was managed effectively and pain scores were being completed. Staff had access to information they needed to support patients.
- We found that staff members' understanding and awareness of assessing peoples' capacity to make decisions about their care and treatment was good and applications for deprivation of liberty safeguarding were completed correctly. There was good recording of both verbal and written consent.
- The service participated in all of the clinical audits for which it was eligible through the advancing and national quality programmes.
- Data provided by the service showed that the service met all the recommendations from the national COPD Audit programme: resources and organisation of pulmonary Rehabilitation services in England and Wales 2015.
- There were frequent local audits that had been completed in the service these included documentation, the community services referral process and infection prevention control. There was evidence of regular audit meetings and they were able to demonstrate specific improvements to the quality of care provided for patients. An example of this was the introduction of integrated groups for patients with both respiratory and cardiovascular conditions. Local policies and procedures were followed in relation to the care of patients. The service actively engaged with research networks and recruited well to national research studies.
- The trust contributed to all the national clinical audits it was eligible to. Clinical audit is a quality improvement process for healthcare practitioners and providers, which aims to enhance the care of patients by systematically reviewing medical practice against explicit criteria, modifying it where necessary.
- We saw reference to national guidelines in patients 'health care notes and we saw that the cardiac and pulmonary rehabilitation programmes were based on national guidance.
- Patients had an individualised care plan that was reviewed and updated in the majority of the records we reviewed. All the care plans we looked at were reviewed and updated.
- The service had taken part in a "Peer support" visit for stroke service to help assess and drive quality.

Evidence based care and treatment

- Staff provided care to people based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines, and were aware of recent guidance changes. The service was monitoring compliance with National Institute for Health and Care Excellence (NICE) guidance and was taking steps to improve compliance where further actions had been identified.



Are services effective?

Pain relief

- Pain relief was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individual patients.
- Pain relief was managed on an individual basis and was monitored at each treatment session. Patients told us they were consistently asked about their pain and supported to manage it.
- We saw that patient's pain levels were recorded on early warning scores documentation.

Nutrition and hydration

- The hospital used the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. An audit of the completion of the tool was undertaken and the trust scored a green rating.
- Staff referred patients to a GP and/or dietician where required.

Technology and telemedicine

- Staff had a limited number of handheld computer devices to access the trust's intranet and current NICE guidance.
- Some test results were accessible to staff from the patient's home. The trust was trialling the use of remote patient monitoring which used electronic information and communication to provide long distance health care to patients rather than going into hospital.
- The service was looking to develop further opportunities for supporting patients in the community using technology.

Patient outcomes

- The community service had a series of Outcome measures and assessment tools in place to ensure evidence based practice including smoking cessation, walking improvement questionnaires, breathlessness scores and oxygen assessment in line with the British Thoracic Society guidelines (2013). Outcome measures were assessed prior to commencing Pulmonary Rehabilitation (PR) to establish a baseline for each patient. The outcome measures for the PR service at were split into three groups, exercise capacity, quality of life and knowledge of condition.

- The service also produced an end of year annual report April 2015—March 2016 including information on referral rates, outcomes and functional outcomes such as return to work statistics and evidence of patient reviews at 6 weeks, 6 months and 12 months. This showed the service was proactive in reviewing the outcome of service provision for patients.
- The community respiratory service used a nationally recognised scale rating of 'perceived exertion' to assess the impact of rehabilitation and therapy programmes. There was clear data and evidence from audits that the patients benefited from the rehabilitation in the community and showed clear improvements in quality of life indicators such as breathlessness and walking improvement.
- The 2013/2014 heart failure audit showed the service performed better than average in six of the seven clinical (discharge) indicators in to the community. This showed that the service had excellent processes in place for the seamless transition of care.
- Data provided by the trust showed that the service had achieved a reduction in admissions by 54% for respiratory conditions in the geographical area.
- The trust monitored community services' performance through locality quality dashboards and key performance indicator reports.
- The service produced dashboards were used to record and monitor safety performance indicators such as incidents, assessments and referral times. Results were monitored and discussed during the locality team meetings and the local commissioners.
- Performance reports were used to review and monitor service delivery standards such as referral acceptance rates, 'did not attend rates' and face to face contacts. These were monitored by the locality managers and executive leads. The service had met all the local commissioner contract targets for the twelve month period prior to our inspection.

Competent staff

- Staff told us they received an annual appraisal. The trust's figures at the end of March 2016 showed 100% of community nursing and other staff in community services had received their annual appraisal. All medical staff had an appraisal. The trust target was 85%.



Are services effective?

- There were systems in place to ensure that staff were enabled to deliver effective care and treatment. Locally managers held the training needs analysis for their teams and were aware of the skills and knowledge required to ensure that the staff were able to care for their patients.
- The trust had developed a clinical supervision model which focused on meeting individual staff needs. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. All the community care staff we spoke with, told us they had monthly meetings with their manager and were able to speak to their manager at any time.
- Staff we spoke with confirmed they had an adequate induction. There was a preceptorship programme in place which supported junior nursing staff. The staff competency in undertaking care procedures was assessed by qualified staff. We saw that competency records were available for each service, which ensured team leaders were aware of the skills staff had.
- Staff were actively supported to undertake additional training and education to enhance their skills. For example, therapy staff confirmed that they were accessing post graduate qualifications.
- Staff in bands one to four were offered opportunities to undertake appropriate vocational qualifications. There were a number of staff in community services who had gained such qualifications. Members of the therapy service had accessed the independent prescriber's course to allow more flexibility in managing appropriate medicines for the patients' conditions.
- We saw there was a range of specialist nurses; for example heart failure nurse and leads for both the pulmonary and cardiac rehabilitation programmes. Staff told us they knew how to contact these specialists and other links in the acute hospital such as the dementia lead and safeguarding team.
- Our specialist advisor observed throughout our visit very knowledgeable skilled and competent staff across a range of areas particularly in the management of medicines and the use of assisted medical equipment e.g. nebulisers and inhalers.

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary team (MDT) working was established within community services. We saw good examples of MDT working across community services in all the locations we visited. This included nursing staff as well as therapy staff such as a physiotherapists and specialist nurses.
- Each team worked closely with other parts of the community service. They had access to the full range of allied health professionals and team members described good, collaborative working practices. There was a joined-up, thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.
- Discussion of exchange of information with GPs, other teams, other professionals including mental health professionals
- Staff had access to a psychologist who provided advice and support to staff.
- The service utilises the key named worker approach who was then able to liaise with other agencies i.e. palliative care team, primary care and acute hospital partners. There was clear sharing MDT sharing information
- The service held a monthly Multidisciplinary (MDT) team meeting to ensure that patients were accessing the correct part of the service.
- We observed positive multidisciplinary working /multi-agency. Care agency representatives arrived during an observed visit. We observed full discussion of medicines management and the use of the nebuliser and support required to meet the needs of the patient between the staff and members of the care agency.

Referral, transfer, discharge and transition

- Patients were referred to community services from the acute services in the Trust if they required on-going aftercare.
- The service was able to refer onwards after initial rehabilitation programmes to general activity classes provided by the local council.



Are services effective?

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments, and medical and nursing records.
- Policies, protocols and procedures were kept on the trust's intranet, which meant staff had access to them when required.
- In the majority of areas we visited there were files containing minutes of meetings, treatment protocols and audits, which were available to staff.
- We observed a nurse on a home visit who was able to access the patient's medicines information and blood results remotely via a secure electronic system. Staff told us they were looking forward to a new electronic system to improve faster and more secure access to patient's information.
- Patients' test results were accessible by staff at health centres.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had knowledge and understanding of the procedures relating to the Deprivation of Liberty Safeguards (DoLS).
- Staff received training in the principles of DoLS. 100 % of staff had completed this training, which was above the trust target of 95%.
- Staff understood the legal requirements of the Mental Capacity Act 2005, its associated Codes of Practice and Deprivation of Liberty Safeguards (DoLS).
- Staff were able to give us recent examples of how they had considered a patient's capacity when delivering patient care. Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to tell us clearly about how they sought informed verbal and written consent before providing care or treatment.
- In the 13 case records we reviewed, we saw examples of where patients had given both written and verbal consent for treatment.
- A trust-wide safeguarding team provided support and guidance for staff in relation to mental capacity assessments and DoLS.
- If a patient lacked the capacity to make their own decisions, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals appropriately.



Are services caring?

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

Summary

We rated community services as 'Outstanding' for Caring because:

- Staff at the trust provided compassionate and highly personalised care to patients in the community. Staff were highly motivated to offer support to patients which was kind and caring and they were willing to go the extra mile. We saw that staff were committed to providing high quality care to people and their families, which went beyond more than their physical needs.
- Throughout our visit we observed a high standard of interactions with patients and their families. Care was person-centred, and the majority of people we spoke with during the inspection were complimentary about the staff who cared for them. We observed staff spending time with patients, and built a good rapport with them
- We were told numerous stories by patients that demonstrated the compassion, kindness and thoughtfulness of staff including sorting out transport for patients and holding parties for patients.
- Feedback from patients and families was positive about the care they received.
- Patients told us staff were caring, kind and respected their wishes.
- In results from the most recent staff survey the question "Care of patients/service users is my organisation's top priority" scored 22 % compared with national 9%.
- Patients and their relatives were supported with their emotional needs and there were services in place to provide support for patients and relatives. Patients could be referred to psychological support if required. The friends and family test feedback was overwhelmingly positive for community services.
- Patients and their relatives confirmed they were kept informed about their treatment plans and felt that it was a partnership approach to their treatment planning and support decision-making.

Compassionate care

- Community services were delivered by caring and compassionate staff. We observed numerous examples of compassionate care provided to patients. There was an obvious positive rapport between patients and staff.
- Staff treated patients with dignity and respect. Patients and their relatives told us conversations were held regularly where they were updated on their progress or condition. We spoke to 13 patients throughout our inspection. All the patients we spoke with were positive about their care and treatment. Patients said that staff always introduced themselves.
- Staff told us and we observed that staff kept seeing patients, even if they deteriorated or become palliative to support the patient and families to maintain continuity as well as working with other teams involved in the care of the patients.
- Staff demonstrated flexibility and kindness when meeting people's wishes. We were told of the example of a patient not being able to qualify for external travel support and how staff had managed to liaise with other agencies to enable the patient to be supported to travel for their therapy programme.
- Although the service did not take part in the national patients survey there was a robust process for seeking on-going patients' feedback to meet the service contractual arrangements. The patient feedback results were overwhelmingly positive for the service. The feedback questions asked patients how likely they were to recommend the service.
- For the twelve month period January 2015-December 2015 survey results across COPD, CVD and diagnostic services ranged from 98-100% of people would recommend community services.

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients said they had been actively involved in their care and



Are services caring?

were aware of the treatment plans and goals in place. Most patients could explain their care plan. Patients we spoke with said they had received good information about their condition and treatment.

- Pulmonary rehabilitation patients took part in an eight week programme with different education topics each week. The patients were then given an individualised education pack upon discharge with all the information from the programme.
- We found examples of staff accompanying patients with lung transplants to the local hospital to understand their treatment and build relationships with the acute provider to improve patient care.
- We saw an example of the lead consultant providing educational talks at a local hotel on 'Breathing easier'. This was for both patients and families to help them further understand their conditions. We were told and patients confirmed that staff offered these opportunities on a regular basis.
- Patients and families were encouraged to participate through routine feedback and local surveys.
- Patients we spoke with reported they had been involved in making decisions about their care and their wishes had been taken into account. Patients reported staff explained procedures before they were carried out and were understanding of their needs. Patients were involved in discussions and decisions regarding prospective treatment and rehabilitation choices.
- Nurses showed clear evidence of promoting self-care, self-management skills in partnership with patients. Patients were advised on the correct use of inhalers and monitoring of their own heart and breathing rates as part of their exercise activity programme.

Emotional support

- The community care team provided emotional support to patients and their families. We saw records of this in patient's records. We observed that all staff were very good at establishing rapport with individuals who by nature of the condition were in discomfort or pain. One patient told us, "my CVD nurse has gone the extra mile to try and make my quality of life just that little bit more bearable"
- The service held parties twice a year which offered social and peer support for patients and their families. Staff ran these voluntarily and also arranged a 'Santa walk'. These both encouraged activity as well as emotional support.
- Staff felt they had sufficient time to spend with patients when they needed support.
- Patients and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to. Patient anxieties and questions were openly discussed and patients spoke positively of the emotional support they received.
- The service used a national recognised tool to measure psychological distress in different patient groups. The tool gave clinically meaningful results as a psychological screening tool and was sensitive to change during the disease process and in response to medical and psychological intervention.
- We observed that all staff were very good at establishing rapport with individuals who by nature of condition were in discomfort or pain. Patients and relatives we spoke with were satisfied with the information and the emotional support they received from the staff.



Are services responsive to people's needs?

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

Summary

We rated community services as 'Outstanding' for Responsive because:

- Services were planned to meet the needs of the local people that were flexible, adequately resourced and provided choice.
- There was a proactive approach to understanding the needs of different groups of people accessing the services including those with complex needs.
- The services were delivered in local leisure centres as well as health centres to provide choice and flexibility for service delivery.
- People were supported to raise a concern or a complaint. Complaints were investigated and lessons learnt were communicated to staff and improvements made.
- The health outcomes on patient knowledge all showed significant improvements for the service. The discharge information packs provided by staff helped to improve patient knowledge, and had been well received.
- The service had merged rehabilitation groups to engage with more patients and increase the
- Translation services were provided by an external provider. Staff were aware of when an interpreter should be used where effective communication is critical to patient care such as during outpatient appointments.
- The community team worked in close partnership with primary care and to implement a rapid response service as well as other clinical pathways, such as home oxygen assessments to ensure seamless transition between acute and community.
- The trust was committed to ensuring that the needs of the wider population were addressed and took part in network audit projects with the wider community to develop standards and guidelines to support community professionals.

- There were very few complaints relating specifically to community services. The senior managers of the team reviewed all complaints. To ensure the response to the complaint was thorough, any lessons learned were captured and families informed of any actions taken.

However:

The service was continuing to work with the local commissioners to work across a wider geographical area to provide quality services in a timely manner and to continue to develop the merged groups, and to work more collaboratively with the community CVD team.

Planning and delivering services which meet people's needs

- The facilities and premises were appropriate for the services that were planned and delivered.
- There was a clear standard operating procedure which detailed the inclusion and exclusion criteria for the types of patients suitable for the service to ensure they received the best care available.
- Daily one stop consultant led clinics were held each day at a different clinic with the aim of early intervention and to reduce hospital admissions
- The service proactively liaised with the early discharge nurses going into the hospital to facilitate early discharge. The service had also made links with the local ambulance service to identify regular ambulance attenders and meet any unmet needs which could be managed in the community.
- The service had been set up to respond to changing needs of the population outlined by local commissioners. Plans had been agreed to include all respiratory conditions due to the needs identified in the local population. The service was able to demonstrate their objective of 'right care at right time'. Two patients we spoke with discussed their care pathway from hospital discharge particularly the speed at which they were picked up by the service.



Are services responsive to people's needs?

Equality and diversity

- One to one sessions were also available for cultural reasons if patients felt unable to take part in the group sessions.
- There was clear evidence of integrated pathways between different heart and chest services. Several patients commented on the seamless pathway from hospital to community.

Meeting the needs of people in vulnerable circumstances

- The trust used a red symbol of a person falling to indicate if a patient was at risk of falls. This alerted staff to look at risk assessments and care plans to ensure that any necessary reasonable adjustments were made.
- Patients had comprehensive assessments of their needs both before during and after rehabilitation programmes and one to one interventions.
- For new referrals the health care assistants made a visit and introduced themselves at home or clinic to tell them about the service such as the annual review/ inhaler technique checks and spirometry. They encouraged patients to contact the service as first point of contact.
- The service was also able to arrange other tests in addition to spirometry and refer on to pulmonary rehabilitation, smoking cessation, community support services and psychology services. As part of the rapid response team the acute hospital send through blood gases prior to discharge to ensure that the most up to date patient information was available..
- Do not disturb signs were displayed at clinics to maintain privacy and dignity for patients
- The service also offered telephone triage calls to aid access for patients.
- Systems were in place to contact people the day before their appointment to give advice about getting to clinic where to park etc.
- All patients were provided with an on-going exercise plan and offered referral to activity for life. Patients were provided with a discharge education pack in line with national COPD guidance.
- The health outcomes on patient knowledge all showed significant improvements for the service. The discharge packs provided help with patient knowledge, and had been well received. These included advice on breathlessness and advice on anxiety management.
- The service had merged rehabilitation groups to engage with more patients and increase the number of extended programmes offered for patients awaiting thoracic surgery, lung cancer treatments and lung transplantation as appropriate.
- Translation services were provided by an external provider and staff were aware of when an interpreter should be used where effective communication is critical to patient care such as during outpatient appointments.
- There was a specialist nurse who was the clinical lead for dementia. The community service staff were able to access this staff member for support. People living with a learning disability and their families were offered specific appointments to help support them with the unfamiliar surroundings. Family members were invited to come and see what their family member could do and to encourage them to get involved with education and treatment plans.
- Care plans we saw were personalised to identify individual needs and contain the necessary information to ensure that patients were not at risk and their care was managed safely.
- The service was involved in a pilot to reach hard to group patients such as those on methadone. Staff encouraged patients to have spirometer tests when attending for drug therapy to try and reach people early in the disease process.
- The service also followed up patients recently discharged from hospital checking on their general health as well as respiratory conditions. Staff identified if patients required additional communication support when they received the initial referral information externally from GPs or other Trusts, or from internal referrals.



Are services responsive to people's needs?

Access to the right care at the right time

- The service had open referral to offer group sessions as well as home based programmes. The service was able to refer onwards after initial rehabilitation programmes to general activity classes provided by the local council.
- There were clear inclusion and exclusion criteria for the different parts of community services.
- Patient referrals were triaged and allocated to an assessment at their closest venue, or are assessed at home if the patient is housebound. The patients were allocated to the appropriate venue for PR depending on their assessment. By assessing patients in the leisure centres the service was able to assess more patients in a week, on average, 23 patients a week. This meant that patients, did not wait more than 5 weeks for an assessment, and usually started them in the groups the following week.
- Patients were very clear about whom to access in a crisis, or if their condition deteriorated.
- The community team worked in close partnership with primary care to implement a rapid response service. Clinical pathways such as the home oxygen service assessments helped to ensure a seamless transition between acute and community.
- The rapid response service consistently achieved its two hours maximum response. 98.61% of patients are seen within 24 hours.
- All patients we observed at the time of our visit had contacted the service that morning and a nurse visited the same morning.
- The service also offered telephone triage calls to aid access. There was a clear escalation procedure to ensure there was a safe flow of patients from admission to the service through discharge.
- Data provided by the service as part of its contract monitoring showed the service had met or exceeded the targets set by the commissioners in terms of access and flow. The service was 2 % above the target set by commissioners for eligible patients to have early supported discharge. 100% of patients identified as being in their last 12 months of life were offered referral to appropriate specialist palliative care services if they had a clinical need. 100% of all patients seen had a

summary sent to their GP within 2 working days of their appointment. The service achieved its target of 95% of patients with a specific lung condition being seen to be seen within 10 working days of referral from diagnosis.

- 100% of all diagnosed patients received a full single visit assessment to include Health & Social care assessment, dietetics advice, mental health screening and a personalised management plan agreed taking into account carer input.
- 100% of all identified smokers were offered support to quit smoking.
- The service achieved 6% 'do not attend' and/or cancellations for new appointments and follow ups in line with the target of 10% or less.
- The service achieved its target of 95% of patients requiring a face to face contact to be seen within 2hrs of contact.
- The COPD service did have an issue with the reporting on new patient's letters being completed five working days following the patient consultation, which was below target for one month only. An action plan was put in place to recover the position.
- The community service was able to offer group sessions as well as home based programmes. There was a clear escalation procedure to ensure there was a safe flow of patients from admission through to transfer or discharge.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Patients told us they knew how to make a complaint. Leaflets detailing how to make a complaint were readily available in all areas.
- The trust recorded complaints electronically on the trust-wide system. The local managers and team leaders were responsible for investigating complaints in their areas.



Are services responsive to people's needs?

- Information provided by the trust showed there had been one complaint raised across community services between February 2015 and January 2016. All trust complaints had been acknowledged within three days and responded to within the agreed timeframe.
- An example of learning from a complaint was to ensure that the reasons for eligibility were clearly explained to patients on acceptance to the service.
- Complaints were discussed at the divisional governance meetings which also outlined key lessons learnt to be shared with staff. Staff told us and records showed managers discussed information about complaints during team meetings to facilitate learning.



Are services well-led?

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

Summary

We rated community services as 'Outstanding' for Well led because;

- The community service was fully integrated across the trust and worked in partnership to provide seamless care between the hospital and community. The service was held in high regard by all parts of the trust. The community service had a well-developed identity which was part of the medicine division.
- The trust had a clear comprehensive vision and strategy for both the hospital itself as well as community services. The vision was to further research and develop community services.
- The service had set their own challenging targets and objectives to drive improvement in the delivery of high quality person centred care.
- There were systems in place to audit the quality of community services that were regularly reported and monitored at all parts of the trusts. The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level. The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level.
- Good governance was a high priority and was monitored through a number of groups such as the Medicine division governance group. There was a clear governance structure and risk registers were in place and had actions identified. Staff felt supported and able to speak up if they had concerns.
- Community services captured views of people who used the services with learning highlighted to make changes to the care provided. Staff worked across partner agencies, providers and divisions to work towards improving the quality of care and peoples' experience.
- There was comprehensive leadership within the community services team with clearly defined responsibilities. These included close links with the Chief Executive who was described by staff as, "very visible and involved."

- There was a focus on staff development, education and training for the community services which provided nursing and medical staff with the skills necessary to provide high quality care to community patients.
- We found that there were high levels of staff satisfaction from managers to ward staff working within community care. Staff were proud of their service, and spoke highly about their role and responsibilities. People would recommend the hospital to friends or a relative.
- The service had been awarded both team of the year internally and also had external recognition for their work. They were proactive in their approach to establishing new ways of working and participating in research projects to trial new technology for monitoring and self-management of patient's conditions.

Service vision and strategy

- The trust had a comprehensive vision and strategy. Their vision was "to be the primary integrated cardiothoracic healthcare organisation in the country". The trust had set out corporate and quality objectives to ensure the service was forward thinking and improved the quality of care to patients. The mission underpinning this was excellent, compassionate and safe care for every patient every day. The values were patient and family centred, accountability, continuous improvement and teamwork (PACT).
- Staff were aware of the vision and values and these were freely displayed across the areas we visited.
- The community service was fully integrated across the trust and worked in partnership to provide seamless care between the hospital and community. The service was held in high regard by all parts of the trust. The community had a well-developed identity which was part of the medicine division. The service had set their own challenging targets and objectives beyond those set by the local commissioners to drive improvement in the delivery of high quality person centred care.



Are services well-led?

Governance, risk management and quality measurement

- The community service had a risk register that monitored and reviewed any risks relating to the service it provided. We reviewed the risk register relating to community and it showed there were no high to moderate risks associated to the service. All risks had been updated in January 2016 and actions highlighted. For example the service had identified a risk to patient safety caused by the lack of community electronic patient record system (EPR) leading to the potential mismanagement of patients and/or fragmented care local plans in place.
- Funding had been secured to develop community systems to ensure that electronic patient records can be accessed and updated whilst staff are out on visits. Controls were in place to manage the risk including the manual updating of records or service requests when back on the LHCH site to ensure accurate clinical records for all patients are maintained. Risks were reviewed regularly senior staff knew there was a risk register and team leaders were able to tell us what the key risks were for their area of responsibility.
- There was a clear governance reporting structure in community services and the main governance committee was held on a monthly basis. During the meeting a review of the risk register, incident, infection, audits, complaints and feedback from services were undertaken.
- Medicine division governance committee minutes we looked at for example 20/01/2016 included regular use of community service patient stories to highlight the service provided in the community. We also saw an example of audit feedback on the efficacy of the community service referral process. This showed that the service was continuously reviewing its systems and processes to deliver a high quality service.
- Staff were able to tell us how their team performance was monitored, through team meetings and meetings with commissioners to review their performance.
- Staff said and data confirmed that multidisciplinary team meetings were held across community services. Minutes from meetings were and cascaded to staff via email. There was also a copy of the minutes in a file for staff to read.

- The trust was introducing a nursing assessment and accreditation system which looked at individual team performance. The aim was for all areas to achieve ECS (excellent, compassionate and safe care) status by 2017.

Leadership of this service

- There was comprehensive leadership within the community service with clearly defined responsibilities. These included the Chief Executive who was visible and included the community services as a key part of the wider trust.
- The community leadership team demonstrated effective leadership, and the leaders understood the challenges to provide high quality palliative care in the community.
- Staff felt the team were visible, approachable and supportive, supporting the staff to care for patients in the community.
- Staff reported there was clear visibility of members of the trust board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff.
- All nursing staff spoke highly of the team leaders as leaders and told us they received good support. We observed good working relationships within all teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.

Culture within this service

- The majority of staff said they felt supported and able to speak up if they had concerns.
- In the 2015 staff survey, 99% of staff in community services said they were enthusiastic about their job and 100% of staff in the COPD service looked forward to going to work. These scores were better than national average. The community services scored significantly better than the trust average in six questions, in line with the trust average for 80 questions and no answers were significantly worse than the trust average. This showed that there was a very positive culture across the community service.



Are services well-led?

- 70% of staff in community services believed that the organisation provided equal opportunities for career progression. However 23% did not know the answer to the question. 6% of staff felt their wasn't equal opportunities for progression.
- There was an open and honest culture within the service and staff were candid about the challenges they faced. The latest staff survey results for 2015 results showed that 93% of staff would recommend community services as a place to be treated. 68% of staff would recommend the service as a place to work.
- Staff were aware of the trust's whistleblowing procedures and how to raise concerns.
- There was a culture of openness, team working and support across the adult community service. Staff were positive about the future of the community services.
- All staff told us about the importance of the multidisciplinary person centred approach to the care and support of patients and their families. We observed many examples of this throughout our visit.
- All staff told us they were proud of the care they provided to patients and felt they were supported by the trust to give high quality care.
- All the nursing staff were positive about the trust leadership. One nurse was effusive about the Chief executives leadership, "Not sure how she does it but if she meets you once she remembers your name"
- Staff were very positive about the about the safety huddle and how effective it was in terms of closing the gap between management and frontline staff as well as making staff feel they were listened to.
- Staff were observed to be open and honest with patients. Staff told us that they wanted to get it right for the patients.
- There was a strong collaborative approach to working between the individual teams within the community service as well with other partners and providers.

Public engagement

- The acute hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. This was a very positive response with 99%

of patients who would recommend inpatient services at the hospital to friends or a relative. Due to the arrangements with the community service they did not participate in this survey. However as part of the contract specification the service was continuously seeking feedback from patients using the service. Responses were overwhelmingly positive regularly achieving over 90% of people who would recommend the service rising to 99% for the rehabilitation programmes and COPD service in the period January 2015-December 2015.

- The governance committee heard a patient story at the beginning of each meeting and any learning was taken forward to improve services.
- The service encouraged people who used services, and those close to them to provide feedback about their care and review the outcome of their treatment.
- The governance committee heard a patient story at the beginning of each meeting and any learning was taken forward to improve services.
- The service held twice yearly parties for patients as part of their inclusive approach to care and service delivery.

Staff engagement

- In the Staff Survey 2015, the trust was in the top 20% of acute specialist trusts for 20 findings. Areas where the trust performed well included staff recommendation of the trust as a place to work or receive treatment, staff satisfaction with the quality of care they were able to deliver and support from immediate managers. This related to staff satisfaction with the quality of work and patient care they are able to deliver and for effective team working.
- Physical and psychological support services were available to staff and staff were aware of how to access them.
- The trust celebrated the achievements of staff at an annual event. At the last event community services had a number of staff nominated for their work at the trust.
- There was also the employee of the month scheme which recognised staff who had gone the extra mile to provide patient care. There were several staff from community services who had been awarded this title.



Are services well-led?

- The trust held regular listening into action meetings to capture staff feedback from all areas.
- Staff participated in the 2015 staff survey. This included how staff felt about community services and their personal development. 97% of staff at the trust felt the training and development they had undertaken had helped them to deliver a better patient experience and 95% felt it had helped them to do the job more effectively. 81% felt they were valued by their manager. These scores were all better than the national averages. The majority of staff we spoke with told us they felt valued and the team leaders were fantastic and supportive.
- The service had two research projects on-going with higher education establishments looking at social identity and exercise adherence to improve patient outcomes.
- Knowsley Community COPD service had been awarded external network funding to undertake a study utilising a self-monitor system on patients with COPD. This worked by using web-connecting electronic tablets which are provided to patients, for self-monitoring. The aim of the study was to reduce sudden declines in health which in turn, will reduce admissions and readmissions to our hospital, and provide our patients and their family carers, with a higher quality of service.

Innovation, improvement and sustainability

- Staff in community services; told us they felt they were able to make suggestions to improve the work of their team/department.
- We also saw many examples of staff showing initiative and being involved in deciding on changes to improve services for patients. Staff had received both local and national external recognition for their work with patients.
- The service had presented a Poster presentation for its work looking at cross over integration between the rehabilitation teams.
- Knowsley CVD service had introduced a 'cancer rehabilitation' project using the blueprint of cardiac rehabilitation to continue the clinical and psychological outcomes. The service was using this project as an opportunity to bring additional specialist resources and clinical expertise to support a more individualised rehabilitation programme for a group of patients who require specific clinical expertise to promote improvement outcomes in cancer management.
- The service had been able to describe the example of patient with an internal cardiac device (ICD) who had their heart rate monitored during an exercise session and then the physiotherapist had access to the readings to plan their own individualised treatment plan.