# Bridgewater Community Healthcare NHS Trust

## Quality Report

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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 we hold about quality, and information given to us from patients, the public and other organisations.

# Summary of findings

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# Summary of findings

## Overall summary

Bridgewater Community Healthcare NHS Trust provides community and specialist health care to people in Ashton, Leigh, Wigan, Halton, St Helens and Warrington. It also provides community dental services to these areas (and more widely) and health care including dental services at three prisons.

The trust provides a range of 127 different clinical services. The largest services are district nursing, health visiting, physiotherapy, podiatry, and speech and language therapy. They are usually delivered in patients' homes, clinics and local health centres. The trust provides healthy living and lifestyle advice services. It manages three walk-in centres; provides health care in three prisons dental services. The trust has two inpatient facilities, at Newton Community Hospital, and at Padgate House which it jointly manages with the local authority.

The trust employs 3,400 staff and has around 11,000 contacts a day and 2.5 million a year across all its services.

During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We talked with carers and/or family members, observed how people were being cared for, and reviewed patients' care and treatment records. We visited 26 locations including the two community inpatient facilities at Padgate House and Newton Community Hospital. The remaining locations included six dental practices, and two walk-in centres, St Helens Walk-in Centre and Leigh Walk-in Centre. We carried out unannounced visits on 5 and 6 February 2014 to Newton Community Hospital, Padgate House and the Wheel Chair Centre.

We judged that services were safe. Most staff were able to describe the systems for reporting incidents. However we identified a range of errors and weaknesses in risk and quality reporting and action taken following the identification of risks at Newton Hospital, which could affect the trust's overall assurance of the unit, and mirrored concerns previously identified from an external review of the hospital carried out in 2013. There was evidence that improvements had been made to services through sharing of lessons learned. However, this sharing of learning was usually within individual teams, rather than more widely across clinical services.

Staff were able to describe how to use pathways of care and treatment that are based on nationally agreed best practice. There was multidisciplinary team work taking place. Most staff members said there were enough staff, and health visiting staff had seen increases in numbers as part of the 'Every Child Matters' policy. However there were some staff vacancies that were affecting the delivery of services

Most patients commented on the caring and compassionate approach of staff across the organisation. We saw staff treating patients with respect. Patient surveys carried out by the trust showed high levels of patient satisfaction.

The services we reviewed were responsive to the needs of the patients. There was good triage in the walk-in centres as well as good coordination of care for people with learning disabilities and their families. Multidisciplinary teams were working to make sure patients were discharged smoothly and the children's care services were centred on the needs of families.

At Newton Community Hospital we heard about the rapid response team who support patients for up to two weeks in their own homes to reduce readmissions.

The trust had recently finished a management restructure process. Staff commented positively about how they were engaged with during this process. The trust's board had a clear focus on quality. There was a governance framework in place and regular reporting to the board took place. There were programmes of leadership development in place for the new levels of managers across the trust, and these were evolving. Some staff did say that there had been a lack of handover to new managers at the start of the new structure. Some of the new managers had greater responsibilities, and they were not yet fully up to speed with all the risks and challenges of their new roles.

# Summary of findings

There was a lack of vision about the use of Newton Community Hospital, which was having a detrimental effect on staff, and there were also weaknesses in reporting arrangements at the hospital.

# Summary of findings

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

We always ask the following five questions of services.

**Are services safe?**

We judged that services were safe. There were systems to identify, investigate and learn from incidents. Staff at all levels of the organisation said that there was an open culture that supported them to report and learn from incidents. The trust's board had a focus on quality and this was reflected across the organisation.

However we identified a range of errors and weaknesses in risk and quality reporting and action taken following the identification of risks at Newton Hospital, which could affect the trust's overall assurance of the unit.

Staff were aware of children's and adult's safeguarding procedures and training was in place. Any problems were investigated to find out their root causes, and many staff had received training to carry out these investigations.

Systems to share findings across the organisation tend to be local, and while there are examples of individual teams learning locally, this wasn't always shared across the trust.

**Are services effective?**

Staff provided care based on evidence-based guidance and policy, and were provided with training to support delivery of care. The effectiveness of care was monitored both at the board and across clinical teams, including a robust audit programme. However, not all effectiveness targets were being met.

Staffing levels were generally acceptable across teams. However, there were pockets where vacancies had stood for some time, or staff were not clear when vacancies would be recruited to. This had affected timely access to services in some cases.

There was evidence of good multidisciplinary team working, though this could be in silos. To address this, the trust is developing its 'One Bridgewater' directorate-based structures, moving away from the borough-based structures it inherited.

There was evidence of partnership working with other organisations, and while telehealth services were in their infancy, teams sought to work with partners to support patients in their own home where possible.

**Are services caring?**

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

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

The trust had a focus on the 'six Cs', which centred on staff providing services that offered care; compassion; competence; communication; courage and commitment. While not all staff were aware of this initiative, patient feedback did not suggest that staff were anything other than caring and compassionate towards them.

**Are services responsive to people's needs?**

Services were responsive to people's needs across the majority of services. There was some evidence where waiting times were longer than expected. This was reflected in patient surveys, which while very positive about the quality of care, noted that waiting times could be a frustration for some patients.

# Summary of findings

Staff worked well in multidisciplinary teams across organisations to provide support to patients in the community. The trust sought multiple opportunities to learn from patients' experiences and, where care had gone wrong, to improve the overall quality of care.

**Are services well-led?**

The trust was well-led, and the board has a clear vision for the organisation. The majority of staff were aware of that vision, though the recent restructure meant that some staff were not clear on their chain of command was and who their immediate line manager was.

Quality was high on the trust's agenda, and staff across the trust were working to engage effectively with commissioners. There was a lack of clear vision for some services, and in particular the use of Newton Community Hospital. This had a negative effect on staff working there.

The board engaged with staff effectively, and staff reported involvement in the ongoing evolution of the trust. However, not all staff received supervision or appraisal, and the impact of the 'One Bridgewater' approach to a directorate-led organisation had yet to be fully realised. Many services still reflected the old borough-based approach, with staff working in silos.

# Summary of findings

## What people who use community health services say

We spoke with a range of patients and relatives during the inspection and with patient representative groups before the inspection. We also gathered comment cards from patients and relatives during the week of the inspection.

Overwhelmingly feedback on services was positive, with patients saying they were listened to by their health professional and involved in decisions about their care. Where negative comments were made, this tended to be about waiting times for first appointment.

The trust's patient surveys showed that the majority of patients were satisfied with their care. For example the district nursing survey carried out in 2012/13 showed that 99% of respondents were either satisfied or very satisfied with their care. There were similar levels of satisfaction in both podiatry and health visiting services.

Although not specifically required by community trusts, the trust has introduced the Friends and Family test to further develop its patient feedback mechanisms. It reported these in its monthly patient experience report for November and December 2013. The higher the Friends and Family test score, the more likely people are to recommend the trust's services. The score can range from 100 to -100. During this period, the net scores increased across the boroughs of Halton and St Helens, Warrington and Wigan. The trust's overall score also increased, from 73 in November to 79 in December.

## Areas for improvement

### Action the provider MUST take to improve

- Develop effective reporting mechanisms to ensure that the board are fully sighted on activity and performance at Newton Community Hospital.
- Develop effective systems to identify, assess and manage of risks at Newton Community Hospital.

### Action the provider SHOULD take to improve

- In conjunction with commissioners agree a clear vision for Newton Hospital including appropriate commissioning arrangements.
- Complete actions identified during the independent review of Newton Community Hospital in 2013 and review the effectiveness of those changes.
- Develop and approve specific guidance and protocols that are focussed on inpatient services.
- Commission and provide training that meets the needs of staff working within an inpatient facility.
- Make sure staff are aware of the process for recording DNA CPR and test that this is recorded appropriately.
- Review staff levels at Newton Hospital in light of the current commitment and ensure that permanent staff are recruited including those employed by other organisations.
- Ensure that all staff have received appropriate training to identify, review and report incidents accurately including root cause analysis.
- Work with commissioners to make sure that there are clear commissioning intentions and agreements for all services, and that CQUIN targets are met.
- Take action to ensure that teams don't work in isolation, there is shared learning to drive improvement and staff and resources are shared as required.
- Provide clarity to staff regarding the management of vacancies and recruitment to roles across the trust; and ensure vacancies are recruited to with the minimum of delay
- Continue to develop information technology systems to enable full integration and connectivity across the trust.

### Action the provider COULD take to improve

- Collate formal feedback from patients (for example thorough surveys) where this does not take place, and use child friendly documents where necessary.
- Collate patient safety data and data for end of life care indictors so there is a consistent and robust approach across all the end of life services.

# Summary of findings

- Ensure sufficient staff with the right skills and qualifications are in place for the provision of children's services at the walk in centres.
- Develop information transfer documents for new managers so that they are fully briefed on the services they are taking responsibility for.

## Good practice

- The trust invites patients to each board meeting to tell their story of how services have impacted on them both positively and negatively. The trust also has a programme called patient partners; this is a group of around 150 patients who the trust calls on to help them develop services across different clinical services.
- The trust has a robust clinical audit programme that includes evidence of service changes and re-audit.
- The trust carries out quarterly staff surveys using the same format as the National NHS Staff Survey. This allows them to track progress made in improving staff satisfaction at work, and identify potential new areas of concerns more quickly.
- Padgate House was in the process of, and Newton Community Hospital had implemented intentional rounding. This involved staff reviewing each patient at set intervals. A systematic approach to intentional rounding can improve the patient's experience of care and can increase their trust. This is recognised as good practice. Prior to starting this approach the manager had audited the current call bell response times to ensure that the new system did not have a negative impact on people who use the service
- The dignity champion at Padgate House told us of social event to raise awareness was a good example of staff being supported to initiate new developments. We found this to be good practice to support staff to take on leadership roles.
- The single point of contact for access to child and adolescent mental health services was effective and helped to ensure children had a smooth transition to adult services.
- There was good joint working between the trust and partner organisations to address local public health issues such as child obesity and breast feeding.
- The physiotherapy and occupational therapy services in Warrington developed a research study including testing the use of specific equipment such as large gym balls and mirrored boxes.
- Community matrons had developed 'clinical risk stratification' for patients with long-term conditions.

# Bridgewater Community Healthcare NHS Trust

**Detailed findings**

**Locations we looked at:**
Bridgewater CHCT – Padgate House; Bridgewater CHCT – Newton Community Hospital; Bridgewater CHCT – Bevan House

## Our inspection team

**Our inspection team was led by:**

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

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

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

## Background to Bridgewater Community Healthcare NHS Trust

Bridgewater Community Healthcare NHS Trust is a provider of community and specialist services to people living in Ashton, Leigh and Wigan; Halton and St Helens and Warrington. It also provides community dental services to these areas and more widely and provides services at three prisons. The trust provides a range of 127 different clinical services across its core footprint. The largest are general services, such as district nursing, health visiting, physiotherapy, podiatry and speech and language therapy, usually delivered in patients' homes, clinics and local health centres. The trust provides services for over 830,000 people.

The Health profiles for the areas covered by the trust indicate, in general, a higher level of deprivation than the England average (with the exception of Warrington) and poorer health than the national average for a number of the health indicators, particularly for children's and young people's health. Life expectancy for males and females is generally lower than the national average and there's a higher incidence of early deaths, heart disease and stroke and smoking and related deaths.

Bridgewater Community Healthcare NHS Trust has been inspected 4 times prior to this inspection. Three of these inspections took place at the prisons that the trust provides

# Detailed findings

healthcare for. The fourth inspection took place at Bridgewater CHCT – Bevan House where community services are provided from. All four inspections were judged compliant at the time of these inspections.

## Why we carried out this inspection

Bridgewater Community Healthcare NHS Trust was inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

## How we carried out this inspection

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

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

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

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Bridgewater Community Healthcare NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 3 and 6 February 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 26 locations including two community inpatient facilities Padgate House and Newton Community Hospital. The remaining locations included 6 dental practices, and two walk-in centres, St Helens' Walk-in Centre and Leigh Walk-in Centre. We carried out unannounced visits on 5 and 6 February 2014 to Newton Community Hospital, Padgate House and the Wheel Chair Centre.

# Are services safe?

## Summary of findings

We judged that services were safe. There were systems to identify, investigate and learn from incidents. Staff at all levels of the organisation said that there was an open culture that supported them to report and learn from incidents. The trust's board had a focus on quality and this was reflected across the organisation.

However we identified a range of errors and weaknesses in risk and quality reporting and action taken following the identification of risks at Newton Hospital, which could affect the trust's overall assurance of the unit.

Staff were aware of children's and adult's safeguarding procedures and training was in place. Any problems were investigated to find out their root causes, and many staff had received training to carry out these investigations.

Systems to share findings across the organisation tend to be local, and while there are examples of individual teams learning locally, this wasn't always shared across the trust.

## Our findings

### Safety in the past

Overall we found that care had been safe in the past. Between November 2012 and November 2013 no never events were recorded as having occurred at the trust. There were 83 serious incidents at the Trust in the same time period, the majority of which took place in the patient's own home. The most common type of serious incident reported was pressure ulcers (grades 3 and 4), which accounted for 70 of the 83 incidents. Data prior to the inspection had not identified any serious incidents at Newton Hospital, however during the inspection we identified 2, which did not appear to have been investigated appropriately. The trust provided clarification for the two incidents noted, indicating that "the incidents had already been identified within the Trust as part of a review of those incidents reported to the NRLS. On review the impact scores had been amended. This is why the 2 incidents had not been originally included as SUIs in the incident reports submitted to CQC". They were both subsequently reported as SUIs.

CQC received 186 notifications via the national reporting and learning system (NRLS) between November 2012 and November 2013. It was noted that the trust had been slow to report into the NRLS system; on average incidents were 72 days old when reported.

The trust monitors performance as part of the national safety thermometer programme. With regard to pressure ulcers, whilst there was some fluctuation in the rates they are under the England average. The rate for falls with harm for all patients is around the England average and for patients over 70 below the England average. The trusts rates for new urinary tract infections among patients with a catheter were below the England average.

Data regarding walk-in centre performance demonstrated that the centres consistently met or exceeded the threshold of 5% set by the Department of Health, for re attendance (the re attendance rates are important as they may indicate an initial incorrect diagnosis or poor initial treatment).

Staff were familiar with safeguarding procedures, and the majority of staff had received safeguarding training at the level correct for their roles. An audit carried out in November 2013 by one of the local authorities identified communication, multidisciplinary working and escalation across the partner agencies as areas of good practice.

### Learning and improvement

Most staff were aware of the process for investigating when things had gone wrong, including the use of root cause analysis to investigate serious untoward incidents. The board reviewed incident data monthly, including detailed analysis of pressure ulcers, and the detail of all complaints received. The quality and safety committee, a formal subcommittee of the trusts board has been delegated responsibility for all aspects of quality and safety.

Staff at Newton Community Hospital reported that they had not received training to undertake root cause analysis, and we found evidence of one incident that had been closed on the Ulysses system (incident reporting system) before any root cause analysis investigation had taken place. An RCA was subsequently undertaken at the request of commissioners and subsequently placed on the risk register as a serious untoward incident. However when we reviewed the outcomes of the action plan at least one of the actions (in relation to signing for controlled drugs) had

not been implemented. We also identified discrepancies between incidents recorded on Ulysses and incidents reported in the monthly quality report which did not match.

We were provided with a range of examples where improvements to services had taken place following incidents. For example as a result of the medication administration errors at Padgate House the manager introduced a clinical competency framework for administering medicines; data since the introduction demonstrates that no medication errors have occurred in the last 4 months.

Staff told us that they tended to discuss learning from incidents during team meetings, however learning tended to be localised. For example, the Halton team presented a patient story to the trust board and this was discussed during their team meetings. The lessons learned included improving communication with district nurses and GP's; however, staff were not able to describe how this information was shared with the Warrington and Ashton, Wigan and Leigh teams so they could also improve their services.

### Systems, processes and practices

Staff were familiar with the process for reporting incidents, near misses and accidents using the trusts electronic system (Ulysses), and were confident to do so citing an open culture in the organisation which supported them to report concerns and incidents.

Staff received mandatory training in key areas such as medication, health and safety, fire safety, infection prevention and control, safeguarding children and adults and falls prevention.

The majority of staff showed a good understanding of the different types of abuse and how to detect these. Staff were aware of the process for reporting safeguarding concerns and allegations of abuse within the trust and to external organisations such as the local authority safeguarding teams. There was a trust-wide safeguarding lead and staff were aware of how to contact them.

Premises run by the trust were noted to be clean and well maintained. Premises had procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Audits had been completed for issues such as hand hygiene. At Newton Community Hospital we saw staff following a recently introduced procedure of 'you use it, you clean it' where by every item of equipment had an 'I'm clean' sticker dated and initialled. The sticker was removed when someone used a piece of equipment and reapplied once the equipment had been cleaned.

Systems were in place to removed clinical waste from patients' homes using a local collection service directly from patients' homes.

Consent was sought from patients prior to the delivery of treatment; patients told us that they felt involved in decisions about their care. Consent was recorded in the majority of notes that we reviewed, but this was not universally so.

When reviewing the do not attempt cardiopulmonary resuscitation process at Newton Community Hospital whilst staff were aware of the process, and an annotation was made on the patients electronic records, we could not find evidence in the patients paper records that this decision had been discussed with patients and/ or their relatives and recorded prior to the decision being made. We saw evidence in one file that the family were told after the decision had been made.

### Monitoring safety and responding to risk

There are systems in place to monitor safety and respond to risks. The trusts quality and safety committee is the formal subcommittee through which issues relating to quality and safety are discussed. The committee is chaired by a non-executive director, and the executive nurse and medical director attend the meeting in conjunction with general managers and other clinical staff.

The board received quality and safety information and discussed this in detail at its board meeting. There has been particular focus on the prevention of pressure ulcers. The trust had a target of zero grade 3 or 4 pressure ulcers as part of its quality monitoring. We discussed this with senior members of the board who acknowledged that this had originated as an aspiration, but had been translated into a target. However they were clear that this meant the board had focussed on ensuing systems were in place to reduce pressure ulcers. We explored this further with specialist tissue viability staff; there were systems to assess risks and plan care to reduce the incidence of pressure ulcers. There

was regular discussion and information sharing with commissioners, and a training plan in place for staff across the trust to access pressure ulcer management and prevention training.

We reviewed action taken at Newton Community Hospital following an independent review completed in 2013. It was difficult to ascertain when the plan had been reviewed as action taken was not dated. Original target dates remained in place and had not been revised. As a consequence many of the actions remained incomplete some months past their target date. We were unable to determine from the completed actions when they had been completed and if they had been effective in reducing risk.

Patients received risk assessments to determine the level of intervention and care that they required. For example patients with long term conditions have a falls risk assessments completed by district nursing staff using a falls risk assessment tool (FRAT) to identify patients at high risk of falls. At Padgate House, staff used the Nursing Risk Assessment Tool to meet the needs of their patients; pre and post treatment outcomes were measured including the Bartell outcome measure and the Elderly Mobility Scale scores.

### Anticipation and planning

Staff across the trust seek to ensure that services remain safe for people. For example the walk-in centres rotate staff across the different units to help manage changes in patient flow and peek activity times. There are contingency plans in place in the event major events, such as outbreaks of flu or winter weather affecting staffs ability to travel.

Some staff highlighted concerns regarding staffing levels, and whilst the majority of staff indicated that they had enough staff there was evidence of vacancies impacting on care, for example vacancies in musculoskeletal services had meant that waiting times had increased.

There were concerns regarding the use of Newton Community Hospital. The trust had commissioned an independent review of the unit following a range of concerns regarding quality and safety at the unit. The review took place at the beginning of 2013, and whilst a number of the resultant actions had been met, a number have not been achieved in the desired timescales. Of the 31 actions in total, 14 had not been completed, 8 of which had a target date for completion of August 2013 or earlier.

# Are Services Effective?

(for example, treatment is effective)

## Summary of findings

Staff provided care based on evidence-based guidance and policy, and were provided with training to support delivery of care. The effectiveness of care was monitored both at the board and across clinical teams, including a robust audit programme. However, not all effectiveness targets were being met.

Staffing levels were generally acceptable across teams. However, there were pockets where vacancies had stood for some time, or staff were not clear when vacancies would be recruited to. This had affected timely access to services in some cases.

There was evidence of good multidisciplinary team working, though this could be in silos. To address this, the trust is developing its 'One Bridgewater' directorate-based structures, moving away from the borough-based structures it inherited.

There was evidence of partnership working with other organisations, and while telehealth services were in their infancy, teams sought to work with partners to support patients in their own home where possible.

## Our findings

### Evidence-based guidance

Staff we spoke with all indicated that the guidance they followed to deliver care was based upon best practice, which included the use of recommendations from the National Institute of Health and Care Excellence.

Staff caring for children followed specific guidelines relevant to their sphere of work for example the Healthy Child Programme (Department of Health 2009). Staff also informed us that they followed the Fraser guidelines when assessing the competency of children to consent to treatment.

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

At Newton Community Hospital, staff had developed their own inpatient guidelines and standard operating procedures, though at the time of our inspection these were still awaiting ratification through the trusts quality and safety committee.

### Monitoring and improvement of outcomes

The trust monitors the effectiveness of care through the quality and safety committee and the trust board. The dashboard that the trust reports against contains nearly 20 indicators, including accident and emergency response times, cancer waiting times, pressure ulcers, and other safety thermometer indicators. The trust reported in December 2013 that the majority were rated green. However, serious untoward incidents (including pressure ulcers) and pressure ulcers were both rated red as they had exceeded their respective targets of zero.

There was evidence from the Commissioning for Quality and Innovation (CQUIN) data that not all targets, which demonstrate the effectiveness of care, were being met. For example payment framework data from August 2013 evidence indicated that an assessment of Preferred Place of Care (PPC) was in place for 85.3% of all palliative care patients against a target of 95%; that pain was assessed and controlled at time of death for patients supported by the Liverpool Care Pathway (LCP) for 12.5% of patients compared with a target of 80%; and that patients supported by the LCP who reported symptoms of respiratory secretions, terminal agitation, and nausea and vomiting were assessed and controlled at time of death for 8.6% of patients compared with a target of 80%.

There was a detailed audit programme in place for the trust and staff we spoke with were aware of clinical audits taking place within their area of the trust. Each directorate had an audit champion, and there was a clinical audit sub group. The dental directorate undertook a number of audits to monitor performance such as timescales for new patient referrals; waiting list performance and 'did not attend' (DNA) rates. Data received from the dental sector highlighted high DNA rates across the division with an

# Are Services Effective?
## (for example, treatment is effective)

overall rate of 21.2%. Evidence highlighted that the division was aware of the level of DNA rates and was taking action such as reminding patients of forthcoming appointments by telephone.

### Staffing arrangements

The majority of staff told us they had their full staffing complement and we found there were enough suitably trained staff to meet the needs of patients. However we noted some teams had experienced delays to recruit to vacant posts which in some cases had impacted negatively on performance.

At Newton Community Hospital, the unit has increased in size over the previous three years from 18 to 30 beds. The recruitment of additional permanent nursing staff has not kept pace with this increase, partly due to the commissioning intentions for the unit not being agreed, and the unit had two qualified nursing vacancies since the summer of 2013. The therapy team (which is employed by 5 Boroughs Partnership NHS Foundation Trust) had the same numbers of staff since the unit had only 18 beds.

New starters received a corporate induction programme as well as local training. Induction covered topics such as incident and risk management assessment and reporting, safeguarding and other health and safety training. Following the generic induction local induction provided new starters with training specific to the area they were working in.

### Multidisciplinary working and support

Multidisciplinary working was evident across the organisation; however there was evidence of silo working. The trust was changing from a structural position of autonomous individual boroughs delivering care, to a clinical directorate based approach. Strategically the board is moving towards this with its 'One Bridgewater' philosophy, and the trust is now structured in functional directorates rather than boroughs, but it was evident that further time is needed to embed these changes.

For example, in end of life care, there was limited communication and sharing of resources and information across the three teams. Each team worked in isolation of the other. There were no formal meetings that involved staff across the three localities. The trust had started a clinical review group, which met every six weeks and was chaired by the medical director and attended by staff across the three teams.

There were however examples of good practice; the dental directorate worked in partnership with primary and specialised dental services to ensure a responsive and patient focussed service. We saw evidence of referrals to other professionals such as orthodontists.

Multidisciplinary team working was integral to the successful delivery of care at both Newton Community Hospital and Padgate House where nursing staff, therapists and medical staff all worked effectively together to provide intermediate care to patients under their care.

### Co-ordination with other providers

Staff at various levels of the organisation told us how they worked with partner organisations to ensure information and care was jointly managed where appropriate. Managers from executive staff to service managers met with their counterparts in commissioning organisations to share information, be that performance data related to CQUIN targets or pressure ulcer management.

Partnership working was integral to the relationship and services provided by teams such as the intermediate and reablement service in Warrington. The service included three providers who were all located in one building and working together to meet the needs of the patients to help people receive either short term care and rehabilitation at home or to act as a transition between hospital and home.

We also saw evidence of integrated working between the community dental team and other organisations as part of the Oral Health Promotion Service (OHPS). This service works with a range of target groups including young children; teenagers; adults; vulnerable groups and other health professionals to deliver better oral health in accordance with evidence based practice.

### Effective care delivered close to home

Telehealth and telemedicine were being developed by the trust in order to move care closer to patients own homes. Community matrons told us about telehealth developments which had been introduced to some patients in the community for blood pressure monitoring.

At Newton Community Hospital, staff worked with a clinical connection point (CCP) team who worked with GPs in the community to help assess patients in their own homes. Patients told us they were provided with information and the support they needed to stay at home.

# Are Services Effective?

## (for example, treatment is effective)

Within children's and family services there were examples of clinics being run at differing times and locations and home visits being timed to minimise disruption, including joint visits where this was appropriate.

# Are services caring?

## Summary of findings

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

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

The trust had a focus on the 'six Cs', which centred on staff providing services that offered care; compassion; competence; communication; courage and commitment. While not all staff were aware of this initiative, patient feedback did not suggest that staff were anything other than caring and compassionate towards them.

## Our findings

### Involvement in care

Patients and their carers told us that they were involved in planning care. For example in the Talk to Us survey in podiatry services carried out in 2012, 99% of patients were satisfied or very satisfied with the information they were given about their treatment, and 97% of patients were satisfied or very satisfied with the time they were given to ask questions.

Patients, relatives and families that we spoke with all indicated that they were involved in care decisions, and records we reviewed confirmed this. The majority of records we reviewed contained evidence of consent from patients for treatment; however, this was not always the case.

In end of life services, staff respected the patients' right to make choices about their care. We observed staff speaking with patients clearly in a way they could understand. We saw staff discussing options relating to areas such as equipment or medication to allow patients to make an informed decision. The patients and relatives we spoke with told us the staff kept them involved. One patient said "they explain everything and provide care based on what I want".

### Trust and respect

Patients and their relatives told us that staff treated them with respect, and that they trusted them. One relative at Newton Community Hospital, shared anxieties with us regarding their relative, and after we raised this, medical staff immediately took time to offer reassurance. We spoke to the relative later who was happy that they had been able to discuss their concerns with staff and were reassured.

Staff endeavoured to ensure that there were enough staff to care for patients. Where there were vacancies staff tried to book the same agency staff or use block bookings to ensure the same staff would work with them to aid continuity of care.

Parents we spoke with were very positive about the interactions of nurses, health visitors, midwives and therapists with both themselves and their children. Where there had been feedback from families that was not as positive staff indicated that they made efforts to improve the service, for example using social media to provide information and developing a phlebotomy service that visited the child at home.

### Patient understanding of their care and treatment

Patient satisfaction was high across the organisation. Patient surveys the trust carried out were positive; the main areas of concern were with regard to t access to treatment and the timeliness of appointments.

The Community Dental Network survey carried out in September 2013 considered the views of 321 people. Overall the results were positive and patients were satisfied with the care that they received. The areas where patients were least satisfied were not being seen on time and a lack of general health advice.

The trust had introduced the family and friends test, and reported these within their monthly patient experience report for November and December 2013. Data indicates that patient satisfaction increased between the two dates reported thus far.

### Emotional support

Patients told us that they were supported by staff. Patients at Padgate House told us that they were on a journey to go home. They felt supported to get better and achieve their goals if at all possible. One person told us "the staff are just like family".

# Are services caring?

We spoke to one patient who had received support from one of the specialised community teams. They described the service as 'stunning.' They described their journey from initially not knowing who to turn to, to their initial self-referral and making a phone call to an administrator who reassured them they could help and started the process of providing support from a team who 'cared.' They felt completely included in their journey and experienced support from staff who instinctively knew what to do and were always readily available to show their support and showed they cared.

We spoke with a patient at Newton Community Hospital who was anxious about going home. Later we observed the multidisciplinary team meeting when the patients care was reviewed. The person's discharge date was delayed pending some further conversations with a community matron to help allay the patient's anxiety.

### Compassion, dignity and empathy

Patients were treated with dignity, compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. The patients we spoke with were complimentary about staff attitude and engagement.

The trust had a focus on the 'six' Cs', which were centred on staff providing services that offered care; compassion; competence; communication; courage and commitment. There were various responses from staff regarding the 'six C's', most were aware of the initiative but a small number of staff were unsure about the 'six C's initiatives encompassing the trusts focus on dignity of patients. Some staff were 'dignity champions' and 'community champions' which had enhanced their knowledge about how they embedded their practices for patients.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

Services were responsive to people's needs across the majority of services. There was some evidence where waiting times were longer than expected. This was reflected in patient surveys, which while very positive about the quality of care, noted that waiting times were often a frustration for some patients.

Staff worked well in multidisciplinary teams across organisations to provide support to patients in the community. The trust sought multiple opportunities to learn from patients' experiences and, where care had gone wrong, to improve the overall quality of care.

## Our findings

### Meeting people's needs

We observed care, and records supported the notion that staff endeavoured to provide care that met the needs of their patients. Staff worked across multi-disciplinary teams and in conjunction with other providers to ensure services met the needs of their patients.

We were informed that in one borough there was a backlog of health assessments for looked after children; however the provider was taking actions to address this including engaging with partners to improve service provision.

Staff we spoke with had a good understanding of the needs of the local population. For example in end of life services staff worked as part of multi-disciplinary teams and routinely engaged with local hospices, GP's (through local gold standards framework meetings), adult social care providers and other professionals involved in the care of patients.

### Access to services

Access to services was good for the majority of patients across the provider's services, though there were some services where waiting times were longer than expected. For example, the waiting times for access to musculoskeletal services was long even through this had reduced recently. Staff described what actions they had taken to prioritise access to the service and ensure that scheduling was run efficiently and to minimise the number of non-attenders at clinics Data from the trust indicates that for musculoskeletal physiotherapy, the number of people waiting over 6 weeks had increased from 10% to13% between April and October 2013.

However within dental services, the target for assessment was 20 days from referral. Patients told us that they had been seen by the dental service within this timescale. Data received from the Community Dental Network indicated that there was a 95% threshold and confirmed all sectors within the directorate had achieved the target each month.

The physiotherapy/ occupational therapy team in Warrington usually worked to a two week target in response to patient referrals. Due to a current staff vacancy they had shown the impact in their target rate being extended to four weeks. At the time of the inspection staff were awaiting recruitment and selection to employ to the vacant post.

### Leaving hospital

At both inpatient units, there was evidence that discharge was discussed with patients and their families when they were admitted to the units. At Newton Community Hospital discharge was discussed regularly at multidisciplinary team meetings, and we found evidence that discharge was varied to ensure that the patient was fully fit to be discharged. In addition to this the hospital provided up to 2 weeks support in the community for patients who were discharged to help reduce the risk of readmission.

The majority of community nurses reported good relationships with hospital staff to support early discharge. The community matrons described a proactive service that identified and managed patients using a case management approach. They aimed to prevent unnecessary hospital admissions, reduce the length of stays in hospital, and improve patient self-care and self-management. They had two staff members seconded to accident and emergency services at Warrington and Whiston hospital to help assist with these services.

Support for children with long term conditions was shared with other agencies to help to prevent readmission to hospital. Community nurses assisted in the training and development of carers involved from other agencies where more specialist interventions were required. This was illustrated by the development of competency assessments for interventions such as gastrostomy feeding.

# Are services responsive to people's needs?

## (for example, to feedback?)

### Support in the community

The trust had systems in place to ensure that patients and their relatives had the support they required in the community. Patients reported that they had individual care plans and they had been involved in the development of these. The records we reviewed demonstrated that care had been planned around the needs of the patient and their family.

For those patients receiving in-patient care, equipment needs were assessed prior to discharge to allow this to be provided on discharge.

### Learning from experiences, concerns and complaints

Staff told us that there was an open culture at the trust in which staff were supported to report where care had gone wrong to improve quality in the future. Patient stories were heard at each board meeting, and it was clear that these stories provided powerful messages for the board about the reality of care delivery for patients in their community, be that a positive or negative experience. This had taken place at each board meeting for the last 2 years.

The trust had a patient partner's programme that has so far recruited over 150 patients to help support the trust to develop its services when required. This had originated within children's services where staff had engaged with a mother who was frustrated about the service that she was receiving. This had led to changes in how the service was delivered to better meet the needs of families.

The trust had a "Talk to Us" patient feedback form that they receive feedback from as well as carrying out formal patient surveys. We did note that the survey was not particularly 'child friendly' staff also commented that they received little feedback from children from these surveys.

Complaints were recorded on the trusts centralised trust side system. Lead nurses and clinical leads investigated formal complaints relating to their specific teams. The trust target was to respond to formal complaints within 25 days. The trust received 125 written complaints in 2012-2013, a slight reduction from 2011-2012.

# Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

## Summary of findings

The trust was well-led, and the board has a clear vision for the organisation. The majority of staff were aware of that vision, though the recent restructure meant that some staff were not clear on their chain of command was and who their immediate line manager was.

Quality was high on the trust's agenda, and staff across the trust were working to engage effectively with commissioners. There was a lack of clear vision for some services, and in particular the use of Newton Community Hospital. This had a negative effect on staff working there.

The board engaged with staff effectively, and staff reported involvement in the ongoing evolution of the trust. However, not all staff received supervision or appraisal, and the impact of the 'One Bridgewater' approach to a directorate-led organisation had yet to be fully realised. Many services still reflected the old borough-based approach, with staff working in silos.

## Our findings

### Vision and governance framework

There was a vision for the organisation and the majority of staff were aware of this. The trust had recently completed a restructure of its management arrangements and introduced service and clinical managers. The next step in the trusts vision is articulated through its 'One Bridgewater' approach, where it aims to implement a clinical directorate approach to service delivery and not a borough based approach.

The majority of staff were aware of the 'One Bridgewater' approach, and how this impacted upon them, but this has yet to fully embed. As a consequence we identified numerous examples where staff continued to work across borough boundaries, or where learning was only being shared within teams. The trust is aware of this and is working to embed its new approach.

There was a governance framework in place with associated committee structures. Quality was high on the board's agenda, as was risk with detailed discussion at each board meeting. There was tacit agreement from senior staff that the boards overall balance between operational and strategic leadership was currently weighted towards operational, but considered this balance to be correct at present given the major change programmes currently taking place.

Governance and risk systems were evolving as the trust matures. The risk register now reflects the organisation as a whole, and service level risk registers fed into this. It was less clear how risks from Newton Community Hospital were fed into the risk register, whether all risks from the hospital were included on the trust wide register, and whether this had a detrimental impact on assurance at the board.

There are evolving relationships with commissioners, but there was evidence that staff a various levels of the organisations regularly meet with their commissioning colleagues to discuss care provision including opportunities for improvement and learning.

There was a lack of agreed vision for Newton Community Hospital. The service had evolved over time from a home caring for ex miners into a service providing intermediate care in a new local improvement financetrust (LIFT) building. As a consequence services has grown rather haphazardly and required a clear purpose and commissioning intent for the future.

### Promoting innovation and learning

The trust regularly undertakes staff surveys. The trust's national staff survey results are in line with the England average. The trust replicates the national staff survey on a quarterly basis to track overall staff satisfaction, and to identify areas of concern. The last quarters report indicated ongoing staff satisfaction in line with the last national survey, and the trust received over 600 responses.

Staff told us how senior managers listened to them when they had identified areas for improvement and innovation. For example, the district nursing service in Leigh told us how they had developed a business case to request administration staff to help improve the service they offered. They were positive regarding the feedback and the resulting additional staff supplied to the team. Staff were freed up to enable them to focus on patients' needs and were able to manage their workloads effectively.

The majority of staff we spoke with told us they had good access to training, including specialist external courses and they were supported by their line managers to access training. The majority of staff told us that they received

# Are services well-led?

## (for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

regular performance reviews and supervision, though this was not the case for all staff that we spoke with where pockets of staff reported poor access to supervision and performance reviews.

### Leadership development

The majority of staff were aware of who their manager was, but this was not universally the case; some staff since the management restructure were not clear who their manager was. Some of the new managers we spoke with were not fully conversant with their span of control and consequently were not clear on all the risks within their scope of responsibility. Some managers told us that there had been no handover of services to them from predecessor staff which had not assisted their initial management of services.

Staff knew who board members were, and many had spent time with these senior managers. Each board meeting was held in a different part of the trusts geographical foot print, and board members met with staff in the area after the meeting. Staff were on the whole positive about their interactions with board members.

During the trusts recent restructure the board took a conscious decision to ensure that there was greater clinical leadership. We were told that of the 56 managers now in place across the trust, only 3 do not have a clinical background. There was a programme of leadership and management training in place for managers and clinical leads at different levels of the organisation, which formed part of the trusts overall organisational development programme.

### Staff engagement

The trust engaged well with staff through its quarterly staff surveys, and regular contact with board members. The majority of staff we spoke with knew who the members of the board were, especially the executive members. Staff reported an open culture at the trust which empowered them to report concerns.

The trust had a focus on the 'six' Cs', which were centred on staff providing services that offered care; compassion; competence; communication; courage and commitment. There were various responses from staff regarding the 'six C's', most were aware of the initiative but a small number of staff were unsure about the 'six C's initiatives encompassing the trusts focus on dignity of patients.

The trust has introduced clinical reference groups that had wide staff representation on them. All changes associated with the trusts cost improvement plans, and directorate restructuring was led through the clinical reference groups to ensure staff were engaged and involved.

Staff turnover rates were not high, though rates of sickness/ absence were. Between April 2012 and August 2013 the trusts rate of staff sickness was higher than both the England average as well as other community provider trusts. The trust had taken various actions to reduce its level of staff sickness, and through its review of sickness management had also identified familial redundancy as having an impact on rates of sickness in certain parts of the trust where there were high levels of unemployment in the local community.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.<br><br>The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users at Newton Community Hospital.<br><br>Regulation 10(1)(b) and 10(2)(c)(i) |