# Care Quality Commission

# Liverpool Community Health NHS Trust
RY1

# Community health services for adults

**Quality Report**

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This report describes our judgement of the quality of care provided within this core service by Liverpool Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Liverpool Community Health NHS Trust and these are brought together to inform our overall judgement of Liverpool Community Health NHS Trust.

# Summary of findings

## Ratings

| | | |
|---|---|---|
| **Overall rating for Community Health Services for Adults** | Requires Improvement | 🟠 |
| Are Community Health Services for Adults safe? | **Good** | 🟢 |
| Are Community Health Services for Adults caring? | **Good** | 🟢 |
| Are Community Health Services for Adults effective? | **Requires Improvement** | 🟠 |
| Are Community Health Services for Adults responsive? | **Requires Improvement** | 🟠 |
| Are Community Health Services for Adults well-led? | **Requires Improvement** | 🟠 |

# Summary of findings

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# Summary of findings

## Overall summary

Most services were safe at the time of our inspection. There were arrangements in place to minimise risks to patients including measures to prevent pressure ulcers. Staffing levels were safe in the majority of services and there was on-going recruitment to fill staff vacancies.

There were arrangements in place to manage and monitor the prevention and control of infection, management of medicines and safeguarding people from abuse with dedicated teams to support staff and ensure policies and procedures were implemented.

Staff were familiar with the process for reporting incidents, near misses and accidents and were encouraged to do so. There were some inconsistencies in practice with regards to learning from incidents and sharing of that learning within individual teams and across the organisation.

Most services were effective, evidence based and focussed on the needs of patients. We saw some examples of good collaborative work and innovative practice.

The majority of staff were up-to-date with mandatory training however staff experience of clinical or reflective supervision was variable across community nursing teams and some staff were not accessing regular protected time for reflection of clinical practice.

Waiting times for wheelchair assessments were significantly higher than the expected target although a recovery plan was in place the service remained under pressure and waiting times were not expected to improve in the short term.

Services were caring. Patients and relatives or carers told us they were well supported by staff in multidisciplinary teams. We observed a compassionate and caring approach of staff in clinics and in people's homes. Staff in the multidisciplinary teams were aware of the emotional aspects of care for people living with long term health problems and ensured specialist support for people where needed.

Services were responsive to people's needs across the majority of services. Staff worked well in multidisciplinary teams across organisations to provide support to patients in the community. Patients were on the whole able to access the right care at the right time.

Services encouraged patients to provide feedback about their care. Complaints procedures were in place and there were examples where the service had acted on information about the quality of care that it received from patients.

The organisations vision and values were not fully embedded across all teams. The roles and responsibilities for governance and quality performance were understood at a local level however not all staff were aware of the quality issues affecting their service.

There was good leadership and support from local managers and most staff felt engaged with senior management. There was a positive shift in the culture of the organisation and staff felt leadership models encouraged supportive relationships amongst staff and compassion towards people who used the service. Staff were encouraged to raise problems and concerns about patient care without fear of being penalised.

A range of people's views were encouraged, heard and acted upon. Information on patient experience was reported and reviewed alongside other performance data. Where issues were identified, action plans were put in place to ensure improvements to patient care were made.

# Summary of findings

## Background to the service

Those with long term conditions received services from, district nurses and community matrons in their own home. There are also a range of clinics in the community offering specialist services.

We visited many of the clinics, and we accompanied district nurses to a number of people's homes to talk to patients and their relatives about their experiences. We also used information provided by the organisation and information that we requested.

We interviewed over 90 staff across all designations and roles. This included qualified nursing staff, specialist nurses, health care support workers, team leaders and managers. Some interviews were conducted on a one to one basis; other group discussions were arranged as focus groups.

## Our inspection team

Our inspection team was led by:

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

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

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

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

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

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.

2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Liverpool Community Health NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 13 and 15 May 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people

# Summary of findings

were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 23 locations including three community inpatient facilities ward35 Aintree Hospital, and wards 9 and 11 in the Alexandra Wing,

Broadgreen Hospital. The remaining locations included three walk-in centres and various community facilities. We carried out an unannounced visit on 13 May to the evening district nursing services.

## What people who use the provider say

We received a range of comments from patients and their relatives, both through comment cards as well as those

we spoke with during the inspection. The comments were overwhelmingly positive, with patients commenting on the quality of staff, cleanliness of facilities and timeliness of appointments.

## Good practice

- The trust was developing telehealth which used electronic information and communication to provide long-distance healthcare and health related education to patients in their home rather than having to go to hospital unnecessarily.
- Community nurses were able to connect using a tablet devise to mobile technology which enabled them to access and add to the patient's electronic health record whilst working in the community.

- The trust had a virtual ward led by clinicians and was able to manage each patient's condition to keep them well and prevent them from being admitted to hospital unnecessarily. The team were able to access extra advice and help from a range of services that were appropriate for a patient's care such as heart failure nurses, respiratory team, diabetes team and dieticians.

## Areas for improvement

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

- The trust must take action to ensure all clinical staff have access to regular protected time for facilitated, in-depth reflection on clinical practice. (Note – action a provider must take is associated with the issuing of a compliance action. In this case a compliance action against regulation 23 was still in force at the time of the inspection and further inspection activity will take place to assess compliance).
- The trust should continue to develop information technology systems to enable full integration and connectivity across the Trust.

- The trust should continue to monitor and implement the recovery plan to ensure waiting times for wheelchair assessments are reduced to meet the 4 week target.
- The trust should take action to ensure all teams don't work in isolation, there is shared learning and staff and resources are shared as required.

**Action the provider COULD take to improve**

- Continue to implement the action plan to ensure the call centre of single point of contact (SPC) enables patients to access the service out of hours and at weekends, receive the correct information and avoid delays in patients being seen.
- Continue to roll out training on dementia to all clinical areas.

# Liverpool Community Health NHS Trust

# Community health services for adults

**Detailed findings from this inspection**

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

**Good** 🟢

## Are Community Health Services for Adults safe?

### By safe, we mean that people are protected from abuse

#### Summary

At the time of our inspection services were judged to be safe. There were arrangements in place to minimise risks to patients including measures to prevent pressure ulcers. Staffing levels were judged safe in the majority of services and there was on-going recruitment to fill staff vacancies.

There were arrangements in place to manage and monitor the prevention and control of infection, management of medicines and safeguarding people from abuse with dedicated teams to support staff and ensure policies and procedures were implemented.

Staff were familiar with the process for reporting incidents, near misses and accidents and were encouraged to do so. There were some inconsistencies in practice with regards to learning from incidents and sharing of that learning within individual teams and across the organisation.

#### Incidents, reporting and learning

Most staff were aware of the process for investigating when things had gone wrong, including the use of root cause

analysis to investigate serious untoward incidents. Staff were familiar with the process for reporting incidents, near misses and accidents using the trusts electronic system (Datix), and were encouraged to do so.

Staff reported the culture for raising concerns had improved referring to an open culture in the organisation which supported them to report concerns and incidents. For example, changes had been made to the way pressure ulcers were investigated with the emphasis on learning and supporting staff to address areas for action within their teams. The changes made in the 'scoping' of pressure ulcers had been welcomed by district nurses.

Some staff reported they received feedback from incidents during team meetings and handovers however, practices to share information and learn across the organisation were variable, with some district nursing teams unaware of lessons learnt and improvement actions to implement.

Pressure ulcers accounted for the largest proportion of incidents (85%). Outcomes for community acquired

# Are Community Health Services for Adults safe?

pressure ulcers showed during 2012/13 community services had seen a 10% reduction in grade 3 pressure ulcers and a 64% reduction in grade 4 pressure ulcers in the last 12 months.

## Cleanliness, infection control and hygiene

There were policies and procedures for infection prevention and control which were based on the Department of Health's guidance 'Essential steps to safe clean care'. Staff reported they had received infection control training. Policies were adhered to such as 'bare below the elbows' dress code and we saw staff regularly washed their hands and wore personal protective equipment such as gloves and aprons when providing personal care.

Cleaning schedules were in place and there were clear processes for checking the cleanliness of the environment and decontamination of equipment. Monthly cleanliness audits were carried out and results for March 2014 showed adult services were meeting targets. There were dedicated infection control nurses who worked with link nurses in each clinical area providing specialist support and advice where required.

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

## Maintenance of environment and equipment

Premises run by the trust were noted to be clean and well maintained. Premises had procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Procedures were in place to ensure equipment was regularly maintained and fit for purpose. Patients were provided with information detailing the procedure for equipment repairs and reporting of faults out of hours.

## Medicines

There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. There was a dedicated medicine management team (MMT) who provided a range of services to community teams which included referral for

medication reviews of patients at risk or with complex medication needs from secondary care, falls service, GPs and community matrons. Clear procedures were followed in practice, monitored and reviewed for medicine handling that included prescribing, safe storage and monitoring. Targeted medication reviews took place for patients with respiratory disease, diabetes and heart disease the aim being to improve patient education and outcomes. Systems were in place to reflect on the findings of medication audits, learning from adverse events, incidents and near misses relating to medicines so that the risk of them being repeated was reduced.

## Safeguarding

There were effective safeguarding policies and procedures which were understood and implemented by staff. Staff were aware of the trusts' whistleblowing procedures and the action to take. The trust had introduced a Speak out Safely Programme to raise staff awareness about raising concerns. There was a dedicated Safeguarding Adults Team consisting of a specialist team of nurses who provided a range of expertise, support, advice and training to all staff. Staff confirmed they had completed three yearly safeguarding training. Data for April 2014 showed 89% of staff had completed level 3 safeguarding adults training and 97% had completed level 3 safeguarding children's training.

## Records

The clinical records we looked at were completed to a good standard and contained a clear pathway of care which described what the patient should expect at each stage of their treatment. For example, goals for treatment had been agreed with patients with worsening symptoms of heart failure.

We looked at a district nursing clinical records audit 2013/ 2014. Evidence of good practice included completion of falls risk assessments and end of life tools however there was a lower level of compliance with completion of skin bundles and wound care planning. Recommendations and an action plan had been developed with a repeat audit in 12 months to identify improvements in practice. When not in use records were kept safe in line with data protection.

## Lone and remote working

There were systems in place to promote the safety of staff when lone working. Staff told us they operated a joint working system for high risk activities although some community nurses working on the 5-8 shift told us they

# Are Community Health Services for Adults safe?

mostly worked alone and were not always familiar with the high risk areas they covered. We saw reporting systems were in place to ensure that the whereabouts of staff were known and staff were provided with mobile phones.

## Adaptation of safety systems for care in different settings

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

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

## Assessing and responding to patient risk

We found that teams in the community were aware of key risks such as falls and pressure care. We saw that risk assessments were completed and staff responded to findings by referring people for additional assessments or for relevant equipment. We observed safe patient handovers. The senior nurse provided a clear clinical overview and identified relevant information to ensure patient safety.

## Staffing levels and caseload

The board minutes showed that safe staffing levels were a key theme in the national reports. It was identified that current workforce tools were limited in their usefulness and scope for community services. The trust used benchmarking with other similar community trusts and had used the accredited tool for determining safe staffing levels.

Staff told us that in some community teams there had been vacancies that meant many staff had been working over their contracted hours. We found most vacancies had been filled and teams were now usually able to meet the demand for patient referrals. Where this was not the case staffing issues had been escalated to the trust risk register and the trust had responded to information about incidents occurring and staff views by recruiting additional staff.

## Deprivation of Liberty safeguards

The Deprivation of Liberty Safeguards (DOLS) were used appropriately. Staff were aware of the procedures to follow and had received training in this area. There were three trained DOLS assessors. Additional training for staff was being provided following amendments to the DOLS legislation.

## Managing anticipated risks

We found there were systems and processes in place to maintain patient safety. There were specialist nurses leading services and clinics and within community teams. This meant that people with long term conditions were triaged and assessed accurately so that safe treatment and care was provided to guard against risks associated with their complex condition. Risk assessments in areas such as falls, nutrition, and pressure care were complete and updated as patient's needs changed.

Contingency plans were in place in the event major events, such as outbreaks of flu or winter weather affecting staffs ability to travel.

## Major incident awareness and training

Business continuity plans were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery. A trust assurance process was in place to ensure compliance with NHS England core standards for Emergency Preparedness, Resilience and Response. A mix of training was available for key staff utilising emergency plans such as table top exercises and practical training.

# Are Community Health Services for Adults effective?

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

## Summary

Staff provided evidence based practice and focussed on the needs of patients. We saw some examples of very good collaborative work and innovative practice.

The majority of staff were up-to-date with mandatory training however staff experience of clinical or reflective supervision was variable across community nursing teams and some staff were not accessing regular protected time for reflection of clinical practice.

## Evidence based care and treatment

Individual roles and responsibilities were understood by staff in the delivery of evidence based care. This included involvement in the development of policies and procedures, and in the assessment and monitoring of the quality of care provided to adults with a long-term condition. Care pathways demonstrated they had referred to NICE (guidance issued by expert body, the National Institute for Health and Care Excellence) guidelines to ensure patients were appropriately assessed and supported with their needs.

Community staff used nationally recognised assessment tools in order to screen patients for certain risks, and referred to relevant codes of practice, for example infection control and mental capacity.

## Pain relief

Records showed patients where provided with options and information relating to pain relief. Those requiring pain relief had pain assessment charts in place which included end of life tools such as symptom control management.

## Nutrition and hydration

Nutrition and hydration assessments were completed on all appropriate patients. These assessments were detailed and used nationally recognised nutritional screening tools. Where patients were at risk of malnutrition referrals had been made to the dieticians for advice and support. The Community Nutrition Support Dietetic Team worked across Liverpool as well as having good links with the city's secondary care settings enabling collaborative working. This ensured smooth patient care across all healthcare

settings as well as allowing clinical expertise to be maintained. Dietetic assistants were an important part of the team providing an on-going review service for nursing home patients.

## Patient outcomes

We saw evidence that community teams monitored the performance of their treatment and care. The trust had an annual clinical audit plan with 52 audits of adults services completed between September 2013 and February 2014. Examples of these audits included record keeping, hand hygiene, respiratory palliative care outcomes and re-audit of smoking cessation documentation. Action plans were implemented following conclusion of all local audits to ensure any issues were addressed for future practice. There was evidence of staff reviewing the care planned and delivered with changes made to documentation and staff training, and increased awareness of trigger factors for patients accessing supportive palliative care.

The service used clinical and quality dashboards to develop and provide staff with relevant and timely information to inform daily decisions that improve quality of care. The dashboards showed key performance indicators were reviewed each month against targets to enable the service to measure the effectiveness of care delivered.

## Performance information

The trust used the NHS Safety Thermometer which is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. We looked at the figures for the last 12 months which showed the trust was the same as the national average for falls with harm but was below the national average for venous thromboembolism (VTE) and new urinary tract infections (UTIs) for patients with a catheter. The results for district nursing services showed between 90% - 100% harm free care was achieved in most localities.

## Competent staff

The majority of staff told us access to mandatory training had improved including specialist external courses. Records showed over 80% of staff had completed mandatory training and had received performance reviews.

# Are Community Health Services for Adults effective?

All staff we spoke with told us they had had an appraisal within the last 12 months and most staff thought it was a supportive and valuable process. Staff experience of clinical or reflective supervision was variable across community nursing teams and some staff were not accessing regular protected time for facilitated, in-depth reflection on clinical practice. The trust had already taken action to improve performance in this area; however, further work was needed to ensure supervision was effectively implemented in line with trust policy.

## Use of equipment and facilities

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

## Telemedicine

The trust was developing telehealth which used electronic information and communication to provide long-distance healthcare and health related education to patients in their home rather than having to go to hospital unnecessarily. The trust had carried out a telehealth patient experience survey in May 2014 which showed improvements in patient

health and wellbeing, management of blood pressure and weight and greater control of their long term conditions. Patients we spoke with were very positive about the system and confirmed they felt in control of their condition and could access clinical advice quickly.

## Multi-disciplinary working and working with others

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices were in place. Staff told us there was effective communication and collaboration between teams who met regularly to identify patients requiring visits or to discuss any changes to the care of patients. Teams also attended meetings with GP's and other community services with the aim of preventing re-admissions to hospital and achieving patient's preferred place of care.

Patients receiving care and treatment for long term conditions told us the staff communicated well with their GP and other professionals. They gave examples of how community staff had referred them to other services or support and advice groups, or had arranged other professionals to carry out assessment visits.

## Co-ordinated integrated care pathways

Staff told us they had developed good links with a range of key professionals and understood each other's roles. This meant that care was well co-ordinated. Care records showed the involvement of other agencies in providing integrated care pathways, for example the respiratory team worked closely with national and regional networks such as the British Lung Foundation and Breath Easy Groups.

# Are Community Health Services for Adults caring?

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

## Summary

Services were caring. Patients and relatives or carers told us they were well supported by staff in multidisciplinary teams. We observed compassionate and caring approach of staff in clinics and in people's homes. Staff in the multidisciplinary teams were aware of the emotional aspects of care for people living with long term health problems and ensured specialist support for people where needed.

## Compassionate care

We observed positive interactions between staff and patients in a number of different care settings. Patients were treated with 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.

Patients said they received very good care. One patient told us the podiatry service was "excellent and staff were very kind" another patient said the district nursing service was 'excellent and treated her as an individual'. The Friends and Family test results for March 2014 showed that the majority of patients were extremely likely or likely to recommend adult services to their family or friends.

## Dignity and respect

We observed staff treated patients and their relatives with dignity and respect. Patient confidentiality was respected when delivering care, in staff discussions with patients and their relatives and in any written records or communication.

## Patient understanding and involvement

Patients and relatives we spoke with all indicated they were involved in care decisions, and records we reviewed

confirmed this. All records we reviewed contained evidence of consent from patients for treatment; In relation to involvement in care we found all the services delivered person centred care and that people, their relatives and/or people's representatives were involved in and central to decisions made about the care and support needed. Where patients were unable to make decisions about their treatment records showed assessments of the person's mental capacity and best interests had been taken which followed the principles of the Mental Capacity Act 2005.

## Emotional support

Patients and relatives told us they were well supported when they had been told difficult diagnosis. We observed that staff used a holistic approach encompassing physical, social and spiritual well-being and this was incorporated into care planning. The Preferred Priorities of Care guidance was used for patients to express their wishes, preferences and beliefs at the end of life. This ensured staff were aware of patient choices and how they wished to be cared for.

## Promotion of self-care

The community nurses, therapists and matrons visiting people in their own homes were highly valued in promoting people's independence and providing meaningful information about self-care. For example, staff supported patients to learn and recognise early signs and symptoms of heart failure and chronic respiratory disease. We saw information leaflets were provided to patients for health promotion and self-management of their conditions, including the prevention of pressure ulcers, breathing exercises and self-administration of medication such as insulin and inhalers.

# Are Community Health Services for Adults responsive to people's needs?

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

## Summary

Services were responsive to people's needs across the majority of services. Staff worked well in multidisciplinary teams across organisations to provide support to patients in the community. Patients were on the whole able to access the right care at the right time.

Waiting times for wheelchair assessments were significantly higher than the expected target although a recovery plan was in place the service remained under pressure and waiting times were not expected to improve in the short term. Not all patients receiving care from district nursing or community matron's were seen within agreed time bands.

Services encouraged patients to provide feedback about their care. Complaints procedures were in place and there were examples where the service had acted on information about the quality of care that it received from patients.

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

Managers we spoke with for each service were aware of the risks in their areas such as staffing levels and skill mix, geography of the various sites and investment in community services. Some staff told us they worked with local commissioners of services, the local authority, other providers, GP's and patients to co-ordinate and integrate pathways of care that met the health needs of patients. Service specifications were in place which detailed the aims, objectives and expected outcomes for patients and were monitored against national and local performance indicators.

We found services responded to changing local priorities and addressed the demands on services. In several areas there was weekend, evening and early morning clinics or educational courses, to improve access for patients. Some patients receiving community nursing visits at home told us staff would attend at a certain time if asked. We heard good feedback about telehealth equipment which supported patients to monitor their health condition at home. This helped reduce the number of visits to the surgery or clinic and unplanned visits to the hospital.

The trust employed a range of specialist teams to support staff in the community to ensure patient needs were met. These included continence nurse specialists, falls teams and therapists. Patients were able to self-refer too many of these services.

The trust set its priorities around its dementia strategy for 2013/2014. This included the roll out of dementia screening to a number of different services, continued training and development for staff and ensuring the right support was in place. Some staff we spoke with confirmed they had received training in dementia care however others although they were aware of the training had not accessed it.

## Access to care as close to home as possible

Patients and relatives told us that services were accessible and tailored by staff to meet their individual needs, at the times and in the places to best suit their lifestyle. We observed areas of good practice to ensure patients were managed in their own home. For example, the respiratory nurses described a proactive service that identified and managed patients using a case management approach. Respiratory patients admitted to hospital with an exacerbation of their condition were assessed within two hours of referral by the respiratory nurse practitioner to determine whether with suitable medication, nursing and social support they could be safely cared for at home. The aim was to prevent unnecessary hospital admissions, reduce the length of stays in hospital, and improve patient self-care and management.

## Access to the right care at the right time

Community services were provided in people's home as needed and clinics and groups were established in community locations. The majority of services provided good access to services across the trust, with some services proving flexible clinic opening times including weekends and out of hours. For example, the anticoagulation and blood testing services operated several clinics across Liverpool providing flexible appointment times and domiciliary visits for housebound patients. Advice lines were also available for patients to contact and discuss medication or clinical changes. Patients confirmed they were able to choose appointment times which best suited their needs. Figures showed waiting times in most services

# Are Community Health Services for Adults responsive to people's needs?

were meeting national targets. At March 2014 waiting times for adult therapies had reduced from 10 weeks to the target of 8 weeks and 63.6% of patients accessing district nursing and 87.3% patients accessing community matrons were seen within agreed time bands.

As at March 2014 waiting times for a wheelchair assessment was 20 weeks which was significantly above the target of 4 weeks. The increase in waiting times was due to increase in demand and the specialism of the service. The trust had implemented a recovery plan to ensure that the capacity within the service was maximised through additional funding and recruitment of staff. However the service remained under pressure and waiting times were not expected to improve in the short term.

There was good communication and use made of other organisations to support people at the end of life. The community nursing teams worked closely with Marie Curie nursing service and local hospice services to co-ordinate care at home and including out of hours.

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

The majority of community nurses reported good relationships with hospital staff to support early discharge. However, some teams told us they were not able to access or view parts of patient records from other systems for example the GP electronic records did not always share information which occasionally caused delays in referrals and discharge of patients.

## Flexible community services

District nurses in Liverpool told us they covered a large geographical area. They identified challenges to provide flexible services in North Sefton which was managed by a different provider. Staff told us the distance between sites meant patients had longer waiting times particularly during winter months. The teams also worked differently which

prevented access to electronic systems and patient health records. The locality manager told us they were meeting with commissioners to review the provision of services in this area.

Community nursing teams identified the call centre of single point of contact (SPC) as a continuing risk which affected the flexibility of community services. The teams remained concerned about possible delays of patients being seen, confusion for patients trying to contact them at weekends and out of hours and ensuring that SPC gave patients the correct information. The trust had identified the telephony infrastructure on its strategic register and an action plan was in place to mitigate the risks.

## Meeting the needs of individuals

Patients reported they had individual care plans and they had been involved in the development of these. The records we reviewed demonstrated that care had been planned around the needs of the patient and their family. Processes were in place to ensure vulnerable patients had access to specialist support such as mental health teams, substance misuse or social services where required. Phlebotomy staff had been trained in 'safe hold' which facilitated a relaxation approach when collecting blood samples from vulnerable patients. A range of leaflets about care and treatment was available in different formats and languages and there was access to interpreting services.

## Moving between services

There was continuous assessment of patient needs using the Single Assessment Process (SAP) with patients and carers to facilitate decisions regarding future care. Community matrons told us they provided assessment and diagnosis in conjunction with GPs and nurse prescribers to ensure patients received care which met their needs following discharge. There was good collaborative working between services to ensure continuity of care. One patient told us they were aware of the care responsibilities given by district nurses and the Macmillan team and felt the service they received was seamless.

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

Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at service level or through the trusts Patient Advice and Liaison Service. Training for staff on complaints was provided. Learning

# Are Community Health Services for Adults responsive to people's needs?

from feedback was evident and improvements had been made in areas such as the referral process and waiting times in the wheelchair service, training sessions for staff to ensure they were aware of the importance of assessing a patient's nonverbal signs of pain or discomfort and improved communication for patients being discharged from intermediate care.

# Are Community Health Services for Adults well-led?

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

## Summary

The organisations vision and values were not fully embedded across all teams. The roles and responsibilities for governance and quality performance were understood at locality level however not all staff were aware of the quality issues affecting their service.

There was good leadership and support from local managers and most staff felt engaged with senior management. There was a positive shift in the culture of the organisation and staff felt leadership models encouraged supportive relationships amongst staff and compassion towards people who used the service. Staff were encouraged to raise problems and concerns about patient care without fear of being penalised.

A range of people's views were encouraged, heard and acted upon. Information on patient experience was reported and reviewed alongside other performance data. Where issues were identified, action plans were put in place to ensure improvements to patient care.

## Vision and strategy for this service

The vision and values of the organisation were displayed in clinical areas. Locality managers described areas such as meeting the needs of patients, promoting a learning culture and continuous development as the priorities for the future. We found managers and some staff were aware of the organisations vision and strategy however this was variable and not fully embedded amongst all teams.

## Governance, risk management and quality measurement

Risk management and quality assurance processes were in place at a local level. Adult community services held governance and patient safety meetings and records showed risks were escalated and included on risk registers and monitored each month. Local quality dashboards were also completed which showed how each service was performing against key quality indicators. We found managers were aware of the quality issues affecting their services and some shared this with staff although we found understanding of quality measures was variable amongst different teams.

## Leadership of this service

Staff we spoke with said they received good leadership and support from their immediate line manager and some staff told us members of the trust board were visible and had accompanied them on patient visits. Staff confirmed there were monthly formal cascade processes including messages from the interim chief executive and board of directors.

The trust had recently introduced License to Practice which was a two year management development programme, focussing on leadership, behaviours and skills. Some staff we spoke will were participating in the programme and spoke positively about the professional development they had received.

## Culture within this service

Most staff reported a positive shift in culture in the service. They reported increased engagement and felt they were being listened to. Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority. Staff told us they were encouraged to raise concerns about patient care and this was acted on. Staff were dedicated and worked well as a team. We found some district nursing teams worked in silos which meant sharing of best practice and concerns between teams wasn't as effective as it could be. Figures showed staff sickness levels were within expected numbers in most areas with higher than average sickness rates in community nursing services. The majority of staff told us morale had improved following recent culture changes within the service.

## Public and staff engagement

Records showed services sought feedback from patients who received care in community settings or in their homes. Patient surveys had been undertaken in respiratory, podiatry and district nursing services. Results from the surveys showed patient feedback was positive. In clinical areas we saw feedback forms were available for patients to provide comments, concerns and compliments. We saw patients were encouraged to attend service events. The community equipment and disability advisory service had held a user event to encourage users of community

# Are Community Health Services for Adults well-led?

services to feedback on their experience and to sustain the engagement of individuals who could be lifelong users of the service. Minutes of the June 2014 meeting showed a number of improvements had been made in communication, delivery times and replacement equipment.

Most staff told us staff engagement had improved. They spoke positively about the Listening into Action programme which the trust had introduced to enable staff to raise concerns and make suggestions for improvements. However we found there was some variability in practice with regards to communication and some community nurses said they did not feel engaged with senior managers in the organisation.

## Innovation, improvement and sustainability

We saw examples of innovation and improvement. The respiratory team had developed point of care testing for blood gas analysis which enabled trained nurses to carry out tests in patient homes avoiding unnecessary admissions to hospital.

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