Bridgewater CHCT - Bevan House

Quality Report

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This report describes our judgement of the quality of care at this location. 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 healthcare to people living in Ashton, Leigh, Wigan, Halton, St Helens and Warrington. It also provided community dental services to these areas and (more widely) and health services at three prisons.

The trust provided 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 employed 3,400 staff. It has around 11,000 patient contacts a day and 2.5 million a year across all its community services.

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, talked with carers and/ or family members and reviewed personal care or treatment records of patients.

We judged that services were safe. Most staff were able to describe systems for reporting incidents. There was evidence of improvements made to services through learning, though sharing of lessons learned. However this was often within individual teams and not across clinical services.

Staff used of pathways of care to treat patients, based on nationally agreed best practice. There was multi-disciplinary team work taking place. Most staff said that they felt there were enough staff in teams, and health visiting staff had seen increases as part of the 'Every Child Matters' policy; however there were examples where staff vacancies were impacting on service delivery.

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. Multi-disciplinary teams were working to make sure patients were discharged effectively, and the children care services were centred on the needs of families.

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, and there was a governance framework in place and regular reporting to the board took place. There were evolving programmes of leadership development for the new levels of managers across the trust. Some staff did say that there had been a lack of handover to new managers at the start of the new structures. Some of the newly appointed managers had an expanded span of control which meant that they were not fully conversant with all the risks and challenges.

Summary of findings

The five questions we ask and what we found at this location

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 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.

Staff were aware of children's and adults safeguarding procedures and training was in place. Root cause analysis takes place and the majority of appropriate staff had received training to carry out these investigations.

Are services effective?

The services were generally effective, and focussed on the needs of patients. Staff were able to demonstrate that care was provided through the use of best practice or evidence based guidance. Staff had regular opportunities to meet with colleagues and share learning.

There was a focus on quality at the board. For example it reviews all complaints to make sure that appropriate action and learning takes place. The trust monitors the effectiveness of care through its governance structures.

There was a lack of recognised workload dependency tool for community services in use across the organisation. Despite this the majority of staff reported that they considered their staffing levels to be safe. However there were some services where staff vacancies were affecting the delivery of services.

Are services caring?

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

Are services responsive to people's needs?

Most services were responsive to people's needs. In one or two cases parents raised concerns about the speed of diagnosis for their child. Patient surveys showed that most patients were satisfied with the responsiveness of community services. Where problems were reported it was usually the time taken to secure an appointment or the waits for treatment on the day of their appointment.

Staff provided a range of evidence as to how they had developed or enhanced their services. Often these improvements were done in partnership with other providers.

Are services well-led?

The trust was well-led. Staff said there was an open supportive culture. Most knew who the executive team were and had spent time with them. Staff had been well engaged in the recent staffing restructure and the ongoing service restructure. There was strong clinical leadership across the organisation, with the majority of managers having a clinical qualification.

There are organisational, governance and risk management structures in place. Staff said that they felt supported to raise any concern and that the culture of the trust encouraged them to do so.

There were some concerns about feedback mechanisms. Some staff were not sure about who their manager was, but acknowledged that this was due to the recent restructure of the organisation.

Summary of findings

What we found about each of the core services provided from this location

Community services for children and families

We found that the children's and families' service was safe, effective, caring and in the main responsive to the needs of the local population.

There were systems in place for reporting incidents and near misses and staff were using these appropriately. The safeguarding arrangements were well embedded in practice and staff felt well supported by the specialist safeguarding team. Staff were provided with supervision although in some cases due to management changes there had been gaps in management supervision. There was access to mandatory training and a system to remind staff when they needed to refresh their training. There were safe systems for the management of medicines and the removal of clinical waste. Risk assessments were generally clear and mitigating actions were in place, although some of these were not regularly reviewed. There were some staff shortages but these were being resolved.

Staff were supported using nationally recognised guidelines. There was evidence that audit was used to measure patient outcomes and patients were encouraged to provide feedback on their experience of care. There was a policy to support staff working alone but the strategies in place to protect staff were not consistent across the trust. It was clear that all professional staff were committed to multi-agency working and the delivery of care as close to home as possible. There were assessments of young people's competence for consent using the Fraser guidelines where this was necessary.

All the people we spoke with agreed that the professionals were caring, and they were committed to putting the child and family at the centre of all that they did. We did see some records that were not fully completed and this had not been picked up by the trust's audit. However the interactions we saw between professionals, children and their families were respectful. We saw records that showed emotional support was given to children and families in a variety of situations and there was evidence of services working around the needs of the families.

There was evidence that the trust was aware of the needs of the local population and that it had led or been involved in projects to improve public health. There was evidence of good multi-agency as well as multi-disciplinary working across the trust. There were some areas of therapy and nursing where there were long waiting times. These had come about during the reorganisation and action was being taken to address them. Staff had actively pursued effective planning for discharge with the local acute trusts and this was mostly effective. There was evidence that staff supported and encouraged feedback from parents and children but the trust's feedback form was not child friendly.

There was a trust vision that all staff were aware of. There had recently been changes to the management structure bringing all the teams providing the same service across the trust under one manager. The trust promoted innovation and learning but this innovation was in pockets and not trust-wide. The managers we spoke with were passionate about their role and about developing services to meet local needs. All the staff we spoke with said that the trust's board were open, responsive and visible to the workforce.

Community services for adults with long-term conditions

We found that patients and their needs were placed at the centre of their care. There was a high regard for safety and we could see that lessons had been learned following incidents. The trust shared learning with staff using among other things intranet updates and a trust-wide newsletter.

The services were effective and led by the needs of the patient. There was a real attempt to be 'joined-up' in the teams' approaches to care. The trust had a clear vision for the organisation, and a commitment to sharing best practice across its wide geographical area.

Patient were overwhelmingly positive about the services received. Patients were complimentary about the staff and told us they had received good standards of care that met their needs.

Summary of findings

Community matrons and reablement teams showed great pride, vision and expertise. They showed a great appreciation for reducing unnecessary admissions to hospital and speeding up patients' discharge back into the community. We saw evidence of close integrated partnership working and proactive monitoring of the quality of services.

Staff were generally proud of working for the trust. They said it offered an open and listening culture with senior executives visiting teams and regular communication via the trusts intranet.

The recent reconfiguration and lack of clarity of changes to management within teams had raised some anxieties among staff, although most staff on the frontline felt they just got on with the job regardless of managerial changes. The management of change was unclear to some managers taking over new services, with no clear direction of the services strengths and weaknesses.

End-of-life care

There were systems and processes in the end of life care services to provide safe care and support for patients and these were working effectively. Patient safety was being monitored and incidents were investigated to learn and improve care.

The end of life care services followed national guidelines and staff used care pathways effectively. The trust took part in national and local clinical audits. The processes for collecting patient safety data and complying with end of life care indicators could be further improved. There were enough staff with the right skills to meet patients' needs. Patients were supported with the right equipment. Patient records and clinical notes were completed appropriately.

Patients spoke positively about their care and treatment. There were systems in place to support vulnerable patients. The end of life care services engaged with other care providers and professionals to make sure that coordinated care took place. There was enough capacity to ensure patients referred to the services could be seen promptly and receive the right level of care.

Staff were appropriately supported with training and supervision and encouraged to learn from mistakes. The end of life care services did not have clear leadership roles. Individual teams were effective but worked in isolation of each other and there was no shared learning across teams.

Community dental services

The community dental service had systems and processes in place to keep people safe. The service had learned from incidents and mechanisms were in place to identify and control risks to patients.

The dental service was effective and focussed on the needs of patients and best practice. There were systems in place to audit both clinical practice and the overall service.

Patients and their representative's spoke highly of the care provided. They confirmed they had been given privacy and were treated with dignity and respect whilst receiving treatment.

The community dental service was responsive to the needs of patients. The maintenance of clear, concise and detailed clinical records confirmed that care and treatment was provided in a way that met the diverse needs of patients.

The community dental service was well-led. Initiatives had been established to improve services, and there were quality assurance processes in place. Staff spoken with confirmed that they felt valued and supported in their roles and that managers within the dental service and overall trust were approachable and visible.

Other services

There were systems and processes in the end of life care services to provide safe care and support for patients and these were working effectively. Patient safety was being monitored and incidents were investigated to learn and improve care.

Summary of findings

The end of life care services followed national guidelines and staff used care pathways effectively. The trust took part in national and local clinical audits. The processes for collecting patient safety data and complying with end of life care indicators could be further improved. There were enough staff with the right skills to meet patients' needs. Patients were supported with the right equipment. Patient records and clinical notes were completed appropriately.

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Summary of findings

What people who use the 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 that 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 Family and Friends 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 increase, from 73 in November 2013 to 79 in December.

Areas for improvement

Action the community health service SHOULD take to improve

- 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 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 about the management of vacancies and recruitment to roles across the trust; and make sure vacancies are recruited to with the minimum of delay.
- Continue to develop its information technology systems to enable full integration and connectivity across the trust.
- Reduce waiting times for access to specific services.
- Take steps to improve the timeliness of reporting via the NRLS system.
- Make sure all staff have opportunities to receive supervision and support on a regular basis.
- Improve the quality of record keeping to reduce the risk of inaccurate information, including the recording of consent.
- Develop more appropriate means for school nurses to transport drugs that require refrigeration.
- Ensure that all staff have access to appropriate safeguarding training.
- Take measures to protect the safety of all staff, and in particular staff working alone, in a consistent way.

Action the community health service 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.
- 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.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

- 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. This helped them to identify patients at risk of their condition getting worse, prioritise any clinical interventions or management, and provide a framework for a clinical strategy for those patients.

Bridgewater CHCT - Bevan HouseBridgewater CHCT – Community Services

Detailed findings

Services we looked at:
Community services for children and families; Community services for adults with long-term conditions; End-of-life care; Dental services, Other services

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; a 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 receiving care or caring for someone who uses the type of service we were inspecting.

Background to Bridgewater CHCT - Bevan House

Bridgewater Community Healthcare NHS Trust was a provider of community and specialist services to people living in Ashton, Leigh, Wigan, Halton, St Helens and Warrington covering an area of 225 square miles. It provided community dental services to these areas (and more widely) and provides services at three prisons. The trust provided a range of 127 different clinical services across its core footprint. The largest services are district nursing, health visiting, physiotherapy, podiatry and speech & language therapy. They are usually delivered in patients' homes, clinics and local health centres.

The Trust employed 3,400 staff. It has around 11,000 patient contacts a day and 2.5 million per year across all its services.

Bridgewater Community Healthcare NHS Trust had been inspected four times before this inspection. Three of these inspections took place at the prisons at which the trust provides healthcare. The fourth inspection took place at Bridgewater CHCT – Bevan House from where community services are provided from. At all four inspections we judged the trust to be meeting standards at the time of the inspections.

Detailed findings

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. We used information we held and gathered about the provider to decide which services we looked at during the inspection and the specific questions to ask.

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:

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

Before visiting, we reviewed a range of information we held about Bridgewater Community Healthcare NHS Trust and asked other organisations to share what they knew. 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 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.

Community services for children and families

Information about the service

Children's and families services were provided across all geographical areas served by the trust and include the following;

Health visiting and specialist health visiting

Children's community nursing and complex health needs

Child and adolescent primary mental health

School nursing

Midwifery

Children's specialist nursing

Child protection

Children's therapists (Speech and Language, physiotherapy, occupational)

The inspection of children's and families services was undertaken by two inspectors from CQC, a school nurse, midwife, continuing care nurse and a health visitor. We visited nine locations, went on three home visits, one school visit, and observed clinics. During our inspection we spoke to approximately 100 people, including families and children, and reviewed the information from comment cards received during the inspection. We also took into account information gathered at a patient and professional focus group hosted by a local voluntary organisation prior to the inspection.

Summary of findings

We found that the children's and families' service was safe, effective, caring and in the main responsive to the needs of the local population.

There were systems in place for reporting incidents and near misses and staff were using these appropriately. The safeguarding arrangements were well embedded in practice and staff felt well supported by the specialist safeguarding team. Staff were provided with supervision although in some cases due to management changes there had been gaps in management supervision. There was access to mandatory training and a system to remind staff when they needed to refresh their training. There were safe systems for the management of medicines and the removal of clinical waste. Risk assessments were generally clear and mitigating actions were in place, although some of these were not regularly reviewed. There were some staff shortages but these were being resolved.

Staff were supported using nationally recognised guidelines. There was evidence that audit was used to measure patient outcomes and patients were encouraged to provide feedback on their experience of care. There was a policy to support staff working alone but the strategies in place to protect staff were not consistent across the trust. It was clear that all professional staff were committed to multi-agency working and the delivery of care as close to home as possible. There were assessments of young people's competence for consent using the Fraser guidelines where this was necessary.

All the people we spoke with agreed that the professionals were caring, and they were committed to putting the child and family at the centre of all that they did. We did see some records that were not fully completed and this had not been picked up by the trust's audit. However the interactions we saw between professionals, children and their families were respectful. We saw records that showed emotional support was given to children and families in a variety of situations and there was evidence of services working around the needs of the families.

Community services for children and families

There was evidence that the trust was aware of the needs of the local population and that it had led or been involved in projects to improve public health. There was evidence of good multi-agency as well as multi-disciplinary working across the trust. There were some areas of therapy and nursing where there were long waiting times. These had come about during the reorganisation and action was being taken to address them. Staff had actively pursued effective planning for discharge with the local acute trusts and this was mostly effective. There was evidence that staff supported and encouraged feedback from children, young people and families but the trust's feedback form was not child friendly.

There was a trust vision that all staff were aware of. There had recently been changes to the management structure bringing all the teams providing the same service across the trust under one manager. The trust promoted innovation and learning but this innovation was in pockets and not trust-wide. The managers we spoke with were passionate about their role and about developing services to meet local needs. All the staff we spoke with said that the trust's board were open, responsive and visible to the workforce.

Are community services for children and families safe?

(for example, treatment is effective)

Safety in the past

We found that there were systems in place for reporting incidents. Staff reported that the system was easy to use and that they were encouraged to report incidents and near misses. The trust reported an increase in the numbers of incident reports of 17% between quarter 1 in 2012-13 and quarter 1 in 2013-14.

Nursing and support staff were confident about safeguarding children, they were aware of the local authority procedures and were well supported with regular safeguarding supervision every three months. Staff reported that they were able to access additional support when it was needed from the safeguarding leads both within the organisation and the local authority. An audit carried out in November 2013 by one of the local authorities identified communication, multi-disciplinary working and escalation across the partner agencies as areas of good practice.

We were told of occasions where interagency working had improved the outcomes for staff, children and families. For example when problems were identified with pupils by the school nurses or teacher's assistance was provided by specialist nurses, which improved the outcomes for children in education.

Learning and improvement

The method used for investigating incidents was described by the staff and managers. It included the use of root cause analysis where appropriate and staff were able to discuss where prompt action had been taken or lessons had been learned to improve practice. For example the immediate action taken following the reporting of an accident caused by an accumulation of leaves on paths and roads outside a clinic.

A few staff were unclear about what was meant by a 'never' event and others were unsure about their responsibilities in investigation once an incident was reported. However most managers we talked to were aware of their responsibilities in identifying trends and patterns of incident reporting, addressing issues promptly and reporting back to their teams; as well as the thresholds and need to escalate

incidents within the organisation. A manager informed us that she reported back to her team through various means depending on the incident and the learning that came out of it, the feedback was either individual or team wide and if it had a multi-disciplinary impact then it would be raised at the weekly MDT meeting.

Nursing and support staff accessed safeguarding training and most reported this was delivered in conjunction with partner agencies. However from data supplied by the trust Halton and St Helens were not meeting an 85% target for relevant staff achieving level 2 training and in Warrington the training for relevant staff at level 3 did not meet the 95% target.

Most nursing staff and all health visitors we spoke with reported using peer supervision to assist in developing practice. They valued the opportunities provided to develop support staff in their roles and to mentor students. Management supervision had not always been provided due to the changes in structure but this was now developing.

Both managers and teams reported that they were supported to carry out their roles and were encouraged to develop and innovate in their practice. For example, the development of a single point of access to improve the timeliness of assessment and treatment for children/ young people with mental health problems.

Systems, processes and practices

There are systems in place for responding to serious incidents including those that are not the responsibility of the trust alone and these were used effectively in the instances discussed with team managers. An incident involving the safety of a staff member which required the involvement of three agencies to resolve was effectively managed to maintain ongoing safety.

The majority of staff we spoke with felt supported by their managers even though in some cases this was qualified by the managers recent appointment and them not being fully 'up to speed' with the complexities of their role.

There were regular audits undertaken of services and their effectiveness, and action plans put in place where necessary; these were reported at board level and to commissioners. However we did identify that an audit carried out on records failed to identify gaps in care planning (see section on caring).

Where the management of medicines was the responsibility of the trust, procedures were in place, but for the majority of patients the medicines were held in their home and accessed by the nursing staff, from the child's supply. Where children were in receipt of controlled drugs in the management of serious pain, the visits to administer this medication were carried out by two staff to ensure doses were correctly calculated. School nurses were required to carry vaccines to schools in heavy fridges which were difficult to get into their cars.

Clinical waste was effectively managed in patients' homes using a local collection direct from the home. Where sharps bins were required in patients' homes these were provided and collected by a waste disposal company when full.

Monitoring safety and responding to risk

All staff we spoke with were aware of the lone working policy and the responsibilities they had to ensure they complied with the local procedures for ensuring their safety. These procedures were not consistent across the trust with some staff being provided with mobile phones and others with monitoring devices that allowed them to trigger a response when they were in a vulnerable situation.

Risk assessments were undertaken for a wide variety of issues and we were able to see effective record keeping in relation to risk in some patient files although in others this was not as well documented or reviewed.

Mandatory training was undertaken including training to support emergencies, such as anaphylaxis, where relevant and there was an IT based system that alerted staff to the need to complete this. Staff found this supportive and commented that it ensured they actually made the time to do the training before the due date.

The midwifery service was operating with a ratio of 1:70/80 midwives to mother which is better than the birth-rate plus guidelines of 1:100. This is good practice and allowed midwives to provide care within the National Institute of Health and Care Excellence guidelines.

Anticipation and planning

The trust had undergone considerable change over the last two years including changes to staffing and skill mix. There had been some delays in the recruitment of nursing staff, which had resulted in some staff having to take on extra work to meet the needs of children and young people, or delays in access to services. This was improving and staff noted that in the three cases identified where this was

Community services for children and families

having an impact the vacant posts had been recruited to and new staff were due to start within a matter of weeks; staff told us they could 'see light at the end of the tunnel'. The 'Call to Action' for health visiting had improved the staffing in all the health visiting teams and they were positive about the impact increasing numbers had made to their case loads and ability to support parents.

Are community services for children and families effective?

Evidence-based guidance

All health visitors, midwives and nurses we spoke with were aware of the guidelines relevant to their sphere of practice and reported they were supported to practice to the standards identified. For example, Healthy Child Programme, DH 2009. Implementation of the guidelines was evident in discussion with the staff and in the review of records. Where commissioners had not commissioned services to best practice guidelines there was evidence that staff were raising the issue through managers to try to influence the local commissioning strategy. For example health visitors were not routinely commissioned to carry out ante natal visits but this is part of the Healthy Child programme and the Trust continue to work with commissioners to achieve full implementation by November 2014.

We identified good practice by many of the teams we met with, for example the development of evidence based competency training and assessment for non-professionals to enable them to carry out interventions, such as gastrostomy feeds, in either school or home settings.

We were informed that the Fraser guidelines were used to assess the competency of children to consent to treatment. In the case where children were not able to give consent parental consent was sought and dependant on the treatment planned was either given verbally or in writing. When we looked at notes we found that some of them did not record consent to treatment.

Monitoring and improvement of outcomes

There was clinical outcome data provided to managers to enable them to monitor effectiveness within the teams, although one manager did indicate that she felt this data could be improved, looking at some areas in greater depth, not just the contact but the outcome of it, and she was intending to take this forward.

There had been evidence based initiatives to improve support to mothers in a number of areas which had resulted in positive outcomes that have been measured. For example improving the emotional wellbeing of mothers by the use of group creative activities. It was evident that teams were aware of the initiatives and were working to support their success.

Feedback was sought from children and their families using experience based design that allowed improvements to be made to services by asking people who had used the service to provide information to encourage improvement, for example one project improved its information giving prior to the delivery of a service because people expressed anxiety about attending in the first instance.

Staffing, equipment and facilities

It was clear from speaking to most of the team and service managers that they were passionate about providing a 'good' service to the local population and to encourage innovation and embedding of best practice within children and families services. All staff were happy to develop practice and confident that if they produced the correct evidence base for a particular innovation that they would receive a fair hearing from managers and the trust board.

We were informed that staff new to the service were provided with an induction and worked alongside colleagues before they worked in the community on their own. We did not speak to anyone who was newly employed so could not verify the process.

There were arrangements in place to ensure that staff working alone in the community were supported and one member of staff who described a risky situation she had been in was very happy with the support she had received from the organisation to ensure her future safety.

It was noted that there were some delays in accessing services and we were given examples by parents of times when communication from the trust had not allowed them to understand what would happen next. The teams involved acknowledged that there had been occasions when this had happened but hoped that these cases would become less prevalent as the numbers of staff increased as planned.

Multidisciplinary working and support

There was an integrated service provided to children aged 0-19. During interviews with health visitors, midwives, nurses and therapists it was clear that there was effective

communication between teams within the trust and evidence provided showed that there was also effective communication with partner agencies. For example where children with complex needs were due to be discharged from hospital it was reported and recorded that staff from the community would become involved in care prior to discharge. This ensured that there was an understanding of specific needs, appropriate equipment could be provided and staff could be adequately trained in its use if necessary.

Attendees at a focus group held prior to the inspection agreed that for the most part communication between the teams was effective and that the child was at the centre of the care delivery. This was confirmed when talking to parents as part of the inspection.

Effective care delivered close to home

All professionals we spoke with were able to demonstrate ways in which they respected children within their family unit. 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 community services for children and families caring?

<Summary here>

Involvement in care

It was clear from discussions with families and professionals that children and families were involved in the decisions about care delivery. Care observed showed that compassionate and person centred care was provided although in one case the care was delivered in a rather mechanistic way. Good practice was seen in dealing with difficult subjects when talking to adolescents. However we did get feedback from one parent who felt they had been left with a diagnosis and no support for an extended period of time.

The assessment processes and ongoing assessments were observed to include goal setting and were revisited on a regular basis to ensure progress was being made. All staff discussed the use of multi-disciplinary team working to identify and assist in developing children to their potential. There were care plans in place that were usually agreed by the child or parent however some of the records did not contain sufficient information. For example we saw records that did not contain a needs assessment and others where care plans were referenced but not seen within the notes. In some cases consent to treatment was not in evidence or had been dated two days before our visit when treatment had clearly been ongoing prior to that. There had been a recent audit of records which did not identify these issues.

The trust had a large amount of information to support children and families. All professionals we spoke with were clear that time must be spent with parents and children to assist them in understanding the choices available to them.

For children with complex learning disabilities, the transition to adult services began at 16 years and there was a gradual handover from that time. The trust was also feeding into a national pathfinder for SEND which aims to provide support to people with learning disabilities from 0-25 years.

Trust and respect

Parents were clear in discussion with us that they trusted that the professionals would respect their confidentiality. Parents told us staff were 'really helpful' that they were 'really caring' and 'always treated (me) with respect'.

School nurses were clear where their responsibilities lay in supporting young adults and the need to assess competence and respect confidentiality. Staff also informed us that they were able to have the right conversation with young people when there were matters disclosed that could not remain confidential.

It was clear in all conversations with professionals employed by the trust that they were very child and family focused and they looked at the family unit when making their assessments. In some cases it was clear that the professionals worked with families as well as the young people referred for emotional and mental health support to help them develop their relationships to the benefit of the young person.

When we spoke to parents they were very positive about the interactions of nurses, health visitors, midwives and therapists with both themselves and their children. We were told that '(I) always see the same health visitor'. 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.

Community services for children and families

Staff were able to illustrate that they were working to be inclusive to the minorities in their areas and had access to interpreting services if this was required. For example, staff had set up of a group for new mothers who spoke the same language which was not English.

Patient understanding of their care and treatment

Patient survey feedback had been positive reaching 90% in most areas. Most parents we spoke with and those at the focus group were clear that they would be able to contact relevant people at the trust once they were in receipt of care although there was one incidence where a parent had received no contact for a considerable period when waiting to access a service and did not feel able to make any contact with that service.

The majority of patients hold their care plans at their homes as there is multi-disciplinary input to the care, or they have the 'red book' which records their contact with midwives and health visitors. In some cases we observed the red book was not fully completed and some mothers were not clear about the contact they would receive in the future.

We observed staff in conversations with children and young people using age appropriate language to assist their understanding. There did not appear to barriers to effective communication in these encounters.

Emotional support

We were given examples of practice that supported the emotional health and wellbeing of parents and children, such as supporting children in nursery and school access, enabling respite for families and the provision of specialist multi-disciplinary support for changing conditions. We identified in patient notes that this support was recorded and we observed some of this in practice.

Compassion, dignity and empathy

We observed that professionals were tactful, respectful and open in their communication with both parents and children. Staff were able to discuss how they would maintain dignity and privacy for children in different settings and there were many examples given of the use of non-verbal communication to aid in their assessment of children's immediate needs, such as the assessment of pain, anxiety and emotional distress.

All staff and most parents we spoke with were positive about the ways in which services worked together to provide care around the child and where additional needs were identified there were well established channels of communication to facilitate this.

Are community services for children and families responsive to people's needs? (for example, to feedback?)

Meeting people's needs

Information we received from the trust and stakeholders showed that needs in the local community were understood by the trust and there was evidence of joint initiatives designed to improve public health. For example there were initiatives to improve the percentage of mothers choosing to breast feed and to tackle obesity in young people.

There was a clear emphasis in all the teams we met that working with others both within and outside the organisation was expected and practiced to ensure the best outcomes for patients, including working with the local authority on public health issues such as childhood obesity, and local acute trusts to ensure effective discharge from hospital. We also saw that there were good arrangements for working with McMillan nursing teams and the local hospices.

We did identify from discussion with some parents and professionals that they were extended waiting times for access to some services. This was particularly evident in access to specialist learning disability nursing services in one area. This was being addressed but it was likely that the waiting time would be increased for a considerable time. Waits for speech and language therapy were raised by families but the evidence from the trust showed that the waiting times were within the standard and that perhaps this had not been effectively communicated to the parents.

We were also given information that there were delays in diagnosis of some conditions for children. We did have this confirmed by one parent but from all other information we saw and discussions we had with professionals this was not the norm.

Community services for children and families

Access to services

From interviews with staff and managers, they were aware of the risks of people not effectively accessing services and they had put into place methods to assist with access for example the use of phone texting and making clinics available out of hours and at weekends.

It was also reported that the emphasis on interagency working helped to signpost individuals to services more effectively both within the trust and external to it. This cross agency working also ensured that practitioners were aware of other services that were available to patients they were caring for and they could be signposted to therapies, education support and local support groups run by other agencies.

Leaving hospital/Support in the community

There were systems in place to support children's discharge from hospital. Community nurses reported good relationships with hospital staff to support early discharge for the most part and this has been achieved through the efforts of the community nurses.

Support for children with long term conditions was shared with other agencies to help to prevent readmission to hospital. It was also clear from processes we saw that the community nurses actively 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.

We were also told that it was possible for the community nursing service to support children in the short term on discharge from hospital until other arrangements were made.

Where concerns were identified regarding substance misuse with attendees at the accident and emergency department, support was provided through good communication between the A&E department and community services so pathways of care could be developed for the family.

Learning from experiences, concerns and complaints

There was a trust wide questionnaire for patients and families which we saw in all the clinics and centres we visited, however this was not child friendly and nurses commented that it was difficult to get feedback from children using it.

When we spoke with staff they considered that the trust was open and transparent and responded to complaints and concerns. There was evidence in the use of patient partners and experience based design that the trust sought to actively involve patients in talking about their experience of care and helping to design solutions where issues were identified. Some of these initiatives also involved partner agencies, such as the experience of the journey through child development support groups.

Developments such as changes to clinic times and the use of technology, including social media, were being developed to improve the trusts visibility in the community

Are community services for children and families well-led?

Vision and strategy

There was a vision for the service and staff were aware of this but it was also evident that this was not fully embedded in practice. Staff reported that teams delivering services across the organisation were only just beginning to come together to standardise their approaches. The middle management of the trust had recently changed and some teams had only recently met their new managers. There had been little opportunity for teams to come together with others carrying out similar roles, except where this had been initiated by the teams concerned.

Promoting innovation and learning

It was clear from information gathered during the inspection that the trust promoted innovation and learning and that it was particularly successful in doing this in association with partner agencies but because of the reorganisation this innovation was in pockets and had not been developed trust wide for example the single point of contact for child and adolescent mental health services.

Leadership development

Many of the newly appointed managers were 'home-grown' which showed a commitment to staff development. All of the managers we spoke with were passionate about their role and the opportunities to develop services further to meet the needs of the local population and to spread good work across the trust.

Staff engagement

Staff were engaged, they stated that there was an open culture and they were encouraged to develop themselves

and the trust. They felt as though they were listened to and that the board members were visible. They could identify times when members of the board had been to meetings and some had taken a board member on visits with them.

Community services for adults with long-term conditions

Information about the service

Adults with long-term conditions services provided by the trust cover residents in the north west of England in the areas of Ashton, Wigan and Leigh; Halton and St Helens and Warrington. They deliver a wide range of services that allow people to be cared for in the community and to remain as independent as possible. Some services are clinic based while others are delivered out of hours and in people's own homes.

Services include;

- District nursing services
- Speech and language therapy
- Occupational therapy
- Cardiac rehabilitation
- Stroke rehabilitation
- Physiotherapy services
- Reablement and intermediate care
- Specialist support services for example Parkinson's disease and diabetes.

A large part of the trusts work ranges from the prevention of ill health to very complex care for some individuals.

Summary of findings

We found that patients and their needs were placed at the centre of their care. There was a high regard for safety and we could see that lessons had been learned following incidents. The trust shared learning with staff using among other things intranet updates and a trust-wide newsletter.

The services were effective and led by the needs of the patient. There was a real attempt to be 'joined-up' in the teams' approaches to care. The trust had a clear vision for the organisation, and a commitment to sharing best practice across its wide geographical area.

Patient were overwhelmingly positive about the services received. Patients were complimentary about the staff and told us they had received good standards of care that met their needs.

Community matrons and reablement teams showed great pride, vision and expertise. They showed a great appreciation for reducing unnecessary admissions to hospital and speeding up patients' discharge back into the community. We saw evidence of close integrated partnership working and proactive monitoring of the quality of services.

Staff were generally proud of working for the trust. They said it offered an open and listening culture with senior executives visiting teams and regular communication via the trusts intranet.

The recent reconfiguration and lack of clarity of changes to management within teams had raised some anxieties among staff, although most staff on the frontline felt they just got on with the job regardless of managerial changes. The management of change was unclear to some managers taking over new services, with no clear direction of the services strengths and weaknesses.

Community services for adults with long-term conditions

Are community services for adults with long-term conditions safe?

Safety in the past

Staff told us about previous examples of serious incidents where they had listened and shared their learning from such events across the trust. They gave examples where such events had improved all their practices with the aim of always trying to keep their patients safe.

For example staff told us of previous learning from a root cause analysis (RCA) investigation, where a patient was given the wrong dose of insulin. Staff told us that they received training on how to undertake a RCA. Following learning from this event changes were made to the trusts policy and procedure for recording insulin to help improve staff practice and to avoid any further errors in the administration of insulin and other medications. This information was dispensed throughout the trust at team meetings, staff bulletins and through the trusts intranet to help ensure all staff were updated and given the opportunity to learn from past issues.

The trust monitors its safety performance; for example there were 83 serious incidents reported by the trust between November 2012 and November 2013. The most common type of serious incident reported was pressure ulcers (grades 3 and 4), which accounted for 70 of the 83 incidents. The infection rates for Methicillin-resistant Staphylococcus aureus **(**MRSA**)** and for Clostridium Difficile (C.diff) infections were within an acceptable range for the size of the trust.

Learning and improvement

Staff advised they had learnt lessons from reported incidents and discussed examples of incidents to aid their learning, for example the prevention and reporting of pressure ulcers. District nursing staff reported all pressure sores that were grade two and above within their trust wide reporting system (Ulysses). The trust had lowered the threshold for reporting so that all pressure ulcers were monitored to establish where the patient was when they developed the pressure ulcer and why the ulcer had developed.

Staff had implemented a pressure ulcer care pathway; this included a robust method of identifying patients at risk and providing a pathway to treat and reduce the incidence of pressure ulcers. They had developed detailed, wound mapping assessments, and referrals for pressure relieving equipment were assessed as needed. Staff had all been updated and trained in wound care and had access to specialist advice and support from the tissue viability nurses. Staff were proud of actions they had taken to reduce the incidence of pressure ulcers and felt they had achieved an effective method of supporting patients at risk of developing wounds.

We reviewed a sample of care records in respect of people with pressure ulcers. We found them to be up to date and comprehensive. There was a robust approach towards preventing and managing pressure ulcers and staff were very proactive in acknowledging the improvements they had made in the management of pressure ulcers.

Staff were able to demonstrate a good understanding of safeguarding and their roles and responsibilities in protecting vulnerable patients. Staff were aware of indicators of different types of abuse and had received regular updated training in safeguarding. They were confident in understanding the trusts policies and guidance for safeguarding vulnerable people. Staff were confident they would be listened to by managers and supported with their referrals and reporting procedures to safeguard patients.

Staff from the acquired brain injury unit acknowledged their management of positive risk taking with patients and that capacity was assumed. They had previously made arrangements to assess a vulnerable patient's mental capacity through working with multi-agency teams. They were conversant with patient safeguarding procedures having initiated a referral previously and could see how the process aimed to protect any potential vulnerable person.

Systems, processes and practices

We found that there were systems and processes in place to keep people safe. Records provided evidence of good assessments of people's needs and provision of care to meet those needs.

The trust had many pieces of clinical equipment that were being used in the community such as air flow mattresses and bed rails that were in need of quality assurance and preventative maintenance. Staff ensured all equipment used by patients was recorded within their record systems to allow maintenance to take place when required. One group of district nurse's we spoke with were clear that as

part of their role and responsibility to keep people safe they checked patients equipment every time they visited the person to ensure essential equipment was operating appropriately.

All community staff were conversant and knowledgeable of the trusts web based Ulysses risk management system that allowed staff to report all actual incidents and near misses, where patient safety may have been compromised. Staff told us they were supported to proactively and openly report patient safety concerns.

Falls risk assessments completed by district nursing staff helped identify older people at risk of falls and fractures and enabled them to take appropriate actions to reduce risks to these patients. Staff used a falls risk assessment tool (FRAT) to identify patients at high risk of falls. All health and social care staff had access to FRAT and could liaise and refer patients on to the falls prevention team (the falls prevention team provided multifactorial assessments which included osteoporosis risk assessments and referral to a medical consultant clinic when appropriate).

All staff completed infection control training which was updated on an annual basis. Regular training provided staff with qualifications in infection prevention. Infection control audits were undertaken in clinics. The environmental audits demonstrated compliance with infection prevention standards focusing on cleanliness.

We observed good practice of hygiene and infection prevention within treatment rooms based at the district nursing clinics. Staff adhered to the trusts guidance in wearing uniforms that were above their elbow leaving lower arms clear of clothing to help prevent cross infection.

Monitoring safety and responding to risk

We looked at patient case notes that included assessment processes to help identify patients at risk. The records set out specific actions to help reduce patient risks and to help treat patients to reduce the incident and effects of such risks.

Case records offered evidence of planning and assessing the condition of patient needs including wounds and the effectiveness of their treatment. Detailed records showed improvements to wound care provided by staff. We found staff were following best practice guidance when treating and caring for patients.

Most staff teams were knowledgeable about the process for gathering data as part of the NHS Safety Thermometer initiative. This tool monitored improvements in patients subjected to pressure ulcers; falls; venous thromboembolism (VTE's) and catheter acquired urinary tract infections with the aim of improving clinical care. The trust had also developed their own pressure ulcer quality indicator audit proforma for 2013-2014 which allowed them to monitor and review all incidents of recorded pressure ulcers.

We looked at a selection of CQUIN (quality targets agreed between the trust and the commissioning organisation) reports including one for district nursing team's in St Helens dated May 2013. The results of the report were overall positive and included patients comments regarding waiting times; cleanliness, information and choice and dignity and respect. The overall satisfaction from patients was measured as quite high with 97% overall patient satisfaction with this service.

Various specialist services had implemented auditing systems specific to the service they offered. The neurological services had implemented an audit for their acquired brain injury service which applied 'The Health of the Nation' outcomes and scales relating to ABI (acquired brain injury). The community neuro team used a 'goal attainment scale audit' which referred to recommended national guidelines for patients who had a stroke. Most staff were knowledgeable about serious untoward incidents and reporting procedures and were confident in reporting any serious incident. However, a small number of staff including a small number of managers did not know what a 'never event' meant.

Anticipation and planning

The trust calculated district nursing staffing levels using a caseload weighting tool that had originally been developed by staff in their Warrington borough. We considered the use of the tool to plan effective numbers of staff to meet patients' needs in the community to be good practice. The trust demonstrated openness and transparency by providing the results of the staffing assessments on a daily basis.

Patients were very positive about their experiences and standards of care provided. Staff told us they would often rearrange their caseloads due to the increasing complexities of their patients which they had all experienced over the last year to ensure their patients'

needs were always met. Some district nursing teams were more positive than others regarding the use of the tool; some teams felt that although they completed the tool daily it had limitations, especially when a patient became poorly and needed extra assistance and some felt the tools were inconsistently used among teams.

One group of district nurses in Halton and St Helens had identified their staffing vacancies within the trusts risk register. Actions taken by the trust following the identified risk of low staffing levels resulted in being provided with bank and agency staff to fulfil the vacancies. However 12 months later the staffing vacancy was still on the risk register and staff were unclear what actions the trust were taking long term to plan on providing stability to their teams. Some staff expressed concerns about the lack of clarity regarding the management of staffing vacancies. They had no knowledge of rationale used for not replacing staff on maternity leave and for replacing some senior grade staff with lower grade staff.

Student nurses who were in training all told us that they really enjoyed working within the district nurse teams and had gained lots of experience regarding planning and delivering good standards of patient care in people's own homes.

Are community services for adults with long-term conditions effective?
(for example, treatment is effective)

Evidence-based guidance

A range of policies and clinical guidelines were in place and accessible by all staff within community settings. These policies were based on best practice and were evidence based. Specialist teams had developed specific documentation that demonstrated the care pathway of patients receiving their care and support in areas such as cardiac rehabilitation; acquired brain injuries and continence care. The care records were clear in demonstrating they had referred to NICE (guidance issued by expert body, the National Institute for Health and Care Excellence) guidelines to ensure patients were thoroughly assessed and supported with their needs.

Staff were updated in mandatory training and were positive in being able to access e-learning (computer based courses). Staff were positive about the availability and support from the trust to access training that helped them in their role and development of their skills to meet patient needs. Community matrons in Halton had all been supported to achieve their master's qualification. Another of the community matron teams told us that they were soon to attend a bespoke training course at Chester University developed for them to further their learning.

District nursing managers ensured clinical competency frameworks were utilised and in practice to demonstrate how staff were supported in keeping updated with their clinical skills in topics such as wound care; administrating medications and catheterisation. The framework assessments were documented and signed by staff when assessing a staff member's competency and skills. We heard from a small number of new staff that they had received a good induction to the trust and good support and training from their colleagues.

The physiotherapy and occupational therapy services in Warrington were very proactive in developing their services. They had developed a research study including the use of specific equipment such as large gym balls and mirrored boxes which they were currently trialling. They were innovative in their practice and keen to improve their patient experience. They hoped they would eventually achieve an equipment budget to purchase specialist equipment for patients at the end of the trial.

The acquired brain injury service was consultant led with further additional specialists such as a psychologist and physiotherapists. They provided a specialist service for over 40 patients with acquired brain injuries with complex needs. The service was embedded with best practice and followed a 'step care model' of support and reablement service to their patients. Their care pathways followed national acquired brain injury outcomes with links to trauma pathways for some patients. They had close working links with other partners such as Headway and Stroke partnership groups which helped signpost further support for their patients.

Monitoring and improvement of outcomes

Staff provided us with numerous examples and documents of how they had clinically monitored the service to show positive outcomes and services for patients. They produced detailed audits covering pressure ulcer quality indicator audit proforma for 2013-2014; urinary catheter quality indicator audit for 2013-2014; care of the dying quality indicator tools and audit results.

Community services for adults with long-term conditions

We found that patients admitted to services had received a full assessment of their individual needs and records we viewed had been completed to reflect this. The care records were complete and up to date; and had a number of risk assessments in place, including falls; catheter care; pressure area and nutritional risk. Risk assessments were complete and updated as patient's needs changed. There was also evidence of staff working with other health professionals to ensure that appropriate care was provided for patients.

The Halton speech and language therapy team had devised a quality checking system for the service they delivered. This involved randomly contacting people every three months who used the service to ask their opinions on the service they received. Carrying out these quality checks enabled the team to measure their effectiveness and change elements of the service they provided if required.

Most staff were aware of clinical audits and the framework they were measured against however some staff including recently appointed managers to teams were unsure of the processes and results of any previous audits they had inherited. Various audits including those developed within the cardiac rehabilitation team looked at the documentation of patient clinical records.

Staffing, equipment and facilities

The community matron for learning disabilities (LD) in Halton was the only LD community matron in the trust. They were also a qualified Deprivation of Liberty assessor and best interest assessor. Staff felt this was a useful initiative and resource to have as they were able to get advice and guidance from them regarding any patient with a learning disability.

In most teams 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 recruitment to vacant posts. Although overall staff felt there was no impact to patient care, one team gave an example of how it had affected their overall performance targets. The physiotherapy/ occupational therapy team in Warrington usually worked to a two week target in response to patient referrals. Due to the current staff vacancy they had shown the impact in their target rate being extended to four weeks. They recognised the link to the extended performance target correlated to the current staffing vacancy. At the time of the inspection staff were awaiting recruitment and selection to employ to the vacant post.

A district nursing team from St Helens and Halton reported ongoing sickness and vacancy levels that had yet to be filled. In their opinion they felt there had been long standing delays resulting in bank staff and staff from other areas trying to help the team.

Multidisciplinary working and support

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. Staff identified that although there may have been three different providers, who in effect operated with three different forms of policy guidance, they all worked for patients to ensure a seamless service. Staff told us; “We are all in the same room and we all feel it works together.”

Are community services for adults with long-term conditions caring?

Compassion, kindness, dignity and respect

We spoke to 8 patients and they all told us that staff were caring and that staff treated them with dignity and respect.

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.

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 groups of district nursing staff were 'dignity champions' and 'community champions' which had enhanced their knowledge about how they embedded their practices for patients.

Involvement in care

Patients told us that they understood what was happening to them and they were involved in planning their own care. One patient was complimentary about the staff always valuing their rights and always gaining their consent on lots of occasions during their treatment and support.

We observed good practice with staff in clinics asking patients for their consent to share their medical information before carrying out any physical tasks or assessment. Staff gave a clear and understandable explanation to the questions raised by patients.

A policy was available in relation to obtaining consent. Staff demonstrated a good awareness of the differing forms of obtaining consent. Most of the patient records seen across the different services included sections within the records to ensure they recorded patient views and consent about their care. However not all of the care documents had identified the need for a patients signature or written consent.

We noted some inconsistency's with records produced by each service, specifically regarding how consent was recorded with one team using a tick to identify a patient had been included in their care and had given consent. This practice lacked clarity and accuracy regarding whether the patient had seen their care plan and agreed with all aspects of care that staff had recorded.

We observed good practice between staff supporting patients with their cardiac rehabilitation. Staff respectfully discussed their clinical needs and current condition and quietly advised them with various needs including aspects of their health promotion and any risks to their health.

Trust and respect

Patients said that they had positive experiences of care and support provided to them. We received 41 comment cards from patients who had received support from either community services or district nurses. They were all very positive and indicated how helpful and caring staff were. We received nine comment cards from patients who had used the physiotherapy service. They offered various positive comments regarding the advice given to them and the fact that staff listened to them. One patient mentioned access times were longer than they had hoped, but was equally complementary about the care and treatment they had received.

One patient told us about their negative experiences with another provider and how it had highlighted the positives they had experienced from the trust staff. They trusted the staff completely and had great faith in how they had been supported preparing them for discharge which they were fully prepared for.

Emotional support

Two patients felt strongly about the support they had been offered by the staff including extending this support to their family. Staff had visited them in their own home and included their next of kin in the support that was available.

Are community services for adults with long-term conditions responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

The trust provided services to people who did not have English as their first language. We spoke to two staff who described their experiences in accessing an interpreting service to help them to communicate with certain patients helping them to understand their care needs and to help them gain consent before providing any support.

We looked at the 'speech and language therapy' leaflet which gave clear information and contact details to patients about supporting them with communication and swallowing independently. Staff had also developed specific tick box surveys for patients to help them to get direct feedback about their service.

We looked at information leaflets for patients to help inform them about pressure ulcers; urinary incontinence; bowel incontinence; pelvic floor exercises and continence advice for people with dementia enabling them to self-care wherever possible.

Staff from specialist services produced information leaflets that had been developed to help their patients to understand the service and to help meet their needs.

Community services for adults with long-term conditions

Access to services

The Parkinson/ neurological team had experienced recent changes to their overall service due to staff sickness and reorganisation of the service. To cover for the specialist nurse this service had been reduced from five days to 2 days via one of the community matrons. They explained that the service had temporarily changed to a reactive service until the specialist nurse returned later in the year. Staff were clear that their supporting consultants and GP's were aware of the current changes to their service. However the patient leaflets still advertised the previous service and referred to the specialist nurse who was not currently at the service.

Community matrons told us about developments of telehealth, which was in its early stages of development in the community. Telehealth had been introduced to some patients in the community for blood pressure monitoring which helped in their initiatives for supporting patients in 'self-care' in their own home.

Speech and language therapy staff were frustrated about their experiences of the trusts information technology systems which they stated did not share information between each other. They had been involved with a unique project with patients being provided with iPad's to help them to facilitate improved communication. However, staff were frustrated as they were unable to access available programmes due to IT problems and therefore the iPad was functionless and service users were unable to benefit from this specialist equipment.

Vulnerable patients and capacity

Systems were in place to safeguard vulnerable people. Risk assessments were completed appropriately to assess the mental capacity of people to assist them to make decisions with their care. Senior staff were knowledgeable and had received training about the Mental Capacity Act and completing capacity assessments.

Community matrons utilise a "clinical risk stratification" tool for patients with long term conditions to identify patients most at risk of an unscheduled care admission. This helps to prioritise any clinical interventions and management of exacerbations and provide a framework for a clinical strategy for those patients. They had developed good working links with the bed managers based at the hospital; the rapid response team based at Warrington and Whiston hospital and social services. District nursing staff were clear they had identified risk registers identifying their vulnerable patients who they would review in periods of emergencies such as extreme winter weather.

Community matrons from the Woolston clinic explained they had previously visited a local neighbouring council who had developed a strategy encouraging people to 'self-care'. They had also collaborated with NWAS (North West Ambulance Service) to discuss frequent callers to the ambulance service to try and work with services and patients to promote their 'self-care' at home. They told us this work had been successful in producing positive results for patients in managing their care within their own home and had reduced the number of calls made to the ambulance service. In addition the team had recently introduced a new initiative called 'helping with the frailty pathway' which was a care project for people within the area over the age of 90 who had dementia; received catheter care or had recurring urinary tract infections.

Leaving hospital

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; enable patients with long-term conditions to stay at home with appropriate support services; improve patient self-care and self-management and reduce the number of primary care patient attendances. They also had two staff members currently seconded to A and E (accident and emergency) services at Warrington and Whiston hospital to help assist with these proactive services.

All care of the elderly services had a community matron attached and recently staff in one area had started to attend weekly MDT (multi-disciplinary meetings) at the local hospital. The aim of these meetings was to prevent re admission to and prevent early discharge from acute services. In Halton a community care worker was attached to the team. Staff felt that having this service shortened any response time for meeting patients' needs as they were able to arrange for the implementation of care services across the borough.

Staff were positive about the use of health care passports for vulnerable people throughout the borough. They

helped provide necessary information and updates about vulnerable patients to help optimise and update professionals about patient care needs when travelling from home to hospital or to other services.

Learning from experiences, concerns and complaints

We saw many examples of compliment letters and thank you cards around the service. One team, the cardiac rehabilitation team encouraged patients to record any comments in a comment book they openly provided at their clinics. The comments from patients were very positive and gave a good insight to what patients thought about the service they received from this team.

The trust actively sought the views of patients and their families. There were suggestion boxes at each of the clinics we visited. Visitors to clinical areas were able to see displays of information, including information about how to make a complaint.

Staff described how they had learned from previous complaints and discussed some examples where they had reviewed the recording for the assessment and use of bed rails. They felt the revision of their records helped them to ensure it was clear why risk assessments had been carried out relating to decisions made to help minimise risks associated to each patient.

Are community services for adults with long-term conditions well-led?

Vision and strategy

The majority of staff were knowledgeable regarding the visions and values of the trust. Staff felt well led and updated by the trust of all issues of relevance to their work. Staff accessed various lines of communication such as the team brief, staff bulletin, the trusts intranet and the chief executive's blog to help keep them updated with the organisations messages and developments.

Quality, performance and problems

The trust had provided data regarding the number of grade 3/4 pressure ulcers identified in the community. Community staff felt they had made making significant improvements regarding the management of pressure ulcers although they acknowledged they had not been completely eliminated. We noted they had reduced significantly in some months in 2013, and we did not find staff to be complacent. We saw that pressure ulcer reduction was a high priority and steps were being taken to ensure patients at risk were identified, assessed and their care was well managed.

Staff explained they were committed in reporting all incidents of pressure sores including patients discharged into the community who had already sustained a pressure sore. Staff identified the inevitability of regularly having to identify and treat pressure ulcers however they were clear in their focus in trying to treat and improve the patient's condition and pressure ulcer care pathway.

Staff knew how to access the most updated information from the trust's information system and were fully conversant and knowledgably about clinical policies and patient care pathways. District nursing staff were clear in their focus in patient care pathways for end of life patients.

Leadership and culture

Staff collectively made positive comments about the culture within the trust and felt there was an open culture across the organisation.

Staff were proud of working for the trust, felt it was well led and an organisation they could openly speak up. Most staff told us that they did feel listened to and that they could see the effects of change following their suggestions and raising issues and suggestions.

Executive directors were visible among the community services and many staff commented that they could approach them if they wanted to talk with them. Staff gave examples were members of the executive team had been to work with them visiting patients in the community to experience the work they encountered and the challenges to their work load when carrying staffing vacancies. One group of district nurses in Halton and St Helens described how they received agency staff to help resolve their staffing vacancy following such a visit.

Patient experiences and staff involvement and engagement

Staff gave examples of how the trusts senior managers were responsive to their suggestions to improve the quality of service. 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 then freed up to enable them to focus on patients' needs

and were able to manage their workloads effectively by arranging for administration work to be transferred to their newly appointed administrator. Staff were positive about the experience and felt listened to and enabled to ensure patients benefited from the changes.

One group of physiotherapists and occupational therapist in Leigh described the benefits to their patients since developing their service to meet the needs of bariatric patients. One patient had been supported by the team and other professionals through joint working to enable the patient to eventually progress from being cared for in bed to eventually losing weight and gaining mobility and independence. Staff were proud of the positive outcomes experienced by their patients; they also acknowledged the moral boost to the team in achieving what they set out to and requested from the senior team.

Staff told us about a previous initiative were one patient was supported by a community matron to attend an open board meeting. This was considered good practice and promoted patient inclusion at senior management level with patients giving the opportunity to ask questions and to contribute to meetings.

Learning improvement, innovation and sustainability

Most staff had undertaken their personal development review (PDR) in order to ensure they were appropriately trained to deliver safe and effective community healthcare services. However staff in some teams had not had regular PDR reviews or supervision and were not sure how often they would be provided with them. There seemed to be various inconsistencies across teams regarding how staff were supported with their PDR's, and clinical supervision. While the majority of staff were positive with the support systems in place to enable them to have effective supervision and clinical supervisions for clinicians, some were not, and this had been compounded by the recent changes to managers following the trusts restructure.

The majority of staff felt well trained and supported in their roles. Staff had received mandatory training and a list of topics covered by e-learning (computer based training) covering various topics such as risk management; safeguarding; health and safety; lone worker and record keeping. Staff also described various clinical training sessions they regularly attended and training matrixes showed a list of specialist topics such as, leg ulcers; supra pubic catheterisation; cannulation; phlebotomy; diabetes; end of life/ care of the dying; medication and updates regarding the management of syringe drivers.

End-of-life care

Information about the service

The trust provides a range of community based end of life care services for people living in the three localities of Ashton, Wigan and Leigh, and Halton and Warrington. Services in the Halton and Warrington areas were delivered by Macmillan palliative care teams.

Services included;

- Occupational therapy
- Physiotherapy
- Speech and language therapy
- Dietician services

As part of the inspection, we visited the three end of life care teams in Ashton, Wigan and Leigh, and Halton and Warrington.

We spoke with five patients and the relative of one of the patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, a doctor, clinical leads and the clinical manager for community services. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

There were systems and processes in the end of life care services to provide safe care and support for patients and these were working effectively. Patient safety was being monitored and incidents were investigated to learn and improve care.

The end of life care services followed national guidelines and staff used care pathways effectively. The trust took part in national and local clinical audits. The processes for collecting patient safety data and complying with end of life care indicators could be further improved. There were enough staff with the right skills to meet patients' needs. Patients were supported with the right equipment. Patient records and clinical notes were completed appropriately.

Patients spoke positively about their care and treatment. There were systems in place to support vulnerable patients. The end of life care services engaged with other care providers and professionals to make sure that coordinated care took place. There was enough capacity to ensure patients referred to the services could be seen promptly and receive the right level of care.

Staff were appropriately supported with training and supervision and encouraged to learn from mistakes. The end of life care services did not have clear leadership roles. Individual teams were effective but worked in isolation of each other and there was no shared learning across teams.

End-of-life care

Are end-of-life care services safe?

Safety in the past

There were a number of measures in place to monitor patient safety and reduce the risk of harm to patients. There were no never events (mistakes that are so serious they should never happen) in the end of life care services during the past 12 months.

There were 83 serious incidents reported by the trust between November 2012 and November 2013. The most common type of serious incident reported was pressure ulcers (grades 3 and 4), which accounted for 70 of the 83 incidents. The infection rates for Methicillin-resistant Staphylococcus aureus (MRSA) and for Clostridium Difficile (C.diff) infections were within an acceptable range for the size of the trust.

The trust's new pressure ulcer rate for all patients and rates of falls with harm fluctuated above and below the national average between December 2012 and December 2013. New pressure ulcer rates for patients aged over 70 had been below the national average since February 2013. The trust's venous thromboembolism (VTE) rate was above the national average for the majority of the period between December 2012 and December 2013.

The clinical lead for community services and the clinical manager (district nursing) told us they could not attribute the fluctuating rates of falls and pressure ulcers to any one factor. Staff across the three end of life care teams were confident any patients identified at high risk of falls or pressure ulcers were monitored and placed on care pathways to reduce the risk of patient harm.

Learning and improvement

The end of life care teams monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to staff, patients or visitors. All incidents, accidents, near misses, never events, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system (Ulysses). All staff had access to the electronic system and reporting of incidents was encouraged.

All incidents were investigated and remedial actions were put into place to minimise reoccurrence. For example, we looked at two completed incident report records, one relating to a medication error by staff and the other an incident of assault on a member of staff. Each incident had been investigated and the incident form listed remedial actions taken, such as additional training for staff in medication processes. There was a learning culture in place. The staff we spoke with told us they received feedback if they had made an error to aid future learning and they were supported by the management team within their local team.

Staff told us incidents and complaints were discussed during routine staff meetings so shared learning could take place. We saw evidence that shared learning took place within each of the three teams we inspected. However, we did not see any clear evidence that learning from incidents and complaints was routinely shared across the teams. 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 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 staff we spoke to demonstrated 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. Information leaflets on how to report safeguarding concerns were given to patients. There was a trust-wide safeguarding lead and staff were aware of how to contact them.

Staff were aware of current infection prevention and control guidelines. We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff used portable hand gels before and after they engaged with patients during home visits. Staff had access to personal protective equipment, such as gloves, if needed.

All end of life care services were carried out within the community, either in peoples' homes or in local hospices (these were not in the scope of our inspection). Patient

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records showed that staff carried out risk assessments that included health and safety and general environment checks in people's homes so that staff and patients were protected.

There were effective procedures in place for the management of medicines for patients receiving end of life care. There were a number of nurse prescribers within each team. Staff followed clear guidelines for prescribing medicines for patients receiving end of life care, based on the 'Merseyside and Cheshire Palliative Care Network Audit Group Standards and Guidelines''. The nurse prescribers told us they only prescribed medication listed in the guidelines to ensure there was a controlled and consistent process. Staff with no prescribing responsibilities discussed changes to patients' medicines with the patient's general practitioner (GP).

Monitoring safety and responding to risk

Patient records demonstrated that staff monitored individual patients through the use of nursing care pathways and staff were using these effectively. Issues relating to patient safety were routinely discussed through multi-disciplinary staff meetings within each team and actions were taken where patients were identified as being at risk.

There was a clear process for investigating staff errors, complaints and patient safety incidents, including serious untoward incidents (SUI's). Staff with the appropriate level of training and seniority, such as clinical managers carried out root cause analysis (RCA) investigations following any serious incidents, such as patients acquiring grade 3 and 4 pressure ulcers. We looked at two recently completed RCA reports for serious untoward incidents and saw these involved nursing and clinical staff and action plans were put in place to aid improvement.

The trust had a lone workers policy. Staff in the Halton team used portable electronic call systems when carrying out visits within the community. Staff in the other two teams did not use the electronic system and only had use of their mobile phones. The clinical manager for community services told us the trust had plans to introduce portable devices for recording patient information and monitoring of staff for all the teams during the next year.

Anticipation and planning

The end of life care teams we inspected were well placed within the three localities they served. There was routine engagement with the district nurses, GP's, hospice staff and social workers so the staff were kept informed and could make arrangements for patients that were awaiting referral for end of life care services.

There were systems and processes in place to identify and plan for patient safety issues in advance. Where staff identified potential concerns relating to patient safety, these were assessed and placed on service risk registers, so the risks could be assessed and minimised through action plans. We looked at the risk registers and these included assessments for key areas such as staffing, infection control and staff non-compliance with policies. The clinical manager for community services told us risks associated with end of life care services were incorporated into adult services service risk registers. There was a scoring system in place so high risk issues could be escalated to the trust-wide register.

Staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and infection control risks. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.

Are end-of-life care services effective?
(for example, treatment is effective)

Evidence-based guidance

The trust's end of life care procedure was based on the Liverpool Care Pathway for the Dying Patient (LCP). Patient records showed that this was correctly implemented by staff. The trust planned to phase out use of the LCP by July 2014. Staff told us they were awaiting the publication of national guidance and internal procedures to replace the pathway. Staff told us they discussed the use of the LCP with patients or their representatives. Where a patient did not want to receive care based on the LCP, the staff were able to provide care using nursing care pathways and checklists.

The trust also had procedures based on other national and regional guidelines, including the Preferred Priorities for Care (PPC), the Gold Standards Framework (GSF) and the

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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.

Commissioning for Quality and Innovation (CQUIN) Payment Framework Data from August 2013 showed that the trust was not meeting the targets for key end of life care measures. 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 LCP for 12.5% of patients compared with a target of 80%; and that patients supported by the LCP who reported symptoms of the following (Respiratory Secretions, Terminal Agitation, Nausea and Vomiting) were assessed and controlled at time of death for 8.6% of patients compared with a target of 80%. There was no data to support whether the trust achieved a 35% target for the percentage of patients who chose end of life care at home that had their care supported by the Liverpool Care Pathway (LCP).

The staff we spoke with indicated that end of life indicators were not routinely measured collectively across all the localities and this would be introduced during the next year. The CQUIN data showed that improvements were needed in the quality of the documentation for end of life care patients so that performance against key measures could be accurately measured.

Monitoring and improvement of outcomes

Patients received care according to national guidelines. Clinical audits included monitoring of National Institute for Health and Clinical Excellence (NICE) and other professional guidelines. There was a clinical governance system in place and findings from clinical audits were reviewed at all levels of the trust. Action plans were put in place where gaps were identified.

Patients receiving end of life care were managed effectively. Patients received effective support from a multi-disciplinary end of life care team, which included specialist palliative nurses, consultants and therapists. Multi-disciplinary staff meetings took place on a routine basis to ensure any changes to patients needs could be addressed promptly. The end of life care teams engaged with other community healthcare professionals, such as GP's and local hospice staff. This meant that staff could act swiftly to referrals to ensure patients received an effective service.

The patient records we looked at were accurate and clinical notes were completed to a good standard. The patients and relatives we spoke with told us they were happy with the end of life care and support provided by the trust.

Staffing, equipment and facilities

There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care. The Halton and Warrington teams were made up of specialist palliative care (Macmillan) nurses employed by the trust and were supported by trust-based physiotherapy, occupational therapy and speech and language therapy staff. The Ashton, Wigan and Leigh team consisted of therapists with specialist palliative care training. The specialist palliative care nurses were employed by a local hospice. There were four specialist end of life consultants across the trust with at least one consultant linked to each local team.

Staff we spoke with told us they were able to manage their workload and ensure patient care was maintained. Within the Ashton, Wigan and Leigh team, a locum was in place to provide sickness cover for a dietician and staff told us they could use bank staff to provide cover for sickness and leave. The Warrington and Halton teams told us they did not have access to bank staff.

There were integrated equipment stores located in each of the three localities we inspected. Staff told us they could access the patient equipment they needed, such as beds, commodes and mobility equipment. Staff told us they were well supported and equipment could be delivered within a number of hours if requested. We looked at the equipment being used by patients in their homes and found equipment such as beds and commodes to be safe and well maintained.

Multidisciplinary working and support

There was effective communication and multi-disciplinary team working within each local team. Each team routinely conducted staff meetings and we saw evidence of shared learning within the teams. Each team carried out multi-disciplinary meetings at least weekly involving palliative care nurses, consultants, hospice staff and other

End-of-life care

professionals to ensure all staff had up-to-date information about patient risks and concerns. The end of life care staff also engaged with district nurses, GP's, acute trust staff and social workers to ensure care was coordinated across other organisations within their localities.

However, there was limited communication and sharing of resources and information across the three teams. Each team worked in isolation of the other (silo effect). 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. The clinical review group aimed to review existing end of life care processes and standardise these across the trust.

Are end-of-life care services caring?

Compassion, kindness, dignity and respect

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. We saw that two patients that had difficulty with their speech were listened to patiently and staff responded to their queries appropriately. The comments received from patients demonstrated that staff cared about meeting patients' individual needs

Involvement in care

Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff underwent mandatory training in consent and this was updated every three years. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment. We looked at records which showed that verbal or written consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.

Staff respected 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".

Staff also provided patients or their representatives with a range of information leaflets and booklets relevant to their care, including information on end of life care or bereavement support.

Trust and support

We observed staff providing reassurance and comfort to patients. The patients we spoke with told us they were supported with their emotional needs. One patient commented that the emotional support that their medical conditions 'was such an emotional thing to deal with and I got fantastic support from the staff'.

Patients could access the multi-faith chaplaincy services for support. Staff told us they regularly interacted with relatives of patients to provide bereavement support and also referred them to family support services, if needed. Relatives of patients were also given bereavement booklets that provided additional information.

Are end-of-life care conditions services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

The trust provided a range of end of life care services across the communities it served.

The staff we spoke with had a good understanding of the needs of the local population. 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. There was also routine involvement from other organisations within the community in the trust's clinical governance processes, including from commissioners and GP's.

Staff were responsive to patients' needs and provided the right level of care and support. Staff monitored patients using nursing care and end of life care pathways in line with national guidance. Patient records we looked at included specific risk assessments and patients at high risk were

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monitored using detailed care plans. All the patients and relatives we spoke with were happy with the care and support they received. A patient and their relative commented that "they are always available on the phone".

Access to services

The staff we spoke with told us they were confident patients could access the end of life care services when needed. The teams within the three localities routinely engaged with GP's, local hospices and adult social care providers so patients could be referred promptly.

Staff told us patients were referred to the end of life care services through a number of routes including via GP or consultant referral, or they could visit local hospices or access the service via outpatient appointments. Staff across the three teams told us there were limited or no waiting times for patients awaiting specialist end of life care services and patients would be seen promptly on referral.

Information about care and treatment was provided verbally by staff. Patients or their relatives were given a range of written information and leaflets relating to the end of life care. We did not see written information readily available in different languages or other formats, such as braille in the areas we inspected.

The majority of patients were able to speak English. Where this was not possible, staff could access a language interpreter if needed. Where a patient was identified with learning disabilities, staff could contact a trust-wide specialist nurse for advice and support. Staff were also aware they could contact a specialist nurse when dealing with homeless and vulnerable patients (such as refugees or asylum seekers). The Halton team told us they engaged with members of the travelling community to ensure they had access to services.

Vulnerable patients and capacity

Staff received mandatory training in safeguarding children and vulnerable adults, which included aspects of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLs). Staff understood the legal requirements of the Mental Capacity Act 2005.

Staff carried out mental capacity assessments to identify patients that could not make decisions for themselves. We saw evidence that capacity assessments had been carried out in the patient records we looked at.

Where patients lacked the capacity to make their own decisions, staff sought consent from their carers or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

Staff told us they routinely took part in multi-disciplinary meetings where patients lacked capacity to make decisions and for whom a decision had been made not to attempt cardio pulmonary resuscitation (DNA CPR). We looked at the records for two best interest meetings that had taken place recently and saw that the appropriate people, such as the patient's GP and relatives, had been involved in the decision making process.

Patient records showed that where DNA CPR decisions had been made, the appropriate people had been involved in the decision making process and that the decision had been clearly documented in the patient's notes.

Leaving hospital

The trust did not provide in-patient specialist end of life care services. The majority of patients receiving care were based in their own homes with some patients in nursing or residential homes. There was a discharge form in the patient records which included a checklist to ensure patients were discharged in a planned and organised manner.

The process for the discharge and transfer of patients was well managed within the end of life care services. Patients that no longer required specialist end of life care support were transferred to the care of district nurses. Staff told us patients and their relatives receiving end of life care were often reluctant to be discharged from the specialist services. The end of life care nurses provided support to and advised patients they could contact the team at any time if their condition deteriorated or they felt additional specialist support and guidance was needed.

Learning from experiences, concerns and complaints

Staff told us all complaints were recorded on a centralised trust-wide system. The lead nurses and clinical leads investigated formal complaints relating to their specific team. The trust target was to respond to formal complaints

within 22 days. The number of complaints received within the end of life care services was not significant and staff told us they only received occasional complaints about the services they provided.

We saw that leaflets were given to patients to provide information on how to make complaints. There was a centralised team that managed formal complaints. The patients we spoke with were aware of how to make complaints. Staff told us that information about complaints was discussed during routine team meetings to aid learning. However, this shared learning did not take place across the three teams.

The National Bereavement Survey 2011 showed that community NHS trusts within Greater Manchester performed within the expected ranges for the majority of indicators. However, they did not perform well in 'choice and involvement at the end of life' and the quality of 'out of hours care'.

The end of life care team in Halton had carried out their own patient feedback surveys by telephone. We looked at the report from the September 2013 survey, which involved 22 patients and the patients reported they were very satisfied with all areas except the quality of information offered about other services. The staff responded to this by providing patients with additional information leaflets which included contact details for the team.

The Warrington and the Ashton, Wigan and Leigh teams did not carry out formal feedback surveys. The staff we spoke with told us they sought feedback from individual patients and shared this within the teams to improve the services.

Are end-of-life care services well-led?

Vision and strategy

The trust had a clear vision and strategy with clear aims and objectives. The trust vision, values and objectives had been cascaded across the end of life care services and staff had some understanding of what these involved. The teams within the three localities had a clear understanding of their roles and responsibilities and where they fitted in as part of the multi-disciplinary care process.

Staff in each team were aware of the challenges and key risks to the services they provided. They told us that they had sufficient capacity and suitably trained and qualified staff to meet the needs of patients within their localities. The main risks they identified related to maintaining staffing levels in order to sustain the services.

Quality, performance and problems

Staff performance was reviewed and monitored. We saw that routine audit and monitoring of key processes took place within the areas we inspected. However, information relating to core objectives and performance targets was not readily available in the areas we visited. For example, patient safety data such as pressure ulcers and falls data was collated locally within each team but there was no robust process in place to collate combined data across the end of life care services. The trust was aware of this and planned to introduce a process for collating combined patient safety data by April 2014.

The end of life care services were incorporated into community services within the adult services service, along with the district nursing teams. There was an effective clinical governance system in place that allowed risks and performance issues to be escalated to service and trust board level through various committees and steering groups. There were action plans in place to address the identified risks. In each locality we inspected, there were routine multi-disciplinary staff meetings to discuss the day to day issues and to share information.

Leadership and culture

Staff were highly motivated and positive about their work. The staff we spoke with told us they received good support from their line managers. The majority of staff were aware of or had met members of the trust's executive team.

There were clearly defined and visible leadership roles within each local team. There was a nursing lead in each team. There were two clinical leads in place that acted as interim managers for the Halton and Ashton, Wigan and Leigh teams respectively. The Warrington team was managed by the clinical manager for community services (including district nursing). The end of life care consultants reported to the medical director.

The end of life care staff worked effectively within each local team and there were routine staff meetings. However, there was no clear leadership across the three end of life care teams we inspected. The trust had created a post for a clinical manager for end of life care services with full

responsibility for end of life care services across the trust; however this position was vacant at the time of the inspection. The clinical manager for community services told us they expected this position to be filled by May 2014.

Patient experiences and staff involvement and engagement

The trust was either better than or similar to the average for community trusts in 24 of 28 indicators from the 2012 survey of NHS staff, and worse than average for four indicators. This indicated that there was a good level of staff satisfaction in the majority of staffing indicators. The four indicators in which the trust was below average related to access to training, effective team working, career progression and contributions towards improvements at work. The trust had an action plan in place to improve the issues identified by the staff survey.

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. One member of staff told us there were sometimes delays in accessing external training as part of their professional development. Staff were required to document any external training requests in their PDR and these had to be approved at the beginning of the year. The Macmillan nurses also told us they could also access specialist training through the Macmillan Cancer Support service.

There were no concerns relating to staff sickness in the areas we inspected. There was a low rate of staff turnover, which meant staff had good relationships and knowledge of end of life care processes within their local teams. A nurse who was appointed during the past year told us there was an open and 'no blame culture' and that they had been well supported through their induction and encouraged to access specialist training.

The patients and relatives we spoke with were complementary towards the staff and had received good care. The clinical manager for community services told us they liaised with 'Patient Partners' to look for improvements to the end of life care services. Patient Partners was a trust-wide project to actively encourage patients, clients and parents to work with staff to identify areas for improvement in quality of care and service delivery.

Staff in each team had also presented a 'patient story' to the trust board. This allowed staff to review the patient experience and look for ways to improve the services they delivered. Staff in the Warrington team told us they planned to discuss a new patient story during their routine team meetings to aid learning among the team.

Learning, improvement, innovation and sustainability

The trust reported that during the 2012-2013 period, 90% of staff had completed mandatory training. The trust also reported that by the end of September 2013, 89% of staff had completed a personal and development review (PDR) meeting (in a rolling 12-month period). The majority of staff had completed mandatory training and annual PDR meetings within the three teams we inspected. The majority of staff also had regular access to clinical supervision.

There was an open culture that supported learning within each team. Staff were encouraged to report incidents and errors. Staff received feedback to aid learning. The staff we spoke with told us they had been fully supported when they made an error.

The end of life care services worked effectively as individual teams and they engaged with other professionals to ensure patients received the required level of care and support. However, they worked in isolation of each other. There were differences in staff practices in each team, for example the teams had different methods for recording patient notes (electronic and paper based), collecting patient feedback or collating patient safety data. There was no shared learning to drive improvement in trust-wide end of life care services or sharing of staff and resources (e.g. to provide sickness cover).

The absence of a clinical manager for end of life services meant that there was no overall leadership across the three local teams. The trust had already identified this as an issue and had started to look at trust-wide end of life care processes through clinical review meetings, but this process was still at an early process-mapping stage. The trust also planned to implement a trust-wide electronic patient records system during April 2014, in order to improve the quality of patient records and communication across the trust.

Community dental services

Information about the service

The community dental service provides specialist dental services to a population of over 2.2 million people and covers a geographical area of more than 80 square miles. The network employs over 60 dentists and 130 support staff. On an average week the division runs over 353 clinics and processes over 8000 new referrals annually. Half of all the referrals relate to children. A quarter are received into the minor oral surgery service; the remainder are split between adult special care and domiciliary.

The range of services provided include:

- Special care dentistry.
- General anaesthesia.
- Inhalation sedation and IV sedation.
- Paediatric dental services.
- Minor oral surgery.
- Prison dental services.
- Dental access centres (in hours emergency).
- Out of hours emergency dental services.
- Oral health promotion and prevention programmes.
- Epidemiology.
- Undergraduate teaching for dental students.

Summary of findings

The community dental service had systems and processes in place to keep people safe. The service had learned from incidents and mechanisms were in place to identify and control risks to patients.

The dental service was effective and focussed on the needs of patients and best practice. There were systems in place to audit both clinical practice and the overall service.

Patients and their representative's spoke highly of the care provided. They confirmed they had been given privacy and were treated with dignity and respect whilst receiving treatment.

The community dental service was responsive to the needs of patients. The maintenance of clear, concise and detailed clinical records confirmed that care and treatment was provided in a way that met the diverse needs of patients.

The community dental service was well-led. Initiatives had been established to improve services, and there were quality assurance processes in place. Staff spoken with confirmed that they felt valued and supported in their roles and that managers within the dental service and overall trust were approachable and visible.

Community dental services

Are community dental services safe?

Safety in the past

Trust level data indicates that of the 186 incidents reported between November 2012 and November 2013 via the NRLS system only 1 related to dentistry and was rated as a moderate incident. Information sought from other regulatory bodies did not raise any concerns regarding dentistry provision or individual dentists.

Staff told us about two historic incidents that had occurred within the dental division and confirmed the trust had taken appropriate action to investigate and ensure appropriate learning from the incidents. One incident concerned the incorrect extraction of a child's milk tooth; the second incident concerned the temporary loss of patient data. Evidence was present during the inspection which demonstrated that trust had carried out reviews of these incidents and that learning and sharing had taken place.

The National Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. However due to the nature of care that is provided by the dental service the majority of safety thermometer data has limited impact, for example pressure ulcer rates, and catheters and urinary tract infections. However, the infection rates for Methicillin-resistant Staphylococcus aureus (MRSA) and for Clostridium Difficile (C.diff) infections were within an acceptable range for the size of the trust.

Learning and improvement

Data held about the trust was reviewed prior to our visit which highlighted there had been two previous serious untoward incidents. Full investigations had taken place and staff spoken with reported that they had been updated on the key lessons learned following a full analysis of the events. The management of records and patient safety checks had been reviewed and improved in response to the incidents to improve working practices and safeguard patient safety. For example, in the case of the accidental extraction, a full investigation of the incident was undertaken, together with a review of general anaesthetic procedures. A service cascade of information concerning the circumstances of the incident and the correct / revised procedures to follow was shared with staff, in addition to the incident being discussed at team meetings.

Staff were aware of safeguarding procedures and what may constitute a safeguarding concern. Safeguarding featured as a topic for discussion in staff meetings and minutes indicated that the division had safeguarding champions in each sector. Staff spoken with during our inspection demonstrated understanding and knowledge of the action they should take in the event they had suspicion or evidence of abuse.

Systems, processes and practices

The dental service had developed a number of policies to provide guidance to staff on safe working practices including infection control. Staff utilised the same incident reporting system as the rest of the organisation (Ulysees) and were fully conversant with how it operated.

We looked at a sample of dental notes across the service. Records were well-maintained and provided comprehensive information on the individual needs of patients such as; oral examinations; medical history; consent and agreement for treatment; treatment plans and estimates and treatment records. Clinical records viewed were clear, concise and accurate.

We spoke with staff and reviewed the arrangements for infection control and decontamination procedures within different sectors. Staff were able to demonstrate and explain in detail the procedures for the cleaning of dental equipment and for the transfer, processing and storage of instruments to and through designated on-site decontamination rooms. We noted that for some locations within the service, decontamination processes were undertaken off site.

Staff demonstrated an awareness of HTM 01-05 (a guidance document released by the Department of Health to promote high standards of infection control) and confirmed that they had access to personal protective equipment to undertake their roles when supporting patients during their treatment. Patients told us that treatment rooms were clean and that staff had worn appropriate uniform such as gloves and masks during treatment.

The service had arrangements in place with contractors for the disposal of dental waste such as teeth, amalgam, gypsum, sharps and other products.

Records for medical devices and equipment in use at each location were available to view. We noted that equipment had been routinely serviced and certificates were in place

to confirm key equipment such as x- ray systems, autoclaves, washer disinfectors and pressure vessels had been maintained. Likewise, supporting documentation such as; local rules for the use of x-ray equipment and radiation protection advisor reports; radiograph, hand hygiene, clinical and infection control audits; monthly clinic reviews; risk assessments and other supporting documentation such as dental unit water line surveys and waste audits were also in place.

Emergency equipment was readily available and included medications, oxygen and a defibrillator. We saw that audit checks had been carried out regularly, to check on the resources and the expiry dates of the drugs/ equipment.

Monitoring safety and responding to risk

The service monitored incidents and risks across all three sectors on an ongoing basis. Following any incidents staff were expected to update the trust's database (Ulysses) with a summary of the incident, immediate action taken and root cause description. A manager was then expected to grade the incident according to the level of risk. Incident records viewed had been completed in detail and graded in accordance with the trust's procedures.

A monthly 'Bridgewater Dental Division Report' was produced for the trust. This report captures key information on all incidents and risks within a reporting period, an overview of all incidents / risks by team and any outstanding, ungraded or incidents older than a month that have not been closed or with outstanding information. As part of the trust's integrated performance reporting arrangements the dental division had a performance group which met each month to review key indicators such as incidents and complaints and to understand and identify any corrective action that may be required. Any action required or significant learning points were conveyed to staff via meetings.

Incidents, risks and/ or lessons learned were standard agenda items within all of the dental division's staff meetings. This helped to raise staff awareness of health and safety issues across the dental network and ensure appropriate monitoring and accountability.

Anticipation and planning

Staff demonstrated a good understanding of the diverse needs of patients using the community dental network. We noted that sufficient time was allocated for assessment and treatment in response to the complex needs of patients.

Clinical notes provided evidence of risk assessment and treatment planning processes in partnership with patients and their representatives. This helped to ensure that treatment was individualised and took into account the physical, emotional and environmental needs of patients.

Staff reported that they had access to adult and child protection training as part of their employment with the trust either at level 1, 2 or 3 dependent on their role. We were told that some staff had experienced difficulties in completing child protection level 1 e-learning due to problems with the trust's information technology (IT) systems. Staff reported that the IT infrastructure was not yet fully integrated and highlighted this had resulted in difficulties accessing information and completing training. We were informed that the trust is aware of this issue and that action was being taken to ensure IT systems with the dental division were developed to ensure full integration and connectivity.

Are community dental services effective?
(for example, treatment is effective)

Evidence-based guidance

In order to ensure that best practice was shared across the dental network, Bridgewater Community Healthcare NHS Trust had developed clinical networks for paediatric and special care dentistry and minor oral surgery.

Each group was clinically led and all grades and professions of staff within the dental division were invited and expected to contribute. This enabled staff to maintain, develop and raise awareness of National Institute for Health and Care Excellence (NICE) guidelines and remain up-to-date on other best practice such as information published by the British Society of Disability and Oral Health (the specialist society for special care dentistry).

Staff reported that key information from the clinical networks was shared with staff across the service following

the production of guidance. Examples of guidance produced to date by the clinical network include: paediatric pathway; access and discharge; recalls; sedation and oral health promotion.

Monitoring and improvement of outcomes

Staff 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 overall rate of 21.2%. Minutes of meetings 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.

Clinical notes viewed were generally well constructed and included evidence of treatment plans and patient notes. Patients and their relatives spoken with confirmed they were satisfied with the standard of care and treatment provided. No concerns or complaints were brought to our attention from patients or staff while visiting various dental locations.

We were informed that an annual report of the audit of dental records is undertaken each December by the trust. This audit was undertaken to monitor standards of record keeping and to ensure compliance with NHS dental regulations and the expectations of the trust. The report for December 2013 was not available for review at the time of our inspection as it was in the process of being prepared.

We saw evidence of the previous audit of dental records undertaken by the trust during 2012. The key findings of the audit were that there was scope for improvement in; recording and updating medical histories; fully recording examinations; recording discussion with patients about their treatment and options; complying with NHS dental regulations in regard to FP17DC forms; recording consents; recording reasons why drugs were prescribed and the recording of dental x-rays. It was also noted that there were significant variances between the sectors. Records indicated that clinical directors had been requested to take the findings forward and to ensure records and standards were discussed at staff meetings.

Staffing, equipment and facilities

Staff across the service confirmed that they were able to meet the needs of the volume of patients using the community dental service. We were informed that no clinics or appointments had been cancelled. Evidence of workforce planning and staff deployment was in place for different sectors to ensure the smooth running of the service and ensure it remained responsive to individual needs.

Business impact assessments had been completed for each sector to ensure the service had effective contingency mechanisms in place, in order to respond to any adverse incidents impacting on the delivery of the service.

Staff throughout the service reported that they were supported and encouraged to work across the dental network to share skills and to ensure business continuity.

Multidisciplinary working and support

Staff worked in partnership with other primary and specialised dental services to ensure a responsive and patient focussed service. For example, we saw evidence of referrals to other professionals such as orthodontists. Staff spoken with were able to explain the procedures for screening and making referrals to other specialists outside of the community dental service.

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.

Are community dental services caring?

Involvement in care

Patients and their relatives told us that they were involved in their care where appropriate. The use of individualised clinical notes and patient treatment plans enabled patients and their relative to understand and participate in their treatment wherever possible.

Staff told us about the different ways they responded to and cared for the diverse and complex needs of patients using the community dental service. For example, staff described how they ensure they have appropriate staffing levels for the needs of their patients to allow enough time when patients are attending appointments. This helped to ensure that patients were treated with dignity and receive treatment at an appropriate pace and which is geared to both their personal, emotional and oral health needs.

Community dental services

Trust and respect

Patients told us that they had experienced positive care, treatment and support while accessing the community dental service. We observed staff to communicate and engage with patients in a respectful and dignified manner.

The Community Dental Network Survey carried out in September 2013 looked at the view of 321 people. Overall the results were positive and patients were satisfied with the care that they received. The areas where less positive feedback was received was not being seen on time and a lack of health advice.

Emotional support

We observed people being spoken to with respect by staff when attending the clinics. Patients and their carers told us they had been treated with dignity and respect while receiving treatment, however due to the complex needs of patients attending appointments during our inspection we were not able to gather many views from patients.

Compassion and empathy

Patients and their representatives told us they had been given privacy and treated with dignity and respect while receiving treatment.

Staff told us that they had completed equality and diversity training and confirmed their awareness of the value base of the trust and the unique needs of the patients they cared for.

Are community dental services responsive to people's needs? (for example, to feedback?)

Meeting people's needs

We looked at a sample of dental notes across the service. Records were well-maintained and provided comprehensive information on a range of areas including; the individual needs of patients; medical history; extra and intra oral examinations; basic periodontal examinations; diagnosis; charting; treatment plans; consent and agreement for treatment; estimates and treatment records. Clinical records viewed were clear, concise and accurate.

Access to services

From January 2013, a new key performance indicator (KPI) was introduced in order that all new referrals into the service were seen for assessment within 20 working days.

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 division had achieved the target each month thereafter.

All locations viewed as part of our inspection were fully accessible for people with a physical disability or who required the use of a wheelchair.

Vulnerable patients and capacity

The dental network provided care, treatment and support to a large number of vulnerable patients who lack capacity. A consent policy had been developed by the trust to provide clarity for practitioners working within the service.

Clinical records viewed provided evidence that the capacity of patients had been taken into consideration when assessing new patients and obtaining consent or agreement for treatment. Copies of form FP17DC

(a written treatment plan, part of the consent process) and the relevant consent forms from the trust were available for reference in records reviewed.

Staff confirmed their awareness of the need to obtain consent wherever possible and were clear as to what action should be taken when an adult patient does not have the capacity to give or withhold consent in order to justify best interest decision making processes.

Records showed that training entitled 'An introduction to valid consent' and 'The Mental Capacity Act 2005' had been provided for key staff within the division during April 2013, to increase staff awareness of the importance of obtaining consent and their individual roles and responsibilities.

Audits of dental records were undertaken by the trust periodically and these focused on a range of criteria including consent. Separate consent audits were also completed periodically to monitor performance in this area. Records sampled contained information on the treatment band and the method used to obtain consent such as verbal; FP17DC; NHS consent documentation and / or other methods. Audit records viewed identified no concerns.

Patients and their representatives spoken with during the inspection confirmed they had given consent to treatment and confirmed that the treatment options and plan had been discussed with them prior to making consent.

Community dental services

Leaving dental practice

Staff spoken with reported that in a large number of cases patients were referred to the community dental service for short-term specialised treatment. On completion of treatment, patients were discharged to the patient's own dentist so that ongoing treatment could be resumed by the referring dentist.

Referral systems were in place, should the community dental service decide to refer a patient on to other external services such as orthodontic or maxillofacial specialists.

Learning from experiences, concerns and complaints

An information leaflet entitled 'Compliments, Comments, Concerns and Complaints' had been produced by the trust for patients, which was available in reception areas. Likewise, a 'Guide to Dental Services' had been produced for each service which included the contact details of the divisional director and clinical director, should patients wish to comment about any aspect of the service.

The service maintained records of any formal complaints received within each sector, together with details of the outcomes and any action taken to improve the service. This provided evidence that complaints were listened to and acted on.

Minutes of meetings highlighted that patient experience was a topic for discussion and confirmed the organisation was monitoring feedback on an ongoing basis.

The service had also introduced 'Talk to us' forms to enable patients to share their experience of using the community dental service. The results were collated, analysed and a summary report of the results was produced on a monthly basis which included the details of any action taken in response to patient feedback. Words used by patients to describe their experience were captured in a word cloud. The more times a word was used within all the responses, the stronger it feature in the cloud.

Patients told us that they were aware of how to complain should the need arise however no complaints were brought to our attention during the inspection.

Are community dental services well-led?

Vision and strategy

Staff informed us that the value base of the trust was openly discussed as part of the performance and development review (PDR) system.

Staff also confirmed that they understood the vision of the trust and were aware that information on strategic plans for the organisation could be accessed via the trust's intranet.

Staff spoke highly of senior management within the trust who they felt had provided good direction and leadership to the service following the merge of eight previous PCT provider arms to form a single community dental service under Bridgewater Community Healthcare NHS Trust.

Staff were passionate about working within the service and providing good quality care for patients. We saw evidence of service improvement initiatives and regular monitoring of the quality of the service. For example, in order to ensure that best practice was shared across the dental network; staff had developed clinical networks for paediatric and special care dentistry and minor oral surgery.

Quality, performance and problems

The dental sector had developed a range of quality assurance systems to monitor the service and ensure best practice. Key performance indicators (KPI) were reviewed on a regular basis to ensure performance targets were met. Examples of KPI 's for the dental division included; the 20 working day waiting time (from receipt of referral to assessment); hand hygiene audits and HTM 0105 audit reports which were undertaken twice annually. Overall, results viewed were positive and confirmed targets were being met.

We saw evidence that the performance of the service was also reviewed as part of clinical governance and divisional performance meetings. Systems were in place to ensure any problems were responded to in a timely manner.

Leadership and culture

Staff during our inspection, reported that they had opportunities to meet with team members, managers and members of the senior management team including the chief executive of the trust. For example, a range of

meetings were co-ordinated at different intervals throughout the year to enable opportunities for staff to communicate and engage and to share and receive information.

The trust had also developed a number of initiatives to share and receive information from staff. These included a trust and dental division staff newsletter; a dental division quarterly team brief and annual staff survey process.

Staff confirmed that they felt valued in their roles and that managers within the service and trust were approachable, supportive and visible.

Patient experiences and staff involvement and engagement

Bridgewater Community Dental Network introduced patient partners in October 2012. Since that time 44 patients, relatives or carers had been recruited, 30 of whom had been actively involved in focus groups and patient stories. Patient partner leads were also in place in all sectors and each area was expected to hold a minimum of four focus groups per year and to compile a minimum of two patient stories. After each focus group was held, a 'let us know' newsletter was produced and sent to the people involved to ensure transparency and accountability. Any issues raised were recorded and an action plan produced. A lead person within the service was also assigned responsibility for any required action.

The trust was also part of a patient participation steering group working with Manchester Dental School to address, define and measure dental quality in primary care settings.

The benefits of understanding patient and the public's perception and experience of the quality of their dental care is considered essential and was being factored into the key stages of a research grant.

Learning, improvement, innovation and sustainability

Staff reported that they had access to mandatory, ongoing training and continuous professional development opportunities which had been funded by the trust. The dental network had also developed clinical networks to share and promote best practice throughout the sector. Training records viewed demonstrated that staff had completed mandatory and other continuous professional development courses and systems were in place to ensure refresher training was undertaken periodically.

A learning and development and professional bulletin was produced by the trust for staff to identify up-and-coming training opportunities. Likewise, a human resources skills programme has been developed to equip managers with the skills to effectively manage their teams, encouraging motivation and a culture of quality and improvement.

A performance and development review (PDR) system was also in place for all staff within the dental division. The PDR system enabled managers and staff to identify individual learning needs and ensure staff were supported to maintain and develop their professional skills and competence. There was evidence that sickness levels, PDR and mandatory training was monitored.

Staff reported that the service had a good relationship with commissioners and we noted that service contracts had recently been extended for a further year.

Other services

Information about the service

As part of the inspection process we visited two walk in centres run by the trust. We also carried out an unannounced visit at the wheelchair service and met with staff from the adult learning disability and musculoskeletal services. We spoke with eight patients and the relatives of three of the patients. We observed care and treatment and looked at care records. We also spoke with 18 staff from a range of professions at different grades including nurses, therapists, clinical leads and the clinical managers from across the services.

The provider operates three walk in centres in St Helens, Leigh and Widnes. The walk in centres are nurse led and are open every day of the year with extended opening hours. They offer a range of treatments from experienced specially trained nurses. Conditions seen vary from minor illnesses such as sore throats, minor burns and fractures, sprains, viral illnesses and infections. We were able to observe care and treatment at two walk in centres and were able to track patients care through the electronic patient system.

The adult learning disability service (ALD) offered a person centered approach to meet individual health needs. This included health education, promotion and guidance in relation to clients specific health needs. The service provides training for specific health needs to clients and carers. It offers liaison and joint working directly with other health and social care specialists, identifying risk areas of client need in health care and vulnerability

Musculoskeletal (MSK) physiotherapy service was a clinic based service available in numerous sites across the trust. The team consisted of experienced chartered physiotherapists and support staff with the knowledge and skills to provide highly specialist advice, support and/ or rehabilitation for people with musculoskeletal conditions.

Summary of findings

The services we reviewed included, walk-in centres, the wheel chair centre, musculoskeletal services and adult learning disability services. There were effective systems and processes to provide safe care and support for patients. Patient safety was monitored and incidents were investigated to help learning and improvement.

Staff followed national guidelines and used care pathways effectively and appropriately. The trust took part in national and local clinical audits.

Systems were in place to support vulnerable patients. Patients and their relatives spoke positively about their care and treatment.

There was enough staff to make sure that patients referred to the services could be seen promptly and receive the right level of care.

Teamwork was effective. Staff were aware of the “One Bridgewater” approach to development at the trust and felt part of the trusts new structures. The middle managers had recently been appointed as part of the organisational restructures and some did not have updated information on their services. We felt that the lack of maturity in job roles may affect on the overall coordination and over-view of the delivery of these services.

Staff told us and records showed that they had been appropriately supported with training and supervision, and encouraged to learn from mistakes.

Other services

Are other services safe?

Safety in the past

There were a number of measures in place to monitor the safety and reduce the risk of harm to patients attending the services. Overall the walk in centres perform well when compared against the England average performance for the key indicators. Data showed that the centres consistently met or exceeded the threshold of 5% set by the department of Health, for re attendance. The reattendance rates are important as they may indicate an initial incorrect diagnosis or poor initial treatment.

Staff across the services were aware of the reporting system and were encouraged to report incidents and near misses. Staff were trained to use the electronic reporting system Ulysses and reported that they appreciated the feedback from the system to acknowledge that they had reported an incident or near miss. Staff told us incidents and complaints were discussed during routine staff meetings so shared learning could take place.

Patients in the walk in centre were cared for in a safe environment. Systems were in place to ensure the safe running of the building and all activities within the building such as maintenance and infection prevention and control. We observed staff complying with hand washing procedures and staff had access to alcohol hand gel. There were also ample hand washing facilities and liquid soap and hand towel dispensers were adequately stocked.

A panic button for staff to call for assistance was available at each of the walk in centres. We saw that the buildings were clean and well maintained. The St Helens centre had the facility for parents to wait with their child in a cool room if they presented with a fever. This was fully equipped and appropriate for the patient group.

Learning and improvement

Staff across the services told us they attended regular meetings to allow them the opportunity to raise issues and discuss how to improve the delivery of the service. The adult learning disability team told us that monthly meetings with dedicated time for learning and reflections had been held. Findings and action plans from audits such as infection and prevention control were monitored by the managers.

Data showed that the walk in centre in St Helens had received complaints about staff attitude. The manager was able to outline the action pan and training that had been put in place to respond to these issues. Staff we spoke with confirmed that this had happened.

We were told that staff had implemented a consultation assessment and improvement instrument for nurses to assist in the assessment of competence to describe the skills and ability to practice safely and effectively.

All the nurse prescribers had been monitored regularly (PACT prescribing data) by mangers to ensure that best practice was being followed in line with the trust agreed nurse prescribing formulary list.

Systems, processes and practices

We found that there were systems and processes in place to keep patients safe across the different services. Staff were able to show how they accessed the relevant polices on the trust intranet. The policies were current and based on best practice guidance.

Staff we spoke with were knowledgeable about the incident reporting system. Appropriate risk assessments had been carried out to minimise the risks to patients, relatives or staff working at the trust or visiting the walk in centres or departments. A staff member at the walk in centre described that they had received training in root cause analysis and had been supported to use the appropriate investigation tools following an incident.

Systems were in place to ensure the safe running of the walk in centres including security and infection prevention. Service Level agreements were in place with other providers to provide services such as x-ray within two of the walk in centres.

We saw completed checklists to ensure that emergency equipment was checked regularly and well maintained. Staff at the walk in centres were clear about the process for managing safeguarding concerns. Systems to ensure that patient's follow-up care were in place and we were able to track a particular issue when the staff had been involved with the safeguarding team.

Staff received mandatory training in key areas such as medication, health and safety, infection prevention and

Other services

control, safeguarding children and adults. The adult learning disability team were knowledgeable in their understanding of the management of risk for vulnerable adults.

Monitoring safety and responding to risk

Staff told us that they had monitored incidents and were able to talk through an example of lessons learned. The monitoring of incidents had highlighted an increase in sharps incidents. In response to this the staff had identified a change in practice when managing needles and implemented training for staff to raise awareness of the safe use of needles in practice.

Staff reported that they felt safe. One staff member told us "There is plenty of peer support and I am not asked to take charge of procedures until I feel t confident to do so". We noted that overall there was a low level of complaints across all the services.

Anticipation and planning

We were told of improvement initiatives being carried out by the service such as the introduction of staff rotation across the walk in centres to help manage changes in patient flows and peek activity times. We were told that the musculoskeletal service was introducing acupuncture clinics as a service development.

Regular contract monitoring meetings had been held with the commissioners of the services to review the service delivery and plan for further service developments. The trust had clear business continuity plans in place. Throughout the services we saw winter season plans with escalation plans, business continuity plans and major incident plans including different levels of escalation.

Some staff in the walk in centres said that they had been very busy on Wednesdays when GPs were not open. However we were told by the managers that they had closely monitored the activity through the centres to identify peak period and "bottle necks". Staffing levels had been adjusted to manage the peak activity periods.

Staff we spoke with were able to describe the process for seeking senior manager support out of hours through the on call rota.

Are other services effective?
(for example, treatment is effective)

Evidence-based guidance

The delivery of care and treatment was based on guidance issued by professional bodies and expert bodies such as the National Institute for Health and Care Excellence (NICE). For example the musculoskeletal service team were able to describe the treatment plans which had been carried out in line with the NICE guidance on "The management of low back pain."

We were shown examples of audits on clinical management within the walk in centres. This included an audit of ambulance calls from the centres to transfer patients to the acute hospital. The results showed that the service had transferred patients safely and appropriately to the acute centre for further emergency care.

We also saw the results of an audit of fever management in children less than five years old who attended the service. The aim of the audit was to ensure that patients had been treated effectively and safely. Recommendations from the audit were adopted and the agreement that all staff complied with the use of the traffic light system of assessment of children with fever.

Use of NICE guidance, best practice patient advice leaflets and other information was readily available to the nursing staff through the electronic record system.

We saw staff attending to people's needs appropriately and in a timely manner. We were shown examples of clinical pathways staff followed to ensure that patients were treated appropriately and effectively, for example chest pain pathway, and safeguarding protocols.

Clear patient pathways were in place and we were told that all the services were working to standardise practice across all the legacy organisations. We were shown examples of clinical pathways that had been introduced. This included the chest pain process map and the limping or non-weight baring child care pathway. This pathway also indicated possible red flag concerns or risk that may indicate serious harm or disease.

Monitoring and improvement of outcomes

The services all had clear processes for monitoring the outcome of care provided to patients. The walk in centres reported monthly on the National Accident and Emergency

Other services

Department Clinical Quality Indicators. This was a national set of targets which included the monitoring on four hour waiting for treatment, attendance and the number of patients who choose to leave without being seen. The trust had consistently performed well in regards to all the quality indicators.

The managers of the services told us that they had key department performance indicators which were monitored monthly, this included, mandatory training, performance reviews, sickness and staffing turnover. This was also monitored for trends as part of the ongoing performance management processes of the trust.

Staff told us care plans for adult learning disability patients were translated into management guidance for the patients care team to ensure that the patients received the most appropriate care. The trust participated in national and local clinical audits. Patients received care according to national guidelines such as the management of asthma patients or treatment of low back pain and osteoarthritis.

We observed that baseline health and wellness data such as smoking history was a mandatory field within the electronic patient record to ensure that health interventions were encouraged with the patient population. We observed that clear discharge summaries and handover notes were in place across the walk in centres.

Staff we spoke were knowledgeable in safeguarding and the Mental Capacity Act 2005. Staff told us that they provided care to adult learning disability patients in line with the Mental Capacity Act. For example they had been involved in a best interest meeting for a patient and had worked with the consultant, patient and family to ensure the care was provided in line with the provisions of the Mental Capacity Act 2005.

Although staff had been involved in audits some staff were unclear about the process for audit plans at trust level. Some staff had not seen the service audit plans but knew that it was in the process of being compiled. One new manager had not seen the audit plans for the service but was aware that regular audits had taken place.

Staffing, equipment and facilities

Staff monitored daily activity data across the individual treatment centres. They were also able to benchmark themselves against national performance targets. Staff told us they there was enough staff to carry out their job roles. However some staff described difficulties in getting permanent staff in post and that some days they could be very busy.

Patients we spoke with in the walk in centres said they felt safe. The use of agency staff was utilised to accommodate staff shortages. Staff told us that where possible the manager filled the hours with permanent staff to ensure the continuity of care and maintenance of the appropriate skill mix. We were told by some staff that the trust policy on using temporary contracts had made it difficult to fill posts. We were told that this practice had now been stopped

Staff reported that they had some staff vacancies during the service redesign period but had now secured permanent staff and had locum cover in place until the new staff were in post. The managers told us that staff had started to rotate across the centres to enable sharing of best practice and to meet the needs of the services.

Data indicated that there were concerns regarding long waiting times for the musculoskeletal services. We were told the average waiting time had come down to an average of eleven weeks although some staff stated that the wait had been up to eighteen weeks. 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.

Multidisciplinary working and support

We saw evidence of close integrated working between the partner organisations including the acute trust and the local GP practices. The staff at the centres were able to show us records of examples of patient transfers to the acute hospital and described the process for ensuring that all the relevant information was shared in a timely manner.

Staff across all the services told us that they had access to specialist staff including infection and prevention control leads, safeguarding and governance teams. Staff told us the local computerised interface with doctor's surgeries limited some transfer of patient information. We were told that the trust IT strategy would address the issues to improve data transfer between different patient information systems.

The adult learning disability team described their close working with the acute and community services to enable patients to be well supported across different health and social care settings. The staff were passionate about their

Other services

partnership working across a multi-disciplinary team. We saw examples of best practice cross organisation working as well as between internal departments. For example, the staff worked with the children's team to ensure that children with a learning disability had a coordinated transition into adult care. The training of support staff by the adult learning disability service assured us that all staff had the skills and knowledge to meet the care plans and needs of individual service users.

Are other services caring?

<Summary here>

Compassion, kindness, dignity and respect

We spoke with 7 patients during our inspection who told us that they were very happy with the service they received. We received only positive comments about the care and support from the services at the trust.

We saw staff treating people with dignity and respect. Staff maintained privacy by ensuring that doors were closed and knocking before entering a room. Curtains were in place to maintain privacy if someone was undergoing a procedure.

Involvement in care

Patients we spoke with told us they were fully involved in their care and that they understood what was happening to them and they were involved in planning their own treatment goals. The electronic records system at the walk in centres automatically asked for consent to be obtained. Consent audits were carried out regularly to ensure that staff were complying with best practice.

All of the staff we spoke with were able to describe the processes for obtaining consent and the importance in clear communication with patients. The adult learning disability team told us that they had clear communication plans in place which had been signed off by either the patient or their carer.

Trust and respect

We observed that all the staff treated patients with dignity and respect. Staff were passionate about supporting patients in their care.

Patients told us that they had been treated with respect "I have been really well treated, really pleased with care." Another told us "They always explain what they are doing and ask your permission". Records seen were person centred and specific to the individual needs. Staff respected patients' confidentiality and sought permission to share personal information with other professionals as required.

Emotional support

Parents told us they felt reassured from the advice and information from both the nurse and the consultant advice sought from the acute trust they had received while their children had been cared for at the walk in centre.

The adult learning disability team outlined the work of the cancer champion who was able to offer emotional support to patients.

Are other services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

Patients arriving in the walk in centre were seen by a nurse promptly and triaged according to their needs.

We were able to observe response times and track individual's journey through the walk in centres. We observed that one person who was unwell was triaged and taken through for treatment within two minutes.

We were told that triage had been introduced in response to an increase in patient mix and the need for more efficient pathways and flows for patient care. Staff reported that they had managed the workload and had been able to staff according to peak hours to respond to peaks in activity.

Staff worked well across multi-disciplinary team to ensure that patients received the appropriate care in a timely manner. The patients we spoke with told us they were fully involved in their care and that they understood what was happening to them and they were involved in planning their own treatment goals.

Managers were able to describe how they identified the training needs of staff to align with the patient profile case mix, for example ensuring that there were enough physiotherapy staff trained in advanced musculoskeletal assessments and treatments to meet the needs of patients.

Other services

Access to services

The use of staff rota's allowed the services to meet the varying demands on the service. Staff also described ways in which they prioritised patients requiring access to therapy services to ensure they had been seen in a timely manner.

The walk in centre electronic information system "System 1" provided evidence of triage and response times. We were able to track patients' progress through the walk in centres and an alert system was in place to indicate the severity of patients' needs within the department. During our visit the average time we saw patients waiting was between seven and nine minutes.

Information about care and treatment for all of the services was freely available. Patients or relatives were given a range of written information and leaflets such as advice leaflets and exercise plans. We did not see written information readily available in different languages or formats, such as braille in the areas we inspected.

We clarified the access to the learning disability service. The service is open to people who are eighteen years or over with a learning disability and are resident within the Wigan borough. The service also provides transition support to young people with severe learning disabilities aged 14-25 years and behavioral support for young people aged 16 and over. The service offers an open referral system. Referrals are taken from carers, general practitioners, social workers, hospital staff, social care providers, other professionals and independent, private and voluntary organisations. We noted that there was lack of a clear service specification for the service which meant that staff were unable to tell us the commissioner's expectation of service delivery. The lack of clarity may impact on the service ability to plan their capacity to meet the demands of the service.

Data showed issues with the waiting times for Musculoskeletal services. We were told the average waiting time had come down to an average of eleven weeks although some staff spoke with other inspectors that the wait had been up to eighteen weeks. 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.

Vulnerable patients and capacity

Staff attended a variety of training to equip them to support vulnerable patients who use the services. Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA), Deprivation of Liberty (DOLs) safeguards and safeguarding children and vulnerable adults. Staff had received safeguarding training at levels 1, 2 and 3 as was appropriate to their role. Where staff suspected abuse we were shown clear pathways for staff to follow which would be used as part of the alert process.

The adult learning disability team told us they had taken on care coordinator roles to support and be responsive to patient's needs, not care organisers as such but support to help patients coordinate their lifestyle pathways. We were also told that they held a list of vulnerable patients as part of their winter snow plans to highlight individuals at high risk. The team was very clear in the management of risk for vulnerable adults and had been proactive locally to support vulnerable adults through a hospital stay.

All the staff we spoke with were able to give appropriate answers on how they would manage a safeguarding concern. They knew how to access polices and specialist support if required.

Leaving hospital advice and follow up care

The trust had good relationships with the ambulance service which enabled discharge to be facilitated in a timely manner in line with its own transfer of patient's policy. All of the staff we spoke with, and records demonstrated that staff understood the need for clear discharge information. We saw that discharge summaries were clearly written and shared with the appropriate professionals such as the original referrer to the service.

Learning from experiences, concerns and complaints

Staff told us all complaints were recorded on a centralised trust-wide electronic system. The lead nurses and clinical leads investigated formal complaints relating to their specific team. The trust target was to respond to formal complaints within 22 days.

Trust data showed that there had been a complaint from the patient opinion website (patient opinion is an independent non-profit feedback platform for health services) relating to poor staff communication. We were able to review actions taken following a couple of

complaints re attitude. We saw that the service responded in a timely manner and implemented customer care training to address some of the lessons learnt from the complaint.

We saw opportunities for patients to feedback on the quality of services. We saw that "Talk to us" forms were available in the reception areas of the walk in centres.

The staff were knowledgeable about the trust complaints policy. Staff were aware of complaints and compliments about services and received feedback at staff meetings. We saw that information on how to complain was available within an information leaflet available at the walk in centres.

Are other services well-led?

<Summary here>

Vision and strategy

All the staff we spoke with were aware of the "One Bridgewater" approach the trust was taking to develop fully integrated services, and felt that the senior management team understood their work. Some people expressed anxiety that the service redesign may have an impact on service delivery but that they were engaged with the process. Staff in each team were aware of the challenges and key risks to the services they provided.

Quality, performance and problems

All the services we inspected had clear systems in place to monitor their service. Staff performance was reviewed and monitored. We saw that routine audit and monitoring of key processes took place such as waiting times and staff performance. Mandatory training was closely monitored in addition to sickness absence and staffing levels.

The walk in centres were engaged and monitored through the Department of Health Clinical Quality Indicators for Accident and Emergency Departments. Other services were aware of both internal and external monitoring arrangements such as commissioner contract meetings and in-house key performance indicators.

Leadership and culture

Staff were aware who their manager was. Staff were highly motivated and positive about their work. The staff we spoke with told us they received good support from their line managers. The majority of staff were aware of who the trust's executive team were. Despite organisational change staff were positive about individual managers describing them as "brilliant and supportive" and enabling.

The adult learning disability services and musculoskeletal services were engaged at local, regional and national level working with other colleagues to drive improvements in their own professions.

We observed that the majority of middle managers we met were new in role. Some managers did not have access to edit the latest service risk register or audit calendar.

Patient experiences and staff involvement and engagement

There was patient engagement as part of individual treatment and care planning. The adult learning disability team were very proactive in engaging with patients and their families to ensure that they were involved in the delivery of their care. All the patients and families we spoke with were complementary towards the staff and had received good care.

Staff told us that they valued the regular staff surveys and felt confident to respond. 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. The trust was either better than or similar to the average for community trusts in 24 of 28 indicators from the 2012 survey of NHS staff, and worse than average for four indicators. This indicated that there was a good level of staff satisfaction in the majority of staffing indicators.

Learning, improvement, innovation and sustainability

Staff told us and we saw evidence of training needs analysis to understand the skills required by staff to deliver the service. One manager explained that each year they identified the needs of the service and how many staff would be required to have specific training such as acupuncture training. Training was readily supported across the staff groups. Staff told us that they had access to master's course and that each module was evidence based.

The staff told us that they had access to regular clinical supervision. One person told us "We work together as a team; we are innovative and move things on". Any issues with patients were discussed at supervision and supported to ensure effective practice.

Other services

Staff were encouraged to report incidents and errors. Staff we spoke with spoke of an open culture at the trust with regard to incident reporting, and were encouraged to develop ideas and take part in service improvement initiatives, for example the introduction of new acupuncture clinics.

The adult learning disability team told us that they held monthly service meetings with formal learning and reflection agenda items with dedicated time for discussion.

Staff had appropriate training to allow them to carry out their job role. There were paediatric trained nurses available to care for children at the walk in centres. Some staff had identified the need for additional paediatric training, and this had been facilitated by the trust through training and secondments to the acute children's services to gain the relevant skills required for the delivery of the service. Some staff told us that they would still prefer more training to deal with the number of children that attended the service.