Pennine Care NHS Foundation Trust

RT2

Community health services for adults

Quality Report

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Date of inspection visit: 14 to 17 June 2016
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT2HQ	Ellen House, Waddington St, Oldham	Speech and Language Therapy Service Falls and Fracture Prevention Team	OL9 6EE
RT2H7	Nye Bevan House, Maclure Road, Rochdale	Musculoskeletal, Orthopaedic Assessment & Physiotherapy	OL11 1DN
RT201	Holcombe House, Fairfield General Hospital	Parkinson's Disease Service	BL9 7TD
RT2	Blenheim House, Little 66, Roach Bank Road, Hollins Brook	Bury District Nursing Service	BL9 8RN
RT2HQ	Clinic at Werneth PCC, Featherstall Rd South	Tissue Viability Service	OL4 1DE
RT2HQ	Callaghan House, Cross Street, Heywood	Posture and Mobility Centre (Wheelchair Services)	OL10 2DY
RT2	George H Carnell Leisure Centre, Kingsway Park, Urmston	Specialist Weight Management Service	M41 7FJ
RT2	Firsway Health Centre,21 Firsway, Sale, Cheshire	Trafford District Nurses	M33 4BR
RT2HQ	Croft Shifa Health Centre, Belfield Road, Rochdale	Podiatry	OL16 2UP
RT2HQ	Moorgate PCC, 22, Derby Way, Bury	COPD Nursing Team	BL9 0NJ

This report describes our judgement of the quality of care provided within this core service by Pennine NHS Foundation Trust, adult community services.. 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 Pennine NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine NHS Foundation Trust.

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

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Summary of findings

Overall summary

Pennine Care NHS Foundation trust adult community provides services across six Greater Manchester boroughs or local authorities. Bury, Oldham, Rochdale, Heywood, Middleton and Trafford.

Adult services are commissioned by four clinical commissioning groups (CCG's). Bury; Oldham; Rochdale, Heywood and Middleton and Trafford. Services are configured to match the CCG locations.

Adult nursing and therapies services provided by the trust includes:-

- district nursing
- palliative care
- physiotherapy
- audiology
- podiatry
- speech and language therapy
- weight management service
- wheelchair services
- occupational therapy
- nutrition and dietetics
- tissue viability
- community enhanced care services
- services supporting the management of long-term conditions such as pulmonary rehabilitation, expert patients, vascular diseases and cardiac rehabilitation.

Overall rating for this core service Requires Improvement

We rated this service as requires improvement because.

- Insufficient numbers of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguard training.
- Efforts to integrate Trafford services into the main body of the organisation were ongoing.
- Staff said and minutes of meetings also indicated that at the time of the inspection Trafford staff felt isolated from the rest of the Pennine Care NHS Foundation trust.

However

- The trust ensured care and treatment was based on best practice guidance.
- The trust promoted and encouraged staff involvement with local and national patient outcome audits.
- The trust frequently monitored the quality of the services provided.
- Patients rated the trust highly and evidence indicated they felt involved in planning their care and were satisfied with the standard of care.
- There were innovative services provided by the trust, for example the chronic obstructive pulmonary disease advisory service.
- Processes and systems were in place to ensure lessons were learnt from incidents and complaints.

Summary of findings

Background to the service

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Our inspection team

The inspection was led by:

Chair: Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust

Head of Inspection: Nicholas Smith, Head of Inspection, Care Quality Commission

Team Leader: Sharron Haworth, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialist advisors.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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?

Before the inspection visit, we reviewed information that we held about this service and asked a range of other organisations for information.

Good practice

The referral process for the musculoskeletal orthopaedic assessment and physiotherapy service was outstanding and had a regional innovation award of funding for developing self-referral processes for patients.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure all staff adhere to aseptic non-touch technique all of the times.
- The trust must ensure all risk assessments are completed including need for bariatric equipment.
- The trust must ensure that the medication policy is adhered to at all times.
- The trust must develop a strategy which specifically looks at improving the outcomes for patients in relation to therapies which are performing well below the England average.
- The trust should support staff to report all incidents that have affected the quality of service to the patient, for example cancelled or delayed visits and patients who are not at home when visited.
- The trust should consider auditing the prevalence of urinary catheter infections and deep vein thrombosis as recommended in the Harm Free care guidance.
- The trust should ensure action plans are carried out so that steps can be taken to reduce the turnover of staff.

Pennine Care NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Information about safety outcomes were incomplete and did not include rates of urinary tract infection or deep vein thrombosis as recommended by Harm Free Care.
- Plans to promote safety were not equitable throughout the service for example there was a full tissue viability team in Trafford and Rochdale and only a single nurse specialist in Bury.
- Out of date medication was found in one of three clinics visited.
- Patients and staff were put at risk because patients were not routinely weighed and the potential need for bariatric equipment was not routinely assessed.
- Staff turnover and sickness was high throughout adult services but particularly in the Trafford district nursing services.
- Staff did not routinely report times when staff shortages caused a delay in treatment. The steps taken to deal with staff shortages did not always mitigate the risks to patients or staff.

However

- Processes were in place for reporting incidents and safety concerns.
- Information about safety was visible to staff.
- Staff were involved in collecting data and monitoring safety.
- The trust was proactive in encouraging staff to report safety concerns.
- Staff had a good understanding of safeguarding issues and how to report and escalate issues of abuse and neglect.
- There was safe access to buildings and equipment was available and well maintained.
- Staff and patients received training in how to use equipment safely.

Requires improvement

Are services safe?

- The quality of hand written and electronic records was good and records were audited by the trust.
- Effective processes were in place to protect patients, staff and the community from risk of cross infection.
- All staff had access to mandatory training courses and the trust was working hard to ensure targets for training were met. The mandatory training programme supported staff in delivering a good standard of care.
- Systems were in place to manage anticipated risks.

Safety performance

- The trust collected data on a specific date each month to complete a safety thermometer performance indicator.
- The NHS Safety Thermometer is a point of care survey which provides a 'temperature check' on harm; this can be used alongside other measures of harm. The safety thermometer results were of data collected on a specific day once a month. The trust analysed this snapshot information and the findings gave an indication of safety performance.
- We saw that the results were displayed in the offices visited and recorded in quality assurance reports.
- Trips, slips and falls, pressure ulcers and medication errors were measured.
- The overall community service safety report indicated the number of new pressure area ulcers reported during the months February to April 2016 fluctuated upwards in that there had been a downward trend from 107 in February down to 94 in March, however, this increased to 132 cases between March and April 2016. Pressure ulcers grade two and above were reported as an incident.
- Pressure ulcer care and prevention provision differed between areas of the trust. For example in Rochdale and Trafford there were specialist tissue viability nurses who worked in small teams. These staff worked closely with community nurses and care homes in raising awareness regarding best practice for managing leg ulcers and preventing pressure ulcers. In Bury the service was delivered by one tissue viability specialist nurse who covered all patients in the borough. This nurse also delivered all the training expected from a specialist service.
- Slips, trips and falls trended down, in February 42 were reported, 40 in March and 28 in April 2016.
- Medication errors reported trended up, there were 15 in February, 16 reported in March and 25 reported in April. Quality assurance reports indicated the increase was due to a successful drive to encourage staff to report medication errors.
- The overall performance indicators or target numbers for these measures was not explicit in the data provided.
- The data was disaggregated into teams or services and so comparisons in performance could be made.
- Staff we talked with understood the purpose of collecting information about patient safety and outcomes. Staff told us auditing had a positive effect because it made them consider the effectiveness of their actions and work processes.
- The outcome of safety checks or 'dashboard' was on display in all the offices we visited.
- Safety performance data was discussed at middle and senior management levels. Operational staff received feedback through intranet briefings, team meetings and newsletters.

Incident reporting, learning and improvement

- There was an accessible electronic mechanism in place for reporting and analysing incidents, including near misses. These were fully accessible and understood by staff.
- All the staff we met understood their responsibilities to raise concerns. All staff, including agency staff, indicated they had raised concerns about various topics.
- However we found that staff did not report all incidents, especially those relating to staff shortages. For example late or missed calls which did not involve insulin or other vital medication were not always reported.
- There was a Patient Safety Incident Group (PSIG) that reviewed all incidents and investigations and produced an action plan for each.
- Lessons learned from incident reviews were cascaded on a monthly basis on a "Message for the month" that was sent out to all frontline staff.

Requires improvement

Are services safe?

- The wheelchair service had raised some safeguarding incidents regarding vulnerable adults and the care of wheelchairs in nursing homes and lessons learnt were shared with the services involved.
- The trust had suitable systems and processes in place to meet its obligations in respect of its duty of candour.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social services to notify patients (or other relevant persons) of notifiable safety incidents.
- We saw that investigations in this regard were thorough and transparent.
- Questions about duty of candour and informing patients and relatives was included in the incident reporting matrix and needed to be answered before incidents could be closed on the system. This provided a useful prompt for staff to consider duty of candour in reporting incidents.

Safeguarding

- How to report and escalate safeguarding and child protection concerns was understood by all the staff teams we spoke with.
- Staff in all the services articulated their responsibilities in relation to recognising and reporting concerns.
- The contact details for the relevant safeguarding team were on display in the offices and areas visited.
- All staff had access to level 2 safeguarding training.
- 90% of Bury, Oldham, Heywood, Middleton and Rochdale staff had completed safeguarding adult training. This met the contractual key performance target.
- The trusts head of safeguarding and nursing also acted as the designated adult safeguarding manager and attended the local safeguarding board. The role included managing and having an oversight of individual complex cases and coordinating investigations into allegations which concerned staff or volunteers.
- The adult safeguarding team were active in sharing information and providing feedback for example they attended the musculoskeletal staff supervision meeting every six months to discuss any cases, outcomes of investigations and to update staff about changes in processes such as contact details.
- Staff from different services and specialism gave examples of safeguarding concerns they had raised and changes that had taken place as result.

Medicines

- The trust medication management policy was due for review in October 2016. The updated policy was due to be approved by senior pharmacists and clinicians; the time scale for completion was January 2017.
- In the meantime there are several on-going initiatives to improve medication management which included the divisional pharmacist reviewing all medication incidents and making a contribution lessons learnt and changes to the policy.
- Medicines safety learning lunchbox sessions for community nursing staff were ongoing and plans were in place to provide sessions to all staff who administered medication.
- Medication errors reported by the community teams between February and April 2016 indicated there were 15 incidents in February16 in March and 25 in April.
- Quality assurance reports indicated that the increase in reporting medicine incidents was due to a drive to raise awareness regarding the importance of reporting medication errors.
- Fridge temperatures were being recorded and were managed within permitted parameters.
- Medication was kept in locked cabinets in the areas we visited. Medication was provided to satellite clinics from central store.
- The stock check book reviewed was up to date and provided an accurate audit of medication received and used.
- We looked at medication management in three clinics and found out of date medication at one service. This was two boxes of Lidocaine injections (2%) that had expired in April 2016.

Requires improvement

Are services safe?

- We were told that Lidocaine 2% injections were no longer in use. These boxes were sealed but should have been removed and disposed of in keeping with the trusts medication policy. This was dealt with by the trust at the time of the inspection.

Environment and equipment

- We visited six buildings used by patients and all were accessible for example there was car park space for both patients who travelled independently and ambulances to park and assist passengers in wheelchairs.
- We noted that the lift in one building was quite small and it took several trips to transport a number of patients who used wheelchairs to the first floor.
- Staff in all areas told us there were no delays in replacing or providing equipment.
- Policies were in place to escalate delays in replacing equipment if this was due to financial pressures. The priority and alternative plans for providing the equipment was reviewed by senior staff. The decision and rationale were fed back as appropriate.
- All equipment we inspected during visits to different services had up to date safety checks.
- Systems were in place to flag when equipment was due to be checked. The district nurses checked their tool kits daily and this was recorded.
- There were a number of bariatric beds available in the department. However there was no evidence that patients were risk assessed in relation needing bariatric equipment. For example the patient's height and weight were not always recorded by community service staff.
- This was of particular concern in the podiatry service because the couch was raised high above the floor to enable the podiatrist to work standing up. This was discussed with the provider's representative at the time of the inspection.
- There were call bells in treatment rooms and in the gym at Bevan House. There was also a ripcord alarm and a hand held button attached to the alarms so there were several ways of raising the alarm.

Quality of records

- We reviewed 28 care records across different teams and locations within the community services. The teams we visited used a combination of paper and electronic record keeping systems.
- Information was not always uploaded into the electronic record simultaneously as in some cases information given by the patient was documented initially on a note-pad and not directly in the patient's records until after the clinic or when staff returned to the office.
- Trafford community nurses were transferring to a paperless system however at the time of the inspection patient records were predominantly paper held.
- Paper records files were standardised and indexed. Information recorded included demographics such as address, referrals, medical history, risk and other appropriate risk assessments.
- Records provided comprehensive information about patient needs and the actions required by staff and the patient.
- Summaries of visits and appointments provided information about the progress patients were making and included any changes to care and treatment.
- Care records files we reviewed were indexed and information was easy to find.
- A trust wide record keeping audit was completed and data was collected from December 2015 to February 2016, the report was published in May 2016. The results showed that most services achieved the 100% for compliance in most areas looked at. Action plans to address identified shortfalls were put in place if this was not the case.
- Pennine Care trust used a number of different electronic patient records which did not interface with one another, this meant paper records needed to be used to share information between different services and disciplines.
- The trust was trialling methods to interface some old electronic systems into the new. For example between the Oldham musculoskeletal services and the new system. However the trust had recently commissioned a new system in Trafford which was completely different

to the new system commissioned for the rest of the service. Trafford's new electronic patient record system is used by other healthcare professionals in the borough, but it will not interface with the rest of the trust. This meant that developing compatible records systems could be further delayed.

Cleanliness, infection control and hygiene

- All areas we visited were clean and tidy with free access to hand sanitiser and handwashing facilities. Floors and chairs were visibly clean and covered in a wipe able material; curtains were clean and labels showed these had been recently changed; disposable paper rolls were being used on examination beds; there were foot operated waste bins; sharps bins were closed appropriately and not full.
- In the areas visited we saw that treatment room cleaning schedules were completed daily.
- We observed that cleansing wipes were provided to clean equipment and beds and couches were cleaned and covered between patients.
- All staff we met adhered to the trusts 'bare below elbows' policy.
- District nurses had access to personal protective equipment (PPE) such as gloves and aprons.
- We observed that staff cleaned their hands before and after seeing a patient.
- PPE equipment was not always available in the clinic rooms which meant staff had to leave the room when they needed to replace soiled items such as gloves and aprons.
- The trusts training records showed that approximately 225 staff from different directorates had completed aseptic non-touch technique training (ANTT) between November 2015 and June 2016.

Mandatory training

- Mandatory training was provided in different formats which included self-directed e-learning, face to face classroom and practical training. Over all the service rated themselves as 99% compliant with mandatory training.
- We reviewed information for individual services and noted that targets for compliance were generally met.
- The cardio obstructive pulmonary disease team achieved approximately 93% compliance; speech and language therapists achieved 99%.
- Areas where the target was not met usually involved small teams because when the target was 100% a team of four would only score 75% if one person missed the course.
- All staff completed moving and handling; conflict resolution; equality and diversity; health and safety; adult safeguarding level one and two; information governance and PREVENT (prevention of radicalisation) training on a rolling programme of between 1-2 years depending on the course.
- A review of community nurse mandatory training was undertaken in 2015 by a band 7 nurse. This showed basic life support training needed to be changed to ensure the service was confident that nurses in different geographical areas were equally competent. The competency of nurses transferring from other trusts was re-checked to ensure the required standard was met.
- The trust had a band 7 continuing education trainer for nurses who provided basic life support; anaphylaxis; leg ulcers and catheter care.Other services were invited to training courses when there was capacity.
- Staff completing e-learning in the office wore high-visibility vests so that other staff knew that they were not to be disturbed.

Assessing and responding to patient risk

- Risk assessments were completed at the time of booking an appointment.
- We saw that appropriate risk assessments and health check were completed at the first appointment and updated when required.
- We saw completed screening tools in the files reviewed. Examples of risk assessments seen were the malnutrition universal screening tool (MUST) used to assess the risk of malnutrition and skin integrity; the universal pain assessment scoring tool was used by physiotherapists; risk of pressure areas assessment (Water low) and a falls-risk tick chart and algorithm was used.

Requires improvement

Are services safe?

- We saw that weight management patients were assessed for discomfort at specific points during any manipulation.
- Emergency equipment was available such as defibrillators in the buildings.
- All staff were trained in use of the defibrillator.
- In the event of a patient suffering anaphylactic shock following an injection, the protocol was to ring 999 immediately.
- We observed three community nursing staff handovers where patient's needs and changes in risk either due to their health or social circumstances were discussed.Information was taken from the patients records and verbal feedback during the meeting, nurses recorded the information in hand over sheet notes. Notes were shredded on return to the office.

Staffing levels and caseload

- The trusts staffing cover report for January 2016 indicated a number of areas were understaffed and turnover was high. The average turnover for the organisation was approximately 18%. This was worse than the national average of 9% detailed in the NHS Workforce Statistics – April 2016 report.
- Data provided by the trust showed that community nursing teams experienced a high turnover of staff. Evidence provided to CQC showed an annual turnover rate of 13.8% for the period April 2015 to March 2016.
- Audits and reports indicated that the trust recognised the high turnover band 5 and 6 nursing staff as a problem but had not fully investigated the reason for this.
- The trust recruited to all band 7 vacancies. The trust had over-recruited nursing staff in Bury to allow for attrition and new ways of working.
- The trust had recruited four band 5 administrator roles (non-clinical) to work within paired clusters to support team leaders (band 7 nurses). Band 5 administrators meant released band 7's to manage the nurses.
- The Trafford services were using an acuity / time management tool called the Warrington Workload Tool. This gave each task a number of points depending on the complexity and the aim was to allocate each nurse up to 24 points.
- Firsway community nursing team comprised mostly of nurses were moved in from other teams. Nurses told us visits were deferred or transferred to the evening service in order to allow urgent patients to be prioritised and patient wishes to be addressed. We observed this process in action during the handover meeting for Firsway community nurses.
- Bury community nursing teams and staff however were stable and we observed that they knew the patients on their caseloads and were confident meeting their needs. In Bury there were five band 5 nursing posts vacant in the community nursing service but this was a reduction from over 30. The Band 5's in Bury completed all human resource tasks and audited the hours of work and visits out by nurses.
- The management teams from each area indicated that there was a shortage of qualified nurses who wanted to work on the community and the service was in the process of recruiting unqualified health assistants who would be trained to provide care and treatment.
- The trust negotiated pay rates and looked at the workforce across the trust rather than in areas.
- Staffing was seen as a medium risk by the trust and scored 9 out of a possible 12 on the risk register, which meant the issue was monitored at the most senior level.
- Junior management nurses (band 7) were aware of certain aspects of plan, for example to increase the proportion of health care assistants but had not been consulted on how they would support untrained staff to complete more complex tasks.
- The community neuro rehabilitation team included a specialist Parkinson's nurse. There role was to support other teams and provide advice to staff. The nurse also monitored and advised on medications for patients under the care of a consultant.
- Adult speech and language therapy (SALT) staffing establishment was one service manager, 1.4 whole time equivalent band 7 therapist and 3.6 WTE band 6 therapists. There was also one clinical lead employed.

Requires improvement

Are services safe?

However at the time of the inspection there were two band 6 members of staff on long term leave of absence. The service manager role was also vacant and at the time the trust was recruiting into this role. Agency staff had not been employed to cover these posts which meant the clinical capacity has virtually halved.

- The wheelchair service was on the Corporate Risk register at the time of inspection because of a shortage of staff.At the time of the inspection there were only four of the established team of seven working in the service. The team were missing a service manager and senior therapist, these staff had been responsible for assessing specialist seating and the needs of complex patients. The service was also down a Band 6 wheelchair therapist; however, a new member of staff was due to start with team in July 2016.
- At the time of the inspection there was one technical instructor and one senior rehabilitation engineer completing the assessments for the service. We were told this member of staff had been carrying out overtime and some evening and
- A triage system was in place however due to the trusts contractual responsibilities staff were instructed to provide a service in a 3:1 ratio depending on the area in which patients lived. This meant that the service was not provided strictly on needs. This meant for example that in one area 14 patients were not seen within the three-week time scale prescribed for their needs and in the other area no patients in the same category were waiting longer this time.
- The staffing for the musculoskeletal service was being remodelled and physiotherapists told us the skill mix had improved.

Managing anticipated risks

- We found that the trust anticipated risks such as bad weather for example the trusts business continuity plan contained a snow plan and staff were able to work from their nearest clinic for supplies and allocation of work in order to maintain a service.
- Staff were aware that the plan stated that the priority was to make sure people who needed insulin and those who could not get out of bed unassisted.
- Patients receiving wheelchairs had to have a wheel chair driving test and sight test to ensure safe use of the equipment. Speed was limited to 4mph on powered chairs.
- The trust had a standard operating policy with the estate management company responsible for the building from which the wheelchair service operated. The service business continuity plan stated that if the building became inaccessible wheelchairs and mobility equipment would be moved to a base in Preston.
- Staff were aware that corporate risk assessments such as lone working were kept on the shared drive.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Pain assessments were used to ensure patients received adequate pain control and inform the scope of interventions offered.
- All services reviewed used best practice standards such as National Institute for clinical and social care excellence (NICE) were used to develop plans of care and treatment.
- There was an established clinical audit program for checking adherence to best practice guidance.
- Patients with nutritional needs were treated as a priority when planning to provide services.
- The trust participated in national and local audits.
- Bury podiatry service met the standards for the monthly foot care audit most of the time.
- Staff received training and supervision to maintain their professional competencies and learn additional clinical skills.
- Overall appraisal rates for the trust were better than the trust target of 80%
- There were no barriers to multi-agency working within the trust or with partner agencies.
- The consent to care and treatment protocols were clear and staff recorded when written and verbal consent was given.
- The trust had a system in place to share information on patients transferring in and out of Bury from Trafford. Patient files were transferred between the services using secure methods, this was due to the commissioners using different electronic patient record systems which did not interface.

However:-

- Insufficient staff had received Mental Capacity Act [MCA] and Deprivation of Liberty Safeguards {DoLS] training.

Evidence based care and treatment

- The Parkinson's disease nurse specialist worked to best practice standards National Institute for Clinical and social Excellence (NICE) guidelines and guidelines from Parkinson's UK. The service also had established links with local research networks and the North West Network for Parkinson's disease nurses.
- The adult speech and language service followed NICE guidance, guidelines from their respective professional body and participated in and attend clinical effectiveness forums.
- The trust had a NICE guidance implementation group who monitored changes and communicated the relevant NICE guidance to different teams and services. This group also assessed the clinical effectiveness of the guidance and how well the guidance was integrated into or changed current practice.
- There were a series or program of clinical audits which identified areas of good practice and improvement. For example the Clinical Audit Programme 2016/17 Final (27 May 2016) report concluded that care pathways throughout the service was based on NICE pressure ulcers quality standard 89and the list of quality statements (SSKIN) pressure ulcer care bundle.
- The peripheral arterial disease (PAD) integrated care pathway was based on consensus interpretation of best practice guidance on managing the causes and symptoms of PAD, and was endorsed by a group of regional medical, surgical and nurse specialists.
- We spoke with specialist teams across the trust including podiatry, weight management, speech and language and the wheelchair service. Each specialism could identify and give examples of the best practice guidance they followed. For example weight loss service staff described the concept of cognitive behavioural therapy to help people change their relationship with food.
- The tissue viability nurse was a member of the North West network of tissue viability nurse specialists. Notes from the March 2016 meeting indicated that issues investigated and discussed included how to provide evidence based care and treatment.

Good

Are services effective?

Pain relief

- Self-help groups were organised to support patients with particular types of pain. For example the podiatry service ran a 'heel pain' group.
- Patient records included pain assessments and evidence that steps had been taken to keep people as pain free as possible.
- We saw that a best practice pain assessment tool was used to ensure the most appropriate solution was offered.
- Pre injection pain relief was available and offered to patients.
- We observed procedures and saw that dynamic pain assessments were completed during a procedure. This meant staff observed and talked with patients to make sure additional pain relief was provided as required.

Nutrition and hydration

- Specialist nutrition and hydration risk were completed as required, for example the malnutrition universal screening tool (MUST).
- The speech and language referral triage process assessed people who needed a swallowing assessment as high risk therefore these were seen as quickly as possible.

Technology and telemedicine

- We witnessed a specialist nurse having a telephone consultation with a patient to discuss and provide support for an already diagnosed condition.
- The Oldham stroke team used telehealth video conferencing which used two-way interactive audio-video technology to connect patients and their family to live, face-to-face interaction with members of the team.

Patient outcomes

- Each service measured patient outcomes as a part of national or local audits.
- However the results were not always disaggregated into areas, for example Trafford, Bury and Rochdale and so it was not always possible to determine the outcomes on a local level.
- There was an end of year report for clinical audits undertaken.
- Audits participated in included the National Audit of Memory Clinics, National Audit of Intermediate Care and Chronic Obstructive Pulmonary Disease;
- All of the community podiatry services for Pennine Care community trust services participated in the National Diabetes Foot Care Audit.
- We saw that Bury services completed a monthly Foot Care audit. The data indicated ongoing improvements. The service did not achieve the 70% target for the six months between April 2015 to September 2015. However, with the exception of January, the service achieved or surpassed the 70% target between October 2015 and March 2016.
- The Sentinel Stroke National Audit Programme (SSNAP) was also completed. Oldham's data was presented as a combined outcome with outcomes for neurological and Parkinson's disease patients. In relation direct outcomes for patients the trusts target was to achieve zero for avoidable readmissions. Between April 2015 and May 2016 this was achieved in all but a single month.
- 80% of patients either strongly agreed or agreed that the exercise sessions provided by the pulmonary service at the Total Fitness and Castle leisure centre were beneficial. This met the service target of between 61 and 87%.
- The Parkinson's service participated in the 2015 UK Parkinson's Audit Individual service elderly care and neurology audit. This looked at whether patients received timely intervention from the correct rehabilitation specialists such as physiotherapists and speech and language therapists. The service performance results were in keeping with England averages in most outcome areas. One area where performance was worse than the England average was monitoring the effect of medication.

Competent staff

- All staff said that they received support from their managers and colleagues to maintain and improve clinical, nursing and therapeutic skills. A small minority of staff felt this was under threat because of staff shortages.

Good

Are services effective?

- Many of the staff described attending courses related to their specialisms.
- Reports indicated that staff had access to formal and in-service training. Training included sessions provided by GPs and guest lecturers.
- Physiotherapists had access to clinical supervision and support from the chest physicians at Fairfield General Hospital. This team met each morning for clinical discussions and peer support. We reviewed the annual professional development reviews for the physiotherapists and these were all in date. These specialists also told us they received 6 weekly face to face supervision sessions.
- Adult speech and language therapists have peer review sessions, face to face supervision and regular team meetings. SALT managers and staff told us there was a competency framework in place and provided peer to peer feedback following a course attendance.
- The wheelchair team were the opportunity to complete the rehab engineering qualification; one member of the team had been supported to complete an NVQ level 3 and post-graduate opportunities were also provided. This team could also access continual professional development modules through a local university intranet portal.
- Staff were encouraged to undertake leadership academy courses and a number of service leads were undertaking these courses, for example the head of adult therapies had just completed a master's degree in healthcare leadership. Leaders who attended the courses continued to meet to discuss issues once the course had finished.
- At the time of the inspection the appraisal rate published March 2016 for the wheelchair service was at 55%. We were told that one additional appraisal had taken place since then. This figure did not include staff on sick and maternity leave. However the absence of managerial staff had stalled the process. Plans were in place for this to be picked up by a more senior manager.
- Overall 81% of community services staff had received appraisal between 1 January 2015 and 31 January 2016. This was better than the 80% trust target.
- A range of competencies for assistant healthcare practitioners (AHP) had been developed for each grade. 50% of staff had started completing the competency documents.
- There was clinical supervision for staff and a re-validation process for nurses.
- There was a nursing and AHP strategy and 10 separate professional forums for staff with some teams connected to regional and national forums.
- Audiology staff had completed an introduction to dementia course which helped staff to identify short-term memory loss in patients and so enable them refer patients to a memory clinic.
- All staff were offered the Prevent training course which covers recognising people at risk of radicalisation.
- Training was multi-professional and if there were enough demand, staff who required certain training modules across the trust, courses could be put on for those staff requiring it.
- Data, based on the 12 months to May 2016, showed that the average rate of supervision across all (163) teams was 90%. The trust did not have an overall target rate for clinical supervision.

Multi-disciplinary working and coordinated care pathways

- Community nurses had easy access to specialist teams which facilitated multidisciplinary working.
- We observed handovers and it was clear that information was exchanged between allied health professionals, GP's, care managers, care homes and others involved in meeting the needs of individual patients.
- We visited a residential home with a community nurse. The manager in charge of the residential home told us the community nurses were a part of the care team were approachable and attended multidisciplinary meetings as appropriate. We saw that the district nurse was known to staff and familiar with the surroundings.
- Specialist nurse teams such as the palliative care and tissue viability nurse were available for advice and conducted joint visits if required.

Good

Are services effective?

- The wheelchair team worked with a number of different teams in the areas who made referrals, such as:GPs; the amputee rehab service; the Oldham vascular service and the head injury service at the Floyd Unit (Birchill Hospital).
- We observed a training course given by the Oldham speech and language therapy team (SALT) for local care home staff.The training was around conditions associated with swallowing problems.
- There were three trainers from the SALT team and 20 attendees on the course with representatives from 10 different care homes. One healthcare assistant said that they would be recommending improvements in feeding for at least one of the care home residents.
- Records reviewed indicated community nurses made referrals to specialist nurse and therapy services.

Referral, transfer, discharge and transition

- Referrals to community services were to the specific disciplines and could be made in different ways, for example phone call; email or fax.
- Some services accepted self-referrals such as the podiatry service and others had to be from the GP such as the Trafford weight loss service.
- All services had a triage system so that people with a high risk of deterioration were seen as quickly as possible and targets by which they should be seen were set.
- Systems were in place to ensure patients were discharged from the service once their needs had been met.
- The trust was a part of the Oldham Urgent Care Alliance and accessed better care funding (BCF). Audits from this organisation showed that between January 2015 and January 2016 the scheme had prevented 269 admissions by keeping people at home.
- The wheelchair service followed a standard procedure for discharging patients but they were also able to contact the service at any time they had any issues with their equipment.

Access to information

- At the time of the inspection the trust were in the process of introducing a number of different electronic patient records systems which included two different patient record keeping systems, one in Trafford and the other for all other boroughs. The Trafford system was able to interface with the GP's in Trafford the system for the other boroughs did not interface with the GP's systems.
- Trust staff had access to trust data through publications and the intranet.
- Community nurses were able to access information about patients test results through telephone contact and fax.
- At the time of the inspection community teams used both paper and electronic records. Paper records were held in the patient's home and then written up when staff returned to the office. Information at the Bury offices was detailed; information at the Trafford services was less detailed because most of the information was kept with the patient.
- There were sufficient computers available for staff to access trust information on the intranet when needed.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- There were issues throughout the adult community services in arranging Mental Capacity Act (MCA) training. Plans for dealing with this were different according to areas and specialisms and ranged from developing train the trainers to enabling the safeguarding lead to deliver sessions.
- Only 36% of staff in the community adult services had completed Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs) training.
- Managers acknowledged that the Mental Capacity Act and Deprivation of Liberty Safeguards were complex topics but the service did not have a means to assure information and training provided would give staff with the opportunity to explore the various application and anomalies of the applying the act and safeguards with experts in the field.
- We were told that when required carers or advocates helped to facilitate consent from vulnerable patients, however the relevance of the using the MCA or DoLs protocols were not always evident.

Good

Are services effective?

- The wheelchair service electronic assessment process had a field to indicate consent and identified whether consent had been verbal, implied or written. The system also identified whether consent was for a specific intervention or referred to all contact with the service.
- This service had a Mental Capacity Act Champion and the service had occasionally conducted telephone conferences to discuss the best interests of the patient.
- Some staff for example the SALT and community nurses were able to explain the principles of the MCA, mental capacity assessments and DoLs.
- At the time of the inspection the musculoskeletal service had one member of staff trained on the Mental Capacity Act and DoLS train the trainer course.They were responsible for rolling out the training to other staff and the plan was for this to commence around September 2016.
- We reviewed 28 care records across different teams and locations. We saw patients had signed consent to care and treatment on the initial assessments in 22 cases. Where consent had not been signed staff had stated why this had not been done.
- We saw that when patient's records were electronic only, such as in the staff recorded that consent had been given in the electronic records.
- The trust provided a wound care photography procedure which included gaining written consent to the taking and storing of images of pressure ulcers and other wounds so that the effectiveness of treatment could be assessed over time.
- We saw that ability to give consent was reviewed during the initial assessment. Written and implied consent was documented in the patient's records.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Patient satisfaction with the adult services was high and the service scored consistently well in Friends and Family tests.
- We observed caring and empathetic interactions between staff and patients.
- Staff listened to patients and ensured information was understood. Staff participated in national audits which checked staff attitude and ability to provide emotional support and scored in line with the England averages for these audits.

However

- A number of consulting areas were not private and so privacy could not always be assured.

Compassionate care

- Managers and staff were aware of the need to protect patient privacy and dignity the primary care centres in the districts.Although modern buildings there were some 3-bedded treatment rooms with beds only divided by curtains. If patients required to have a private conversation there were rooms available.
- The musculoskeletal physiotherapy waiting area had chairs close to the reception desk and at times there was a lack of privacy.
- The gym at Bevan House also had 5 or 6 bedded bays which were screened off by curtains and so if more than one patient was present privacy could be compromised.
- Most clinics visited however had individual treatment rooms which meant privacy was protected.
- We talked with five patients accessing different services and all told us that staff were helpful and kind. We were told clinicians had explained all procedures in full.
- We observed the interaction between seven members of staff from different services including podiatry, community nurses and the weight management service and saw that patients were treated with empathy and compassion.
- The service encouraged staff to monitor their level of caring for example nurses and nurse specialists had completed the consultation and relational empathy (CARE) measure which is a person-centred consultation process measure which was developed and researched at the departments of general practice in Edinburgh and Glasgow Universities. Behaviours and skills measured included ability to put people at ease, listening skills, understanding concerns, empathy and involving people in planning their care. Feedback from patients indicated that the performance of the nurses, for example the Parkinson's disease nurse specialist was above the UK average in all areas.
- Patient satisfaction with services provided by the trust was high. The Parkinson's disease service Friend and Family test for the service April 2015– March 2016 had 11 responses and 91% of patients would recommend the service.
- Trafford's overall score for the Friends and family Test in Q3 2015 showed 98% of 339 respondents would recommend the service to others who needed similar care.

Understanding and involvement of patients and those close to them

- Minutes from the Oldham diabetic pathways meeting indicated that this team were planning to provide a six week patient and carer education course.
- We observed staff involving patients and those close to them in planning and delivering care, for example the podiatrists explained symptom and pain control to both the patient and their escort as appropriate following a procedure.
- The service philosophy of enabling self-care also meant that, with consent, relatives were more involved in supporting patients to learn elf help skills.
- Records indicated that treatment plans included discussions patients about they wanted and could expect.
- The trust referred patients to the expert patient programme where the patient went on a 7 week

programme run by persons who have lived or are living with long-term conditions.We were told that the programme was very successful in enabling patients to better manage their own care and condition and that sometimes patients became trainers on the programme.

- All staff had completed motivational interview training.

Emotional support

- Staff completed Sage and Thyme training that covers enhanced communication skills. The course was designed to train all grades of staff how to listen and respond to patients or carers who are distressed or concerned.
- The trust had a Sage and Thyme trainer working within the trust so did not need to source this training externally.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The chronic obstructive pulmonary disease and the musculoskeletal, orthopaedic assessment and physiotherapy service met national referral to treatment targets.
- The service worked well with other providers such as local district general hospitals, ambulance trusts and independent health providers to ensure patients' needs were met.
- Planning in relation to meeting equality and diversity needs was ongoing.
- Staff knew how to access translation services.
- Staff received training in working with people with dementia.
- Services provided group sessions and Saturday morning sessions to reduce the waiting list.
- The trust at times planned services directly in response to information gathered about the patient experience and complaints.
- Patients received a service for as long as it was needed.
- Patients were provided with sufficient information and support to attend appointments.
- The district nurse services provided a 24 hour seven day a week service.

However

- Speech and language and stroke and neurological service's, failed to provide initial assessment and treatment within the appropriate referral to treatment time. The trust informed us these are currently being reviewed with commissioners.
- With the exception of those seen in the Trafford services, none of the assessments or plans of care identified ethnicity, religious preferences or identified first language.
- Due to different commissioning arrangements Bury patients who required a wheelchair had to wait significantly longer to receive a service compared to Rochdale patients who received a service from the same team.

Planning and delivering services which meet people's needs

- The trust operated in a complex commissioning environment with a number of local authorities and six clinical commissioning groups influencing service provision. The operating plans indicated a clear understanding for developing services in Bury, Rochdale, Heywood, Trafford and Oldham local authorities and borough councils.
- The trusts annual report identified priorities such as improving safety and reducing admissions to hospital. Service planning to achieve these outcomes included working collaboratively with partner agencies such as the local hospital and ambulance trusts, residential homes and GP's.
- The chronic obstructive pulmonary disease service provided education to patients about the service and empowered their position in the home setting. This was achieved by helping them to use the correct devices to self-treat their symptoms.
- The service offered holistic care and considered social circumstances as a priority.
- Referrals to the chronic obstructive pulmonary disease team were from a wide range of health care professionals and services. These were made through a central booking centre. Referrals were scanned onto the electronic record system. The referrals were triaged by clinicians via a 'duty desk' function. Access times were 5-14 days, the service was not an emergency service but urgent patients were seen within the day.
- Referrals were triaged on clinical reasoning and judgement; however, there were no clear triage criteria.
- Referral to the wheelchair service had a clear triage criteria and access was provided to patients whose only means of mobility indoors would be the wheelchair; lack of a wheelchair would mean exclusion from main stream services such as education or work on a daily basis; or/and the patient was on the Gold Standard Framework for end of life care.

Good

Are services responsive to people's needs?

- However the service was not commissioned to carry out annual servicing of chairs and they relied on patients to report faults. This meant patients were at risk of having faulty chairs for a long period of time without realising.
- Some services were set up across several divisional business units. For example, audiology, podiatry and dietetics services were managed across Bury, Oldham and the Heywood, Middleton & Rochdale divisional business units and were known as "3 into 1" services.There was one manager for each of the services across the 3 areas.
- Adult nursing (community nurse) teams were changing their patterns of working to improve access to services.
- Adult Nursing in the Oldham divisional business unit had approximately 17,000 contacts per calendar month, over 200,000 per annum. However, the service was only commissioned for 14,000 contacts per month. The trust was negotiating with the CCG over the shortfall in contracted contacts.
- In some areas of the trust we saw robust measures used to ensure services were developed to meet the needs of local people. For example, the falls service performance and quality assurance committee completed a three month audit in 2015 and found that 18 patients had fallen while on the waiting list. This review indicated that there was no best practice guidance relating to waiting times and the target of 18 weeks did not safe. The findings and concerns were raised through the contract management board, and put on the trust's risk register.Capacity and demand analysis had been undertaken to understand what needed to be put in place to bring waiting lists down.In light of this activity funding had been approved to provide quicker intervention to patients referred due to a risk of falls.
- In addition funding had been procured to provide initial support to patients whilst they were on the waiting list.
- The incidence of patients who did not attend (DNA) appointments was within targets most of the time for most services.
- The incident of unsafe discharges from services was within target for all services the vast majority of the time.

Equality and diversity

- The speech and language therapist did not have ready access to information such as leaflets or booklets in different languages despite serving sizable black and minority ethnic (BME) communities.
- The Parkinson disease nurse accessed the interpreting services where required and information in different languages was provided by Parkinson's UK.
- The musculoskeletal service at Bevan House held female only clinics facilitated by a female physiotherapist. Patients were also provided with advice on what to wear so that dignity and modesty was maintained. Staff undertook equality and diversity training as part of their mandatory training. All leaflets were available in braille or large print if requested.
- Staff in all services told us they had ready access to interpreting services and were clear about adhering to trust policy in respect of not allowing family members to act as interpreters.
- We found conflicting evidence about providing services to Black and Minority Ethnic (BME) communities. Managers told us that action taken to reach the communities included working with the trusts human resources in relation to recruitment processes and working with local Imams and community groups to raise awareness of trust services.
- Managers also told us; however, they felt that health and social care roles were not appealing to BME groups. It was also commented that BME communities had internal networks for caring for sick people.
- The trust would not have been able to check whether their initiatives were successful because, with the exception of Trafford services, none of the assessments or plans of care identified ethnicity or religious preferences. Neither did assessments include information about preferred or first language.
- There were hearing loops in some clinics and large print leaflets and some leaflets had been translated into different languages in some services.

Good

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- The trust had developed resources for people with dementia including memory clinics and provided staff with introduction to dementia training.
- The service was an integrated mental health community service and all staff had ready access to specialist nurses trained in supporting for people with learning to access services.
- The Oldham community occupational therapy team was jointly funded with the Local Authority.The patient only needed to go to a single team for occupational therapy to access assistance and aids required or have their eligibility for a Blue Badge assessed.

Access to the right care at the right time

- Referrals to the adult nursing and therapists could be made by the GP; hospital nurses; social services; and other health professionals. Patients or their carers could also self-refer to the majority of services.
- In the adult nursing team staff were employed and trained to triage and allocate cases according the level of risk by some services. Therapists could also receive the referrals direct and allocation decided by the therapists as a team or individually.
- The trust monitored waiting times April 2015 to March or May 2016 and many services failed to meet national or local targets.
- From January 2015 through to May 2016 (14 months) the majority of stroke patients referred to the Oldham service did not receive their first visit appointment within the two weeks. The target was 95% and this was achieved on four occasions, there were no referrals for two months, for the remaining 12 months between 0% and 33% of patients received a timely service.
- Between this period, on average only 72% of stroke patients were contacted within 24 hours of discharge with the figures ranging between 42% and 84% compliance. The target for compliance was 95%
- The physiotherapy service did not reach the 95% target for seeing urgent referrals within two weeks from April 2015 through to March 2016. The proportion of urgent cases seen within time ranged from 47% to 83%.
- The speech and language service met the target 95% for urgent referral consultations within two weeks of referral for six months out the 10 months in which referrals were made.
- Podiatry service met the 95% urgent referral target of two weeks to consultation four out of the 11 months when referrals were received. The proportion of urgent cases seen within time ranged from 65% and 100%.
- In response to finding a significant staff deficit we paid particular attention to the waiting times in the wheelchair service based in Rochdale. Referral to assessment was averaging 132.7 days against the national standard of 18 days.
- Some time was regained on the assessment to delivery timescale which was lower than the national standard but the overall average time from referral to delivery was 112 days, against a National standard of 90 days.
- Patients were categorised as immediate; urgent (P1) and non-urgent (P2).
- On the day of inspection no 'immediate care' patients were waiting for a service. In total 14 patients in the urgent (P1) category had been waiting for longer than 18 days and target for an initial appointment and 43 non-urgent patients had been waiting for over 18 weeks.
- Further scrutiny revealed that all urgent (P1) Rochdale patients were seen within the target time and the waiting list was mostly patients who lived in Bury.
- We were told that this was because of commissioning arrangements and the service was provided in a ratio of three Rochdale patients to one Bury patient. This was against the NHS principles which states 'Access to NHS services is based on clinical need, not an individual's ability to pay.'
- The wheelchair service operated Monday to Friday and home visits could be carried out from 8am to 4pm.
- Breaches in waiting times were checked by the service leads and reviewed at trust board level.
- Adult nursing was a 24/7 service.
- Services which operated weekend and evening clinics included the community occupational therapy (COT)

team which offered a clinic on Thursday evenings and occasionally a Saturday clinic was used to clear backlogs. However regular Saturdays to prevent a backlog from occurring were not planned.

- The musculoskeletal, orthopaedic assessment and physiotherapy service met national referral to treatment targets. The trust urgent referrals target was 3 days.The national target was 1 week. Although they breeched the local target of 3 days all patients were seen well within the national target of one week. The referral process for this service was outstanding and had jointly won, with Oldham MSK Physiotherapy service, a regional innovation award of funding for self-referral for patients.Self-referral ability had been written into the tender documents.There were patient leaflets called "Physio Direct" in GP practices that informed patients how to refer themselves for treatment.There was also an online referral route for patients which they could use to book an appointment. GP's accessed a 'choose and book' service. GPs had referral access to send patients for an MRI scan at the centre but were encouraged to refer for an orthopedic assessment in the first instance.
- There was a new Orthopaedic pathway group formed by Pennine Community Care trust, Pennine Acute NHS trust and the BMI Highfield hospital in Rochdale.

Learning from complaints and concerns

- Staff provided patients with information about complaints concerns and compliments and this information was readily available on the trust website.
- The trust monthly Community Services quality governance dashboards produced for each service included an analysis of complaints, compliments and concerns.
- Pennine Care quarterly complaints reports were also produced and discussed at board level and highlight trends and proposed action plans developed.
- Feedback from Trafford services indicated that for May 2016, there were 10 complaints; seven patient liaison enquires and 85 compliments. Data indicated 100% compliance with meeting complaint response targets.
- Details of lessons learned from upheld complaints were available in a stand-alone report.
- The trust complaints department supported complaint investigations.Complaints were investigated in line with the trust complaints policy.
- The trust were encouraging more interaction with patients when dealing with complaints so patients would be telephoned and/or met to discuss their issues and to try to resolve the complaint at the earliest opportunity.
- A pre-complaint template was completed in advance of any formal complaint being received if a patient had complained verbally to assist in resolving the matter before it was formalised by the patient.
- The complaints team made the decision on what needed to be investigated, evidence was collected by the appointed manager and the complaints team reviewed the evidence and drafted a response.
- Letters of complaint were shared with any staff members involved as this helped to resolve the matter.
- We were given examples of where the service had learned and made changes from complaints; for example, the female only clinics arose from a complaint.

Requires improvement

Are services well-led?

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

Summary

- Trafford staff told us they were disengaged from the rest of the trust. There were no specific plans in place to enable better integration and actions so far had served to alienate staff.
- Despite a high turnover of staff and staff sickness the service have not completed exit interviews to encourage frank feedback about the service from those who are leaving.
- The trust risk register did not reflect the risks identified at the time of the inspection, for example failure of a significant number of key services to achieve the required referral to treatment time for urgent cases.
- Although monitoring took place action to improve services were ineffective because targets were missed for a full year with little evidence of sustained improvements.
- The organisational model was unwieldy and it was not always clear who had full responsibility for managing the ongoing development and quality of a service.
- The trust did not always make sure all staff were protected from undue stress in relation to providing an adequate service. We saw this in the Trafford district nurse service, the wheelchair service and the speech and language service.
- The local leadership was known to staff and staff had opportunities to voice their opinions.
- Staff were aware and signed up to the trust vision.
- There were clear pathways for staff to escalate concerns to senior managers.
- There were significant examples of innovative projects in community services.
- Staff had good peer to peer relationships and staff were positive about the support and behaviours of their immediate line managers. Staff said they not afraid to speak up about changes that needed to be made.

Service vision and strategy

- The service vision was made up of 10 principles of care and staff we met were able to discuss these and how they applied to patients as well as trust staff.
- The vision included for example promoting independence and empowering patients to self-care. Staff in all areas articulated this and we observed the action taken to raise awareness in partner agencies and educate patients and relatives in order to promote the ethos.
- Joined up working between areas was led at a local level and supported at a corporate strategic level. For example Oldham falls service supported Heywood, Middleton and Rochdale service in developing a falls strategy. The meeting records also noted that this would emphasise the importance of divisions working together within a joined up falls strategy.

Governance, risk management and quality measurement

- The trust valued information about the quality of the service provided by patients. All feedback including compliments was reviewed. We found that almost half of the compliments received were from patients and relatives accessing the adult community health services.
- Managers described a clear route for escalating concerns and success up to board level. All community services held localised quality and governance assurance groups which fed into the divisional business unit quality and performance group. However interventions and changes were not effective because services which were providing a poor service did not demonstrate sustained improvements.

Leadership of this service

- There were regular meeting to discuss all aspects of the service in relation to meeting the trusts strategic plans and day to day running of the services.
- Meetings included a monthly senior management meeting with the director of operations to report what is happening in each of the divisions; monthly executive and director meeting where best practice was shared.
- Directors attended a strategy meeting twice monthly with the chief executive.

Requires improvement

Are services well-led?

- There were also Health Integrated Governance and Senior Leadership Team Meetings.
- The trust had plans to align all staff to a cluster pair with social care and mental health staff integrating with adult nursing under a Multispecialty Community provider (MCP) model.
- We were told that the trust went through due diligence or comprehensive appraisal of business undertaken with any 3rd party providers. There were quarterly sub-contract monitoring meetings with any sub-contractors.
- Consistent local leadership in all services except Trafford district nursing was visible. Staff in Trafford have access to the wider Trafford leadership team.
- We saw evidence of consistent clear and visible leadership through meeting notes for Tissue viability services, Parkinson's service and podiatry services, and district nurses in Bury. Goals were set in relation to improving and developing each service. Each service could demonstrate a visible leadership who had set goals for improvement in certain areas.
- Operational managers met with heads of departments of the divisional business unit (DBU) once a month.
- A quality governance assurance group (QGAG) monitored training, governance, complaints, safeguarding etc.Information was fed down to the Clinical Business Units (CBUs) and Service Leads then took the information back to their teams.

Culture within this service

- There was a no email policy while staff was on leave.Emails were not sent to the staff member whilst away.Instead, a meeting was set up with a manager upon return to deliver any important messages or updates.
- The Managed Care Service leadership met every Monday morning to discuss and catch up on priorities.
- There was a steering group, to enable integration between health and social care and primary medical services, made up of leads for each service, called "Getting It Done".The group was made up of representatives from social care; mental health; learning disabilities and GPs.
- The head of adult therapies told us that they felt supported in their role by the service director.

Public engagement

- The trust facilitated a patient experience steering group which met monthly and the associate director for quality governance and a non-executive director attended these meetings.
- The trust communicated with the public through providing newsletters at clinics, direct emails and a GP survey which resulted in a 'you said we did' briefing.

Staff engagement

- The trust had introduced Schwartz Rounds (an open floor/forum to discuss issues, held by executives of the trust).There had only been one round at the time of inspection.
- Divisional directors held "Tell Me" roadshows for staff to go and raise any concerns, issues or to highlight good work.
- There were clinical presence visits where executive and non-executive directors scheduled visits to clinical services to meet staff and see how they operated.
- In 2016 trust staff had been involved in two integration workshops.
- The workshops also included the voluntary sector as there would be closer working with them in the future.
- The Head of Service told us that they work from the bottom up in order to engage staff.
- In adult nursing, there was a strategic group across the divisional business units.
- Every 3rd meeting was just for nursing practitioners and was used to meet and share good practice between peers and each DBU.
- Board meeting minutes indicated discussion had taken place about incidents and issues recorded in staff and middle management meetings such as loss of equipment, complaints and specific episodes of staff shortages. This indicated effective 'floor to board' communication and flow of information.

Requires improvement

Are services well-led?

- Staff in adult nursing were being consulted in changes to shift patterns and the trust was open to their suggestions.The aim was to accommodate working shift pattern requests as far as possible to improve the work life balance of staff.
- The division had three key quality themes chosen by frontline staff.The choices were created at an away day attended by senior frontline staff and the choice of themes was taken to the Staff Engagement Forum.
- Staff were asked what they are proud of and want to showcase.The trust had a "Star of the month" award for teams and individuals.
- The division had a quarterly away day with staff with a focus on strategy and work had been done with staff on quality improvement and developing an open and transparent culture with patients at the centre of everything. The trust had engaged with community staff in all areas except Trafford.
- As a result of information provided from local staff surveys completed in 2015 a staff experience action plan was reviewed in November 2015 which reviewed the progress of ideas put forward by staff. However this staff engagement had not included the workforces based in Trafford services. Trafford staff said they felt removed from the main body of the trust.
- The Trafford community services divisional business unit quality and performance assurance report for quarter 3 (January to March 2016) showed that sickness rates were in excess of 6% which was above (worse than) the national average 4.7%. The trust identified that the main reason for sickness was home related stress and anxiety.
- The trust reviewed sickness due to work related stress and anxiety on an individual level and action taken and support was provided to enable people back into work whenever possible.
- Turnover was running at 16% by the end of Quarter 3.This is above the divisional 10% target.The top reasons for leaving were voluntary resignation, retirement and flexi retirement.
- Approximately 44% of leavers gave their reason for leaving as voluntary resignation or other/not known.

Staffing was on the trusts corporate risk register and the action plan included completing exit interviews with staff that were leaving, however this had not been made a priority and introduced or piloted in Trafford services

Innovation, improvement and sustainability

- Bevan House musculoskeletal, orthopaedic and physiotherapy service used the patient momentum app.Patients could download the application and the physio could then send patient-specific exercise to their app.The app prompted the patient to do the exercises. Physiotherapists were also able to email chosen exercises to the patient.The app was part of the physiotherapy tools system.We were shown the system and this allowed the physiotherapist to click and select exercises that were appropriate for each patient and them print them or send them in the chosen electronic format.
- The wheelchair service was supplying e-motion wheels on some manual wheelchairs.The wheels were power-assisted to enable patients to go uphill more easily.
- Rochdale tissue viability service piloted the Florence Technology SystemFLO) text support system. The system provided self-management support to people in need of wound care management. The FLO system sends a series of text messages to service users providing information and prompts on how to safely take care of their wound.
- The SPRINT Team were helping to keep people out of hospital.Patients could be assessed in their own homes instead of hospital and the relevant care provided there, if possible. The team was working with the local acute trust on improving discharge times from hospital.
- In relation to sustainability the service worked with other organisations to procure services which could not be provided in-house and sought funding and investment to provide specialist services such as community based lymphedema services and in-reach services to reduce hospital admissions.
- The service developed strategic relationships with partner agencies such as housing associations in order to developed different models of service delivery to meet local health needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment must be provided in a safe way for service users. People who use services and others were not protected against the risks of infections, including those that are health care associated. Regulation 12 (1) (2)(h) How the regulation was not being met: People who use the service were not protected against the risks associated with medications, by the proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to ensure the registered person is enabled to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Regulation 17(1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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