Good

Wirral Community NHS Trust

Quality Report

Wirral Community NHS Trust
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Date of inspection visit: September 2014
Date of publication: 18/11/2014

Core services inspected	CQC registered location	CQC location ID
Community health services for children, young people and families	St Catherine's Health Centre Old Market House Victoria Central Hospital Walk In Centre	RY701 RY7Y3 RY7X2
Community health services for adults	St Catherine's Health Centre Old Market House	RY701 RY7Y3
End of life care	St Catherine's Health Centre Old Market House	RY701 RY7Y3
Urgent care	Eastham Walk In Centre Victoria Central Hospital Walk In Centre Arrowe Park Walk In Centre Riverside Park Call Centre	RY7X1 RY7X2 RY7X3 RY7Y4

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

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We found that the provider was performing at a level which led to a judgement of Good.

At trust level, there were good systems put in place to monitor incidents and there was continued investment in processes and staff to lead this proactively. We saw good examples of how the trust is using data to improve reporting and some teams had excellent examples of how audits, incident reporting had changed practice. Good reporting occurred in teams where staff had had input from the trust's quality team. However this was not consistent across the Trust. Not all the teams we visited were using systems to their full potential or were clear about how to use them. Whilst staff knew how to report incidents, we did come across groups of staff who did not report and managed incidents or risks locally or who could not clearly identify what an incident was.

All the places we visited were maintained to a good standard and we saw good evidence of infection control, although more could have been done in some areas to improve hand hygiene. We were concerned about the impact of high staff sickness on some services and staff did raise concerns about the potential impact this has on the quality of patient care. We saw there was a lack of understanding regarding deprivation of liberty and the Mental Capacity Act.

Care was evidenced based and personalised to the patient. We saw many good examples of multi-disciplinary working and positive working relationships.

Staff across all the core services we inspected were caring and compassionate. We observed this approach not just from nursing staff but from a range of clinicians administrators and volunteers. We saw that staff worked hard, were polite and welcoming and in the majority of cases epitomised the 6Cs.

We saw very many good examples of individualised care; in particular we saw excellent care in the end of life service. Staff across all the core services we inspected had examples of research and development and innovative practice. We observed many examples of a flexible, responsive service which met the needs of the local population they served.

Although patients were treated and discharged within four hours in the walk-in centres, we found that many patients waited far too long to be seen by the triage nurse for initial assessment.

All the staff we talked to during our inspection were able to tell us about the leadership team and their regular visits to the service. Staff knew the Chief Executive and Director of Nursing by name and were aware of the non-executive directors.

Some staff we met during the inspection could not name their head of service and in some cases said they had not met them. It was also felt that there was a lack of clinical engagement in designing and commissioning the services they delivered.

During this inspection, CQC also inspected the GP out of hours service provided by the trust at Arrowe Park Hospital. The inspection forund that services were safe but the trust should implement an annual review of incidents and ensure staff routinely receive feedback regarding individual incidents and complaints they had been involved in. The inspection also found that service were effective, caring and well-led but more could be done to publise the trusts complaints procedure.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Good

We judged this domain to be good but with some aspects requiring improvement. Most staff were able to demonstrate that they knew how to report incidents and felt their concerns were listened to but some staff reported that they received limited or no feedback on the outcomes and potential learning of the incidents they reported. In the last 12 months, the trust has started using the Datix system to report and collate information on a range of information management requirements around safety. In areas where this has been rolled out the trust is confident that incidents were being reported but there is less assurance in those areas where Datix is not readily available. This means there is a potential that there is some under reporting of incidents in some parts of the trust.

Staffing levels and skill mix were generally safe and the trust are using the Safe Staffing NICE guidelines for wards and applying them to the community setting to restructure services.

The clinic environments we visited were generally clean and well equipped. Although hand hygiene was well maintained amongst the majority of staff, there was limited or no prompting for patients to maintain good levels of hand hygiene. Medicines were managed safely. There were good arrangements in place to ensure the staff working alone out in the community were safe.

We found that safeguarding presented an area which although we found no detriment to patients during our inspection, the arrangements in place posed an elevated risk to the trust. The organisational structure and policies to support staff in relation to safeguarding were over complicated and not clear to staff working in the trust.

Are services effective?

Good

We assessed this domain to be good. Care was evidence based and personalised to the patient. We observed good verbal consent and documentation of consent. However, there was a lack of knowledge about the Mental Capacity Act in some areas of the trust. There were good levels of involvement from families, relatives and carers which ensured care was planned and implemented effectively.

The trust were meeting the majority of the contractual Key Performance Indicators (KPI's). Where they were not meeting the monthly KPI's reasons had been identified to the commissioners.

Summary of findings

Staff had access to training opportunities, as well as appraisals. The trust was maintaining high levels of engagement with staff for both of these areas. Appraisals had been linked to the Culture of Compassionate Care 6 C's initiative. They had also been designed to help identify and support future leaders.

There were many examples of good multidisciplinary working and positive working relationships were observed at handover, for example but this was not consistent across all services.

A number of services were able to show us innovative practice and ongoing research in a number of areas. The trust had made links with other providers to ensure that they could meet the future needs of the patients it provided a service to.

Are services caring?

Good

We considered this domain to be good. We saw many exemplary instances of caring, respectful and compassionate treatment. Patients were clearly involved in the decisions being made about their care and we saw many examples of self-management. Patients who were vulnerable were treated with a sensitive manner and emotional support was offered.

Feedback from patients, relatives and families was overwhelmingly positive. It was evident that staff knew their patients very well and that service delivery had been tailored to suit individualised needs. Assessments were holistic and we saw child friendly services

Are services responsive to people's needs?

Good

We considered this domain to be good, with some aspects requiring improvement. Many of the services we inspected were able to offer flexibility around appointment systems and we had many examples of where service delivery had been changed and adapted in response to patient feedback. We saw good use of interpretation services and creative use of online services in the walk in centres to address communication barriers.

Patients using the walk in centre service were usually treated and discharged within four hours, often within two hours. However, patients frequently waited too long to be seen by the triage nurse for an initial assessment of their clinical needs.

Because of a lack of integrated working with primary medical and social services, some patients were not always referred for further support as required from the walk in centre.

Staff were able to demonstrate a good awareness of individual patients needs and were able to deliver care along with other services in order to support patients, such as direct referral systems.

Summary of findings

The trust had an equality and diversity strategy action plan in place and was working through that to completion. They had a dedicated equality and diversity manager to oversee and drive the action plan forward.

The trust had a proactive and personalised approach to responding to complaints, comments and compliments. The trust took all patient observations and remarks seriously and endeavoured to resolve them. They then took the opportunity to learn from these to ensure they continually offered improved services. At board level patient experience was regularly reviewed.

Are services well-led?

Good

We considered this domain to be good, with some aspects requiring improvement. Staff had confidence in the trust's Chief Executive and Director of Nursing and Quality. Staff were aware of the vision and values of the trust and were able to articulate them. They also had quality goals and staff were able to demonstrate that they knew what the goals were. Staff appraisal were linked to the trust vision and values and nearly all the staff we spoke to confirmed they had had an appraisal in the last 12 months.

Front line staff spoke highly of local line managers and said they felt supported and had good access the training. Morale was generally good and this was reflected in the positive attitude we found from the staff we met during our inspection. However, local line managers did not feel sufficiently supported and divisional/middle managers were not visible enough.

There was no overview or leadership of all the services the trust provided for children. This meant that services were working in silos and limited opportunities for cross-team working.

Our inspection team were impressed with the community dental service and acknowledge some of the exemplary work being undertaken, however, the staff working in the service expressed that they did not feel recognised by the board and would like more clinical engagement around service design, development and commissioning.

Risks were identified and mitigating actions reviewed and updated. However not all risks were identified and for some that were, no associated action plan was produced to reduce the risk.

IT and data management presented an elevated risk to the trust. We found a number of areas where there were inconsistencies in data reported by the trust and actual performance. Lack of access to IT in

Summary of findings

some parts of the trust meant there were gaps in data and the incompatibility of some software programs across the organisation, limited the trusts ability to ensure robust management reporting was available.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Professor Siobhan Gregory, Director of Quality and Clinical Excellence, Hounslow and Richmond Community Healthcare NHS Trust.

Team Leader: Debbie Widdowson, Care Quality Commission

The team of 28 included CQC inspectors and a variety of specialists: District Nurses and Tissue Viability Specialists, Ward Matron, Community Matron and Nurse Practitioner, Health Visitor, Therapists, a NHS Managing Director with expertise in governance, GP and a Dentist and four experts by experience

Why we carried out this inspection

We inspected the Trust as part of our comprehensive Wave 2 pilot community health services inspection programme.

The Wave 2 inspection model for community health services is a specialist, expert and risk-based approach to inspection. The aim of this testing phase is to produce a better understanding of quality across a wider range and greater number of service and to better understand how well quality is managed.

How we carried out this inspection

To get to the heart of people who use services' experience 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?

Before visiting, we reviewed a range of information we hold about the Trust and asked other organisations to share what they knew. We also received comments from people who had attended a listening event prior to the inspection. We carried out announced visits on 2, 3 and 4 September 2014. We also visited the trust unannounced out of hours on 3 September 2014. We visited health centres, dental clinics and walk in centres. We went on home visits with district nursing, health visitors and palliative care specialist nurses. During the visits we held focus groups with a range of staff who worked within the service, including nurses, therapists and healthcare assistants. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records.

Information about the provider

Wirral Community NHS Trust was first registered on 1 April 2011 and has 17 registered locations. It delivers a range of community services within the Wirral and some areas of Cheshire and Liverpool, across 145,000 households.

It provides a range of services including nursing and therapy services as well as unplanned care, lifestyle support and primary care services.

The Trust's annual revenue for 2013/2014 was £70 million. They employ approximately 1400 staff and serve a population of around 320,000, with more than 1.1 million patient contacts each year. The Trust delivers services in people's own homes, and from over 50 locations including health centres, hospitals, community settings and dental centres.

Summary of findings

CQC inspected seven registered locations between January 2012 and August 2013. All locations were fully compliant with the Essential Standards of Quality and Safety.

What people who use the provider's services say

On 12 August 2014, we held an event where a range of local community groups came to share their experiences of using the services. The group included local Healthwatch, groups representing older people, multicultural groups, advocacy organisations and groups representing people with physical disabilities. It was felt that there were examples of good treatment and care provided by the trust. However, they felt there was a lack of consistency in terms of communication, information, and access to treatment.

The trust report in their 2013-2014 Quality Account that 97% of patients agreed they would recommend the service they have received to friends and family.

During our visit to the trust, people spoke very positively of the experiences of using services and told us the staff were supportive, considerate and respectful.

Good practice

- There was good multi-disciplinary working in most of the adult community services.
- The sexual health team were innovative and proactive in their efforts to engage young people and encourage the appropriate health tests. For example, the team gave presentations at local high-schools and set up information stalls promoting 'safe sex', providing information and 'goodie bags' attractively and appropriately packaged at venues attended by young people such as 'Fresher's Fairs' at local sixth form colleges and local music festivals.
- The Family Nurse Partnership were proactive in including teenage fathers in preparing them for caring for their child. Initiatives included men's groups and a football team which were used as means of initial engagement and enabling peer support for young fathers.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must review systems to report incidents across the community teams. The frequency of use of the incident reporting procedure varied and staff access to the electronic reporting system was inconsistent across the services.
- The trust must review the policies and procedures for safeguarding to ensure they are fit for purpose and provides staff with clear information to support them when reporting issues.
- Different record keeping systems were in place across services while a new IT system was being rolled out. There was some time consuming duplication of records. Together these may present emerging risk of under reporting of some types of incidents and trends being missed. This must be addressed by the trust.
- The impact of the Mental Capacity Act 2005 code of practice and Deprivation of Liberty safeguards was not well understood by most staff. This has an impact of staff ability to support patient's giving informed consent to treatment. The training that was provided must be reviewed.
- There was no single reference point for all of the different services provided for children by the trust.

Summary of findings

The trust must review the overall management arrangements for services for children and families to ensure there is a shared vision and that opportunities for joined up working are acted upon.

- Triage assessments were not always completed as quickly and efficiently as possible. Patients were often waiting in excess of 30 minutes to be seen by the triage nurse. The trust must ensure that good practice guidelines for triage assessment are fully implemented and monitored to ensure patients are seen as quickly as possible for initial assessment.
- The effectiveness of transition arrangements for children and young people to adult services should be reviewed as community nursing staff had no confidence in current arrangements, including liaison with mental health teams.
- The trust should ensure that community nursing teams are able to monitor and articulate outcomes for patients.
- Staff were not clear about how the trust was defining the difference between a 'complaint' and a 'concern'. This affected the way issues raised by patients were dealt with locally and could result in trends being missed by the trust. The trust should review the clarity of its message about complaints.
- The trust should address the issue of no facilities being available in clinic waiting areas to occupy children. Patients told us this added to the strain of attending for their children's and their own appointments.
- The trust should make sure that infection control measures are effective, comprehensive and consistently applied in keeping with accurate infection control risk assessments or audits in the areas used by children, young people and their families and that all clinics have processes in place that encourage children, young people and families to clean their hands.
- The trust should continue reviewing the robustness of the plans in place for safeguarding children and ensure that plans cover all areas of disparity between interfacing services; ensure that all staff receive the appropriate training and updates in relation to safeguarding so that staff are clear about what needs to be referred to safeguarding, fully understand and the systems in place and routinely inform staff about the outcomes of their referrals.
- Patients should be prompted to wash their hands or use hand gel on entering the walk in centres. Hand gel was available but there were no posters or other information for patients about when and how the gel should be used.
- The walk in centres and minor injuries unit should be included in the local pathway for falls in older people. Older people who came to the walk in centres as a result of a fall were not offered a referral to the falls prevention team.

Action the provider COULD take to improve

- Uptake of staff training specific to staff roles and patient needs could be improved. Bespoke training sessions were not well attended because staff reported having to do this in their own time.
- The walk in centre waiting areas could be improved to make adequate provision for children.
- Privacy for patients at reception desks in the walk in centres could be improved.
- There was no staff role identified within the walk-in centre service to promote good practice when caring for people living with dementia, such as a link nurse. This could be improved.
- Information for patients about how to make complaints could be more visible for patients in the clinic areas so they are aware of the trust's complaints process.
- The trust could develop more formal communication channels with the dental service leads to ensure they feel engaged in service development, design and commissioning.
- Although the trust is introducing SystmOne to the end of life team, record keeping and the review process could be improved to ensure that care and treatment is effectively documented.
- The working relationships with the hospice were on occasions disjointed and could be improved. .

Wirral Community NHS Trust

Detailed findings

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

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Staffing levels and skill mix were generally safe and the trust are using the Safe Staffing NICE guidelines for wards and applying them to the community setting to restructure services.

The clinic environments we visited were generally clean and well equipped. Although hand hygiene was well maintained amongst the majority of staff, there was limited or no prompting for patients and visitors to maintain good levels of hand hygiene. Medicines were managed safely. There were good arrangements in place to ensure the staff working alone out in the community were safe.

We found that safeguarding presented an area which although we found no detriment to patients during our inspection, the arrangements in place posed an elevated risk to the trust. The organisational structure and policies to support staff in relation to safeguarding were over complicated and not clear to staff working in the trust.

Our findings

- Staff knew how to report incidents using the electronic system. Staff were able to describe incidents they had reported and gave examples of what they would report.
- Patients that we spoke with told us that they felt safe using the services provided by the trust.
- We found that the trust had mechanisms in place to report and record safety incidents, concerns, near misses and allegations of abuse. This included the on line reporting tools, policies, procedures and audits.
- The trust had reported zero never events in the last twelve months.
- Between June 2013 and June 2014 the trust made a total of 2286 notifications to CQC via the NRLS system.

Good

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Of these, 383 were considered to be of the type 'moderate', 'abuse', 'severe' or 'death. During the same period there were 19 serious incidents at the trust, 18 of which were related to pressure ulcers.

- When compared to others, Wirral Community NHS Trust could be considered a low reporter of notifications and incidents. The trust scored below average for the percentage of staff reporting errors, near misses or incidents witnessed in the 2013 NHS Staff Survey. Additionally, the trust itself has identified that the incident reporting was decreasing and this posed a potential risk.
- The reason for this could be because there is low occurrence of incidences, but during our inspection we became aware of a number of barriers which could potentially prevent staff from reporting incidents.
- The one barrier was lack of access to the computerised reporting system. If operational staff working out in the community witnessed or were made aware of an incident in a patient's home, they would need to report it by completing an incident form when they returned to base. This would then have to be transcribed on the incident reporting system. (DATIX). The process was time consuming and took staff away from patient care.
- Senior management agreed that a rise in incident reporting was likely when staff had the mobile devices which would enable them to report at source.
- There was evidence that incidents had been downgraded at the time of reporting, or not reported at all due to the prompt action taken by the staff to deal with the situation with the result that they were not collected or reported corporately. Examples of this were given to us by the End of Life Care team.
- Some staff were very clear about what 'an incident' was and what type of incident was their responsibility to report. Other staff were less clear. We found some staff indicated a reluctance to report 'problems' to managers, and to access the computer systems that were used to report, assess and escalate incidents.
- During the inspection we spoke with senior staff regarding the processes involved with classification and investigating of incidents. We noted that there were inconsistencies in the classification of similar incidents, which then resulted in different follow-up management. This could indicate that the trust was missing the opportunities to learn from incidents they had incorrectly classified.
- Senior staff involved with the investigations of incidents had been trained in investigation techniques. We were told that this specialist training was going to be rolled out to further staff to improve their investigation skills. All incidents with a clinical element were reviewed by a clinician within 24 hours.
- The quality team told us that education from incidents was shared at team meetings and there were plans in place for learning to be shared via the trust's intranet. Drug incidents which were investigated also shared learning via an online publication.
- The trust has joined a national initiative called Sign Up To Safety. This initiative aims to deliver harm free care, champions openness and supports staff to improve safety for patients.
- In response to increasing numbers of pressure ulcers, audits were completed in July and November 2013. These identified compliance with best practice across the community nursing teams. Where less than optimal practice was identified an action plan had been produced and completed with the community nursing teams. However, within the Integrated Performance Report for July 2014 numbers of pressure ulcers graded 3 and 4 have increased since the last report. The reasons for this were not clear.

Cleanliness, infection control and hygiene

- The 2013/14 Quality Account states that the trust had no avoidable healthcare acquired infections in their services.
- The trusts' catheter and new urinary tract infection rate for all patients and patients over 70 shows considerable fluctuation during the 12 month period between June 2013 and June 2014 however both rates were below the England average for almost the entire period.
- All the areas we visited were visibly clean. Staff were aware of current infection prevention and control guidelines and good infection prevention and control practices were observed. We saw most but not all staff using hand washing facilities and hand gel (Health visitors were observed not washing their hands). Patients also confirmed that they saw staff washing their hands and using hand gels. The staff wore trust uniforms and adhered to the trust uniform policy when working in the community. Regular audits took place across the services to ensure policies were adhered to.
- Patients were not prompted to wash their hands or use hand gel on entering the walk in centres or in some

Good

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clinic reception areas. Hand gel was available but there were no posters or other information for patients about when and how the gel should be used. There is ample evidence that effective hand hygiene reduces the incidence and spread of infection.

Maintenance of environment and equipment

- Patients were seen in a wide variety of locations throughout the trust ranging from GP surgeries, community hospitals, the new purpose built St Catherines Heath Centre, clinics and in their own homes. There were no concerns raised about the maintenance of the environment and equipment.
- All the areas we visited appeared well maintained. In dental services, for example, all sites were recently refurbished and had mostly all new equipment. Staff knew how to report any issues requiring repair or maintenance. Staff told us that repairs were usually carried out promptly.
- All the equipment we looked at was calibrated and maintained in keeping with the manufacturer's instructions.

Medicines management

- Policies for the safe handling and administration of medicines were in place. Medicines were stored safely and comprehensive recording systems were in place. Controlled medications were stored appropriately in all the areas we visited.
- There were nurses working in the walk in centres who had undertaken additional training so that they could prescribe medicines. The competency of these nurses was monitored by a senior nurse. Staff were aware of medication protocols concerning children such as prescribing and administering medication in ratio to the weight of the baby or young child.

Safeguarding

- Since registration, no safeguarding records have been raised for the trust with CQC.
- Staff were aware of safeguarding procedures and what may constitute a safeguarding concern. Staff spoken with demonstrated understanding and knowledge of the action they should take in the event they had suspicion or evidence of abuse.
- All staff that we spoke with told us they felt confident about speaking up if they had any concern about the welfare of a patient.
- We spoke with senior staff who told us that training for safeguarding was to be completed on a 2-yearly cycle, documents we reviewed supported this. However, we noted that this was a variation from the trust's safeguarding adults policy which stipulated that staff completed level one adult training annually and level two every three years.
- Within children's services "did not attend" (DNA) incidents were recognised as a trigger which could require a safeguarding referral. We reviewed the Safeguarding Children and Failure to Gain Access polices, both of which included advice to staff regarding actions to take when children did not attend booked appointments. We noted that the advice given to staff was not consistent across the two policies, which could potentially impact on when a safeguarding referral and result in the child not being seen for a longer period of time with inherent risks attached.
- Some teams had more contact with children which necessitated them being trained in safeguarding level three. For instance within the walk-in centres, one-quarter of their work is with children, but only 13% of staff had completed this training for their role.
- The head of the safeguarding service had identified this risk and an action plan to address the issue was in place. The action plan set out an objective for 95% of staff requiring level three safeguarding would have received it by March 2015. This demonstrated effective delivery of their role and identification and mitigation of a safety risk.
- The team structure for safeguarding adults and children appeared to be over complicated and potentially confusing, containing 14.2 whole time equivalent (WTE) staff. There were 7.8 (WTE) staff in five named roles.
- We requested and were supplied with a number of documents including policies to demonstrate the processes involved with protecting vulnerable adults and children. We found that the arrangements were over-complicated and lacked cohesion across the policies supplied by the trust.
- The trust prepared and delivered an annual report of all safeguarding activity for the previous 12 months. We noted that grade three and four pressure ulcers were not mentioned as reported. It was unclear of the trust position with regard to raising safeguarding for patients who develop level three or four pressure ulcers. We did

Good

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see a flow chart developed by Wirral CCG which indicated in what instances grade three and four pressure ulcers were to be reported, but this had only recently been developed.

- The trust had produced a safeguarding flow chart for staff to follow if they had a child safeguarding concern which was on display in most of the places visited. However, a review of the policy and discussion with health care professionals in different divisions indicated that the policy was not consistently followed.
- Awareness about the outcomes of safeguarding raised differed between individuals but staff from each division told us they had made successful referrals to safeguarding and had been involved in multiagency meetings and action had been taken to protect the child or young person from harm.

Records, systems and management

- Staff understood the important role that good record keeping played in providing safe care.
- The trust had recently introduced SystmOne IT record and reporting system. This had been piloted by the health visiting service. Staff reported some initial problems but the majority of comments were positive in relation to communicating with the team leader at the base; updating records and having comprehensive information about their patients immediately available whilst in the field.
- In all the dental services we visited, clinical records were kept securely and could be located promptly when needed, confidential information was properly protected.
- All palliative care patients diagnosed as being in the last year of life had an advanced care plan in the form of a patient and carer assessment (PACA). The PACA was a comprehensive, holistic assessment which was in place to record the changing needs of patients and carers and their individual preferences.
- All patient records were held security and confidentially in the walk-in centres. Details of patients' previous attendance at the walk in centres could be accessed quickly.

Lone and remote working

- The trust had a policy and procedure for maintaining staff safety when they were working alone. Staff were aware of the policy and were able to describe how they ensured the team knew where everyone was located within the community.
- Community staff carried personal alarms, none of the staff that we spoke with raised any concerns about the arrangements for their safety at work. A GPS tracking system was planned but as yet there was no date for its implementation.
- Security staff were present in trust buildings in the evenings.

Assessing and responding to patient risk

- The trusts rate for harm free care between June 2013 and June 2014 was consistently better than the average rate for all organisations where community services are provided by district nurses. Although the rate fluctuates over the 12-month period, the lowest is 94% and the highest 97%. The rate of harm free care for patients over 70 follows a similar pattern to that for all age groups.
- The trusts rate for new pressure ulcers also shows considerable fluctuation during the same 12-month period. The rate oscillated above and below the England average. In June 2014 the rate for the trust was 1.98% and the England average was 1.29%.
- The rate for falls with harm was well below the England average for the entire 12-month period, June 2013 to June 2014. For four of these months the rate was zero which would indicate no falls with harm or a lack of reporting for these months.
- Staff recognise and respond appropriately to changing risks within services. For example at Victoria Central walk in centre patients were initially assessed by the triage nurse to be directed for treatment by walk in centre or minor injuries unit staff. The triage nurses used defined criteria and professional judgement to assess who the patient should be seen by and how urgently they needed to be seen. Patients were referred to acute services if necessary, including accident and emergency.

Staffing levels and caseload

- The trust are using the Safe Staffing NICE guidelines for wards and applying them to the community setting to restructure services. This initiative is mandatory for acute trusts but not for community trusts,

Good

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demonstrating an innovative and proactive approach to assessing safe staffing levels. Where national guidance was in place for staffing levels such as dentistry and health visiting, this guidance was being followed.

- 14 community nursing teams had had their safe staffing levels identified. We saw an action plan produced to support this work and the trust was part way through identifying what the safe staffing numbers needed to be for the entire service. The trust had also worked "head room" into the formula enabling staff that had responsibility for appraisals and personal development time to complete this part of their role.
- The walk- in centres were the most advanced with safe staffing process. A computerised system had been implemented which gave them the ability to identify staff requirements well in advance, giving them the opportunity to ensure safe staff cover requirements were reached.
- The trust had a process for monitoring the number of staff required for both permanent and temporary roles. Senior management including trust board members, met weekly to review applications from divisional leads requesting resources to fill staffing gaps. The service leads were required to complete a business case for each position they needed to fill. One board member said they had not turned any requests down but had sometimes requested more information. This process had been in place for a few months. One board member said that this was time consuming and may not have needed such senior staff to be involved at such an operational level. Some senior staff mentioned that this approach did not empower them or enable them to utilise their clinical leadership skills.
- Staff sickness is an area that the trust had identified as a quality strategic goal and also a risk to safe patient care. The trust wants to reduce this to 4.2% for 2014/15. As at July 2014 it was 4.9% and had reduced from a previous spike of 5.3%. These figures were higher than the England average. The trust had identified that there was a lack of consistency within the services in the management of staff sickness and this was being actively addressed. It had also been identified as a risk to patients and impacted upon the trust ability to deliver quality care.

Deprivation of Liberty safeguards

- There was limited understanding among most staff of the relevance of 'deprivation of liberties safeguarding' (DoLS) and the application of the Mental Capacity Act to their work. It was not well understood by staff in services in clinics, the walk in centres or in the community nursing teams. However, we saw that there were good systems in place for obtaining consent to treatment.
- We found this conflicting level of understanding across a range of staff roles. There was a view held among some clinic staff that it was unlikely they would come into contact with patients who were living with dementia as the service 'would tend to see them in their own home'. Yet a community manager told us that DoLS was covered as part of safeguarding training; they were aware that it applied to some patients within care homes, but not to patients being treated in their own homes where family members were assuming responsibility. This suggested that training was ineffective and the trust could not confidently assure itself that people were able to consent to their treatment.

Managing anticipated risks

- The trust had a risk register in place. Risks were identified and mitigating actions reviewed and updated. Senior staff we spoke to were able to articulate the trusts key risk areas. For example, Pressure ulcer care has been identified as a priority for 2014-15 and action plans had been developed to manage the risk. However not all risks were identified and for some that were, no associated action plan was produced to reduce the risk.
- The trust had a staffing escalation policy which describes what actions staff are to take in relation to staffing pressures. Staff were able to tell us how and when they had used the policy to good effect

Major incident awareness and training

- The trust had a major incident plan in place. This included specific details of the role of the unplanned care division in the event of a major incident.
- Some staff from the unplanned care division had taken part in a mock-up exercise of a major incident with the local acute trust in 2013. Managers had also attended a commissioner led table top exercise looking at the response to a major incident by all of the local health services.

Are services effective?

Good

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 of findings

We assessed this domain to be good. Care was evidence based and personalised to the patient. We observed good verbal consent and documentation of consent. However, there was a lack of knowledge about the Mental Capacity Act in some areas of the trust. There were good levels of involvement from families, relatives and carers which ensured care was planned and implemented effectively.

The trust were meeting the majority of the contractual Key Performance Indicators (KPI's). Where they were not meeting the monthly KPI's reasons had been identified to the commissioners.

Staff had access to training opportunities, as well as appraisals. The trust was maintaining high levels of engagement with staff for both of these areas. Appraisals had been linked to the Culture of Compassionate Care 6 C's initiative. They had also been designed to help identify and support future leaders.

There were many examples of good multidisciplinary working and positive working relationships were observed at handover, for example but this was not consistent across all services.

A number of services were able to show us innovative practice and ongoing research in a number of areas. The trust had made links with other providers to ensure that they could meet the future needs of the patients it provided a service to.

Our findings

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Planning and delivering evidence based care and treatment

- Staff under take comprehensive assessments which cover all health needs and develop plans for care and treatment which reflect nationally agreed guidelines and best practice. For example, in dental services conscious sedation provided by the service was delivered according to the standards set out by Royal College of Anaesthetists and the Department of Health Standing Committee Guidelines in Conscious Sedation 2007, the sexual health service followed best practice guidance on prevention of sexually transmitted infections and the Gold Standard Framework for end of life care was followed to enable people to receive co-ordinated care.
- We found that the walk in centres and minor injuries unit were not included in the local pathway for falls in older people. This meant that older people who came to the walk in centres as a result of a fall were not offered a referral to the falls prevention team. Managers told us that the onus was on GPs to read and act on the information sent to them regarding the patient's attendance and treatment at the walk in centre or minor injuries unit. This meant that patients may not have a timely referral to appropriate services to reduce their risk of falls
- Protocols for the treatment of minor injuries were currently being developed by a doctor recently appointed to do this. Patient information leaflets regarding knee and ankle injuries were also being developed.

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- All aspects of health visiting and services in support of babies and children under five years was based on best practice guidance. The infant feeding service provided literature, verbal and practical guidance in line with the UNICEF infant feeding guidelines. All care observed in relation to children under 5's met in full the National Institute for Health and Care Excellence (NICE) Clinical Guidance (CG) 37.
- Service lead managers told us that they conducted regular audits of their services and we noted national audit information was collected to provide a comparison with the performance of other trusts regionally and nationally, for example in the cardiac rehabilitation clinic.

Pain relief

- In the End of Life Care service patients told us that they had received good pain relief which was well managed with appropriate advice. Within the patient and carer assessment (PACA) each patient had their pain assessed and recorded at every visit. This assured the patient they would be pain free and gave the nurses good continuity of care. In their advisory role the specialist palliative care team supported patients to be pain free. They promoted the use of anticipatory prescribing to ensure analgesia was available when necessary. Patients were referred to the pain clinic at the hospice when pain control was unstable or staff felt that they would benefit from a second opinion. We were told that nerve blocks could be arranged for some pain cases. Counselling was available for patients in pain with contributing anxiety issues.
- We saw that patients were given appropriate advice about pain and pain relief in the walk-in centres. For example, a patient with a knee injury was advised on an appropriate medication to take to relieve pain and swelling; a patient with back pain was advised about exercise and the use of heat treatment and appropriate medication.

Approach to monitoring quality and people's outcomes

- There was an approach to monitoring, auditing and benchmarking the quality of their service. There was an audit committee which oversaw the audits throughout the trust for all of the divisions. The Clinical Audit Annual Report 2013/2014 provided an overview of the audits completed and identified improvements and areas for further improvement as a result of audits.
- The trust was invited to participate in one national audit and took part in 36 clinical audits over 2013/2014.
- They also had 145 key performance indicators (KPI's) to report on that were agreed with their commissioners. We received documentation regarding KPI's and found that in the majority of cases the trust was on target to meet them on a year-to-date evaluation. However we noted in a report dated July 2014 that the trust was having some difficulty reporting on activities due a number of issues such as IT system failures, staff input problems and staff sickness absence.
- We spoke with stakeholders who told us they felt that there was some difficulty getting all of the data required from the trust at times. This made it difficult to plan the trajectory of future services.

Patient outcomes performance

- The national performance target of 95%of patients in minor injuries units being discharged within four hours was being monitored by the trust and the local commissioners. Information provided by the trust showed that they had met or exceeded this target most weeks from April to August 2014.
- The head of the unplanned care division told us the best practice guideline was for patients to be seen by the triage nurse within 15 minutes of arrival at the walk in centre or minor injuries unit, (referred to as the triage time). However, some staff told us the triage time was 20 minutes and other staff said within 30 minutes. This lack of clarity for patients and staff meant staff were not working towards the same objective. We found that triage times were variable and patients frequently waited more than 30 minutes, sometimes up to 45 or 50 minutes.
- The percentage of patients on an end of life pathway at the time of death had fallen significantly over the last six months. It was reported that there were a number of factors which were out of the organisation's control in relation to this target and the performance had been queried by the commissioners.
- The trust integrated performance report in April 2014 stated that 38% of patients on the service list were on an end of life pathway at their time of death against target of 90% and was rated red in the report.

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Good

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Competent staff

- The trust offered job role specific and mandatory/ essential training to staff. This was part of the process to ensure that staff were competent in delivering their roles. We noted that within the quality strategic goals set for 2014/15, 95% of staff were to have received mandatory training. The trust gave us documents to demonstrate they had achieved 96% of staff attending this training in 2012-2014. However, further analysis showed that the trust had counted people who had attended more than once, making the percentage for some services over 100%. This meant that some staff may not have attended at all and raised concerns about data management.
- Within the trusts Quality Account 96% of staff had an annual appraisal in 2013/14, the highest of any community trust. One trust board member told us that the appraisals had been linked to the 6 C's (care, compassion, competence, communication, courage and commitment). The trust was seeking feedback from staff regarding the appraisal process to see if its introduction had been effective. We saw within an action plan that this process was completed in April 2013, but continuous monitoring would continue.
- The trust had a system in place to ensure healthcare workers professional registration was up to date. The trust had a contingency for staff failing to register but they had never needed to utilise this at the time of the inspection.
- The specialist end of life care team had all received advanced communication skills training and received clinical supervision sessions and support and advice from the oncology service at Clatterbridge Cancer Centre. Since April 2014 the team had been adopted by Macmillan and had benefitted from professional development and the provision of on-going education and advice.
- The health visitors were highly regarded by their peers in other organisations and had presented papers about the Wirral Community Trusts service at international forums such as the 25th 'International Networking for Healthcare Education 2014' conference at Cambridge University.
- We noted when we accompanied them on visits, that community nursing teams were well functioning and highly skilled. Community Matrons were competent to prescribe medications and met regularly for professional peer support and development.

Multidisciplinary working and co-ordination of care pathways

- There was effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care in the dental services. A good example of this was collaboration in relation to patients with head and neck cancer. Staff liaised with various specialists and the patient's own dentist to ensure that everyone was aware of the patients' needs.
- We also found good examples of MDT working in the end of life care service and in the community nursing teams, for example, close work with specialist nurses, GPs and social workers to aid effective care delivery and smooth discharge.
- There was effective communication between midwives; health visitors and social workers. Health visitors had one hour protected time with the GP's meeting each week.
- There was little evidence of integrated working between primary care and the walk in centres / minor injuries unit. This had led to inappropriate referrals by GPs to the walk in centres. Examples of this were a patient sent to the walk in centre for ear syringing because the GP's own equipment for this was not working.
- The lack of integrated working was also partly responsible for patients returning to walk in centres for follow up of their treatment, such as redressing of wounds or removal of sutures, which is not an effective use of the trust's resources.

Good

Are services caring?

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

Summary of findings

We considered this domain to be good. We saw many exemplary instances of caring, respectful and compassionate treatment. Patients were clearly involved in the decisions being made about their care and we saw many examples of self-management. Patients who were vulnerable were treated with in a sensitive manner and emotional support was offered.

Feedback from patients, relatives and families was overwhelmingly positive. It was evident that staff knew their patients very well and that service delivery had been tailored to suit individualised needs. Assessments were holistic and were saw many child friendly services.

Our findings

Compassionate care

- Patients and relatives we spoke to throughout our inspection spoke highly of the staff and told us they were caring, sympathetic and understanding. In dental services patients told us the staff were very good putting them at ease before and during treatment.
- We observed real compassion and respect for dignity across all of the services we visited. There are many examples of this in clinics, patient's own homes and in the walk –in centres.
- All staff we observed were eager to be helpful to people. In a number of services managers told us that staff worked over their contracted hours to make sure patients got what they needed, including in the equipment store.
- Most staff that we met demonstrated a real pleasure at their work and seemed happy to be at work. A happy working atmosphere was generated by the majority of staff, "I love my Job"; "I'm proud of the service".

Dignity and respect

- Patients and families told us they were treated with dignity and shown respect. Relatives told us that the staff were very professional and sensitive.
- We observed nurses responding in a helpful, practical way to patients with sensitive issues. Staff knocked before entering closed treatment rooms. Patients were covered appropriately during their treatment and their privacy was respected at all times during treatments.
- We observed staff speaking respectfully to all patients, including those with disabilities.
- Patients could request a chaperone in the walk-in centre if they wanted someone with them during assessment and treatment.

Patient understanding and involvement

- Most patients and families we spoke with told us that staff were very good at talking them through their treatment and providing information so that they felt involved in their care.
- We saw that throughout the trust there were information leaflets available on various conditions, accessing services and the types of support available. Staff confirmed that they could access interpreter services for patients.
- Patients treated in their own homes had a copy of their care and treatment plan and were made aware of what was in it. Those who we spoke with told us they felt part of their care and were pleased with their treatment. In the walk-in centres, patients were asked if they understood and were happy with the advice and treatment given. This was noted in the clinical records. A patient told us, "The doctor explained everything. I know what to look out for."

Emotional support

- During our visit we saw many examples of staff offering emotional support to patients and families to help them cope with their care and treatment.
- Staff were clear on the importance of emotional support when delivering care. We observed positive interactions between staff and patients,
- In the end of life care service, all patients were offered spiritual and religious support appropriate to their needs and preferences. We saw this documented in patient records.
- We observed in clinics and in community nursing services, empathetic responses made to sad news and the difficulties physical illness can put on the individual patient emotionally and their family.

Good

Are services caring?

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

Promotion of self-care

- We saw patients independence was respected and actively encouraged We observed staff talking with patients and involving them in planning their care
- A wide range of information leaflets and booklets about the different treatment of health conditions and after care had been produced by the trust. The trusts offered advice on self-care and seeking advice from a pharmacist for minor illnesses and injuries.
- Written information was backed-up with verbal advice, we saw examples of this in the walk-in centre and dental services.

Are services responsive to people's needs?

Good

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

Summary of findings

We considered this domain to be good, with some aspects requiring improvement. Many of the services we inspected were able to offer flexibility around appointment systems and we had many examples of where service delivery had been changed and adapted in response to patient feedback. We saw good use of interpretation services and creative use of online services in the walk in centres to address communication barriers.

Patients using the walk in centre service were usually treated and discharged within four hours, often within two hours. However, patients frequently waited too long to be seen by the triage nurse for an initial assessment of their clinical needs.

Because of a lack of integrated working with primary medical and social services, some patients were not always referred for further support as required from the walk in centre.

Staff were able to demonstrate a good awareness of individual patients needs and were able to deliver care along with other services in order to support patients, such as direct referral systems.

The trust had an equality and diversity strategy action plan in place and was working through that to completion. They had a dedicated equality and diversity manager to oversee and drive the action plan forward.

The trust had a proactive and personalised approach to responding to complaints comments and compliments. The trust took all patient observations and remarks seriously and endeavoured to resolve them. They then took the opportunity to learn from these to ensure they continually offered improved services. At board level patient experience was regularly reviewed.

Our findings

Service planning and delivery to meet the needs of different people

- They were currently working through their Equality and Diversity (ED) Strategy action plan. This would improve access to the services from nine protected groups.
- The trust was publicising this strategy via publications available to stakeholders, staff and the public. For example, they had produced a leaflet for all staff and published an article in a newsletter.
- The trust had a number of milestones on the strategy which had not been completed by the given deadline. For example, identification of training needs was overdue. It was not clear who the Director level lead for ED was. The trust had recently appointed a manager to oversee the ED strategy and the trust felt this was a positive step forward.
- The Wirral has a relatively high older population and a relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole. 3.0% of the population in Wirral belong to non-White minorities.
- Staff across all of the services told us that data about patients age, ethnicity and other 'protected characteristics' was collected when they accessed services. Staff were unable to tell us what this data was used for and said they were not asked by the trust to report on it. It was not clear if this data was being used to plan and develop services.
- The trust had a contract with a multicultural centre at Birkenhead for interpreter services. Staff told us that most patients could speak or understand sufficient English without the need for translation or interpretation. A telephone translation service was available for staff to use to communicate with patients who did not have English as their first language.

Access to the right care at the right time

- People were able to access the right care at the right time There were a number of examples across the services we visited of flexible provision to enable patients to attend at times and place which fitted in with their lives. Patients could choose between different locations for some clinics to reduce travel. For example, the nurse led heart failure clinic and the equipment

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store, scheduled extra services or staff shifts if demand rose. The heart failure clinic provided home visits by the specialist nurse if patients were unable to attend at one of the three locations.

- The walk in centres provided care and treatment for patients close to their homes. This was helpful for patients who would have to travel further to use the accident and emergency department if the walk in centre or minor injuries unit was not available.
- Waiting times for services were good on the whole, but there were some exceptions. Tissue viability nurses reported to us that their service had no waiting list and that people were generally seen within a week. The equipment stores monitoring of response routes showed a 100% response rate for emergency equipment calls (within 24 hours) and a 91% response for all other calls (within 7 days). However the Podiatry services staff told us that waiting times were poor especially for follow up appointments which could be five to six months. Podiatrists told us the target was to see routine cases within four weeks. We spoke with a patient who said they waited eight weeks for their appointment.
- Parents described the health visiting service as responsive. One parent said "the service met my needs I was visited every week for the first seven weeks." Another told us "handy being open five days a week because there is good availability."
- Information provided by the trust showed that the total time from arrival to discharge for most patients attending the walk in centres and the minor injuries unit was less than two hours. 56% of patients attending the minor injuries unit from April to August 2014 waited more than 15 minutes from arrival to seeing the triage nurse. We asked for the same information relating to patients attending the walk in centres, but this was not provided.
- We observed that some patients in the walk in centres were waiting in excess of 30 minutes to see the triage nurse. Records we looked at confirmed this. Triage is used to make a quick assessment of patients' presenting problems to prioritise those in most urgent need. If patients are waiting to see the triage nurse, there is a risk of delay in urgently needed treatment for patients most in need.

Discharge, referral and transition arrangements

- Arrangements for discharge or transfer between services were in place and generally met the patient's needs and happened in a timely manner. Patients and families told us that referrals to other services were made quickly and they were kept well informed.
- Communication between the trust and local acute hospitals were in place and were effective to ensure continuity of care for patients. For example, Community Matrons were involved with ward rounds in acute sector hospitals locally to contribute to the assessment of patients who were ready for discharge to community services.
- There were effective arrangements in place where patients needed referral to acute health services. For example, appointments for the fracture clinic were usually made before the patient left the walk in centre or minor injuries unit. Patients were transferred to the surgical or medical assessment units of the local acute trust and transport was arranged if needed.
- The trust is signed up to the Joint Strategy of Young People with Disabilities and Complex Needs from Children to Adult Services. Community Matrons told us they did not feel equipped to respond, as they were expected to do, to the needs of young people transferring from children's services. They told us children and young people, particularly those with learning disabilities, have been transferred from children's services, without the correct support in place from other adult services.

Responding to and learning from complaints and concerns

- The trust listened to and acted on complaints and comments. For the period 01 December 2013 – 20 June 2014 the trust received 26 complaints, 354 concerns and 2479 compliments. When complaints and comments were received these were investigated and the complainant received feedback. If the complaint or comment required a change in practice the learning was shared with the staff group.
- We saw that a monthly summary was produced by the patient experience team which identified the types of complaints and concerns and for what service they occurred. We noted that the largest proportion of complaints were for unplanned care.

Are services responsive to people's needs?

Good

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

- The trust had a Concerns and Complaints Policy which had been approved by the quality and governance committee. The trust policy was to respond to all complaints and concerns within three working days.
- We requested information from the trust regarding resolution timescales. The trust policy is to agree this with the complainant, and in the majority of cases 25 working days was agreed for resolution. For 2013-2014, 40 complaints were investigated of which half were resolved before the agreed resolution time. We noted that some complaints took much longer than this for resolution.
- We noted that within the Concerns and Complaints policy patients were given advice regarding who else they could complain to, but this was not presented consistently. This was not helpful to either staff or complainants wanting further information and support to complain.
- The Chief Executive told us he had telephoned complainants in the past and the Director of Nursing has visited complainants in their own homes to help the resolution process. This demonstrates a commitment to resolution and learning from the trust.
- During our visits to locations across the trust, we noted that information about how to raise concerns or complaints were not prominently displayed or provided in alternative formats.
- We noted that patient experience cards were very visible in most clinics and patients did use them. Staff told us the trust set targets for services to get returns of patient experience questionnaire forms. We did not see these questionnaires provided in any alternative formats in adult services and this could result in some groups of patient's being systemically excluded.
- We heard a number of good descriptions by staff of local handling of verbal concerns.
- The trust's website had information about how patients could raise concerns, complain or make comments about their care and treatment. Patients could make comments online through the trust's website.

Are services well-led?

Good

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 of findings

Instructions

We assessed this domain as good with some aspects requiring improvement. Staff had confidence in the trust's Chief Executive and Director of Nursing and Quality. Staff were aware of the vision and values of the trust and were able to articulate them. They also had quality goals and staff were able to demonstrate that they knew what the goals were. Staff appraisal were linked to the trust vision and values and nearly all the staff we spoke to confirmed they had had an appraisal in the last 12 months.

Front line staff spoke highly of local line managers and said they felt supported and had good access the training. Morale was generally good and this was reflected in the positive attitude we found from the staff we met during our inspection.

However, local line managers did not feel sufficiently supported and divisional/middle managers were not visible enough. Staff reported a blockage in communication and said they did not always feel listened to by that level. Not all staff groups could articulate from where or who was their professional lead at board level.

There was no overview or leadership of all the services the trust provided for children. This meant that services were working in silos and limited opportunities for cross-team working.

Our inspection team were impressed with the community dental service and acknowledge some of the exemplary work being undertaken, however, the staff working in the service expressed that they did not feel recognised by the board and would like more clinical engagement around service design, development and commissioning.

Risks were identified and mitigating actions reviewed and updated. However not all risks were identified and for some that were, no associated action plan was produced to reduce the risk.

IT and data management presented a potential elevated risk to the trust. We found a number of areas where there were inconsistencies in data reported by the trust and actual performance. Lack of access to IT in some parts of the trust meant there were gaps in data and the incompatibility of some software programs across the organisation, limited the trusts ability to ensure robust management reporting was available.

Our findings

Instructions

Vision and strategy for this service

- Staff throughout the organisation were able to articulate the trust's vision and strategy. We noted that the vision and strategy was published and available to the trust staff, public and stakeholders.
- The quality goals were all measurable with action plans associated with them such as the safer staffing quality goal which we saw that the trust was on target with. We also saw that the innovation and research action plan which was associated with the quality goal was establishing a funding stream for innovation and research. This meant that the quality goals were planned for and implemented with the associated action plan. The action plans were dated and had staff identified as responsible for the completion within the timescales. They were all attached to a committee or group for continuous monitoring.
- The trust had identified they lack the capacity to identify and pursue new business opportunities and we were made aware of examples of this. The trust had agreed to deliver an additional service requested by commissioners, which was supporting patients and care staff within care and nursing homes. We were told that additional funding was not agreed for this therefore no additional staff were employed to deliver this service. This put extra pressure on existing staff. The trust have produced action plans with achievements required such as identifying future leaders within the trust and making strategic partnerships to strengthen their business skills.
- Dental staff told us they were not aware of strategic plans for the organisation. Staff were anxious that the service was going out to tender. They were uncertain of the future for all of the clinics and felt there was a lack of communication with the trust at times. There were plans to reduce the domiciliary care visiting service over the next three years with a vision to stopping it

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altogether. Staff felt it was a vital service to the local community and there would be a gap in provision of care to those who are housebound. Staff felt they had not had opportunity to discuss their concerns with trust leaders or the commissioners.

- At the time of our inspection a tendering process was underway in the Wirral for all community services for children and young adults aged 0-19 years. This would include school nurses. The trust had submitted a bid for this service and were awaiting the outcome. The trust were keen to secure this service and had clear strategies in place if their bid was successful.
- Individual specialist teams used by children, young people and families had strategies and vision in relation to their area of expertise and within their divisions. However the trust did not have a single point of contact with a total overview of the quality of care and future visions for all the services used by children, young people and families throughout the trust.

Governance, risk management and quality measurement

- The trust had a system of governance in place. The governance structure of groups and committees fed into the trust board.
- The Board Assurance Framework was not being fully utilised to identify key risks and set objectives to achieve quality targets. The individual risks on the board assurance framework were not always clearly articulated with clear, measurable objectives. This means that it is difficult for the trust to accurately measure whether a risk is reducing.
- We identified three areas where the data may not be relied upon:
  - incident reporting categorisation,
  - safeguarding training numbers, and
  - mandatory training numbers.
- The trust had reported that their internal IT systems did not always support them to report. This had been added to the board assurance framework document and an associated action plan was in place.
- Where actions were required to reduce the risk, associated action plans were usually in place. However, where no gaps had been identified, therefore generating no action plan, it was not clear how the trust would reduce an overall risk rating from its current to its target risk rate.
- There was an issue with the delayed roll-out of mobile devices for community based staff. These devices would enable staff to record information whilst working out in the community, rather than having to return to base. This would have clear benefits for staff. All of the senior members of the trust board were aware of the delay, but the reasons cited by managers we spoke to for the delay were different. Additionally, affected staff had not been told about the delay.
- This demonstrated for this particular issue a number of failings on the part of the trust to manage the implementation of this system. The trust had failed to re- recruit a project manager to keep the plan on target. They had failed to effectively communicate the delays to operational staff, and there was a cost implication if training had to be undertaken a second time. However the trust does recognise that this is a risk and it has been identified and is present on their trust-wide risk register.
- The trust effectively used DATIX (a data management tool) to identify risks to the service. The highest rated risks which have strategic or reputational risk are collated and placed on the board assurance framework document. However, as access to the system is not universal across the trust then there are gaps in the collection and dissemination of information from the system.
- A May 2014 review of the service undertaken by Wirral Clinical Commissioning Group provided an overview of the specialist palliative care team commissioned by Wirral CCG from Wirral Community NHS Trust. The focus of the review was on its integration between the three settings of the community, hospital and hospice and it also looked at the activity of the PAIL jointly provided by Wirral Community NHS Trust and Wirral Hospice St John's. The recommendations following this included improved communication and further integrated working.

Leadership

- Staff told us that the Chief Executive was a good leader and was visible within the trust. It was clear that staff had a rapport with him and we only heard positive comments about his abilities. Staff said he was well respected and led by example.
- The board members engaged in monthly visits to various services. These were opportunities to talk to staff and patients and share news and information

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about the trust. The directors all had questionnaires to complete, which covered areas such as patient safety, infection control and leadership. Board members we spoke to said they enjoyed these visits which sometimes took place out of hours. They told us staff felt comfortable to share their concerns with them. A summary of the visits were produced quarterly and presented to the trust board. This allowed the board to see first-hand what staff were dealing with and whether messages they communicated were being shared and acted on.

- Middle management arrangements appeared to be overly complicated, with staff at an operational level finding this confusing. The trust was in the early stages of addressing this with the restructure. Additionally, non-nursing clinical staff could not articulate who on the board was their professional lead.
- Health professionals and staff from different divisions which provided a service to children, young people and families were unable to articulate which senior member of staff had an overall view of or responsibility for ensuring the services provided where consistent in their approach

Culture across the provider

- We found highly motivated, committed and caring staff working in this service. Staff told us that in general the trust was a good place to work and they felt supported to do their jobs well. They said there was a positive culture. Staff told us about the genuine 'open door' policy of the senior management and executives.
- Staff in the Health Visiting teams told us there is a forward thinking culture of development and good leadership progression. One member of staff told us "the service has been developed with cohesion and provides positive outcomes" and another said "we have a good supportive relationship with the board."
- Staff were aware of the Whistleblowing policy known as 'speaking out safely' – they were encouraged by management to use it and they felt confident that staff would if necessary. Staff felt that the Lead Nurse and Clinical Director would act in a prompt manner if they raised any concerns to them.

Public and staff engagement

- The trust regularly seeks to understand patient's experiences when using their services. Trust board members told us they regularly heard patient stories at board meetings. The patient experience story presented in May 2014 resulted in the production of an action plan to improve the service.
- The trust had a patient experience team who undertook innovative practice to ensure they captured patients' opinions of the service. In addition to leaflets and posters requesting feedback the trust also took adverts in the local press to get feedback from the public.
- The trust undertook feedback called the Friends and Family Test. For the period of April 2013- March 2014 the trust returned results that 97% of patients agreed they would recommend the service they have received to friends and family.
- The trust proactively took steps to engage with staff through a staff council. The staff council had representation at committee level which fed into the board, although it was felt that more representation from community nurses and health visitors would enhance it further.
- A staff survey was undertaken in 2013. 51% of staff took part in the survey and the trust scored better than the England average for 19 out of 28 measures. They were worse than average for 4 out of 28 measures.
- The trust had as one of its quality goals for 2014/15 the Friends and Family Test for staff. This will give the trust, with one measure, the staff impression of the service overall.

Innovation, improvement and sustainability

- The trust promoted learning throughout the organisation. It placed high importance on staff continual development and had identified mandatory training and appraisals as a quality goal for 2014/15.
- We noted in the board assurance framework two risks had been identified which an HR action plan was associated with around management and succession planning. The trust wanted to identify and develop its own leadership and proposed to do this by implementing a leadership development academy.
- We note in the HR action plan the trusts commitment to support innovation in teams and staff. Which would help to keep the staff engaged and ultimately improve patient outcomes.
- The trust placed great importance on innovation. During our inspection we were made aware of a number of research programmes in place. We were told about research to support patients improve their inhaler

Are services well-led?

Good

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technique. Another example was the services provided by the infant feeding Team. This included engagement with local shop keepers and cafes and developing infant feeding 'champions' from different communities, encouraging the development of support groups and one to one mentorship. This team had also developed a Breast Safe 'App' which had now been taken up by 25 other NHS trusts.

- The trust was also part way through a process to enable staff to access funds for innovation regarding patient safety.
- A model of integrated care with local community, social and primary medical services had been developed by the trust and agreed with the local commissioners to sustain services. There were plans to put this into action.
- Managers told us about plans for the minor injuries unit to become nurse led. This was in response to the difficulty in recruiting doctors for this service.