

Southport and Ormskirk Hospital NHS Trust

RVY

Community health services for adults

Quality Report

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

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

Where applicable, we have reported on each core service provided by Southport and Ormskirk Hospital NHS Trust and these are brought together to inform our overall judgement of Southport and Ormskirk Hospital NHS Trust

Summary of findings

Ratings

Overall rating for Community health services for adults

Requires Improvement



Are Community health services for adults safe?

Requires Improvement



Are Community health services for adults effective?

Requires Improvement



Are Community health services for adults caring?

Good



Are Community health services for adults responsive?

Requires Improvement



Are Community health services for adults well-led?

Requires Improvement



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
Background to the service	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	6
What people who use the provider say	6
Good practice	7
Areas for improvement	7

Detailed findings from this inspection

Findings by our five questions	8
Action we have told the provider to take	21

Summary of findings

Overall summary

Community nurse staff numbers were mainly historical, despite an increase in community nursing referrals. A need to review the equity of caseloads by the trust had been identified, although this was to be met within the existing community staffing budget. Staffing concerns regarding the size of caseloads in some district nursing teams had been raised on a number of risk registers since January 2013 and remained an identified high risk.

The provision of new therapy services within the trust had adversely affected community GP therapy provision. Patients with complex needs were supported by community matrons and specialist nursing teams including Palliative Care.

Patients told us that they felt safe using the community services provided by the trust. The trust had mechanisms in place to report and record safety incidents, concerns, near misses, allegations of abuse and to audit the quality of treatment. Staff said that they were confident to report incidents and usually received feedback on the incidents and concerns they had reported. Incident reporting within the trust was in the lowest 20% compared to other trusts; most incidents reported were low or no harm although reporting in the business unit was increasing.

Community nursing teams, therapists and staff in clinics were skilled and appropriately qualified. However there was a need that the trust ensured that staff and particularly community nurses received appropriate professional development training in areas such as prescribing. Therapy staff received regular clinical supervision although there were no similar arrangements for community nurses. Staff followed up to date nationally agreed guidelines and procedures for treating patients that were within trust policy. Patient's needs were assessed; they were involved in their care planning and provided with the equipment they needed to support their care and independence.

Patients told us that the staff were kind and caring, supporting them with their needs. They were pleased with the care and treatment provided by Southport and Ormskirk Hospital NHS Trust.

Some services were working to improve access such as running clinics in the evening, so that working age people could more easily attend. Most patients did not have to wait long once they arrived for their appointments but waiting times for first and follow up appointments varied between clinics. Patients being discharged from hospitals were usually seen by the community nursing service either on the same day or the next day. There was a need to ensure that arrangements were improved to ensure that timely prescriptions required by community nursing patients were available.

Patients who received care in their own home had information in their records about how to raise concerns, although not all patients were aware of this. There was generally a lack of information for patients in community clinics about raising concerns about the service.

Leadership arrangements required improvement and particularly by senior managers from outside the local teams. Staff spoke positively of the contribution they made to patient care. There was some engagement with staff although many staff felt community services were the 'poor relation' compared to acute services and that issues that affected the community were not seen as a priority.

There were notable examples of innovation including the Community Emergency Response Team (CERT) team and the impact it had on avoided hospital admission and shorter lengths of stay.

We spoke with approximately 53 patients, 9 carers or relatives and 55 staff across a range of roles within the trust.

Summary of findings

Background to the service

Southport and Ormskirk Hospital NHS Trust was first registered with CQC on 01 April 2011. The trust is an Integrated Care Organisation providing both acute hospital and community services commissioned by Sefton and West Lancashire Clinical Commissioning Groups (CCG's).

A range of adult community services including nursing and therapy services as well as unplanned care such as community emergency response teams (CERT) were provided within community clinics and GP practices throughout Sefton and West Lancashire by the trust. Physiotherapy, occupational therapy, speech and language therapy and diabetes care were mainly located at either Southport or Ormskirk Hospitals, from which community visits could be undertaken. The adult community nursing services were provided by nine district nursing teams of which 5 are in West Lancashire and 4 in Southport and Formby, two out of hours community nursing teams and eight community matrons. The trust provided 24 hour community nursing service for West Lancashire patients. An out of hours service was provided up to 12 midnight in Sefton by the trust,

overnight community nursing was provided by another trust on an on call basis. There was a plan that a 24 hour district nursing service would be provided to all by the trust from January 2015.

For adult community services we inspected the regulated activities of across a number of locations and teams. The trust provided adult community services to support people in staying healthy, to help them manage their long term conditions, to avoid hospital admission and following a hospital admission to support them at home. Services we inspected were provided in people's own homes, residential homes, clinics and GP practices and included;

- Community nursing including out of hours services, community matrons and treatment room services.
- The Community Emergency Response Team (CERT) .
- Physiotherapy including falls management
- Occupational Therapy
- Speech and Language Therapy
- Leg ulcer care
- Continence management
- Podiatry

Our inspection team

Our inspection team was led by:

Chair: Dr Christopher Tibbs, Medical Director and Consultant Gastroenterologist at The Royal Surrey County Hospital.

Team Leader: Tim Cooper and Alan Thorne, Head of Hospital Inspection, CQC

The team of included a CQC inspector, district Nurse and continuing healthcare nurse, Community Matron, Physiotherapist and Speech and Language Therapist and an 'expert by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme and part of the comprehensive inspection of Southport and Ormskirk Hospitals NHS Trust as it is an integrated care organisation.

Summary of findings

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?

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

- Community nursing services or integrated care teams, including district nursing, community matrons and specialist nursing services:
- A range of care is provided such as long-term condition management, case management and coordination of care for people with complex needs or multiple conditions, wound care, medicines management and acute care provided at home.
- Intermediate care in the community:
- Usually short term care involving a range of professionals providing symptom and condition management or more intensive rehabilitation

provided after people leave hospital or following an exacerbation of symptoms with the aim of helping to maintain independence, or avoiding the need for hospital admission or residential care.

- Community rehabilitation services:
- Rehabilitation and reablement following illness or injury usually involving a range of therapists nursing and medical staff

Before our inspection we reviewed a range of information we hold about the services the trust provides to adults with long term conditions in the community and asked other organisations to share what they knew.

We carried out announced visits between 12 and 14 November 2014. We visited: Southport Health and Wellbeing Clinic; Curzon Road Clinic; Poulton Road Clinic; Churchtown Clinic; Southport and Ormskirk Out of Hours service; Sandy Lane Clinic; Skelmersdale Walk in Centre; Hilldale Clinic; the Diabetes Centre at Ormskirk Hospital and therapy services provided at both Southport and Ormskirk Hospitals. We accompanied community nurse and therapists on visits to people's homes. We spoke with staff and managers as well as patients and relatives who used services, and reviewed records and observed patient care.

What people who use the provider say

We spoke with 53 patients and their carers during the inspection. All responses were very complimentary about the staff and the care and attention patients received.

Patients told us how kind and caring the staff were and how well they understood their needs. Comments we received from patients included:

"I have had outstanding community support".

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

- Care and treatment of provided to patients and their loved ones at the end of their life was compassionate, flexible and responsive.
- The Community Emergency Response Team (CERT) which prevented hospital admission and shortened admissions for other patients was an excellent initiative.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Ensure safe district nurse staffing in all teams across Sefton and West Lancashire
- Improve the reporting of incidents and the response to recognised risk.

Southport and Ormskirk Hospital NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Requires Improvement 

Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

Summary

Community nursing numbers were mainly historical, despite an increase in community nursing referrals. A need to review the equity of caseloads by the trust had been identified, although this was to be met within the existing community staffing budget. The provision of new therapy services within the trust had adversely affected community GP therapy provision. Patients with complex needs were supported by community matrons.

The trust's October 2014 monthly staffing report identified all community nursing teams with the exception of Ainsdale as having below the required 90% staffing establishment. Community and Long Term Conditions reported at 70.71%. No other ward or division within the trust had nurse staffing levels that raised similar levels of concern.

Community staff told us that their case loads were 'open ended'. Community nursing staff told us that unlike the hospitals when the ward was full and no other patients

could be admitted they had to visit all priority referred patients. Community nurses told us that this was a challenge but they had ensured that all high priority patients were visited.

Staff felt able to report incidents and raise concerns in a 'no blame' culture. However some staff said that they had not always reported 'near misses'. This meant that the opportunity to learn from near misses and prevent risk was lessened. Where incidents had been reported, there had been an investigation, practice changed and information disseminated to staff. Community nursing teams safety information was available but there was a need for all staff to be aware of this information. Staff adhered to infection control principles and equipment used was well maintained and decontaminated between patient use. We saw that medicines were stored and administered safely to patients.

Record keeping was found to be good and provided assurance that patients received the care and treatment

they wanted and needed. Caseloads numbers were high for some nursing and therapy services. The trust's October 2014 monthly staffing report identified all community nursing teams with the exception of Ainsdale as having below the required 90% staffing establishment. No other ward or division within the trust have nurse staffing levels that raised similar levels of concern. The lack of a formal system to assess community nursing numbers gave no assurance that safe and appropriate staffing levels were in place. Staff identified and responded to patient risk in an appropriate way, which ensured the safety of patients using the service.

There was a lone worker policy in place. The trust had historical arrangements for lone workers to carry a device to identify their location and if needed summon emergency assistance. We were told that these devices were not fit for purpose and were no longer being used. The potential risk to lone workers had being identified on the community's risk register. New devices were being introduced from January 2015. There was a plan that these devices would eventually be used by all community lone workers.

Incidents, reporting and learning and improvement

- Incident reporting within the trust is in the lowest 20% compared to other trusts; most incidents reported are low or no harm although reporting in the business unit was increasing.
- There were three serious incidents that required investigation reported since October 2013 to 31 October 2014. The serious incidents related to two grade 3 pressure ulcers which developed whilst under the care of community staff and one information breach.
- Incidents were reported using the electronic Datix system. We saw that when an incident occurred, a full analysis of the issues was recorded and actions planned to prevent similar incidents. We also saw that there was an identified telephone number could be used in addition to the electronic system to report any serious/urgent issues to enable immediate actions to be undertaken to keep people safe.
- Staff were confident about how to report incidents and they told us there was an open, 'no blame' culture when reporting incidents. Staff told us that they usually received feedback about the incidents they reported and gave us examples about how practice had been improved when incidents had previously been reported.

- Staff said that incidents and learning from these incidents was discussed at team meetings and during staff handovers and staff were encouraged to engage with the process.
- Staff in one district nursing team told us that they may not report 'near misses' but would rather contact the ward or staff directly to discuss any shortfalls in care or treatment. This meant that lessons learnt may not be shared more widely within the trust.
- Information regarding incidents was fed through to a representative of the appropriate governance team and serious reportable incidents were also reported at trust board meetings.
- Community nursing team managers had received monthly safety information in the form of 'dashboards' since September 2014. The dashboards showed how the team were doing against identified safety targets such as pressure ulcers, falls and numbers of infection. The information also included compliance with staff training, staff sickness and vacancy rates. Some but not all of the community nursing staff we spoke with were aware of this information.

Safeguarding

- Safeguarding adults and children level one training was mandatory for all trust staff. Staff we spoke with in a range of roles confirmed they were up to date with their required safeguarding training or had updates planned.
- At Hilldale clinic there was a safeguarding flow chart that provided a helpful reminder to staff about actions they needed to undertake if they had safeguarding concerns.
- All of the staff that we spoke with were aware of their responsibility to report any safeguarding concerns that they had.
- 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.

Medicines management

- When we accompanied community nurses on visits to patient's homes we found that medicines were administered safely and appropriately. We also noted that community nurses completed a record of each medicine they administered.
- We saw that controlled medications were safely and appropriately administered and when disposal was required this was witnessed by two staff.

- Community nursing staff raised concerns about delays waiting for medicines and dressings to be prescribed. One patient's relative told us that there had been a delay on several occasions due to the limited number of nurse prescribers, whilst essential dressings were not available. The head of community nursing told us that prescriptions could be repeated up to 12 times and this would be clarified with community team leaders.

Safety of equipment

- Patients were seen in a wide variety of locations throughout the trust ranging from health centres, GP surgeries, residential homes and in their own homes. Equipment we looked at such as resuscitation equipment had received required checks on its safety. There were no concerns raised about the maintenance of equipment.
- Faulty equipment could be reported by any of the trust's staff. Staff told us that they would use the Datix system to report any health and safety issues including near misses and potential hazards.

Records and management

- Patient records were paper based at the time of our inspection although computerised records were being introduced from January 2015 for some community staff. Community staff identified their frustration that they were unable to access or utilise the hospitals computer system for example for appointments.
- Community nursing records were kept in patients' homes, although a computerised summary of care provided during the visit was completed when nurses returned to their base. We reviewed 12 sets of patient records and found them to contain the necessary information to allow staff to carry out clinical treatment, such as care plans and risk assessments. Each visit was recorded and contained sufficient information to ensure continuity of care.

Cleanliness, infection control and hygiene

- Staff followed the trusts infection control policy. Staff were 'bare below the elbow', used hand gel between patients and used personal protect equipment (PPE).
- We saw that hand gel was available in clinics and the gym; decontamination systems were in place for equipment; hoists were cleaned and labelled as such and there was a cleaning schedule in clinic areas.

- Where patient care was provided to people in their own homes, staff took decontaminating equipment with them, such as alcohol gel and wipes.
- Patients we spoke with told us that staff always washed their hands before treating them.

Mandatory training

- The trust's target for compliance with mandatory training was 90%. We saw that overall this target was mostly met by community staff.
- Staff training and attendance was monitored by team managers and senior managers. Team managers told us about their frustration that the mandatory training figures provided by the trust were inaccurate. Team managers told us that they had returned the correct information, confirming that identified staff had attended the training but training information remained inaccurate. The trust was aware of this and had included the inaccuracy of training statistics on their risk register with actions to ensure the accuracy of information.
- Staff confirmed that they received annual mandatory training in areas such as infection control, moving and handling, fire safety and basic life resuscitation although this had been difficult due to staffing challenges in some teams.

Assessing and responding to patient risk

- Staff told us that they had a list of high priority patients who needed a daily visit for essential treatment such as insulin injections, pain relief or end of life care. Team managers told us that they checked that priority patients had received a visit daily, or a visit was planned.
- Community staff were able to book patient visits in advance onto their computer system. Any 'missed' visits were highlighted to the team manager. The team manager then checked if the visit had been undertaken or had been rearranged. This meant that there was an appropriate system in place to ensure that patients received the community nursing visits they needed.

Staffing levels and caseload

- The trust had 9 community nursing teams, two out of hours teams and eight community matrons in post.
- Community Matrons did not manage other staff but held a case load of patients at high risk with multiple, complex and deteriorating conditions.

- Community nurses told us that their rosters were planned with the skill mix and experience of each staff member in mind to meet patient's needs.
- The trust's October 2014 monthly staffing report identified all community nursing teams with the exception of Ainsdale as having below the required 90% staffing establishment. Community and Long Term Conditions reported at 70.71%. No other ward or division within the trust have nurse staffing levels that raised similar levels of concern.
- Community staff told us that their case loads were 'open ended'. Community nursing staff told us that unlike the hospitals when the ward was full and no other patients could be admitted they had to visit all priority referred patients. Community nurses told us that this was a challenge but they had ensured that all high priority patients were visited.
- Community nursing staff recognised that some teams were busier than others. We were told that the busiest teams were the Hants Lane and Churchtown community nursing teams. Several community nurses in Churchtown told us that they had raised concerns about caseloads and staffing numbers with senior managers within the trust but felt it had not been addressed.
- Information provided by the trust identified that the number of patients who had received community nursing care had increased each month from 24,365 in September 2013 to 32,476 in July 2014. The trust had increased the funding for community nurses in April 2014 however the numbers of community nursing referrals continued to be higher than planned. There was a risk that there would be insufficient community nursing services to safely provide the services that patients needed.
- We were told by the head of community nursing that the numbers of community nursing staff in each team was mainly historical. The head of community nursing told us that they were looking at evidence based tools to support setting community staffing levels; this would ensure that caseloads were equitable and patient's needs could be safely met. The trust had identified that whilst the review of neighbourhood staffing was underway revised staffing levels would be considered based on the current community nursing budget. This meant that the trust was not considering an increase in the number of community nurses.
- Community staff told us there had been some long term sickness, maternity leave and staff vacancies. Staff told us that they were able to use bank and long term agency staff to fill the gaps.
- Therapy staff told us that there was a delay in recruiting new staff and this put additional pressure on existing staff.

Managing anticipated risks

- We saw 90% of community and therapy staff were compliant with mandatory basic life support training.
- There was a community and continuing care risk register which identified risks from extreme risk, high Risk , moderate risk to low risk. There were a total of 55 identified risks on the risk register of which eight were extreme risk. All risks were reviewed monthly. District nurse staffing within Church town was identified as an extreme risk on the risk register. Actions identified to reduce the risk included a review of case load and patient visit plans, prioritisation of the work load and caseload management to be reviewed and compared to other teams with an expected date for completion 31 March 2015.
- The provision of the overnight district nursing service for North Sefton which was provided by Liverpool district nurses was identified as an extreme risk and action was being undertaken by the trust to transfer this service to Southport and Ormskirk Hospital NHS Trust.

Major incident awareness and training

- Staff were aware of the trust major incident policy and senior staff were aware of their responsibilities in the event of a major incident being declared.
- Community nurses had identified high priority patients that required essential daily treatment should adverse weather or a local catastrophe occur and this list was checked daily to ensure its accuracy.

Lone and remote working

- There was a lone worker policy in place. The trust had historical arrangements for lone workers to carry a device to identify their location and if needed summon emergency assistance. We were told that these devices were not fit for purpose and were no longer being used. The potential risk to lone workers had being identified

on the community's risk register. New devices were being introduced from January 2015. There was a plan that these devices would eventually be used by all community lone workers.

- Staff we spoke with also ensured that they visited in pairs during in darkness and if any risks were identified.

Are Community health services for adults effective?

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

Summary

Care and treatment was evidence based and staff followed current best practice recommendations. The community emergency response team were seen to be excellent examples of good practice for crisis support at home, reducing the number of hospital admissions and reducing a patient's length of stay in hospital. We saw the measuring of patient outcomes for quality of care was undertaken across adult community teams and therapies.

Staff were competent to carry out their role. There was limited access to developmental training for community nurses.

There were positive examples of multidisciplinary working across internal services and between local healthcare organisations.

However, staff told us that ward staff were unable to make appointments for patients to attend treatment room clinics for procedures such as wound dressings or removal of stitches. Patients were asked to telephone the clinics themselves. Staff told us that sometimes this lead to confusion by the patient about how or when they needed to make the appointment and a delay in their treatment.

Community staff told us about their frustrations and limitations of the current IT system. There was a need to duplicate both paper and computer records and an inability for the current system to link with the hospital computer system. There were arrangements in place to introduce a new and improved IT system from January 2015.

Evidence based care and treatment

- The trust had a range of policies and clinical guidelines available for staff. These were held on the trust's intranet and were readily accessible for staff in the community. We saw that when policies and procedures changed staff were asked by team managers to sign to confirm they had read the policy.
- We observed protocols and procedures in use, for example use of compression bandaging and stroke rehabilitation to recognised standards.

- NICE (National Institute for Health and Care Excellence) Guidelines were available in clinics and copies of guidelines in patient records such as patients requiring pressure ulcer and leg ulcer management. We saw that NICE guidelines for the prevention of falls were also followed.
- We observed that physiotherapists followed recognised and up to date assessment which included tools to check for the patient's strength, balance, pain and range of movements.
- Team managers told us that they conducted a monthly audit of 10 patient records to check the completion of records and the records of care and treatment provided. When required staff were informed that records were incomplete and appropriate changes were made.
- National audit information was collected to provide a comparison with the performance of other trusts regionally and nationally, for example in the intermediate care audit. The intermediate care audit demonstrated that the trust was performing better than similar organisations.
- Community matrons saw their role as crucial in promoting people's health and preventing hospital admissions.

Pain relief

- We saw district nurses asked patients if they were in pain and advised patients to follow their pain management care plan.
- Community nurses told us that they liaised closely with palliative specialist nurses to ensure that palliative care patients received appropriate pain relief.
- We observed in staff checking for feedback from patients related to pain and comfort levels during procedures and treatments including removal of dressings in leg ulcer clinics.
- Patients who attended a pain management clinic spoke positively about the impact it had on their life. One patient told us, "If I had been able to access this service 6 years ago, I might have been able to retain my job".

Are Community health services for adults effective?

Nutrition and hydration

- An assessment was made of patients risks of poor nutrition. We saw staff completing home visits ask patients about their eating and drinking, and encourage good nutrition.
- Dietetic advice was sought when required.

Use of technology and telemedicine

- Most therapy staff told us they had easy access to IT facilities for their work.
- Community staff told us about their frustrations and limitations of the current IT system. There was a need to duplicate both paper and computer records and an inability for the current system to link with the hospital computer system. There were arrangements in place to introduce a new and improved IT system from January 2015.
- Some clinic staff were unable to utilise clinic appointments with the use of the current IT system and were having to book manual appointment on a paper based system.

Approach to monitoring quality and people's outcomes

- The CERT team provided multidisciplinary working to provide treatment and care either within the patient's own home or short term residential care. More than 50% of patients had returned to their own homes, less than 5% had been admitted to a nursing or residential home, 17% had been admitted to hospital the remainder had mostly remained on the caseload.
- The CERT had reduced the number of avoidable hospital admissions and reduced the length of stay for other patients. 389 patients would have gone to hospital and may have required a hospital admission without the involvement of the CERT team.
- End of life audit had demonstrated care improvements that had been made since the previous audit, such as patients experiencing their preferred place of death, improved multidisciplinary working and improved involvement of the patients and their loved ones in choices about their care and treatment.

- There were identified outcome measures for patients identified in physiotherapy/ occupational therapy and speech and language therapy such as assessments of balance and mobility, this enabled a measure to show the effectiveness of the treatment provided.

Competent staff

- The trust had introduced mandatory professional standards for all staff. The professional standards were available on the trust's intranet and were displayed in the education centre. However knowledge of these standards was inconsistent and some community staff felt they were not all appropriate to community working.
- At the end of March 2014 92% of staff had received an annual appraisal. All the community staff we spoke with told us that they received an annual appraisal for 2013/ 14.
- Therapy staff said that they were appropriately supported to undertake further training and development.
- Community nursing staff said that any training must first be identified as part of their development within their annual appraisal. Community nurses told us they were only able to undertake one course annually. Staff received the appropriate training identified through the PDR process however should external training be necessary the trust had tried to limit this due to cost implications to one course or module per staff member. The head of community nursing told us that if there was a requirement within the team to meet patients' needs further developmental training was made available.
- The head of community nursing told us that the trust would support one community nurse to undertake the Community Specialist Practitioner qualification annually. We were told that there had been no suitable candidates for this course previously.
- Community nurses told us that the small number of nurse prescribers was a problem and sometimes this resulted in a delay of medicines and dressings being prescribed.
- Team managers told us that staff competencies were reviewed as part of their annual appraisal and informally when they accompanied staff on joint visits.
- There were no formal arrangements for clinical supervision for community nurses. Team managers told us that they used their daily handovers to review patients and their treatment as an informal clinical supervision arrangement.

Are Community health services for adults effective?

- Therapists told us that they had clinical supervision to review and validate their practice.

Multi-disciplinary working and coordination of care pathways

- We saw good examples of multi-disciplinary working in the community nursing teams, for example, we saw close work with community nursing and the specialist palliative care team. The CERT team reported good communication with other community workers and GPs to ensure patients had continuity of treatment.
- Community nursing staff reported that there was good communication with the out of hours service to ensure continuity of community nursing care.
- Community matrons did not manage other staff but held a case load of patients at high risk with multiple, complex and deteriorating conditions. They could prescribe medication which took some pressure from GP's and they saw their role as preventing people being admitted to hospital.
- Community nurses told us that since community matron were no longer located within community team bases they missed the opportunity for daily contact with the community matrons. Community nurses said they felt that communication with community matrons was not as effective as previously.
- Therapists told us that communication was good within their team and generally good with other health professionals. Therapists had systems in place to ensure a seamless transition of care between hospital and home when further rehabilitation was required.

Referral, transfer, discharge and transition

- Patients could self-refer by telephoning community nurses bases or for treatment by contacting local clinics for a treatment room appointment. Referrals could also be made to community nurses by GPs or other health professionals.
- Staff told us that ward staff were unable to make appointments for patients to attend treatment room clinics for procedures such as wound dressings or removal of stitches. Patients were asked to telephone the clinics themselves. Staff told us that sometimes this lead to confusion by the patient about how or when they needed to make the appointment and a delay in their treatment.

- GPs or other health professionals could make referrals to the CERT and Rapid response teams. We were also told that a member of the CERT visited accident and emergency and wards at both Southport and Ormskirk General Hospitals to check if there were any patients who were suitable to receive their service to either avoid hospital admission or shorten their hospital stay.
- There was a single point of access to therapy services and CERT. All referrals were triaged, referrals assessed as urgent were seen within 48 hours, requiring a walking aid were seen between 10 and 14 days and all other referrals within six weeks. Letters were sent to patients to confirm receipt of the referral and their appointment.

Availability of information

- We observed staff provided patients with information about their condition or treatment. For example physiotherapists provided information leaflets about exercise regimes and community nurses provided patients information about flu vaccination for vulnerable people.
- In the health centres we visited there was a variety of patient information, such information about healthy lifestyle and access to health services. This information was available on notice boards and on leaflet racks.

Consent

- We observed patients being asked for verbal consent prior to procedures being carried out. We observed a community nurse provide information about the importance of a flu vaccination, checking the patients had no previous problems when they had a flu vaccination and possible side effects. The patients were then asked to sign to confirm that they had received information and they agreed to receive the flu vaccination.
- Community nurses were aware of their responsibilities around the mental capacity act and actions they needed to undertake if patients did not have capacity to make decisions.

Are Community health services for adults caring?

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

Summary

All patients and carers spoke positively about the care provided.

Patients received compassionate care and we witnessed positive interactions between patients and staff.

Staff discussed planned care and treatment with patients and provided information to reinforce understanding. Staff promoted self-care to encourage patients to maintain their independence.

Staff provided emotional support for patients and their carers and families.

Dignity, respect and compassionate care

- All patients and carers we spoke with told us that they were extremely happy with the care they received. One patient receiving district nurse care commented: “I have excellent care”; and another: “They (nurses) are very kind”.
- We witnessed clear rapport between staff, patients and carers.
- Patients were treated with compassion, dignity and respect.
- We saw that patients were asked for their consent to treatment and were spoken with in a respectful way.
- We observed staff asking to use hand washing facilities when treating patients in their own homes and asking for permission before they took a seat.

Patient understanding and involvement

- We saw staff discuss planned care and treatment with patients patiently and provide information to reinforce their understanding.
- The NHS Benchmarking Network intermediate care survey identified that the trust compared better than most trusts patient involvement and information about their treatment.

Emotional support

- All staff we spoke with told us that part of their job was to provide emotional support not just to patients but also their carers and families. During home visits staff demonstrated knowledge of people and their unique situations and provided tailored emotional support.
- All patients were given phone numbers of staff so that they could get support as and when required. All patients that we spoke with told us that they knew how to contact services if needed.

Promotion of self-care

- We saw therapy staff provided equipment to enable people to maintain their independence. We witnessed physiotherapists in a falls clinic discuss with patients ways to encourage and maintain their independence.
- Patients who attended the pain management clinic told us about the invaluable support staff had given them to manage their pain more effectively.

Are Community health services for adults responsive to people's needs?

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

Summary

Across the service when possible, people were treated in their own homes or community clinics. Many services had practices in place to prevent unnecessary hospital admissions; a good example of this was the diabetes care team. The CERT was an open access integrated care service that managed adults with long term conditions to avoid unnecessary hospital admissions, reduce the length of hospital stay, maintain health and wellbeing, and improve independence. Between 2013- 2014 88% of patients referred to the CERT avoided admission to hospital, we found multiple examples of how this was achieved.

The majority of patients were seen within required timescales.

Planning and delivering services which meet people's needs

- The CERT provided care and treatment to patients who had long term conditions irrespective of their diagnosis, location or age. The team included a range of health care professionals that aimed to avoid unnecessary hospital admissions, maintain health and wellbeing, and improve independence. When possible, people were treated in their own homes or community clinics rather than in the hospital setting for interventions such as, the administration of intravenous medicines or therapy services. The service was open 8am to 8pm, seven days a week.
- A diabetes nurse told us that they met with local GPs to provide diabetes education to prevent avoidable hospital admissions.
- We were told that staff had access to translation services if required.

Equality and diversity

- We were told that individual cultures, beliefs and values were considered when planning and delivering care.
- Southport & Ormskirk Hospital NHS Trust had a set of equality information that demonstrated their commitment to promoting equality. All staff, patients

and their carers could expect to be treated with dignity and respect and they advertised that they would not tolerate any form of harassment, discrimination or victimisation.

Meeting the needs of people in vulnerable services

- Community nurses told us that they would contact and when needed visit patients who had been referred to for palliative care either the same or following day.
- GPs or other health professionals could make referrals to the Rapid Response teams for an urgent visit to vulnerable patients in the community. A visit was usually undertaken within two hours. Community nurses told us that visits had been arranged to provide urgent equipment or domiciliary care visits when patients condition had deteriorated frequently preventing hospital admission.

Access to the right care at the right time

- Information provided by the trust showed that urgent nursing referrals were seen within 4 hours and therapies urgent referrals within 24/48hours. Community nurses told us that they would see any urgent referral for example end of life care on the same day.
- Step up care was arranged when a need for additional care on a short term basis was required and had shown to frequently prevent hospital admissions. Between 2013 and 2014 there were 452 referred to the CERT for "step up" care and 88% of patients avoided a hospital admission. One example of this was a patient who had fallen and needed additional aids. Staff told us that some patients were able either stay at home with additional support or go into a residential home on a short term basis, where they received the support they needed to keep them safe.
- We saw that for 2013-2014 56% of patients referred to the CERT had returned to their previous accommodation. This was an example of a service responding to provide the right care at the right time to ensure patients could be treated in the community and avoiding a hospital admission.

Are Community health services for adults responsive to people's needs?

- Data for the number of patients who did not attend (DNA) their booked appointments for allied health professional (AHP) clinics showed that rates averaged at 8.5%, for 2013 to 2014, although this has improved for 2014 and was averaged at 7.5%.
- Patients referred for treatment from the therapy team were able to choose their preferred location. We were told although an appointment could be available within one week but some patients preferred to wait for an appointment nearer to their home.

Complaints handling (for this service) and learning from feedback

- Staff we spoke with were aware of the complaints procedure and told us that they tried to resolve complaints locally as they arose.
- District nursing notes held in the patient's homes had information about how to complain. However, not all patients knew this information was there.
- We saw evidence that both complaints and compliments were shared at team meetings.

Are Community health services for adults well-led?

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

Summary

Leadership arrangements required improvement and particularly by senior managers from outside the local teams. We noted that all teams had a team manager with team leaders however team working was not in place. Although team meetings occurred some district nurses did not feel engaged with these meetings. Staff did not feel they had feedback re actions being taken to improve staffing arrangements especially in Churchtown.

We visited one team (Ainsdale) that fully used the team working model and they felt this led to greater continuity of patient care. Delays in recruitment of nursing and therapy staff.

Staff told us that they were happy to come to work and spoke positively of the contribution they made to patient care.

Services engaged with patients to gain feedback and improve services. There was some engagement with staff although many staff felt community services were the 'poor relation' compared to acute services and that issues that affected the community were not seen as a priority. The sustainable provision of safe and appropriate community nursing was questionable within the current provision.

There were notable examples of innovation including the CERT and the impact it had on avoided hospital admission and shorter lengths of stay.

Service vision and strategy

- Staff we spoke with were familiar with the trusts vision and the word SCOPE. The trust expected staff to articulate the values and beliefs of the organisation resulting in the adoption of a number of behaviour statements including supportive, caring, open and honest, professional and efficient.
- The development and increase of CERT since March 2014 had demonstrated the importance of community services and the positive impact they had on acute hospital services.

- The trust had imminent plans to introduce a twenty-four hour community nursing services within both Sefton and West Lancashire.
- There was an increasing demand and referral to community nursing services. There was a strategy in place but staff were unaware of it.
- The development of the new physiotherapy service had been positive. However the strategy to move staff from other teams without adequate staff replacement not been effective and had an adverse effect on other services.

Governance, risk management and quality measurement

- A system of audits was in place, the safety thermometer was completed monthly and services were risk rated. Lead staff were made aware of where improvements were required although this had not been fully cascaded to all staff.
- Incidents were generally well managed at a local level and all staff knew about how that was done. Incident reporting was better embedded in some clinic's practice than others.
- The case load pressure on community nursing teams in some parts of the trust, together with the duplicated recording systems and competing access to IT could generate risk of 'low level' incidents going unreported and trends being missed.

Leadership of this service

- Staff spoke with had an obvious respect for their locality and team managers. Staff we spoke with said team leaders were approachable and supportive. The majority of staff told us that locality managers were visible and they felt able to approach them.
- We saw that leadership arrangements in some team were more effective. We noted that all teams had a team manager with team leaders however team working was not in place. Although team meetings occurred some

Are Community health services for adults well-led?

district nurses did not feel engaged with these meetings. We visited one team (Ainsdale) that fully used the team working model and they felt this led to greater continuity of patient care.

- While staff spoke highly of local community leadership, many told us that they felt they were still an ‘add on’ to the acute hospitals and rarely saw the senior management. Many staff told us that they felt they were the “poor relation” and their contribution was not recognised by the trust.
- Therapy staff told us that there was a delay in the recruitment of new staff this put pressure on staff caseloads. In addition to compensate for vacancies in the team leaders had to take a full caseload and said that they did not have time to focus on other team leader duties.
- Staff told us that the recruitment of new staff took a long time to complete. Team leaders identified that there was an unacceptable delay advertising vacant posts. Staff felt this put pressure on substantive staff to cover vacant posts and this increased waiting times, for examples in the Musculoskeletal team (MSK).

Culture within this service

- The culture within the service was positive and confident. Staff told us it was an open culture and that they were encouraged to report concerns or incidents on the basis of ‘no blame’.
- Community nursing staff told us they were particularly proud of the care they provided to patients and their families at the end of their life.
- Staff told us that communication within community services was good, but generally were less sure of communication between community services and the rest of the trust.

- All staff we spoke with were positive of the contribution they made to patient care and were very positive of the teams they worked in.
- All staff we spoke with told us that most community services were friendly and that they were happy to come to work.

Public and staff engagement

- The trust had a range of patient engagement initiatives which included ‘In Your Shoes’. Public and patient involvement group and general walkabouts by senior managers.
- There was an annual patient experience questionnaire for community based services, including district nursing.
- Patients who received care and treatment from the stroke teams and CERT completed a questionnaire on their views on the service provided. These surveys were discussed in team meetings and used to improve the service provided.

Innovation, improvement and sustainability

- The CERT manager had been awarded the trust manager of the year for 2013/14.
- Speech and language therapy used technology to support communication therapy.
- The CERT contributed to the National Audit of Intermediate Care 2013 and planned to continue this in 2014/15. The audit provides an overview of intermediate care and provision in England.
- The sustainable provision of safe and appropriate community nursing was questionable within the current provision.

Compliance actions

Action we have told the provider to take

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

Regulated activity

Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing
The trust's October 2014 monthly staffing report identified all community nursing teams with the exception of Ainsdale as having below the required 90% staffing establishment. No other ward or division within the trust had nurse staffing levels that raised similar levels of concern. Caseloads were also seen to be high for some staff.

Regulated activity

Diagnostic and screening procedures
Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities)
Regulations 2010 Assessing and monitoring the quality of service providers
Service users were not always protected against the risk of unsafe or inappropriate care and treatment due to lack of management of risk relating to health, welfare and safety of service users. Regulation 10 (1) (b)